

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 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.	Date: 08/21/2015 Time: 10:43
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without audit (3) Settled with audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No.: _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN
		10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARDIN COUNTY GENERAL HOSPITAL (14-1328) ((Provider Name(s) and Number(s)) for the cost reporting period beginning 04/01/2014 and ending 03/31/2015, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

ECR Encryption: 08/21/2015 10:43
fMGXIPfyKtAGivVafHwWyuBlsmWre0
6CoAy0xxVBzS5YxYxRSNsGb0dsx9P4
IPCX02iiA10FE8jr

(Signed) _____

Officer or Administrator of Provider(s)

Title

Date

PI Encryption: 08/21/2015 10:43
49s8IPsOO8xXtMwM3IPbKx80fa0iO0
P0:e40qmlwrGX2oIRjhZaxGBtGLLz:
LHbE0d7Vqk0seteH

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		37,813	-62,096	225,610	239,824	1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-31,176				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			36,497			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		6,637	-25,599	225,610	239,824	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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

Component	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
						V	XVIII	XIX		
0		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 OLTG									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: 04/01/2014	To: 03/31/2015								20
21	Type of control (see instructions)	2									21

Inpatient PPS Information

		1	2	3	
22	Does this facility qualify for and receive disproportionate share hospital payments in accordance with 42 CFR §412.106? In column 1, enter 'Y' for yes or 'N' for no. Is this facility subject to 42 CFR §412.06(c)(2)(Pickle amendment hospital)? In column 2, enter 'Y' for yes or 'N' for no.	N	N		22
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	N		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, 'Y' for yes or 'N' for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, 'Y' for yes or 'N' for no for the portion of the cost reporting period prior to October 1. Enter in column 2, 'Y' for yes or 'N' for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, 'Y' for yes or 'N' for no.	N	N	N	22.03
23	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter 'Y' for yes or 'N' for no.	3	N		23

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

26	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter '1' for urban and '2' for rural.	2					26
27	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, '1' for urban or '2' for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2					27
35	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.						35
36	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			36
37	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.						37
38	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:			38

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N		39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N		40
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	N	45
46	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	N	48

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

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
64	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in 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 Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ col. 1 + col. 2))	
66	Enter in column 1, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)				66
Enter in lines 67-67.49, column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)					
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ col. 3 + col. 4))
	1	2	3	4	5
67					67
Inpatient Psychiatric Facility PPS					
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.	1 N	2	3	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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				71
Inpatient Rehabilitation Facility PPS					
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.	1 N	2	3	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 fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program, enter 6 in column 3. (see instructions)				76
Long Term Care Hospital PPS					
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.		N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.		N		81
TEFRA Providers					
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA? Enter 'Y' for yes or 'N' for no.		N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.				86

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XIX	
Title V and XIX Services		1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/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? (see instructions)	N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elimination would not be on Wkst. B, Pt. I, col. 25 and the program would be cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(g). 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	109
110	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter 'Y' for yes or 'N' for no.		N	110

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, Section 2208.1.	N		115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N		116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N		117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118
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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

All Providers

140	Are there any related organization or home office costs as defined in CMS Pub 15-1, Chapter 10? Enter 'Y' for yes, or 'N' for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number (see instructions)	1	2	140
		N		

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 the 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	3	4	
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	236,675				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)		04/01/2014	03/31/2015		170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no. (see instructions)			N		171

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

Provider Organization and Operation		Y/N	Date		
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)	1	2		1
		N			
		Y/N	Date	V/I	
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.	1	2	3	2
		N			
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

Financial Data and Reports		Y/N	Type	Date	
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.	1	2	3	4
		Y	A		
5	Are the cost report total expenses and total revenues different from those in the filed financial statements? If yes, submit reconciliation.	N			5

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

Bad Debts		Y/N	
12	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	1	2
		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
		N	
14	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14

Bed Complement		Y/N	
15	Did total beds available change from the prior cost reporting period? If yes, see instructions.	1	2
		N	15

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data		1	2	3	4
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	07/15/2015	Y	07/15/2015
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	

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

General Instruction: Enter Y for all YES responses. Enter N for all NO responses.
Enter all dates in the mm/dd/yyyy format.

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

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

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

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

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

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

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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			Total All Patients	
						Title V	Title XVIII	Title XIX		
		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	35,472.00		1,009	241	1,478	1
2	HMO and other (see instructions)						83			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						909		909	5
6	Hospital Adults & Peds. Swing Bed NF								216	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	35,472.00		1,918	241	2,603	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	35,472.00		1,918	241	2,603	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					4,578		13,387	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							125	314	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

WORKSHEET S-3
PART I

	Component	Full Time Equivalents			DISCHARGES				
		Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		9	10	11	12	13	14	15	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)					287	74	445	1
2	HMO and other (see instructions)					29			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)		110.39			287	74	445	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		18.56						26
27	Total (sum of lines 14-26)		128.95						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

WORKSHEET S-7

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

SNF SERVICES

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

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each 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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

COMPONENT CCN: 14-3479

WORKSHEET S-8

Check applicable box: RHC FQHC

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	1	2	
4	Community Health Center (Section 330(d), PHS Act)					4
5	Migrant Health Center (Section 329(d), PHS Act)					5
6	Health Services for the Homeless (Section 340(d), PHS 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 N	2 	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 N	2 	12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	1 N	2 	13
14	Provider name: _____ CCN number: _____			14

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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)		0.588691	1
---	--	--	----------	---

Medicaid (see instructions for each line)

2	Net revenue from Medicaid		2,001,317	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		4,448,619	6
7	Medicaid cost (line 1 times line 6)		2,618,862	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.		617,545	8

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

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

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

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

Uncompensated care (see instructions for each line)

17	Private grants, donations, or endowment income restricted to fundng 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)		617,545		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	653,669	43,975	697,644	20
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	384,809	25,888	410,697	21
22	Partial payment by patients approved for charity care				22
23	Cost of charity care (line 21 minus line 22)	384,809	25,888	410,697	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)			554,658	26
27	Medicare bad debts for the entire hospital complex (see instructions)			188,927	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			365,731	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			215,303	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)			626,000	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			1,243,545	31

