

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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. ☒ Electronically filed cost report Date: 08/13/2018 Time: 13:13 2. ☐ Manually submitted cost report 3. ☐ If this is an amended report enter the number of times the provider resubmitted the cost report 4. ☐ Medicare Utilization. Enter 'F' for full or 'L' for low.		
Contractor use only	5. ☐ 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. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: _____ 11. Contractor's Vendor Code: ____ 12. ☐ 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 CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARDIN COUNTY GENERAL HOSPITAL (14-1328) {(Provider Name(s) and Number(s)} for the cost reporting period beginning 04/01/2017 and ending 03/31/2018, and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

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

Title

Date

PART III - SETTLEMENT SUMMARY

		TITLE XVIII		HIT	TITLE XIX	
		TITLE V	PART A	PART B		
		1	2	3	4	5
1	HOSPITAL		-84,388	-127,353		46,094
2	SUBPROVIDER - IPF					
3	SUBPROVIDER - IRF					
4	SUBPROVIDER (OTHER)					
5	SWING BED - SNF		-90,697			
6	SWING BED - NF					
7	SKILLED NURSING FACILITY					
8	NURSING FACILITY					
9	HOME HEALTH AGENCY					
10	HEALTH CLINIC - RHC			42,134		
11	HEALTH CLINIC - FQHC					
12	OUTPATIENT REHABILITATION PROVIDER					
200	TOTAL		-175,085	-85,219		46,094

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

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**WORKSHEET S
PARTS I, II & III**

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

20	Cost Reporting Period (mm/dd/yyyy)	From: 04 / 01 / 2017	To: 03 / 31 / 2018		20
21	Type of control (see instructions)	2			21

Inpatient PPS Information

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

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	Medicaid HMO days	Other Medicaid days	
		1	2	3	4	5	6	
24	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.							24
25	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid 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 OPPS final rule? Enter 'Y' for yes or 'N' for no. (see instructions)	N			37.01
38	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.	Beginning:		Ending:	38

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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)(i) or (ii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions)	N	N	39
40	Is this hospital subject to the HAC program reduction adjustment? Enter 'Y' for yes or 'N' for no in column 1, for discharges prior to October 1. Enter 'Y' for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40
Prospective Payment System (PPS)-Capital		V 1	XVIII 2	XIX 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
		NAHE 413.85 Y/N 1	Worksheet A Line # 2	Pass-Through Qualification Criteria Code 3	
60	Are you claiming nursing and allied health education (NAHE) costs for any program(s) that meet the criteria under 42 CFR 413.85? (see instructions)	N			60
		Y/N 1	IME 4	Direct GME 5	
61	Did your hospital receive FTE slots under ACA section 5503? Enter 'Y' for yes or 'N' for no in column 1.(see instructions)	N			61
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)				61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)				61.02
61.03	Enter the baseline FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)				61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or 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. Enter in column 4, the direct GME FTE unweighted count.

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1	2	3	4	

Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program (see instructions). Enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the IME FTE unweighted count. Enter in column 4 direct the GME FTE unweighted count.

ACA Provisions Affecting the Health Resources and Services Administration (HRSA)

62	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital 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 through 67. (see instructions)	N			63
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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 is 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 is 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 an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter 'Y' for yes and 'N' for no.	N		87

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PART I**

		V	XIX	
	Title V and XIX Services	1	2	
90	Does this facility have title V and/or XIX inpatient hospital services? Enter 'Y' for yes, or 'N' for no in applicable column.	N	Y	90
91	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter 'Y' for yes, or 'N' for no in the applicable column.	N	N	91
92	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? Enter 'Y' for yes or 'N' for no in the applicable column.		N	92
93	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	93
94	Does title V or title XIX reduce capital cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	94
95	If line 94 is 'Y', enter the reduction percentage in the applicable column.			95
96	Does title V or title XIX reduce operating cost? Enter 'Y' for yes or 'N' for no in the applicable column.	N	N	96
97	If line 96 is 'Y', enter the reduction percentage in the applicable column.			97
98	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	N	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	Y	N	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter 'Y' for yes or 'N' for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.06

Rural Providers

Rural Providers				1	2	
105	Does this hospital qualify as a CAH?			Y		105
106	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106
107	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter 'Y' for yes and 'N' for no in column 1. (see instructions) If yes, the GME elinination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes, complete Wkst. D-2, Pt. II.			N		107
108	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR §412.113(c). Enter 'Y' for yes or 'N' for no.			N		108
		Physical	Occupational	Speech	Respiratory	
109	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter 'Y' for yes or 'N' for each therapy.	Y	Y	Y	N	109

