

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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: 08/23/2016 Time: 10:20
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 04/01/2015 and ending 03/31/2016, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		12,132	196,105	88,953		1
2	SUBPROVIDER - IPF						2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF		-267,350				5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC			59,704			10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		-255,218	255,809	88,953		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.

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

Hospital and Hospital Health Care Complex Address:

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

Hospital and Hospital-Based Component Identification:

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 04 / 01 / 2015	To: 03 / 31 / 2016							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 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.							25

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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		1	2	
39	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V	XVIII	XIX
		1	2	3
45	Does this facility qualify and receive capital payment for disproportionate share in accordance with 42 CFR §412.320?	N	N	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	46
47	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter 'Y' for yes or 'N' for no.	N	N	47
48	Is the facility electing full federal capital payment? Enter 'Y' for yes or 'N' for no.	N	N	48

Teaching Hospitals		1	2	3	
56	Is this a hospital involved in training residents in approved GME programs? Enter 'Y' for yes or 'N' for no.	N			56
57	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y' did residents start training in the first month of this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2. If column 2 is 'Y', complete Wkst. E-4. If column 2 is 'N', complete Wkst. D, Part III & IV and D-2, Pt. II, if applicable.	N			57
58	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub 15-1, chapter 21, section 2148? If yes, complete Wkst. D-5.	N			58
59	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59
60	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter 'Y' for yes or 'N' for no. (see instructions)	N			60
		Y/N	IME	Direct GME	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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
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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				1	2	3	
70	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter 'Y' for yes or 'N' for no.			N			70
71	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost report filed on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						71
Inpatient Rehabilitation Facility PPS				1	2	3	
75	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter 'Y' for yes or 'N' for no.			N			75
76	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter 'Y' for yes or 'N' for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424(d)(1)(iii)(D)? Enter 'Y' for yes and 'N' for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)						76
Long Term Care Hospital PPS							
80	Is this a Long Term Care Hospital (LTCH)? Enter 'Y' for yes or 'N' for no.				N		80
81	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter 'Y' for yes and 'N' for no.				N		81
TEFRA Providers							
85	Is this a new hospital under 42 CFR §413.40(f)(1)(i) TEFRA?. Enter 'Y' for yes or 'N' for no.				N		85
86	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR §413.40(f)(1)(ii)? Enter 'Y' for yes, or 'N' for no.						86
87	Is this hospital a 'subclause (II)' LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter 'Y' for yes and 'N' for no.				N		87

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

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

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 is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.	N		107	
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.	N		108	
		Physical	Occupational	Speech	Respiratory
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Y	Y	Y	N
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

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:				118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N		N	120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121
122	Does the cost report contain state health or similar taxes? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N			125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date, if applicable in column 2.				129
130	If this is a Medicare 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

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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 N	2	140
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If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 2.	N	N	145
146	Has the cost allocation methodology changed from the previously filed cost report? Enter 'Y' for yes and 'N' for no in column 1. (see CMS Pub. 15-2, chapter 40, §4020). If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146
147	Was there a change in the statistical basis? Enter 'Y' for yes or 'N' for no.	N		147
148	Was there a change in the order of allocation? Enter 'Y' for yes or 'N' for no.	N		148
149	Was there a change to the simplified cost finding method? Enter 'Y' for yes or 'N' for no.	N		149

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

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

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y				167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	92,441				168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)					168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)					169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	03 / 31 / 2015	04 / 01 / 2016			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

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

COMPLETED BY ALL HOSPITALS

		Y/N	Date		
Provider Organization and Operation					
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

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

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

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

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

		Part A		Part B	
		Y/N	Date	Y/N	Date
PS&R Report Data					
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	07/12/2016	Y	07/12/2016
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	

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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
42	Employer: KERBER, ECK & BRAECKEL		
43	Phone number: 618-529-1040	E-mail Address: MARKD@KEBCPA.COM	

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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	9,150	33,504.00		912	223	1,396	1
2	HMO and other (see instructions)						144			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						695		695	5
6	Hospital Adults & Peds. Swing Bed NF								201	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,150	33,504.00		1,607	223	2,292	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	9,150	33,504.00		1,607	223	2,292	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					4,947		14,303	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							186	413	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

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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)					256	67	394	1
2	HMO and other (see instructions)					37			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)		104.47			256	67	394	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		19.57						26
27	Total (sum of lines 14-26)		124.04						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32

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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	
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

	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

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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

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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)		0.619423	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid		1,999,538	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		4,563,169	6
7	Medicaid cost (line 1 times line 6)		2,826,532	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.		826,994	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)		826,994	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	277,429	242,485	519,914
21	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	171,846	150,201	322,047
22	Partial payment by patients approved for charity care			22
23	Cost of charity care (line 21 minus line 22)	171,846	150,201	322,047

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)		561,174	26
27	Medicare bad debts for the entire hospital complex (see instructions)		199,513	27
28	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		361,661	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		224,021	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)		546,068	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		1,373,062	31