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		67,616	67,616	17,085	84,701		84,701	1
2	00200	Cap Rel Costs-Mvble Equip		342,797	342,797	4,871	347,668	-99,511	248,157	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department				63,373	63,373		63,373	4
5	00500	Administrative & General	715,426	1,440,390	2,155,816	-55,536	2,100,280	-271,762	1,828,518	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	167,026	194,008	361,034	-2,814	358,220		358,220	7
8	00800	Laundry & Linen Service	34,896	18,643	53,539		53,539		53,539	8
9	00900	Housekeeping	78,244	44,347	122,591		122,591		122,591	9
10	01000	Dietary	88,122	107,441	195,563	-67,316	128,247		128,247	10
11	01100	Cafeteria				66,385	66,385	-4,463	61,922	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration				83,801	83,801		83,801	13
14	01400	Central Services & Supply	30,584	6,598	37,182	-28,225	8,957		8,957	14
15	01500	Pharmacy	67,171	184,607	251,778	-57,197	194,581		194,581	15
16	01600	Medical Records & Library	205,632	57,631	263,263		263,263	-3,146	260,117	16
17	01700	Social Service	16,480	2,866	19,346		19,346		19,346	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,177,037	386,299	1,563,336	-240,048	1,323,288	-113,291	1,209,997	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic	355,985	317,998	673,983	-2,330	671,653		671,653	54
60	06000	Laboratory	368,729	683,029	1,051,758	402	1,052,160	-109,868	942,292	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	121,722	75,411	197,133	-37,463	159,670		159,670	65
66	06600	Physical Therapy	89,844	96,573	186,417	-22	186,395		186,395	66
67	06700	Occupational Therapy								67
68	06800	Speech Pathology								68
69	06900	Electrocardiology	9,069	857	9,926	23,882	33,808		33,808	69
71	07100	Medical Supplies Charged to Patients				120,590	120,590		120,590	71
73	07300	Drugs Charged to Patients				290,083	290,083		290,083	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	1,072,985	263,712	1,336,697	6,444	1,343,141		1,343,141	88
90	09000	Clinic	87,443	89,181	176,624	10,935	187,559		187,559	90
91	09100	Emergency	974,193	224,483	1,198,676	-145,888	1,052,788	-341,689	711,099	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		99,312	99,312	-51,012	48,300	-48,300		113
118		SUBTOTALS (sum of lines 1-117)	5,660,588	4,703,799	10,364,387		10,364,387	-992,030	9,372,357	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
190.01	19001	VENDING MACHINE								190.01
200		TOTAL (sum of lines 118-199)	5,660,588	4,703,799	10,364,387		10,364,387	-992,030	9,372,357	200

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	TO RECLASS SUPPLY COST FROM CS	A	Medical Supplies Charged to P	71	22,938	5,287	1
500	Total reclassifications				22,938	5,287	500
	Code Letter - A						
1	TO RECLASS DON COST	B	Nursing Administration	13	72,242	11,559	1
500	Total reclassifications				72,242	11,559	500
	Code Letter - B						
1	TO RECLASS CLINIC COST	C	Clinic	90	1,259	429	1
500	Total reclassifications				1,259	429	500
	Code Letter - C						
1	TO RECLASS SUPPLY COST	D	Medical Supplies Charged to P	71		92,365	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications					92,365	500
	Code Letter - D						
1	TO RECLASS INSURANCE EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		4,477	1
2			Cap Rel Costs-Mvble Equip	2		7,623	2
3			Employee Benefits Department	4		63,373	3
500	Total reclassifications					75,473	500
	Code Letter - E						
1	TO RECLASS INTEREST	F	Cap Rel Costs-Bldg & Fixt	1		22,994	1
2			Administrative & General	5		19,937	2
3			Radiology-Diagnostic	54		5,812	3
4			Adults & Pediatrics	30		18	4
5			Rural Health Clinic	88		1,427	5
6			Laboratory	60		824	6
500	Total reclassifications					51,012	500
	Code Letter - F						
1	TO RECLASS CAFE COST	G	Cafeteria	11	29,962	36,423	1
500	Total reclassifications				29,962	36,423	500
	Code Letter - G						
1	TO RECLASS CARDIAC MONITORING COST	H	Electrocardiology	69	20,112	3,770	1
2							2
500	Total reclassifications				20,112	3,770	500
	Code Letter - H						
1	TO RECLASS DRUG COST	I	Drugs Charged to Patients	73		290,083	1
2							2
3							3
4							4
5							5
500	Total reclassifications					290,083	500
	Code Letter - I						
1	TO RECLASS CLINIC DEPRECIATION	J	Rural Health Clinic	88		6,705	1
2			Clinic	90		6,433	2
500	Total reclassifications					13,138	500
	Code Letter - J						
1	TO RECLASS CLINIC COST	K	Clinic	90	2,286	528	1
500	Total reclassifications				2,286	528	500
	Code Letter - K						
	GRAND TOTAL (Increases)				148,799	580,067	

(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.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

RECLASSIFICATIONS

WORKSHEET A-6

	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				Wkst A-7 Ref.	
			COST CENTER	LINE #	SALARY	OTHER		
		1	6	7	8	9	10	
1	TO RECLASS SUPPLY COST FROM CS	A	Central Services & Supply	14	22,938	5,287		1
500	Total reclassifications				22,938	5,287		500
	Code letter - A							
1	TO RECLASS DON COST	B	Adults & Pediatrics	30	72,242	11,559		1
500	Total reclassifications				72,242	11,559		500
	Code letter - B							
1	TO RECLASS CLINIC COST	C	Rural Health Clinic	88	1,259	429		1
500	Total reclassifications				1,259	429		500
	Code letter - C							
1	TO RECLASS SUPPLY COST	D	Adults & Pediatrics	30		27,160		1
2			Emergency	91		19,164		2
3			Radiology-Diagnostic	54		8,142		3
4			Laboratory	60		422		4
5			Respiratory Therapy	65		37,463		5
6			Physical Therapy	66		14		6
500	Total reclassifications					92,365		500
	Code letter - D							
1	TO RECLASS INSURANCE EXPENSE	E						12
2								12
3			Administrative & General	5		75,473		3
500	Total reclassifications					75,473		500
	Code letter - E							
1	TO RECLASS INTEREST	F						11
2								2
3								3
4								4
5			Interest Expense	113		51,012		5
6								6
500	Total reclassifications					51,012		500
	Code letter - F							
1	TO RECLASS CAFE COST	G	Dietary	10	29,962	36,423		1
500	Total reclassifications				29,962	36,423		500
	Code letter - G							
1	TO RECLASS CARDIAC MONITORING COST	H						1
2			Adults & Pediatrics	30	20,112	3,770		2
500	Total reclassifications				20,112	3,770		500
	Code letter - H							
1	TO RECLASS DRUG COST	I	Adults & Pediatrics	30		105,223		1
2			Emergency	91		126,724		2
3			Pharmacy	15		57,197		3
4			Physical Therapy	66		8		4
5			Dietary	10		931		5
500	Total reclassifications					290,083		500
	Code letter - I							
1	TO RECLASS CLINIC DEPRECIATION	J	Cap Rel Costs-Bldg & Fixt	1		10,386		9
2			Cap Rel Costs-Mvble Equip	2		2,752		9
500	Total reclassifications					13,138		500
	Code letter - J							
1	TO RECLASS CLINIC COST	K	Operation of Plant	7	2,286	528		1
500	Total reclassifications				2,286	528		500
	Code letter - K							
	GRAND TOTAL (Decreases)				148,799	580,067		