		1		
110	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N		110
		1	2	
111	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter 'Y' for yes or 'N' for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: 'A' for Ambulance services; 'B' for additional beds; and/or 'C' for tele-health services.	N		111

Miscellaneous Cost Reporting Information

115	Is this an all-inclusive rate provider? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 'E', enter in column 3 either '93' percent for short term hospital or '98' percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-I, chapter 22, section 2208.1.	N			115
116	Is this facility classified as a referral center? Enter 'Y' for yes or 'N' for no.	N			116
117	Is this facility legally required to carry malpractice insurance? Enter 'Y' for yes or 'N' for no.	N			117
118	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118
		Premiums	Paid Losses	Self Insurance	
118.01	List amounts of malpractice premiums and paid losses:	67,678			118.01
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General cost center? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
120	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 1 'Y' for yes or 'N' for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions). Enter in column 2 'Y' for yes or 'N' for no.	N	N		120
121	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter 'Y' for yes or 'N' for no.	N			121
122	Does the cost report contain state health care related taxes as defined in §1983(w)(3) of the Act? Enter 'Y' for yes or 'N' for no in column 1. If column 1 is 'Y', enter in column 2 the Worksheet A line number where these taxes are included.	N			122

Transplant Center Information

125	Does this facility operate a transplant center? Enter 'Y' for yes or 'N' for no. If yes, enter certification date(s)(mm/dd/yyyy) below.	N		125
126	If this is a Medicare certified kidney transplant center enter the certification date in column 1 and termination date in column 2.			126
127	If this is a Medicare certified heart transplant center enter the certification date in column 1 and termination date in column 2.			127
128	If this is a Medicare certified liver transplant center enter the certification date in column 1 and termination date in column 2.			128
129	If this is a Medicare certified lung transplant center enter the certification date in column 1 and termination date in column 2.			129
130	If this is a Medicare certified pancreas transplant center enter the certification date in column 1 and termination date in column 2.			130
131	If this is a Medicare certified intestinal transplant center enter the certification date in column 1 and termination date in column 2.			131
132	If this is a Medicare certified islet transplant center enter the certification date in column 1 and termination date in column 2.			132

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

133	If this is a Medicare certified other transplant center enter the certification date in column 1 and termination date in column 2.			133
134	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable in column 2.			134

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA**WORKSHEET S-2
PART I**

All Providers

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

If this facility is part of a chain organization, enter the name of the home office, the home office contractor name, and home office contractor number on line 141. Enter the address of the home office on lines 142 and 143.

141	Name:	Contractor's Name:	Contractor's Number:	141
142	Street:	P.O. Box:		142
143	City:	State:	ZIP Code:	143
144	Are provider based physicians' costs included in Worksheet A?	Y		144
145	If costs for renal services are claimed on Wkst. A, line 74 are the costs for inpatient services only? Enter 'Y' for yes, or 'N' for no in column 1. 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		Title V	Title XIX	
		Part A	Part B			
		1	2	3	4	
155	Hospital	N	N	N	N	155
156	Subprovider - IPF	N	N			156
157	Subprovider - IRF	N	N			157
158	Subprovider - Other					158
159	SNF	N	N			159
160	HHA	N	N			160
161	CMHC		N			161
161.10	CORF					161.10

Multicampus

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

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

167	Is this provider a meaningful user under §1886(n)? Enter 'Y' for yes or 'N' for no.	Y		167
168	If this provider is a CAH (line 105 is 'Y') and is a meaningful user (line 167 is 'Y'), enter the reasonable cost incurred for the HIT assets. (see instructions)	1		168
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter 'Y' for yes or 'N' for no. (see instructions)			168.01
169	If this provider is a meaningful user (line 167 is 'Y') and is not a CAH (line 105 is 'N'), enter the transition factor. (see instructions)			169
170	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	04 / 01 / 2017	03 / 31 / 2018	170
171	If line 167 is 'Y', does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter 'Y' for yes and 'N' for no in column 1. If column 1 is 'Y', enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	2		
1	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1
		Y/N	Date	V/I	
		1	2	3	
2	Has the provider terminated participation in the Medicare program? If yes, enter in column 2 the date of termination and in column 3, 'V' for voluntary or 'I' for involuntary.	N			2
3	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3