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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
		GENERAL SERVICE COST CENTERS								
1	00100	Cap Rel Costs-Bldg & Fixt		69,073	69,073	15,041	84,114		84,114	1
2	00200	Cap Rel Costs-Mvble Equip		249,792	249,792	6,098	255,890	-55,348	200,542	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department				54,157	54,157		54,157	4
5	00500	Administrative & General	745,634	1,562,792	2,308,426	-40,102	2,268,324	-349,234	1,919,090	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	157,338	208,907	366,245	-4,730	361,515		361,515	7
8	00800	Laundry & Linen Service	38,318	13,048	51,366		51,366		51,366	8
9	00900	Housekeeping	83,589	31,942	115,531		115,531		115,531	9
10	01000	Dietary	97,509	96,788	194,297	-63,789	130,508		130,508	10
11	01100	Cafeteria				62,774	62,774	-4,916	57,858	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration				96,677	96,677		96,677	13
14	01400	Central Services & Supply	32,422	14,746	47,168	-36,714	10,454		10,454	14
15	01500	Pharmacy	71,669	209,232	280,901	-65,522	215,379		215,379	15
16	01600	Medical Records & Library	206,657	149,806	356,463		356,463	-3,509	352,954	16
17	01700	Social Service	16,172	1,890	18,062		18,062		18,062	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	1,233,074	429,399	1,662,473	-236,446	1,426,027	-134,134	1,291,893	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic	367,695	379,568	747,263	-969	746,294		746,294	54
60	06000	Laboratory	380,629	675,725	1,056,354	296	1,056,650	-111,314	945,336	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	108,650	66,343	174,993	-41,242	133,751		133,751	65
66	06600	Physical Therapy	95,713	86,156	181,869	-72	181,797		181,797	66
69	06900	Electrocardiology	8,618	746	9,364	15,773	25,137		25,137	69
71	07100	Medical Supplies Charged to Patients				129,676	129,676		129,676	71
73	07300	Drugs Charged to Patients				226,494	226,494		226,494	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	1,200,560	305,210	1,505,770	6,436	1,512,206		1,512,206	88
90	09000	Clinic	136,493	128,208	264,701	12,547	277,248		277,248	90
91	09100	Emergency	975,592	164,042	1,139,634	-80,809	1,058,825	-288,657	770,168	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		70,006	70,006	-55,574	14,432	-14,432		113
118		SUBTOTALS (sum of lines 1-117)	5,956,332	4,913,419	10,869,751		10,869,751	-961,544	9,908,207	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)	5,956,332	4,913,419	10,869,751		10,869,751	-961,544	9,908,207	200

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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
1	TO RECLASS SUPPLY COST FROM CS	1		3	4	5	
500	Total reclassifications	A	Medical Supplies Charged to P	71	24,316	12,398	1
	Code Letter - A				24,316	12,398	500
1	TO RECLASS DON COST	B	Nursing Administration	13	80,356	16,321	1
500	Total reclassifications				80,356	16,321	500
	Code Letter - B						
1	TO RECLASS CLINIC COST	C	Clinic	90	1,161	223	1
500	Total reclassifications				1,161	223	500
	Code Letter - C						
1	TO RECLASS SUPPLY COST	D	Medical Supplies Charged to P	71		92,962	1
2							2
3							3
4							4
5							5
6							6
500	Total reclassifications					92,962	500
	Code Letter - D						
1	TO RECLASS INSURANCE EXPENSE	E	Cap Rel Costs-Bldg & Fixt	1		6,150	1
2			Cap Rel Costs-Mvble Equip	2		8,850	2
3			Employee Benefits Department	4		54,157	3
500	Total reclassifications					69,157	500
	Code Letter - E						
1	TO RECLASS INTEREST	F	Cap Rel Costs-Bldg & Fixt	1		19,277	1
2			Administrative & General	5		29,055	2
3			Radiology-Diagnostic	54		5,486	3
4			Rural Health Clinic	88		1,115	4
5			Laboratory	60		641	5
500	Total reclassifications					55,574	500
	Code Letter - F						
1	TO RECLASS CAFE COST	G	Cafeteria	11	34,128	28,646	1
500	Total reclassifications				34,128	28,646	500
	Code Letter - G						
1	TO RECLASS CARDIAC MONITORING COST	H	Electrocardiology	69	13,272	2,501	1
2							2
500	Total reclassifications				13,272	2,501	500
	Code Letter - H						
1	TO RECLASS DRUG COST	I	Drugs Charged to Patients	73		226,494	1
2							2
3							3
4							4
5							5
500	Total reclassifications					226,494	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	3,589	1,141	1
500	Total reclassifications				3,589	1,141	500
	Code Letter - K						
	GRAND TOTAL (Increases)				156,822	518,555	

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

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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref. 10	
		1	6	7	8	9		
1	TO RECLASS SUPPLY COST FROM CS	A	Central Services & Supply	14	24,316	12,398	1	
500	Total reclassifications				24,316	12,398	500	
	Code letter - A							
1	TO RECLASS DON COST	B	Adults & Pediatrics	30	80,356	16,321	1	
500	Total reclassifications				80,356	16,321	500	
	Code letter - B							
1	TO RECLASS CLINIC COST	C	Rural Health Clinic	88	1,161	223	1	
500	Total reclassifications				1,161	223	500	
	Code letter - C							
1	TO RECLASS SUPPLY COST	D	Adults & Pediatrics	30		24,824	1	
2			Emergency	91		20,080	2	
3			Radiology-Diagnostic	54		6,455	3	
4			Laboratory	60		345	4	
5			Respiratory Therapy	65		41,242	5	
6			Physical Therapy	66		16	6	
500	Total reclassifications					92,962	500	
	Code letter - D							
1	TO RECLASS INSURANCE EXPENSE	E					12 1	
2							12 2	
3			Administrative & General	5		69,157	3	
500	Total reclassifications					69,157	500	
	Code letter - E							
1	TO RECLASS INTEREST	F					11 1	
2							2	
3							3	
4			Interest Expense	113		55,574	4	
5							5	
500	Total reclassifications					55,574	500	
	Code letter - F							
1	TO RECLASS CAFE COST	G	Dietary	10	34,128	28,646	1	
500	Total reclassifications				34,128	28,646	500	
	Code letter - G							
1	TO RECLASS CARDIAC MONITORING COST	H					1	
2			Adults & Pediatrics	30	13,272	2,501	2	
500	Total reclassifications				13,272	2,501	500	
	Code letter - H							
1	TO RECLASS DRUG COST	I	Adults & Pediatrics	30		99,172	1	
2			Emergency	91		60,729	2	
3			Pharmacy	15		65,522	3	
4			Physical Therapy	66		56	4	
5			Dietary	10		1,015	5	
500	Total reclassifications					226,494	500	
	Code letter - I							
1	TO RECLASS CLINIC DEPRECIATION	J	Cap Rel Costs-Bldg & Fixt	1		10,386	9 1	
2			Cap Rel Costs-Mvble Equip	2		2,752	9 2	
500	Total reclassifications					13,138	500	
	Code letter - J							
1	TO RECLASS CLINIC COST	K	Operation of Plant	7	3,589	1,141	1	
500	Total reclassifications				3,589	1,141	500	
	Code letter - K							
	GRAND TOTAL (Decreases)				156,822	518,555		