(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.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	184,852		184,852		1,796,754		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	3,338,999	222,247		222,247	805,007	2,756,239		6
7	HIT-designated Assets	569,045	236,675		236,675		805,720		7
8	Subtotal (sum of lines 1-7)	5,685,370	643,774		643,774	805,007	5,524,137		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	5,685,370	643,774		643,774	805,007	5,524,137		10

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

	Description	SUMMARY OF CAPITAL							Total (1) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	67,616						67,616	1	
2	Cap Rel Costs-Mvble Equip	342,797						342,797	2	
3	Total (sum of lines 1-2)	410,413						410,413	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	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	1,962,178		1,962,178	0.355201					1
2	Cap Rel Costs-Mvble Equip	3,561,959		3,561,959	0.644799					2
3	Total (sum of lines 1-2)	5,524,137		5,524,137	1.000000					3

	Description	SUMMARY OF CAPITAL							Total (2) (sum of cols. 9 through 14)	
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
*		9	10	11	12	13	14	15		
1	Cap Rel Costs-Bldg & Fixt	57,230		22,994	4,477			84,701	1	
2	Cap Rel Costs-Mvble Equip	240,534			7,623			248,157	2	
3	Total (sum of lines 1-2)	297,764		22,994	12,100			332,858	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.)

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	Trace, quantity, and time discounts (chapter 8)					4
5	Refunds and rebates of expenses (chapter 8)	B	-44,968	Administrative & General	5	5
6	Rental of provider space by suppliers (chapter 8)					6
7	Telephone services (pay stations excl) (chapter 21)	A	-2,966	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	-564,848			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	-3,146	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	-48,300	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	A	-99,511	Cap Rel Costs-Mvble Equip	2	9 32
33	VERIZON RENTAL	B	-4,950	Administrative & General	5	33
34						34
35						35
36						36
37						37
38						38
39	SITE FEES	A	-15,800	Administrative & General	5	39
40	LATE FEES	A	-16,916	Administrative & General	5	40
41						41
42	PROVIDER TAX	A	-181,458	Administrative & General	5	42
43	LOBBING PORTION OF DUES	A	-4,704	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)		-992,030			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.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
	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:

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Total Remun- eration	Professional Component	Provider Component	RCE Amount	Physician/ Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	1	2	3	4	5	6	7	8	9	
1	5	Administrative & Gen MED STAFF DIREC	31,886		31,886					1
2	30	Adults & Pediatrics AGGREGATE	113,291	113,291						2
3	60	Laboratory AGGREGATE	117,068	109,868	7,200					3
4										4
5	91	Emergency AGGREGATE	813,546	341,689	471,857					5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,075,791	564,848	510,943					200

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	Wkst A Line #	Cost Center/ Physician Identifier	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	10	11	12	13	14	15	16	17	18	
1	5	Administrative & Gen MED STAFF DIREC								1
2	30	Adults & Pediatrics AGGREGATE							113,291	2
3	60	Laboratory AGGREGATE							109,868	3
4										4
5	91	Emergency AGGREGATE							341,689	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							564,848	200

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 visit(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		882.60				9
10	AHSEA (see instructions)		72.58				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	36.29	36.29				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)						14
15	Therapists (column 2, line 9 times column 2, line 10)					64,059	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)					64,059	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)					64,059	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)					64,059	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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

		Therapists	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtime hours worked during reporting period (if column 5, line 47 is zero or equal to or greater 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
CALCULATION OF LIMIT							
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
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of 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)					64,059	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)					64,059	63
64	Total cost of outside supplier services (from provider records)					52,957	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)						65

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS I-IV

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

PART I - GENERAL INFORMATION

1	Total number of weeks worked (excluding aides) (see instructions)					52	1
2	Line 1 multiplied by 15 hours per week					780	2
3	Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						3
4	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4
5	Number of unduplicated offsite visits - supervisors or therapists (see instructions)						5
6	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(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		446.91				9
10	AHSEA (see instructions)		76.58				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	38.29	38.29				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)						14
15	Therapists (column 2, line 9 times column 2, line 10)					34,224	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)					34,224	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)					34,224	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)					76.58	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)					59,732	22
23	Total salary equivalency (see instructions)					59,732	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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

		Therapists 1	Assistants 2	Aides 3	Trainees 4	Total 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
CALCULATION OF LIMIT							
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
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of 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)					59,732	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)					59,732	63
64	Total cost of outside supplier services (from provider records)					48,956	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)						65

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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)						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 visit(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		9.00					9
10	AHSEA (see instructions)		69.74					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)	34.87	34.87					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)						628	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)						628	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)						628	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)						69.78	21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)						40,821	22
23	Total salary equivalency (see instructions)						40,821	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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

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

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)					40,821	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)					40,821	63
64	Total cost of outside supplier services (from provider records)					540	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)						65