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

		Y/N	Y/N	
Approved Educational Activities		1	2	
6	Column 1: Are costs claimed for nursing school? 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		
PS&R Report Data		Y/N	Date	Y/N	Date	
		1	2	3	4	
16	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Y	06/27/2018	Y	06/27/2018	16
17	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17
18	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file the cost report? If yes, see instructions.	N		N		18
19	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19
20	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N		20
21	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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.	N	25
26	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26
27	Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions.	N	27

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

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

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

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

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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				
						Title V	Title XVIII	Title XIX	Total All Patients	
		1	2	3	4	5	6	7	8	
1	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	30	25	9,125	49,224.00		1,344	411	2,051	1
2	HMO and other (see instructions)						166			2
3	HMO IPF Subprovider									3
4	HMO IRF Subprovider									4
5	Hospital Adults & Peds. Swing Bed SNF						1,306		1,623	5
6	Hospital Adults & Peds. Swing Bed NF								15	6
7	Total Adults & Peds. (exclude observation beds) (see instructions)		25	9,125	49,224.00		2,650	411	3,689	7
8	Intensive Care Unit	31								8
9	Coronary Care Unit	32								9
10	Burn Intensive Care Unit	33								10
11	Surgical Intensive Care Unit	34								11
12	Other Special Care (specify)	35								12
13	Nursery	43								13
14	Total (see instructions)		25	9,125	49,224.00		2,650	411	3,689	14
15	CAH Visits									15
16	Subprovider - IPF	40								16
17	Subprovider - IRF	41								17
18	Subprovider I	42								18
19	Skilled Nursing Facility	44								19
20	Nursing Facility	45								20
21	Other Long Term Care	46								21
22	Home Health Agency	101								22
23	ASC (Distinct Part)	115								23
24	Hospice (Distinct Part)	116								24
24.10	Hospice (non-distinct part)	30								24.10
25	CMHC	99								25
26	RHC	88					4,590		12,318	26
27	Total (sum of lines 14-26)		25							27
28	Observation Bed Days							242	468	28
29	Ambulance Trips									29
30	Employee discount days (see instructions)									30
31	Employee discount days-IRF									31
32	Labor & delivery (see instructions)									32
32.01	Total ancillary labor & delivery room outpatient days (see instructions)									32.01
33	LTCH non-covered days									33
33.01	LTCH site neutral days and discharges									33.01

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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)					352	121	545	1
2	HMO and other (see instructions)					39			2
3	HMO IPF Subprovider								3
4	HMO IRF Subprovider								4
5	Hospital Adults & Peds. Swing Bed SNF								5
6	Hospital Adults & Peds. Swing Bed NF								6
7	Total Adults & Peds. (exclude observation beds) (see instructions)								7
8	Intensive Care Unit								8
9	Coronary Care Unit								9
10	Burn Intensive Care Unit								10
11	Surgical Intensive Care Unit								11
12	Other Special Care (specify)								12
13	Nursery								13
14	Total (see instructions)		107.90			352	121	545	14
15	CAH Visits								15
16	Subprovider - IPF								16
17	Subprovider - IRF								17
18	Subprovider I								18
19	Skilled Nursing Facility								19
20	Nursing Facility								20
21	Other Long Term Care								21
22	Home Health Agency								22
23	ASC (Distinct Part)								23
24	Hospice (Distinct Part)								24
24.10	Hospice (non-distinct part)								24.10
25	CMHC								25
26	RHC		22.77						26
27	Total (sum of lines 14-26)		130.67						27
32.01	Total ancillary labor & delivery room outpatient days (see instructions)								32.01
33	LTCH non-covered days								33
33.01	LTCH site neutral days and discharges								33.01

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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		1
2	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	Y	07/09/2003	2

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	
67	BA2				67
68	BA1				68
69	PE2				69
70	PE1				70
71	PD2				71
72	PD1				72
73	PC2				73
74	PC1				74
75	PB2				75
76	PB1				76
77	PA2				77
78	PA1				78
199	AAA				199
200	TOTAL				200

SNF SERVICES

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

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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HOSPITAL-BASED RHC/FQHC STATISTICAL DATA

COMPONENT CCN: 14-3479

WORKSHEET S-8

Check applicable box: ☒ Hospital-Based RHC ☐ Hospital-Based FQHC

Clinic Address and Identification:

1	Street: 6 FERRELL ROAD	1
2	City: ROSICLARE State: IL ZIP Code: 62982 County: HARDIN	2
3	HOSPITAL-BASED FQHCs ONLY: Designation - Enter 'R' for rural or 'U' for urban	3