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

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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	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	1,796,754					1,796,754		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	2,756,239	105,131		105,131	74,184	2,787,186		6
7	HIT-designated Assets	805,720	92,440		92,440		898,160		7
8	Subtotal (sum of lines 1-7)	5,524,137	197,571		197,571	74,184	5,647,524		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	5,524,137	197,571		197,571	74,184	5,647,524		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	69,073						69,073	1	
2	Cap Rel Costs-Mvble Equip	249,792						249,792	2	
3	Total (sum of lines 1-2)	318,865						318,865	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 line 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	0.347440					1
2	Cap Rel Costs-Mvble Equip	3,685,346		3,685,346	0.652560					2
3	Total (sum of lines 1-2)	5,647,524		5,647,524	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	58,687		19,277	6,150			84,114	1	
2	Cap Rel Costs-Mvble Equip	191,692			8,850			200,542	2	
3	Total (sum of lines 1-2)	250,379		19,277	15,000			284,656	3	

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

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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			Wkst. A-7 Ref.
				COST CENTER	LINE#		
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)	B	-101,439	Administrative & General	5		5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-3,827	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	-534,105				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	-4,916	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	-3,509	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	-14,432	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	-55,348	Cap Rel Costs-Mvble Equip	2	9	32
33	VERIZON RENTAL	B	-6,600	Administrative & General	5		33
34							34
35							35
36							36
37							37
38							38
39	SITE FEES	A	-3,362	Administrative & General	5		39
40	LATE FEES	A	-44,173	Administrative & General	5		40
41							41
42	PROVIDER TAX	A	-185,609	Administrative & General	5		42
43	LOBBING PORTION OF DUES	A	-4,224	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)		-961,544				50

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

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

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

WORKSHEET A-8-1

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

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

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

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

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

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

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

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

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

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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	31,984		31,984					1
2	30	Adults & Pediatrics AGGREGATE	134,134	134,134						2
3	60	Laboratory AGGREGATE	118,514	111,314	7,200					3
4										4
5	91	Emergency AGGREGATE	825,678	288,657	537,021					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	1,110,310	534,105	576,205					200

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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							134,134	2
3	60	Laboratory AGGREGATE							111,314	3
4										4
5	91	Emergency AGGREGATE							288,657	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							534,105	200

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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		729.87				9
10	AHSEA (see instructions)		74.48				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	37.24	37.24				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

Standard Travel Expense							
36	Therapists (line 5 times column 2, line 11)						36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)						38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	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

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

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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		404.14				9
10	AHSEA (see instructions)		78.58				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	39.29	39.29				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

Standard Travel Expense							
36	Therapists (line 5 times column 2, line 11)						36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)						38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	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

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

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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		26.11				9
10	AHSEA (see instructions)		71.57				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	35.79	35.79				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

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

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

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

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

Standard Travel Expense							
36	Therapists (line 5 times column 2, line 11)						36
37	Assistants (line 6 times column 3, line 11)						37
38	Subtotal (sum of lines 36 and 37)						38
39	Standard travel expense (line 7 times the sum of lines 5 and 6)						39
Optional Travel Allowance and Optional Travel Expense							
40	Therapists (sum of columns 1 and 2, line 9 times column 2, line 10)						40
41	Assistants (column 3, line 9 times column 3, line 10)						41
42	Subtotal (sum of lines 40 and 41)						42
43	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

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

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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	84,114	84,114					1
2	Cap Rel Costs-Mvble Equip	200,542		200,542				2
4	Employee Benefits Department	54,157			54,157			4
5	Administrative & General	1,919,090	14,355	34,357	6,779	1,974,581	1,974,581	5
6	Maintenance & Repairs							6
7	Operation of Plant	361,515	8,339	19,960	1,398	391,212	97,368	7
8	Laundry & Linen Service	51,366	3,760	8,999	348	64,473	16,047	8
9	Housekeeping	115,531			760	116,291	28,943	9
10	Dietary	130,508	3,701	8,859	576	143,644	35,751	10
11	Cafeteria	57,858	1,567	3,750	310	63,485	15,801	11
12	Maintenance of Personnel							12
13	Nursing Administration	96,677	8,258	19,764	731	125,430	31,218	13
14	Central Services & Supply	10,454			74	10,528	2,620	14
15	Pharmacy	215,379	1,645	3,937	652	221,613	55,157	15
16	Medical Records & Library	352,954	4,465	10,687	1,879	369,985	92,085	16
17	Social Service	18,062	734	1,758	147	20,701	5,152	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	1,291,893	17,896	42,833	10,360	1,362,982	339,230	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	746,294	5,493	13,148	3,343	768,278	191,215	54
60	Laboratory	945,336	2,481	5,937	3,461	957,215	238,239	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	133,751	1,645	3,937	988	140,321	34,924	65
66	Physical Therapy	181,797	3,199	7,656	870	193,522	48,165	66
69	Electrocardiology	25,137			199	25,336	6,306	69
71	Medical Supplies Charged to Patients	129,676	1,576	3,773	221	135,246	33,661	71
73	Drugs Charged to Patients	226,494				226,494	56,372	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	1,512,206			10,907	1,523,113	379,082	88
90	Clinic	277,248			1,284	278,532	69,323	90
91	Emergency	770,168	4,279	10,242	8,870	793,559	197,507	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)	9,908,207	83,393	199,597	54,157	9,906,541	1,974,166	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		395	945		1,340	334	190
190.01	VENDING MACHINE		326			326	81	190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	9,908,207	84,114	200,542	54,157	9,908,207	1,974,581	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		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	488,580						7
8	Laundry & Linen Service	29,910	110,430					8
9	Housekeeping		4,962	150,196				9
10	Dietary	29,443	4,087	9,641	222,566			10
11	Cafeteria	12,462		4,081	77,683	173,512		11
12	Maintenance of Personnel							12
13	Nursing Administration	65,688		21,510		2,946	246,792	13
14	Central Services & Supply					501	7,770	14
15	Pharmacy	13,086		4,285		3,736		15
16	Medical Records & Library	35,518		11,631		9,917		16
17	Social Service	5,842		1,913		924		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	142,357	73,870	46,616	130,560	52,278	239,022	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	43,696	7,745	14,309		16,232		54
60	Laboratory	19,732		6,462		17,311		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,086		4,285		5,661		65
66	Physical Therapy	25,444	9,082	8,332		4,005		66
69	Electrocardiology					1,194		69
71	Medical Supplies Charged to Patients	12,540		4,106		1,521		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					37,510		88
90	Clinic				14,323	5,565		90
91	Emergency	34,038	10,684	11,146		14,211		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)	482,842	110,430	148,317	222,566	173,512	246,792	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,142		1,029				190
190.01	VENDING MACHINE	2,596		850				190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	488,580	110,430	150,196	222,566	173,512	246,792	202