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
GENERAL SERVICE COST CENTERS								
1	Cap Rel Costs-Bldg & Fixt	84,701	84,701					1
2	Cap Rel Costs-Mvble Equip	248,157		248,157				2
4	Employee Benefits Department	63,373			63,373			4
5	Administrative & General	1,828,518	14,455	42,515	7,981	1,893,469	1,893,469	5
6	Maintenance & Repairs							6
7	Operation of Plant	358,220	8,397	24,699	1,838	393,154	99,537	7
8	Laundry & Linen Service	53,539	3,786	11,136	389	68,850	17,431	8
9	Housekeeping	122,591			873	123,464	31,258	9
10	Dietary	128,247	3,727	10,962	649	143,585	36,352	10
11	Cafeteria	61,922	1,578	4,640	334	68,474	17,336	11
12	Maintenance of Personnel							12
13	Nursing Administration	83,801	8,315	24,457	806	117,379	29,717	13
14	Central Services & Supply	8,957			85	9,042	2,289	14
15	Pharmacy	194,581	1,656	4,872	749	201,858	51,105	15
16	Medical Records & Library	260,117	4,496	13,224	2,294	280,131	70,922	16
17	Social Service	19,346	740	2,175	184	22,445	5,683	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	1,209,997	18,022	53,004	12,100	1,293,123	327,386	30
ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	671,653	5,531	16,269	3,971	697,424	176,570	54
60	Laboratory	942,292	2,498	7,347	4,113	956,250	242,099	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	159,670	1,656	4,872	1,358	167,556	42,421	65
66	Physical Therapy	186,395	3,221	9,473	1,002	200,091	50,658	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	33,808			326	34,134	8,642	69
71	Medical Supplies Charged to Patients	120,590	1,587	4,669	256	127,102	32,179	71
73	Drugs Charged to Patients	290,083				290,083	73,442	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,343,141			12,183	1,355,324	343,137	88
90	Clinic	187,559			1,015	188,574	47,742	90
91	Emergency	711,099	4,309	12,673	10,867	738,948	187,083	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	9,372,357	83,974	246,987	63,373	9,370,460	1,892,989	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen		398	1,170		1,568	397	190
190.01	VENDING MACHINE		329			329	83	190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	9,372,357	84,701	248,157	63,373	9,372,357	1,893,469	202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	492,691						7
8	Laundry & Linen Service	30,162	116,443					8
9	Housekeeping		1,110	155,832				9
10	Dietary	29,690	3,158	10,003	222,788			10
11	Cafeteria	12,567		4,234	76,391	179,002		11
12	Maintenance of Personnel							12
13	Nursing Administration	66,240		22,317		2,702	238,355	13
14	Central Services & Supply					502	7,526	14
15	Pharmacy	13,196		4,446		3,744		15
16	Medical Records & Library	35,817		12,067		10,847		16
17	Social Service	5,891		1,985		502		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	143,556	92,945	48,365	135,465	58,830	230,829	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	44,064	4,991	14,846		16,541		54
60	Laboratory	19,898		6,704		18,279		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,196		4,446		6,254		65
66	Physical Therapy	25,658	7,546	8,645		3,957		66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology					1,448		69
71	Medical Supplies Charged to Patients	12,646		4,261		1,544		71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					35,650		88
90	Clinic				10,932	3,938		90
91	Emergency	34,324	6,693	11,564		14,264		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	486,905	116,443	153,883	222,788	179,002	238,355	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,168		1,067				190
190.01	VENDING MACHINE	2,618		882				190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	492,691	116,443	155,832	222,788	179,002	238,355	202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	19,359						14
15	Pharmacy	1,135	275,484					15
16	Medical Records & Library	142		409,926				16
17	Social Service	46			36,552			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,286		346,093	36,552	2,714,430		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	176		63,833		1,018,445		54
60	Laboratory	11,732				1,254,962		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	165				234,038		65
66	Physical Therapy	61				296,616		66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	57				44,281		69
71	Medical Supplies Charged to Patients	2,857				180,589		71
73	Drugs Charged to Patients		244,574			608,099		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,090	30,910			1,766,111		88
90	Clinic	71				251,257		90
91	Emergency	541				993,417		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	19,359	275,484	409,926	36,552	9,362,245		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					6,200		190
190.01	VENDING MACHINE					3,912		190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	19,359	275,484	409,926	36,552	9,372,357		202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	TOTAL				
		26				
	GENERAL SERVICE COST CENTERS					
1	Cap Rel Costs-Bldg & Fixt					1
2	Cap Rel Costs-Mvble Equip					2
4	Employee Benefits Department					4
5	Administrative & General					5
6	Maintenance & Repairs					6
7	Operation of Plant					7
8	Laundry & Linen Service					8
9	Housekeeping					9
10	Dietary					10
11	Cafeteria					11
12	Maintenance of Personnel					12
13	Nursing Administration					13
14	Central Services & Supply					14
15	Pharmacy					15
16	Medical Records & Library					16
17	Social Service					17
19	Nonphysician Anesthetists					19
20	Nursing School					20
21	I&R Services-Salary & Fringes Apprvd					21
22	I&R Services-Other Prgm Costs Apprvd					22
23	Paramed Ed Prgm-(specify)					23
	INPATIENT ROUTINE SERV COST CENTERS					
30	Adults & Pediatrics	2,714,430				30
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic	1,018,445				54
60	Laboratory	1,254,962				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	234,038				65
66	Physical Therapy	296,616				66
67	Occupational Therapy					67
68	Speech Pathology					68
69	Electrocardiology	44,281				69
71	Medical Supplies Charged to Patients	180,589				71
73	Drugs Charged to Patients	608,099				73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic	1,766,111				88
90	Clinic	251,257				90
91	Emergency	993,417				91
92	Observation Beds (Non-Distinct Part)					92
	OTHER REIMBURSABLE COST CENTERS					
	SPECIAL PURPOSE COST CENTERS					
113	Interest Expense					113
118	SUBTOTALS (sum of lines 1-117)	9,362,245				118
	NONREIMBURSABLE COST CENTERS					
190	Gift, Flower, Coffee Shop & Canteen	6,200				190
190.01	VENDING MACHINE	3,912				190.01
200	Cross Foot Adjustments					200
201	Negative Cost Centers					201
202	TOTAL (sum of lines 118-201)	9,372,357				202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS 0	CAP BLDGS & FIXTURES 1	CAP MOVABLE EQUIPMENT 2	SUBTOTAL 2A	ADMINIS- TRATIVE & GENERAL 5	OPERATION OF PLANT 7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		14,455	42,515	56,970	56,970		5
6	Maintenance & Repairs							6
7	Operation of Plant		8,397	24,699	33,096	2,995	36,091	7
8	Laundry & Linen Service		3,786	11,136	14,922	524	2,209	8
9	Housekeeping					940		9
10	Dietary		3,727	10,962	14,689	1,094	2,175	10
11	Cafeteria		1,578	4,640	6,218	522	921	11
12	Maintenance of Personnel							12
13	Nursing Administration		8,315	24,457	32,772	894	4,852	13
14	Central Services & Supply					69		14
15	Pharmacy		1,656	4,872	6,528	1,538	967	15
16	Medical Records & Library		4,496	13,224	17,720	2,134	2,624	16
17	Social Service		740	2,175	2,915	171	432	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		18,022	53,004	71,026	9,850	10,514	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		5,531	16,269	21,800	5,312	3,228	54
60	Laboratory		2,498	7,347	9,845	7,284	1,458	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,656	4,872	6,528	1,276	967	65
66	Physical Therapy		3,221	9,473	12,694	1,524	1,880	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology					260		69
71	Medical Supplies Charged to Patients		1,587	4,669	6,256	968	926	71
73	Drugs Charged to Patients					2,210		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					10,325		88
90	Clinic					1,436		90
91	Emergency		4,309	12,673	16,982	5,629	2,514	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		83,974	246,987	330,961	56,955	35,667	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		398	1,170	1,568	12	232	190
190.01	VENDING MACHINE		329		329	3	192	190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		84,701	248,157	332,858	56,970	36,091	202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
	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	17,655						8
9	Housekeeping	168	1,108					9
10	Dietary	479	71	18,508				10
11	Cafeteria		30	6,346	14,037			11
12	Maintenance of Personnel							12
13	Nursing Administration		159		212	38,889		13
14	Central Services & Supply				39	1,228	1,336	14
15	Pharmacy		32		294		78	15
16	Medical Records & Library		86		851		10	16
17	Social Service		14		39		3	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	14,092	343	11,254	4,613	37,661	89	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	757	106		1,297		12	54
60	Laboratory		48		1,433		811	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		32		490		11	65
66	Physical Therapy	1,144	61		310		4	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology				114		4	69
71	Medical Supplies Charged to Patients		30		121		197	71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				2,796		75	88
90	Clinic			908	309		5	90
91	Emergency	1,015	82		1,119		37	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	17,655	1,094	18,508	14,037	38,889	1,336	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		8					190
190.01	VENDING MACHINE		6					190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	17,655	1,108	18,508	14,037	38,889	1,336	202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		15	16	17	24	25	26	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	9,437						15
16	Medical Records & Library		23,425					16
17	Social Service			3,574				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		19,777	3,574	182,793		182,793	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		3,648		36,160		36,160	54
60	Laboratory				20,879		20,879	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy				9,304		9,304	65
66	Physical Therapy				17,617		17,617	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology				378		378	69
71	Medical Supplies Charged to Patients				8,498		8,498	71
73	Drugs Charged to Patients	8,378			10,588		10,588	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,059			14,255		14,255	88
90	Clinic				2,658		2,658	90
91	Emergency				27,378		27,378	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	9,437	23,425	3,574	330,508		330,508	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				1,820		1,820	190
190.01	VENDING MACHINE				530		530	190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	9,437	23,425	3,574	332,858		332,858	202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	25,771						1
2	Cap Rel Costs-Mvble Equip		25,671					2
4	Employee Benefits Department			5,680,909				4
5	Administrative & General	4,398	4,398	715,426	-1,893,469	7,478,888		5
6	Maintenance & Repairs							6
7	Operation of Plant	2,555	2,555	164,740		393,154	18,818	7
8	Laundry & Linen Service	1,152	1,152	34,896		68,850	1,152	8
9	Housekeeping			78,244		123,464		9
10	Dietary	1,134	1,134	58,160		143,585	1,134	10
11	Cafeteria	480	480	29,962		68,474	480	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,530	2,530	72,242		117,379	2,530	13
14	Central Services & Supply			7,646		9,042		14
15	Pharmacy	504	504	67,171		201,858	504	15
16	Medical Records & Library	1,368	1,368	205,632		280,131	1,368	16
17	Social Service	225	225	16,480		22,445	225	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,483	5,483	1,084,683		1,293,123	5,483	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,683	1,683	355,985		697,424	1,683	54
60	Laboratory	760	760	368,729		956,250	760	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	504	504	121,722		167,556	504	65
66	Physical Therapy	980	980	89,844		200,091	980	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology			29,181		34,134		69
71	Medical Supplies Charged to Patients	483	483	22,938		127,102	483	71
73	Drugs Charged to Patients					290,083		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic			1,092,047		1,355,324		88
90	Clinic			90,988		188,574		90
91	Emergency	1,311	1,311	974,193		738,948	1,311	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	25,550	25,550	5,680,909	-1,893,469	7,476,991	18,597	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	121	121			1,568	121	190
190.01	VENDING MACHINE	100				329	100	190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	84,701	248,157	63,373		1,893,469	492,691	202
203	Unit Cost Multiplier (Wkst. B, Part I)	3.286679	9.666822	0.011155		0.253175	26.181900	203
204	Cost to be allocated (Per Wkst. B, Part II)					56,970	36,091	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.007617	1.917898	205