Source of Federal Funds:

		Grant Award	Date	
		1	2	
4	Community Health Center (Section 330(d), PHS Act)			4
5	Migrant Health Center (Section 329(d), PHS Act)			5
6	Health Services for the Homeless (Section 340(d), PHS)			6
7	Appalachian Regional Commission			7
8	Look-alikes			8
9	OTHER			9

		1	2	
10	Does this facility operate as other than a hospital-based RHC or FQHC? Enter 'Y' for yes or 'N' for no in column 1. If yes, indicate the number of other operations in column 2.	N		10

Facility hours of operations (1)

		Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		
	Type Operation	from	to	from	to	from	to	from	to	from	to	from	to	from	to	
	0	1	2	3	4	5	6	7	8	9	10	11	12	13	14	
11	Clinic			0900	1700	0900	1700	0900	1700	0900	1700	0900	1700			11

(1) Enter clinic hours of operation on line 11 and other type operations on subscripts of line 11 (both type and hours of operation). List hours of operation based on a 24 hour clock. For example: 8:00am is 0800, 6:30pm is 1830, and midnight is 2400.

		1	2	
12	Have you received an approval for an exception to the productivity standard?	N		12
13	Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter 'Y' for yes or 'N' for no in column 1. If yes, enter in column 2 the number of providers included in this cost report. List the names of all providers and numbers below.	N		13
14	RHC/FQHC name: CCN number:			14

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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)	0.512359	1
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Medicaid (see instructions for each line)

2	Net revenue from Medicaid	3,179,198	2
3	Did you receive DSH or supplemental payments from Medicaid?	Y	3
4	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4
5	If line 4 is no, enter DSH and/or supplemental payments from Medicaid		5
6	Medicaid charges	5,995,709	6
7	Medicaid cost (line 1 times line 6)	3,071,955	7
8	Difference between net revenue and costs for Medicaid program (line 7 minus the sum of lines 2 and 5). If line 7 is less than the sum of lines 2 and 5, then enter zero.		8

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

9	Net revenue from stand-alone SCHIP		9
10	Stand-alone SCHIP charges		10
11	Stand-alone SCHIP cost (line 1 times line 10)		11
12	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9). 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

Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent programs (see instructions for each line)

17	Private grants, donations, or endowment income restricted to 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)		19

Uncompensated care (see instructions for each line)

		Uninsured patients	Insured patients	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	Charity care charges and uninsured discounts for the entire facility (see instructions)	116,307	597,990	714,297	20
21	Cost of patients approved for charity care and uninsured discounts (see instructions)	59,591	597,990	657,581	21
22	Payments received from patients for amounts previously written off as charity care				22
23	Cost of charity care (line 21 minus line 22)	59,591	597,990	657,581	23

24	Does the amount in line 20, column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24
25	If line 24 is yes, charges for patient days beyond the indigent care program's length of stay limit		25
26	Total bad debt expense for the entire hospital complex (see instructions)	727,194	26
27	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	260,202	27
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	400,311	27.01
28	Non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	326,883	28
29	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	307,590	29
30	Cost of uncompensated care (line 23, column 3 plus line 29)	965,171	30
31	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	965,171	31