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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	
		14	15	16	17	24	25	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply	21,419						14
15	Pharmacy	1,787	299,664					15
16	Medical Records & Library	122		519,258				16
17	Social Service				34,532			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	1,357		400,536	34,532	2,823,340		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	177		118,722		1,160,374		54
60	Laboratory	12,984				1,251,943		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	104				198,381		65
66	Physical Therapy	112				288,662		66
69	Electrocardiology	42				32,878		69
71	Medical Supplies Charged to Patients	3,163				190,237		71
73	Drugs Charged to Patients		264,383			547,249		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	752	35,281			1,975,738		88
90	Clinic	93				367,836		90
91	Emergency	726				1,061,871		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	21,419	299,664	519,258	34,532	9,898,509		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					5,845		190
190.01	VENDING MACHINE					3,853		190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,419	299,664	519,258	34,532	9,908,207		202

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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	2,823,340					30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	1,160,374					54
60	Laboratory	1,251,943					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	198,381					65
66	Physical Therapy	288,662					66
69	Electrocardiology	32,878					69
71	Medical Supplies Charged to Patients	190,237					71
73	Drugs Charged to Patients	547,249					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	1,975,738					88
90	Clinic	367,836					90
91	Emergency	1,061,871					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)	9,898,509					118
	NONREIMBURSABLE COST CENTERS						
190	Gift, Flower, Coffee Shop & Canteen	5,845					190
190.01	VENDING MACHINE	3,853					190.01
200	Cross Foot Adjustments						200
201	Negative Cost Centers						201
202	TOTAL (sum of lines 118-201)	9,908,207					202

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	OPERATION OF PLANT	
		0	1	2	2A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General		14,355	34,357	48,712	48,712		5
6	Maintenance & Repairs							6
7	Operation of Plant		8,339	19,960	28,299	2,402	30,701	7
8	Laundry & Linen Service		3,760	8,999	12,759	396	1,879	8
9	Housekeeping					714		9
10	Dietary		3,701	8,859	12,560	882	1,850	10
11	Cafeteria		1,567	3,750	5,317	390	783	11
12	Maintenance of Personnel							12
13	Nursing Administration		8,258	19,764	28,022	770	4,128	13
14	Central Services & Supply					65		14
15	Pharmacy		1,645	3,937	5,582	1,361	822	15
16	Medical Records & Library		4,465	10,687	15,152	2,272	2,232	16
17	Social Service		734	1,758	2,492	127	367	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		17,896	42,833	60,729	8,369	8,946	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		5,493	13,148	18,641	4,717	2,746	54
60	Laboratory		2,481	5,937	8,418	5,877	1,240	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,645	3,937	5,582	862	822	65
66	Physical Therapy		3,199	7,656	10,855	1,188	1,599	66
69	Electrocardiology					156		69
71	Medical Supplies Charged to Patients		1,576	3,773	5,349	830	788	71
73	Drugs Charged to Patients					1,391		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					9,351		88
90	Clinic					1,710		90
91	Emergency		4,279	10,242	14,521	4,872	2,139	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)		83,393	199,597	282,990	48,702	30,341	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		395	945	1,340	8	197	190
190.01	VENDING MACHINE		326		326	2	163	190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		84,114	200,542	284,656	48,712	30,701	202

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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	15,034						8
9	Housekeeping	675	1,389					9
10	Dietary	556	89	15,937				10
11	Cafeteria		38	5,563	12,091			11
12	Maintenance of Personnel							12
13	Nursing Administration		199		205	33,324		13
14	Central Services & Supply				35	1,049	1,149	14
15	Pharmacy		40		260		96	15
16	Medical Records & Library		108		691		7	16
17	Social Service		18		64			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	10,058	429	9,348	3,645	32,275	73	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,054	132		1,131		9	54
60	Laboratory		60		1,206		696	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		40		394		6	65
66	Physical Therapy	1,236	77		279		6	66
69	Electrocardiology				83		2	69
71	Medical Supplies Charged to Patients		38		106		170	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				2,614		40	88
90	Clinic			1,026	388		5	90
91	Emergency	1,455	103		990		39	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)	15,034	1,371	15,937	12,091	33,324	1,149	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		10					190
190.01	VENDING MACHINE		8					190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	15,034	1,389	15,937	12,091	33,324	1,149	202