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
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	63,342						8
9	Housekeeping	604	17,666					9
10	Dietary	1,718	1,134	16,609				10
11	Cafeteria		480	5,695	9,274			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,530		140	69,640		13
14	Central Services & Supply				26	2,199	625,898	14
15	Pharmacy		504		194		36,680	15
16	Medical Records & Library		1,368		562		4,595	16
17	Social Service		225		26		1,502	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
INPATIENT ROUTINE SERV COST CENTERS								
30	Adults & Pediatrics	50,559	5,483	10,099	3,048	67,441	41,562	30
ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	2,715	1,683		857		5,693	54
60	Laboratory		760		947		379,358	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		504		324		5,319	65
66	Physical Therapy	4,105	980		205		1,968	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology				75		1,838	69
71	Medical Supplies Charged to Patients		483		80		92,365	71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic				1,847		35,226	88
90	Clinic			815	204		2,311	90
91	Emergency	3,641	1,311		739		17,481	91
92	Observation Beds (Non-Distinct Part)							92
OTHER REIMBURSABLE COST CENTERS								
SPECIAL PURPOSE COST CENTERS								
118	SUBTOTALS (sum of lines 1-117)	63,342	17,445	16,609	9,274	69,640	625,898	118
NONREIMBURSABLE COST CENTERS								
190	Gift, Flower, Coffee Shop & Canteen		121					190
190.01	VENDING MACHINE		100					190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	116,443	155,832	222,788	179,002	238,355	19,359	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.838322	8.821012	13.413691	19.301488	3.422674	0.030930	203
204	Cost to be allocated (Per Wkst. B, Part II)	17,655	1,108	18,508	14,037	38,889	1,336	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.278725	0.062719	1.114336	1.513586	0.558429	0.002135	205

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

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

GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt						1
2	Cap Rel Costs-Mvble Equip						2
4	Employee Benefits Department						4
5	Administrative & General						5
6	Maintenance & Repairs						6
7	Operation of Plant						7
8	Laundry & Linen Service						8
9	Housekeeping						9
10	Dietary						10
11	Cafeteria						11
12	Maintenance of Personnel						12
13	Nursing Administration						13
14	Central Services & Supply						14
15	Pharmacy	326,743					15
16	Medical Records & Library		46,430				16
17	Social Service			1,510			17
19	Nonphysician Anesthetists						19
20	Nursing School						20
21	I&R Services-Salary & Fringes Apprvd						21
22	I&R Services-Other Prgm Costs Apprvd						22
23	Paramed Ed Prgm-(specify)						23
INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		39,200	1,510			30
ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		7,230				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	290,082					73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	36,661					88
90	Clinic						90
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
OTHER REIMBURSABLE COST CENTERS							
SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	326,743	46,430	1,510			118
NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen						190
190.01	VENDING MACHINE						190.01
200	Cross foot adjustments						200
201	Negative cost centers						201
202	Cost to be allocated (Per Wkst. B, Part I)	275,484	409,926	36,552			202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.843121	8.828904	24.206623			203
204	Cost to be allocated (Per Wkst. B, Part II)	9,437	23,425	3,574			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.028882	0.504523	2.366887			205

Optimizer Systems, Inc.