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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		80,349	80,349	18,175	98,524		98,524	1
2	00200	Cap Rel Costs-Mvble Equip		209,207	209,207	3,847	213,054	-76,678	136,376	2
3	00300	Other Cap Rel Costs							-0-	3
4	00400	Employee Benefits Department				45,074	45,074		45,074	4
5	00500	Administrative & General	793,804	1,919,715	2,713,519	-57,873	2,655,646	-318,749	2,336,897	5
6	00600	Maintenance & Repairs								6
7	00700	Operation of Plant	164,787	222,122	386,909	-4,961	381,948		381,948	7
8	00800	Laundry & Linen Service	43,794	16,973	60,767		60,767		60,767	8
9	00900	Housekeeping	91,558	54,091	145,649		145,649		145,649	9
10	01000	Dietary	90,575	117,485	208,060	-39,373	168,687		168,687	10
11	01100	Cafeteria				37,712	37,712	-2,929	34,783	11
12	01200	Maintenance of Personnel								12
13	01300	Nursing Administration				111,806	111,806		111,806	13
14	01400	Central Services & Supply	33,208	10,274	43,482	-33,699	9,783		9,783	14
15	01500	Pharmacy	73,713	209,156	282,869	-70,901	211,968		211,968	15
16	01600	Medical Records & Library	229,041	71,533	300,574		300,574	-3,686	296,888	16
17	01700	Social Service	32,536	6,864	39,400		39,400		39,400	17
19	01900	Nonphysician Anesthetists								19
20	02000	Nursing School								20
21	02100	I&R Services-Salary & Fringes Apprvd								21
22	02200	I&R Services-Other Prgm Costs Apprvd								22
23	02300	Paramed Ed Prgm-(specify)								23
		INPATIENT ROUTINE SERVICE COST CENTERS								
30	03000	Adults & Pediatrics	1,109,530	639,283	1,748,813	-305,403	1,443,410	-158,893	1,284,517	30
		ANCILLARY SERVICE COST CENTERS								
54	05400	Radiology-Diagnostic	351,436	369,567	721,003	-5,280	715,723		715,723	54
60	06000	Laboratory	371,446	760,410	1,131,856	-158	1,131,698		1,131,698	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	06500	Respiratory Therapy	100,676	70,858	171,534	-39,857	131,677		131,677	65
66	06600	Physical Therapy	94,578	102,718	197,296	-135	197,161		197,161	66
69	06900	Electrocardiology	10,656	1,007	11,663	22,471	34,134		34,134	69
71	07100	Medical Supplies Charged to Patients				129,868	129,868		129,868	71
73	07300	Drugs Charged to Patients				326,060	326,060		326,060	73
76.97	07697	CARDIAC REHABILITATION								76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
		OUTPATIENT SERVICE COST CENTERS								
88	08800	Rural Health Clinic	1,334,384	308,247	1,642,631	7,662	1,650,293		1,650,293	88
90	09000	Clinic	124,166	76,486	200,652	8,914	209,566		209,566	90
91	09100	Emergency	1,028,252	214,322	1,242,574	-131,195	1,111,379	-404,224	707,155	91
92	09200	Observation Beds (Non-Distinct Part)								92
		OTHER REIMBURSABLE COST CENTERS								
		SPECIAL PURPOSE COST CENTERS								
113	11300	Interest Expense		22,754	22,754	-22,754				113
118		SUBTOTALS (sum of lines 1-117)	6,078,140	5,483,421	11,561,561		11,561,561	-965,159	10,596,402	118
		NONREIMBURSABLE COST CENTERS								
190	19000	Gift, Flower, Coffee Shop & Canteen								190
190.0	19001	VENDING MACHINE								190.0
1										1
200		TOTAL (sum of lines 118-199)	6,078,140	5,483,421	11,561,561		11,561,561	-965,159	10,596,402	200

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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RECLASSIFICATIONS**WORKSHEET A-6**

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

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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RECLASSIFICATIONS**WORKSHEET A-6**

		DECREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	Wkst A-7 Ref.
		1	6	7	8	9	10
1	TO RECLASS SUPPLY COST FROM CS	A	Central Services & Supply	14	24,906	8,793	1
500	Total reclassifications				24,906	8,793	500
	Code letter - A						
1	TO RECLASS DON COST	B	Adults & Pediatrics	30	92,585	19,221	1
500	Total reclassifications				92,585	19,221	500
	Code letter - B						
1	TO RECLASS SUPPLY COST	D	Adults & Pediatrics	30		29,437	1
2			Emergency	91		19,515	2
3			Radiology-Diagnostic	54		6,852	3
4			Laboratory	60		373	4
5			Respiratory Therapy	65		39,857	5
6			Physical Therapy	66		135	6
500	Total reclassifications					96,169	500
	Code letter - D						
1	TO RECLASS INSURANCE EXPENSE	E					12
2							12
3			Administrative & General	5		60,074	3
500	Total reclassifications					60,074	500
	Code letter - E						
1	TO RECLASS INTEREST	F					11
2							2
3							3
4			Interest Expense	113		22,754	4
5							5
500	Total reclassifications					22,754	500
	Code letter - F						
1	TO RECLASS CAFE COST	G	Dietary	10	16,304	21,408	1
500	Total reclassifications				16,304	21,408	500
	Code letter - G						
1	TO RECLASS CARDIAC MONITORING COST	H	Adults & Pediatrics	30	18,744	3,727	1
500	Total reclassifications				18,744	3,727	500
	Code letter - H						
1	TO RECLASS DRUG COST	I	Adults & Pediatrics	30		141,689	1
2			Emergency	91		111,680	2
3			Pharmacy	15		70,901	3
4			Radiology-Diagnostic	54		129	4
5			Dietary	10		1,661	5
500	Total reclassifications					326,060	500
	Code letter - I						
1	TO RECLASS CLINIC DEPRECIATION	J	Cap Rel Costs-Bldg & Fixt	1		6,433	9
2			Cap Rel Costs-Mvble Equip	2		3,953	9
500	Total reclassifications					10,386	500
	Code letter - J						
1	TO RECLASS CLINIC COST	K	Operation of Plant	7	3,988	973	1
500	Total reclassifications				3,988	973	500
	Code letter - K						
	GRAND TOTAL (Decreases)				156,527	569,565	