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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	8,161						15
16	Medical Records & Library		20,462					16
17	Social Service			3,068				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		15,784	3,068	152,724		152,724	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		4,678		33,108		33,108	54
60	Laboratory				17,497		17,497	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy				7,706		7,706	65
66	Physical Therapy				15,240		15,240	66
69	Electrocardiology				241		241	69
71	Medical Supplies Charged to Patients				7,281		7,281	71
73	Drugs Charged to Patients	7,200			8,591		8,591	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	961			12,966		12,966	88
90	Clinic				3,129		3,129	90
91	Emergency				24,119		24,119	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)	8,161	20,462	3,068	282,602		282,602	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				1,555		1,555	190
190.01	VENDING MACHINE				499		499	190.01
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	8,161	20,462	3,068	284,656		284,656	202

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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			5,956,232				4
5	Administrative & General	4,398	4,398	745,632	-1,974,581	7,933,626		5
6	Maintenance & Repairs							6
7	Operation of Plant	2,555	2,555	153,749		391,212	18,818	7
8	Laundry & Linen Service	1,152	1,152	38,318		64,473	1,152	8
9	Housekeeping			83,589		116,291		9
10	Dietary	1,134	1,134	63,381		143,644	1,134	10
11	Cafeteria	480	480	34,128		63,485	480	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,530	2,530	80,356		125,430	2,530	13
14	Central Services & Supply			8,106		10,528		14
15	Pharmacy	504	504	71,669		221,613	504	15
16	Medical Records & Library	1,368	1,368	206,657		369,985	1,368	16
17	Social Service	225	225	16,172		20,701	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	1,139,446		1,362,982	5,483	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,683	1,683	367,695		768,278	1,683	54
60	Laboratory	760	760	380,629		957,215	760	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	504	504	108,650		140,321	504	65
66	Physical Therapy	980	980	95,713		193,522	980	66
69	Electrocardiology			21,890		25,336		69
71	Medical Supplies Charged to Patients	483	483	24,316		135,246	483	71
73	Drugs Charged to Patients					226,494		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			1,199,301		1,523,113		88
90	Clinic			141,243		278,532		90
91	Emergency	1,311	1,311	975,592		793,559	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	5,956,232	-1,974,581	7,931,960	18,597	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	121	121			1,340	121	190
190.01	VENDING MACHINE	100				326	100	190.01
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	84,114	200,542	54,157		1,974,581	488,580	202
203	Unit Cost Multiplier (Wkst. B, Part I)	3.263901	7.812006	0.009092		0.248888	25.963439	203
204	Cost to be allocated (Per Wkst. B, Part II)					48,712	30,701	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.006140	1.631470	205

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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 NRS ING HRS	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	71,957						8
9	Housekeeping	3,233	17,666					9
10	Dietary	2,663	1,134	15,182				10
11	Cafeteria		480	5,299	9,011			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,530		153	69,242		13
14	Central Services & Supply				26	2,180	629,573	14
15	Pharmacy		504		194		52,514	15
16	Medical Records & Library		1,368		515		3,599	16
17	Social Service		225		48		4	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	48,134	5,483	8,906	2,715	67,062	39,889	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	5,047	1,683		843		5,189	54
60	Laboratory		760		899		381,623	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		504		294		3,066	65
66	Physical Therapy	5,918	980		208		3,293	66
69	Electrocardiology				62		1,238	69
71	Medical Supplies Charged to Patients		483		79		92,962	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				1,948		22,116	88
90	Clinic			977	289		2,740	90
91	Emergency	6,962	1,311		738		21,340	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	71,957	17,445	15,182	9,011	69,242	629,573	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)	110,430	150,196	222,566	173,512	246,792	21,419	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.534667	8.501981	14.659860	19.255577	3.564195	0.034021	203
204	Cost to be allocated (Per Wkst. B, Part II)	15,034	1,389	15,937	12,091	33,324	1,149	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.208930	0.078626	1.049730	1.341804	0.481269	0.001825	205

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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	256,719					15
16	Medical Records & Library		34,640				16
17	Social Service			1,396			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		26,720	1,396			30
ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		7,920				54
60	Laboratory						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy						65
66	Physical Therapy						66
69	Electrocardiology						69
71	Medical Supplies Charged to Patients						71
73	Drugs Charged to Patients	226,494					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	30,225					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)	256,719	34,640	1,396			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)	299,664	519,258	34,532			202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.167284	14.990127	24.736390			203
204	Cost to be allocated (Per Wkst. B, Part II)	8,161	20,462	3,068			204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.031790	0.590704	2.197708			205

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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4

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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	2,823,340		2,823,340			30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	1,160,374		1,160,374			54
60	Laboratory	1,251,943		1,251,943			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	198,381		198,381			65
66	Physical Therapy	288,662		288,662			66
69	Electrocardiology	32,878		32,878			69
71	Medical Supplies Charged to Patients	190,237		190,237			71
73	Drugs Charged to Patients	547,249		547,249			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	1,975,738		1,975,738			88
90	Clinic	367,836		367,836			90
91	Emergency	1,061,871		1,061,871			91
92	Observation Beds (Non-Distinct Part)	461,585		461,585			92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	10,360,094		10,360,094			200
201	Less Observation Beds	461,585		461,585			201
202	Total (line 200 minus line 201)	9,898,509		9,898,509			202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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	1,267,132		1,267,132				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	435,035	3,462,411	3,897,446	0.297727			54
60	Laboratory	535,841	2,837,685	3,373,526	0.371108			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	123,626	283,666	407,292	0.487073			65
66	Physical Therapy	210,748	819,816	1,030,564	0.280101			66
69	Electrocardiology	25,648	163,793	189,441	0.173553			69
71	Medical Supplies Charged to Patients	429,976	110,284	540,260	0.352121			71
73	Drugs Charged to Patients	775,523	678,111	1,453,634	0.376470			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		1,603,820	1,603,820				88
90	Clinic		406,870	406,870	0.904063			90
91	Emergency	25,239	1,481,139	1,506,378	0.704917			91
92	Observation Beds (Non-Distinct Part)	835	303,000	303,835	1.519196			92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	3,829,603	12,150,595	15,980,198				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	3,829,603	12,150,595	15,980,198				202