WinLASH System

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	---------------------------------------	--	--

POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,714,430		2,714,430			30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	1,018,445		1,018,445			54
60	Laboratory	1,254,962		1,254,962			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	234,038		234,038			65
66	Physical Therapy	296,616		296,616			66
67	Occupational Therapy						67
68	Speech Pathology						68
69	Electrocardiology	44,281		44,281			69
71	Medical Supplies Charged to Patients	180,589		180,589			71
73	Drugs Charged to Patients	608,099		608,099			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	1,766,111		1,766,111			88
90	Clinic	251,257		251,257			90
91	Emergency	993,417		993,417			91
92	Observation Beds (Non-Distinct Part)	312,465		312,465			92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	9,674,710		9,674,710			200
201	Less Observation Beds	312,465		312,465			201
202	Total (line 200 minus line 201)	9,362,245		9,362,245			202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30	Adults & Pediatrics	1,315,880		1,315,880				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	444,455	3,335,142	3,779,597	0.269459			54
60	Laboratory	536,438	2,990,840	3,527,278	0.355788			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	136,500	262,714	399,214	0.586247			65
66	Physical Therapy	249,352	706,010	955,362	0.310475			66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	30,616	168,700	199,316	0.222165			69
71	Medical Supplies Charged to Patients	441,871	107,845	549,716	0.328513			71
73	Drugs Charged to Patients	904,465	896,729	1,801,194	0.337609			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		1,447,044	1,447,044				88
90	Clinic		186,835	186,835	1.344807			90
91	Emergency	30,980	1,461,998	1,492,978	0.665393			91
92	Observation Beds (Non-Distinct Part)		249,079	249,079	1.254482			92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	4,090,557	11,812,936	15,903,493				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	4,090,557	11,812,936	15,903,493				202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	0.269459		1,075,743			289,869	54
60	Laboratory	0.355788		1,557,414			554,109	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.586247		28,412			16,656	65
66	Physical Therapy	0.310475		235,772			73,201	66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	0.222165		153,939			34,200	69
71	Medical Supplies Charged to Patients	0.328513		99,297			32,620	71
73	Drugs Charged to Patients	0.337609		428,446			144,647	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic	1.344807		136,370			183,391	90
91	Emergency	0.665393		425,648			283,223	91
92	Observation Beds (Non-Distinct Part)	1.254482		89,960			112,853	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)			4,231,001			1,724,769	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)			4,231,001			1,724,769	202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.269459							54
60	Laboratory	0.355788							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.586247							65
66	Physical Therapy	0.310475							66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	0.222165							69
71	Medical Supplies Charged to Patients	0.328513							71
73	Drugs Charged to Patients	0.337609							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.344807							90
91	Emergency	0.665393							91
92	Observation Beds (Non-Distinct Part)	1.254482							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period: From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	---	--

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)	
		1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	182,793	62,707	120,086	1,792	67.01	241	16,149	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)	182,793		120,086	1,792		241	16,149	200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period: From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	---	--

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
	ANCILLARY SERVICE COST CENTERS					
54	Radiology-Diagnostic	36,160	3,779,597	0.009567		54
60	Laboratory	20,879	3,527,278	0.005919		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
65	Respiratory Therapy	9,304	399,214	0.023306		65
66	Physical Therapy	17,617	955,362	0.018440		66
67	Occupational Therapy					67
68	Speech Pathology					68
69	Electrocardiology	378	199,316	0.001896		69
71	Medical Supplies Charged to Patients	8,498	549,716	0.015459		71
73	Drugs Charged to Patients	10,588	1,801,194	0.005878		73
76.97	CARDIAC REHABILITATION					76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
88	Rural Health Clinic	14,255	1,447,044	0.009851		88
90	Clinic	2,658	186,835	0.014226		90
91	Emergency	27,378	1,492,978	0.018338		91
92	Observation Beds (Non-Distinct Part)	32,030	249,079	0.128594		92
	OTHER REIMBURSABLE COST CENTERS					
200	Total (sum of lines 50-199)	179,745	14,587,613			200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

(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
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics General Routine Care)					30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	TOTAL (lines 30-199)					200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

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

(A)	Cost Center Description	Total Patient Days	Per Diem (col. 5+ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)
		6	7	8	9
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics (General Routine Care)	1,792		241	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)	1,792		241	200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period: From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	---	--

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 PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1	2	3	4	5	6
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic						54
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
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
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic						88
90	Clinic						90
91	Emergency						91
92	Observation Beds (Non-Distinct Part)						92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)						200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
7	8	9	10	11	12	13		
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	3,779,597						54
60	Laboratory	3,527,278						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	399,214						65
66	Physical Therapy	955,362						66
67	Occupational Therapy							67
68	Speech Pathology							68
69	Electrocardiology	199,316						69
71	Medical Supplies Charged to Patients	549,716						71
73	Drugs Charged to Patients	1,801,194						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,447,044						88
90	Clinic	186,835						90
91	Emergency	1,492,978						91
92	Observation Beds (Non-Distinct Part)	249,079						92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)	14,587,613						200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.269459							54
60	Laboratory	0.355788							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.586247							65
66	Physical Therapy	0.310475							66
67	Occupational Therapy								67
68	Speech Pathology								68
69	Electrocardiology	0.222165							69
71	Medical Supplies Charged to Patients	0.328513							71
73	Drugs Charged to Patients	0.337609							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	1.344807							90
91	Emergency	0.665393							91
92	Observation Beds (Non-Distinct Part)	1.254482							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1
PART I

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 I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,917	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,792	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)	1,478	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	682	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)	227	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	162	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)	54	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,009	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)	682	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)	227	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,714,430	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)	19,542	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	7,081	25
26	Total swing-bed cost (see instructions)	931,187	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,783,243	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,783,243	37

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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)						995.12	38
39	Program general inpatient routine service cost (line 9 x line 38)						1,004,076	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)						1,004,076	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1	2	3	4	5		
42	Nursery (Titles V and XIX only)							42
	Intensive Care Type Inpatient Hospital Units							
43	Intensive Care Unit							43
44	Coronary Care Unit							44
45	Burn Intensive Care Unit							45
46	Surgical Intensive Care Unit							46
47	Other Special Care (specify)							47

							1	
48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						406,435	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)						1,410,511	49

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges							54
55	Target amount per discharge							55
56	Target amount (line 54 x line 55)							56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)							57
58	Bonus payment (see instructions)							58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.							59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.							60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise 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)						678,672	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)						225,892	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)						904,564	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)							67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)							68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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)					314	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					995.11	88
89	Observation bed cost (line 87 x line 88) (see instructions)					312,465	89
		Cost	Routine Cost (from line 27)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	182,793	1,783,243	0.102506	312,465	32,030	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1
PART I

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 I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,917	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,792	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)	1,478	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	682	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)	227	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	162	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)	54	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	241	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,714,430	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)	19,542	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	7,081	25
26	Total swing-bed cost (see instructions)	931,187	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,783,243	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 3)		32
33	Average semi-private room per diem charge (line 30 ÷ line 4)		33
34	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		34
35	Average per diem private room cost differential (line 34 x line 31)		35
36	Private room cost differential adjustment (line 3 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,783,243	37

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1
PART II

Check Title V - I/P Hospital SUB (Other) PFS
 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