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-1328

WORKSHEET D
PART V

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

(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.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	0.297727		1,079,562			321,415	54
60	Laboratory	0.371108		1,401,608			520,148	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	0.487073		29,776			14,503	65
66	Physical Therapy	0.280101		253,645			71,046	66
69	Electrocardiology	0.173553		154,661			26,842	69
71	Medical Supplies Charged to Pat	0.352121		107,837			37,972	71
73	Drugs Charged to Patients	0.376470		171,746			64,657	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic	0.904063		320,611			289,853	90
91	Emergency	0.704917		418,698			295,147	91
92	Observation Beds (Non-Distinct	1.519196		104,247			158,372	92
	OTHER REIMBURSABLE COST CENTERS							
200	Subtotal (see instructions)			4,042,391			1,799,955	200
201	Less PBP Clinic Lab. Services-Program Only Charges							201
202	Net Charges (line 200 - line 201)			4,042,391			1,799,955	202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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/IID

(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.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.297727							54
60	Laboratory	0.371108							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.487073							65
66	Physical Therapy	0.280101							66
69	Electrocardiology	0.173553							69
71	Medical Supplies Charged to Pat	0.352121							71
73	Drugs Charged to Patients	0.376470							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.904063							90
91	Emergency	0.704917							91
92	Observation Beds (Non-Distinct	1.519196							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: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

**WORKSHEET D
PART I**

Check Title V
 Applicable Title XVIII, Part A
 Boxes: 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)	152,724	43,358	109,366	1,809	60.46	223	13,483	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)	152,724		109,366	1,809		223	13,483	200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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	33,108	3,897,446	0.008495			54
60	Laboratory	17,497	3,373,526	0.005187			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	7,706	407,292	0.018920			65
66	Physical Therapy	15,240	1,030,564	0.014788			66
69	Electrocardiology	241	189,441	0.001272			69
71	Medical Supplies Charged to Pat	7,281	540,260	0.013477			71
73	Drugs Charged to Patients	8,591	1,453,634	0.005910			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	12,966	1,603,820	0.008084			88
90	Clinic	3,129	406,870	0.007690			90
91	Emergency	24,119	1,506,378	0.016011			91
92	Observation Beds (Non-Distinct	24,969	303,835	0.082179			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	154,847	14,713,066				200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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)	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	1,809		223		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)	1,809		223		200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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**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/IID PPS
 Applicable Title XVIII, Part A IPF SNF TEFRA
 Boxes: Title XIX IRF NF Other

(A)	Cost Center Description	1 Non Physician Anesthetist Cost	2 Nursing School	3 Allied Health	4 All Other Medical Education Cost	5 Total Cost (sum of col. 1 through col. 4)	6 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
69	Electrocardiology							69
71	Medical Supplies Charged to Pat							71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic							88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct)							92
	OTHER REIMBURSABLE COST CENTERS							
200	Total (sum of lines 50-199)							200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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**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/IID 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	3,897,446							54
60	Laboratory	3,373,526							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	407,292							65
66	Physical Therapy	1,030,564							66
69	Electrocardiology	189,441							69
71	Medical Supplies Charged to Pat	540,260							71
73	Drugs Charged to Patients	1,453,634							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	1,603,820							88
90	Clinic	406,870							90
91	Emergency	1,506,378							91
92	Observation Beds (Non-Distinct	303,835							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	14,713,066							200

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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/IID

(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.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.297727							54
60	Laboratory	0.371108							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.487073							65
66	Physical Therapy	0.280101							66
69	Electrocardiology	0.173553							69
71	Medical Supplies Charged to Pat	0.352121							71
73	Drugs Charged to Patients	0.376470							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.904063							90
91	Emergency	0.704917							91
92	Observation Beds (Non-Distinct	1.519196							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: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,705	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,809	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)	1,396	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	521	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)	174	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	151	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)	50	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	912	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)	521	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)	174	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)	2,823,340	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)	18,215	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	6,557	25
26	Total swing-bed cost (see instructions)	801,532	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,021,808	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)	2,021,808	37

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID 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)					413	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,117.64	88
89	Observation bed cost (line 87 x line 88) (see instructions)					461,585	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	152,724	2,823,340	0.054093	461,585	24,969	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: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1
PART I

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

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	2,705	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	1,809	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)	1,396	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	521	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)	174	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	151	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)	50	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	223	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)	2,823,340	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)	18,215	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	6,557	25
26	Total swing-bed cost (see instructions)	801,532	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,021,808	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)	2,021,808	37

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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

38	Adjusted general inpatient routine service cost per diem (see instructions)					1,117.64	38
39	Program general inpatient routine service cost (line 9 x line 38)					249,234	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)					249,234	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)					249,234	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					13,483	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)					13,483	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: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1
PARTS III & IV

Check Title V - I/P Hospital SUB (Other) ICF/IID 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)					413	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						88
89	Observation bed cost (line 87 x line 88) (see instructions)						89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4 (see instructions)	
		1	2	3	4	5	
90	Capital-related cost						90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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/IID 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		772,787		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.297727	217,258	64,684	54
60	Laboratory	0.371108	277,457	102,967	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.487073	62,382	30,385	65
66	Physical Therapy	0.280101	12,022	3,367	66
69	Electrocardiology	0.173553	13,381	2,322	69
71	Medical Supplies Charged to Patients	0.352121	192,552	67,802	71
73	Drugs Charged to Patients	0.376470	381,451	143,605	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.904063			90
91	Emergency	0.704917	4,808	3,389	91
92	Observation Beds (Non-Distinct Part)	1.519196	86	131	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,161,397	418,652	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,161,397		202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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/IID 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	0.297727	32,552	9,692	54
60	Laboratory	0.371108	78,756	29,227	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.487073	34,998	17,047	65
66	Physical Therapy	0.280101	160,017	44,821	66
69	Electrocardiology	0.173553	1,048	182	69
71	Medical Supplies Charged to Patients	0.352121	126,530	44,554	71
73	Drugs Charged to Patients	0.376470	155,839	58,669	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.904063			90
91	Emergency	0.704917	4,500	3,172	91
92	Observation Beds (Non-Distinct Part)	1.519196	604	918	92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		594,844	208,282	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		594,844		202

(A) Worksheet A line numbers

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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/IID 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	0.297727			54
60	Laboratory	0.371108			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.487073			65
66	Physical Therapy	0.280101			66
69	Electrocardiology	0.173553			69
71	Medical Supplies Charged to Patients	0.352121			71
73	Drugs Charged to Patients	0.376470			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.904063			90
91	Emergency	0.704917			91
92	Observation Beds (Non-Distinct Part)	1.519196			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: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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)	1,799,955			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)	1,799,955			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)	1,817,955			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)	10,827			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	548,115			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)	1,259,013			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)	1,259,013			30
31	Primary payer payments	118			31
32	Subtotal (line 30 minus line 31)	1,258,895			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)	177,423			34
35	Adjusted reimbursable bad debts (see instructions)	115,325			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	172,245			36
37	Subtotal (see instructions)	1,374,220			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)	1,374,220			40
40.01	Sequestration adjustment (see instructions)	27,484			40.01
41	Interim payments	1,150,631			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	196,105			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

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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		1,091,264		1,226,242	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	02/25/2016			3.01
		.02				3.02
		.03				3.03
		.04				3.04
		.05				3.05
		.06				3.06
		.07				3.07
		.08				3.08
		.09				3.09
		.10				3.10
		.50				3.50
		.51		02/25/2016	75,611	3.51
		.52				3.52
		.53				3.53
		.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	147,297		-75,611	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)		1,238,561		1,150,631	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
		.03				5.03
		.04				5.04
		.05				5.05
		.06				5.06
		.07				5.07
		.08				5.08
		.09				5.09
		.10				5.10
		.50				5.50
		.51				5.51
		.52				5.52
		.53				5.53
		.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	12,132		196,105	6.01
		.02				6.02
7	Total Medicare program liability (see instructions)		1,250,693		1,346,736	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.

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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)	394	1
2	Medicare days (Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8-12)	912	2
3	Medicare HMO days (Wkst. S-3, Pt. I, col. 6, line 2)	144	3
4	Total inpatient days (Wkst. S-3, Pt. I, col. 8, sum of lines 1, 8-12)	1,396	4
5	Total hospital charges (Wkst. C, Pt. I, col. 8, line 200)	15,980,198	5
6	Total hospital charity care charges (Wkst. S-10, col. 3, line 20)	519,914	6
7	CAH only - The reasonable cost incurred for the purchase of certified HIT technology (Wkst. S-2, Pt. I, line 168)	92,441	7
8	Calculation of the HIT incentive payment (see instructions)	90,768	8
9	Sequestration adjustment amount (see instructions)	1,815	9
10	Calculation of the HIT incentive payment after sequestration (see instructions)	88,953	10

INPATIENT HOSPITAL SERVICES UNDER THE IPSS & 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)	88,953	32

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

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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)	784,527		1
2 Inpatient routine services - swing bed-NF (see instructions)			2
3 Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	210,365		3
4 Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5 Program days	695		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)	994,892		8
9 Primary payer payments (see instructions)			9
10 Subtotal (line 8 minus line 9)	994,892		10
11 Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12 Subtotal (line 10 minus line 11)	994,892		12
13 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	38,493		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)	956,399		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)	30,698		17
17.01 Adjusted reimbursable bad debts (see instructions)	19,954		17.01
18 Allowable bad debts for dual eligible beneficiaries (see instructions)			18
19 Total (see instructions)	976,353		19
19.01 Sequestration adjustment (see instructions)	19,527		19.01
20 Interim payments	1,224,176		20
21 Tentative settlement (for contractor use only)			21
22 Balance due provider/program (line 19 minus lines 19.01, 20 and 21)	-267,350		22
23 Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

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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	1,437,940	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,437,940	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,452,319	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)	1,452,319	19
20	Deductibles (exclude professional component)	208,780	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,243,539	22
23	Coinsurance	1,890	23
24	Subtotal (line 22 minus line 23)	1,241,649	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	53,181	25
26	Adjusted reimbursable bad debts (see instructions)	34,568	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	53,181	27
28	Subtotal (sum of lines 24 and 26)	1,276,217	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,276,217	30
30.01	Sequestration adjustment (see instructions)	25,524	30.01
31	Interim payments	1,238,561	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 31 and 32)	12,132	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

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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/IID 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	249,234	1
2	Medical and other services		2
3	Organ acquisition (certified transplant centers only)		3
4	Subtotal (sum of lines 1, 2 and 3)	249,234	4
5	Inpatient primary payer payments		5
6	Outpatient primary payer payments		6
7	Subtotal (line 4 less sum of lines 5 and 6)	249,234	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(c)		14
15	Ratio of line 13 to line 14 (not to exceed 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)	249,234	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)	249,234	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)	249,234	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)	249,234	36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		37
38	Subtotal (line 36 ± line 37)	249,234	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)	249,234	40
41	Interim payments	249,234	41
42	Balance due provider/program (line 40 minus line 41)		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		43