38	Adjusted general inpatient routine service cost per diem (see instructions)					995.12	38
39	Program general inpatient routine service cost (line 9 x line 38)					239,824	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)					239,824	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					239,824	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					16,149	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					16,149	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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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)					314	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)	col. 1+col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,046,500		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.269459	186,478	50,248	54
60	Laboratory	0.355788	300,821	107,029	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.586247	63,513	37,234	65
66	Physical Therapy	0.310475	15,422	4,788	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.222165	15,973	3,549	69
71	Medical Supplies Charged to Patients	0.328513	193,926	63,707	71
73	Drugs Charged to Patients	0.337609	409,627	138,294	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.344807			90
91	Emergency	0.665393	2,383	1,586	91
92	Observation Beds (Non-Distinct Part)	1.254482			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,188,143	406,435	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,188,143		202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.269459	25,236	6,800	54
60	Laboratory	0.355788	86,324	30,713	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.586247	33,637	19,720	65
66	Physical Therapy	0.310475	193,708	60,141	66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.222165	2,822	627	69
71	Medical Supplies Charged to Patients	0.328513	132,980	43,686	71
73	Drugs Charged to Patients	0.337609	200,538	67,703	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.344807			90
91	Emergency	0.665393			91
92	Observation Beds (Non-Distinct Part)	1.254482			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		675,245	229,390	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		675,245		202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period: From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	---	--

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	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.269459			54
60	Laboratory	0.355788			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.586247			65
66	Physical Therapy	0.310475			66
67	Occupational Therapy				67
68	Speech Pathology				68
69	Electrocardiology	0.222165			69
71	Medical Supplies Charged to Patients	0.328513			71
73	Drugs Charged to Patients	0.337609			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	1.344807			90
91	Emergency	0.665393			91
92	Observation Beds (Non-Distinct Part)	1.254482			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period: From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	---	--

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)	1,724,769			1
2	Medical and other services reimbursed under OPPS (see instructions)				2
3	PPS payments				3
4	Outlier payment (see instructions)				4
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of line 3 and line 4 divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	1,724,769			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over 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)	1,742,017			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	11,342			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	561,973			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,168,702			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)	1,168,702			30
31	Primary payer payments	320			31
32	Subtotal (line 30 minus line 31)	1,168,382			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	150,699			34
35	Adjusted reimbursable bad debts (see instructions)	114,531			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	149,762			36
37	Subtotal (see instructions)	1,282,913			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	1,282,913			40
40.01	Sequestration adjustment (see instructions)	25,658			40.01
41	Interim payments	1,319,351			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-62,096			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

90	Original outlier amount (see instructions)				90
91	Outlier reconciliation adjustment amount (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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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		1,166,677		1,328,775	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 rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01	10/23/2014	12,743		3.01
		.02				3.02
	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		10/23/2014	9,424	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		12,743	-9,424	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)			1,179,420	1,319,351	4
TO BE COMPLETED BY CONTRACTOR						
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		62,655		6.01
		.02			-36,438	6.02
7	Total Medicare program liability (see instructions)			1,242,075		7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 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		1,071,055			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 rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter a zero. (1)	.01	10/23/2014		35,604	3.01
	.02				3.02
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				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		35,604		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)			1,106,659		4
TO BE COMPLETED BY CONTRACTOR					
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				6.01
	.02		-9,227		6.02
7 Total Medicare program liability (see instructions)			1,097,432		7
8 Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	8

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

Check applicable box: Hospital CAH

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	Total hospital discharges as defined in AARA §4102 (Wkst. S-3, Pt. I, col. 15, line 14)	445	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	1,009	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	83	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,478	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	15,903,493	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	697,644	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	236,675	7
8	Calculation of the HIT incentive payment (see instructions)	230,214	8
9	Sequestration adjustment amount (see instructions)	4,604	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	225,610	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)	225,610	32

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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)	913,610		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 5 and 7, line 202 for Part B) (For CAH, see instructions)	231,684		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	909		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,145,294		8
9	Primary payer payments (see instructions)			9
10	Subtotal (line 8 minus line 9)	1,145,294		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,145,294		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	47,862		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)	1,097,432		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)			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)	1,097,432		19
19.01	Sequestration adjustment (see instructions)	21,949		19.01
20	Interim payments	1,106,659		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-31,176		22
23	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, §115.2			23

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period: From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	---	--

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	1,410,511	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,410,511	4
5	Primary payer payments		5
6	Total cost (line 4 less line 5) (see instructions)	1,424,616	6
COMPUTATION OF LESSER OF COST OR CHARGES			
REASONABLE CHARGES			
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
CUSTOMARY CHARGES			
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
COMPUTATION OF REIMBURSEMENT SETTLEMENT			
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	1,424,616	19
20	Deductibles (exclude professional component)	222,692	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,201,924	22
23	Coinsurance	608	23
24	Subtotal (line 22 minus line 23)	1,201,316	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	53,630	25
26	Adjusted reimbursable bad debts (see instructions)	40,759	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	53,630	27
28	Subtotal (sum of lines 24 and 26)	1,242,075	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,242,075	30
30.01	Sequestration adjustment (see instructions)	24,842	30.01
31	Interim payments	1,179,420	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	37,813	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
COMPUTATION OF NET COST OF COVERED SERVICES				
1	Inpatient hospital/SNF/NF services	239,824		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	239,824		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	239,824		7
COMPUTATION OF LESSER OF COST OR CHARGES				
REASONABLE CHARGES				
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
CUSTOMARY CHARGES				
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	239,824		21
PROSPECTIVE PAYMENT AMOUNT				
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	239,824		29
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	239,824		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)	239,824		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	239,824		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	239,824		40
41	Interim payments			41
42	Balance due provider/program (line 40 minus line 41)	239,824		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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	
CURRENT ASSETS						
1	Cash on hand and in banks	92,875				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	3,432,013				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,160,829				6
7	Inventory	206,203				7
8	Prepaid expenses	7,775				8
9	Other current assets					9
10	Due from other funds	236,675				10
11	Total current assets (sum of lines 1-10)	2,814,712				11
FIXED ASSETS						
12	Land	17,000				12
13	Land improvements	148,425				13
14	Accumulated depreciation	-120,748				14
15	Buildings	1,796,754				15
16	Accumulated depreciation	-1,175,896				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Audomobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	3,654,399				23
24	Accumulated depreciation	-2,602,183				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)	1,717,751				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)					35
36	Total assets (sum of lines 11, 30 and 35)	4,532,463				36
Liabilities and Fund Balances (Omit Cents)						
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	760,463				37
38	Salaries, wages and fees payable	640,897				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	716,454				40
41	Deferred income	213,006				41
42	Accelerated payments					42
43	Due to other funds	19,988				43
44	Other current liabilities					44
45	Total current liabilities (sum of lines 37 thru 44)	2,350,808				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	896,159				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	896,159				50
51	Total liabilities (sum of lines 45 and 50)	3,246,967				51
CAPITAL ACCOUNTS						
52	General fund balance	1,285,496				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58
59	Total fund balances (sum of lines 52 thru 58)	1,285,496				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	4,532,463				60

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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		1,332,676			1
2	Net income (loss) (from Worksheet G-3, line 29)		-47,180			2
3	Total (sum of line 1 and line 2)		1,285,496			3
4	Additions (credit adjustments) (specify)					4
5	PRIOR YEAR ADJUSTMENTS					5
6						6
7						7
8						8
9						9
10	Total additions (sum of lines 4-9)					10
11	Subtotal (line 3 plus line 10)		1,285,496			11
12	Deductions (debit adjustments) (specify)					12
13						13
14						14
15						15
16						16
17						17
18	Total deductions (sum of lines 12-17)					18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,285,496			19