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BALANCE SHEET

WORKSHEET G

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

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
Assets (Omit Cents)		1	2	3	4	
CURRENT ASSETS						
1	Cash on hand and in banks	127,313				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	2,665,189				4
5	Other receivables	168,563				5
6	Allowances for uncollectible notes and accounts receivable	-871,800				6
7	Inventory	185,224				7
8	Prepaid expenses	13,077				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	2,287,566				11
FIXED ASSETS						
12	Land	17,000				12
13	Land improvements	148,425				13
14	Accumulated depreciation	-125,492				14
15	Buildings	1,796,754				15
16	Accumulated depreciation	-1,235,854				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	3,687,249				23
24	Accumulated depreciation	-2,782,160				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)	1,505,922				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)					35
36	Total assets (sum of lines 11, 30 and 35)	3,793,488				36
Liabilities and Fund Balances (Omit Cents)						
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	1,183,838				37
38	Salaries, wages and fees payable	562,047				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	558,493				40
41	Deferred income	237,789				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	10,000				44
45	Total current liabilities (sum of lines 37 thru 44)	2,552,167				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	540,063				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	540,063				50
51	Total liabilities (sum of lines 45 and 50)	3,092,230				51
CAPITAL ACCOUNTS						
52	General fund balance	701,258				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)	701,258				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	3,793,488				60

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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		1,285,496			1
2	Net income (loss) (from Worksheet G-3, line 29)		-584,238			2
3	Total (sum of line 1 and line 2)		701,258			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)		701,258			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)		701,258			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

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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	1,632,204		1,632,204	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	584,439		584,439	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)	2,216,643		2,216,643	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)	2,216,643		2,216,643	17
18	Ancillary services	2,683,624	8,589,849	11,273,473	18
19	Outpatient services	26,276	3,312,401	3,338,677	19
20	Rural Health Clinic (RHC)		1,603,820	1,603,820	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)	4,926,543	13,506,070	18,432,613	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		10,869,751	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)		10,869,751	43

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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	Total patient revenues (from Worksheet G-2, Part I, column 3, line 28)	18,432,613	1
2	Less contractual allowances and discounts on patients' accounts	8,584,159	2
3	Net patient revenues (line 1 minus line 2)	9,848,454	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	10,869,751	4
5	Net income from service to patients (line 3 minus line 4)	-1,021,297	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	579	6
7	Income from investments	7,380	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses	101,439	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	33,749	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	3,157	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (MISCELLANOUS)	7,601	24
24.01	Other (GRANTS)	121,127	24.01
24.02	Other (DEFERRED REVENUE)	55,348	24.02
24.03	Other (SITE FEES)	3,362	24.03
24.04	Other (EHR INCENTIVE)	103,317	24.04
25	Total other income (sum of lines 6-24)	437,059	25
26	Total (line 5 plus line 25)	-584,238	26
29	Net income (or loss) for the period (line 26 minus line 28)	-584,238	29

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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

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

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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

		COMPENS- ATION	OTHER COSTS	TOTAL (col. 1 + col. 2)	RECLASS- IFICATIONS	RECLASS- IFIED TRIAL BALANCE (col. 3 + col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOCATION (col. 5 + col. 6)	
		1	2	3	4	5	6	7	
	FACILITY HEALTH CARE STAFF COSTS								
1	Physician	505,610	70,565	576,175		576,175		576,175	1
2	Physician Assistant								2
3	Nurse Practitioner	173,296	19,415	192,711		192,711		192,711	3
4	Visiting Nurse								4
5	Other Nurse	232,509	29,973	262,482		262,482		262,482	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Technician								8
9	Other Facility Health Care Staff Costs	280,895	73,894	354,789		354,789		354,789	9
10	Subtotal (sum of lines 1 through 9)	1,192,310	193,847	1,386,157		1,386,157		1,386,157	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement	8,250		8,250		8,250		8,250	11
12	Physician Supervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)	8,250		8,250		8,250		8,250	14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		1,492	1,492		1,492		1,492	15
16	Transportation (Health Care Staff)		2,369	2,369		2,369		2,369	16
17	Depreciation-Medical Equipment		6,705	6,705		6,705		6,705	17
18	Professional Liability Insurance								18
19	Other Health Care Costs		30,245	30,245		30,245		30,245	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		40,811	40,811		40,811		40,811	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,200,560	234,658	1,435,218		1,435,218		1,435,218	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		77,257	77,257		77,257		77,257	29
30	Administrative Costs				-269	-269		-269	30
31	Total Facility Overhead (sum of lines 29 and 30)		77,257	77,257	-269	76,988		76,988	31
32	Total facility costs (sum of lines 22, 28 and 31)	1,200,560	311,915	1,512,475	-269	1,512,206		1,512,206	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.

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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3479

WORKSHEET M-2

Check applicable box: RHC I FQHC

VISITS AND PRODUCTIVITY

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	2.02	9,534	4,200	8,484		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.75	4,621	2,100	3,675		3
4	Subtotal (sum of lines 1 through 3)	3.77	14,155		12,159	14,155	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)	3.77	14,155			14,155	8
9	Physician Services Under Agreements		148			148	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)		1,435,218	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)		1,435,218	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)		76,988	14
15	Parent provider overhead allocated to facility (see instructions)		463,532	15
16	Total overhead (sum of lines 14 and 15)		540,520	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		540,520	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		540,520	19
20	Total allowable cost of RHC/FQHC services(sum of lines 10 and 19)		1,975,738	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.

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CALCULATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST

COMPONENT CCN: 14-3479

WORKSHEET M-4

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

		PNEUMO-COCCAL	INFLUENZA	
		1	2	
1	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,386,157	1,386,157	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000260	0.002549	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	360	3,533	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,638	7,819	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	1,998	11,352	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,435,218	1,435,218	6
7	Total overhead (from Wkst. M-2, line 16)	540,520	540,520	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001392	0.007910	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	752	4,276	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,750	15,628	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	54	529	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	50.93	29.54	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	32	389	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	1,630	11,491	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)		18,378	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		13,121	16

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2015 To: 03/31/2016	Run Date: 08/23/2016 Run Time: 10:20 Version: 2016.05 (08/16/2016)
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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

		Part B		
DESCRIPTION		mm/dd/yyyy	Amount	
		1	2	
1	Total interim payments paid to provider		460,228	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero			2
3	List separately each retroactive lump sum adjustment 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	13,016	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	13,016	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)		473,244	
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	59,704	6.01
		.02		6.02
7	Total Medicare program liability (see instructions)		532,948	
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.