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period: From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	---	--

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	1,571,116		1,571,116	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	714,374		714,374	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)	2,285,490		2,285,490	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	2,285,490		2,285,490	17
18	Ancillary services	2,890,000	8,700,877	11,590,877	18
19	Outpatient services	40,110	3,092,067	3,132,177	19
20	Rural Health Clinic (RHC)		1,447,044	1,447,044	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	5,215,600	13,239,988	18,455,588	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		10,364,387	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)		10,364,387	43

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	18,455,588	1
2	Less contractual allowances and discounts on patients' accounts	8,412,664	2
3	Net patient revenues (line 1 minus line 2)	10,042,924	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	10,364,387	4
5	Net income from service to patients (line 3 minus line 4)	-321,463	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	1,539	6
7	Income from investments	12,243	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	44,968	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	6,330	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	4,900	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hospitial space		22
23	Governmental appropriations		23
24	Other (MISCELLANOUS)	5,624	24
24.01	Other (GRANTS)	83,368	24.01
24.02	Other (DEFERRED REVENUE)	99,511	24.02
24.03	Other (SITE FEES)	15,800	24.03
25	Total other income (sum of lines 6-24)	274,283	25
26	Total (line 5 plus line 25)	-47,180	26
29	Net income (or loss) for the period (line 26 minus line 28)	-47,180	29

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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

COMPONENT CCN: 14-3479

WORKSHEET M-1

Check applicable box: RHC I 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	
FACILITY HEALTH CARE STAFF COSTS								
1	Physician	430,501	34,056	464,557			464,557	1
2	Physician Assistant							2
3	Nurse Practitioner	175,529	23,956	199,485			199,485	3
4	Visiting Nurse							4
5	Other Nurse	208,529	37,420	245,949			245,949	5
6	Clinical Psychologist							6
7	Clinical Social Worker							7
8	Laboratory Technician							8
9	Other Facility Health Care Staff Costs	242,776	56,470	299,246			299,246	9
10	Subtotal (sum of lines 1 through 9)	1,057,335	151,902	1,209,237			1,209,237	10
COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement		15,650	15,650			15,650	11
12	Physician Supervision Under Agreement							12
13	Other Costs Under Agreement							13
14	Subtotal (sum of lines 11 through 13)		15,650	15,650			15,650	14
OTHER HEALTH CARE COSTS								
15	Medical Supplies		1,693	1,693			1,693	15
16	Transportation (Health Care Staff)		2,572	2,572			2,572	16
17	Depreciation-Medical Equipment		6,705	6,705			6,705	17
18	Professional Liability Insurance							18
19	Other Health Care Costs		36,661	36,661			36,661	19
20	Allowable GME Costs							20
21	Subtotal (sum of lines 15 through 20)		47,631	47,631			47,631	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,057,335	215,183	1,272,518			1,272,518	22
COSTS OTHER THAN RHC/FQHC SERVICES								
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 through 27)							28
FACILITY OVERHEAD								
29	Facility Costs		70,884	70,884	-261		70,623	29
30	Administrative Costs							30
31	Total Facility Overhead (sum of lines 29 and 30)		70,884	70,884	-261		70,623	31
32	Total facility costs (sum of lines 22, 28 and 31)	1,057,335	286,067	1,343,402	-261		1,343,141	32

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3479

WORKSHEET M-2

Check applicable box: RHC I FQHC

VISITS AND PRODUCTIVITY

	Positions	Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
		1	2	3	4	5	
1	Physicians	1.85	8,057	4,200	7,770		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.73	5,013	2,100	3,633		3
4	Subtotal (sum of lines 1 through 3)	3.58	13,070		11,403	13,070	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	3.58	13,070			13,070	8
9	Physician Services Under Agreements		317			317	9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)					1,272,518	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)						11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)					1,272,518	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)					1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)					70,623	14
15	Parent provider overhead allocated to facility (see instructions)					422,970	15
16	Total overhead (sum of lines 14 and 15)					493,593	16
17	Allowable Direct GME overhead (see instructions)						17
18	Subtotal (see instructions)					493,593	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)					493,593	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)					1,766,111	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.

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3479

WORKSHEET M-3

Check applicable boxes: RHC I Title V Title XIX
 FQHC Title XVIII

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	1,766,111	1
2	Cost of vaccines and their administration (from Wkst. M-4, line 15)	20,474	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	1,745,637	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	13,070	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)	317	5
6	Total adjusted visits (line 4 plus line 5)	13,387	6
7	Adjusted cost per visit (line 3 divided by line 6)	130.40	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)	130.40	130.40	130.40	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)	3,434	1,144		10
11	Program cost excluding costs for mental health services (line 9 x line 10)	447,794	149,178		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		596,972		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)		431,120		16.04
16.05	Total program cost (see instructions)		431,120		16.05
17	Primary payer payments				17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		58,072		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		90,544		19
20	Net Medicare cost excluding vaccines (see instructions)		431,120		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		15,275		21
22	Total reimbursable Program cost (line 20 plus line 21)		446,395		22
23	Allowable bad debts (see instructions)		44,259		23
23.01	Adjusted reimbursable bad debts (see instructions)		33,637		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		44,259		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		480,032		26
26.01	Sequestration adjustment (see instructions)		9,601		26.01
27	Interim payments		433,934		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		36,497		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3479

WORKSHEET M-4

Check applicable boxes: RHC I FQHC Title V Title XVIII Title XIX

		PNEUMO- COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,209,237	1,209,237	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000320	0.003170	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	387	3,833	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,972	8,560	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,359	12,393	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,272,518	1,272,518	6
7	Total overhead (from Wkst. M-2, line 16)	493,593	493,593	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001854	0.009739	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	915	4,807	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	3,274	17,200	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	65	646	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	50.37	26.63	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	50	479	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,519	12,756	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		20,474	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		15,275	16

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2014 To: 03/31/2015	Run Date: 08/21/2015 Run Time: 10:43 Version: 2015.03 (06/16/2015)
---	--------------------------------	--	--

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 I FQHC

	DESCRIPTION	Part B		
		mm/dd/yyyy	Amount	
1	Total interim payments paid to provider	1	2	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero		438,337	2
3	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write 'NONE' or enter zero (1)			
		.01		3.01
		.02		3.02
	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	10/23/2014	3.51
	Provider	.52	4,403	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	-4,403	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		433,934	
TO BE COMPLETED BY CONTRACTOR				
5	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write 'NONE' or enter 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	Determine net settlement amount (balance due) based on the cost report (1)	.01	46,098	6.01
		.02		6.02
7	Total Medicare program liability (see instructions)		480,032	
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.