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

KPMG LLP Compu-Max 2552-10

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

		Acquisitions							
	Description	Beginning Balances	Purchases	Donation	Total	Disposals and Retirements	Ending Balance	Fully Depreciated Assets	
		1	2	3	4	5	6	7	
1	Land	17,000					17,000		1
2	Land Improvements	148,424	108,250		108,250		256,674		2
3	Buildings and Fixtures	1,796,754					1,796,754		3
4	Building Improvements								4
5	Fixed Equipment								5
6	Movable Equipment	2,803,676	38,162		38,162	33,019	2,808,819		6
7	HIT-designated Assets	898,160					898,160		7
8	Subtotal (sum of lines 1-7)	5,664,014	146,412		146,412	33,019	5,777,407		8
9	Reconciling Items								9
10	Total (line 7 minus line 9)	5,664,014	146,412		146,412	33,019	5,777,407		10

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

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	80,349						80,349	1
2	Cap Rel Costs-Mvble Equip	209,207						209,207	2
3	Total (sum of lines 1-2)	289,556						289,556	3

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

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

PART III - RECONCILIATION OF CAPITAL COST CENTERS

		COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
	Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	
*		1	2	3	4	5	6	7	8	
1	Cap Rel Costs-Bldg & Fi	2,070,428		2,070,428	0.358366					1
2	Cap Rel Costs-Mvble Equip	3,706,979		3,706,979	0.641634					2
3	Total (sum of lines 1-2)	5,777,407		5,777,407	1.000000					3

		SUMMARY OF CAPITAL							
	Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
*		9	10	11	12	13	14	15	
1	Cap Rel Costs-Bldg & Fixt	73,916		17,408	7,200			98,524	1
2	Cap Rel Costs-Mvble Equip	128,576			7,800			136,376	2
3	Total (sum of lines 1-2)	202,492		17,408	15,000			234,900	3

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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ADJUSTMENTS TO EXPENSES**WORKSHEET A-8**

				EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED			
	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	COST CENTER	LINE#	Wkst. A-7 Ref.	
		1	2	3	4	5	
1	Investment income-buildings & fixtures (chapter 2)			Cap Rel Costs-Bldg & Fixt	1		1
2	Investment income-movable equipment (chapter 2)			Cap Rel Costs-Mvble Equip	2		2
3	Investment income-other (chapter 2)						3
4	Trade, quantity, and time discounts (chapter 8)						4
5	Refunds and rebates of expenses (chapter 8)	B	-58,696	Administrative & General	5		5
6	Rental of provider space by suppliers (chapter 8)						6
7	Telephone services (pay stations excl) (chapter 21)	A	-3,614	Administrative & General	5		7
8	Television and radio service (chapter 21)						8
9	Parking lot (chapter 21)						9
10	Provider-based physician adjustment	Wkst A-8-2	-563,117				10
11	Sale of scrap, waste, etc. (chapter 23)						11
12	Related organization transactions (chapter 10)	Wkst A-8-1					12
13	Laundry and linen service						13
14	Cafeteria - employees and guests	B	-2,929	Cafeteria	11		14
15	Rental of quarters to employees & others						15
16	Sale of medical and surgical supplies to other than patients						16
17	Sale of drugs to other than patients						17
18	Sale of medical records and abstracts	A	-3,686	Medical Records & Library	16		18
19	Nursing and allied health education (tuition, fees, books, etc.)						19
20	Vending machines						20
21	Income from imposition of interest, finance or penalty charges (chapter 21)						21
22	Interest exp on Medicare overpayments & borrowings to repay Medicare overpayments						22
23	Adj for respiratory therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Respiratory Therapy	65		23
24	Adj for physical therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Physical Therapy	66		24
25	Util review-physicians' compensation (chapter 21)			Utilization Review-SNF	114		25
26	Depreciation--buildings & fixtures			Cap Rel Costs-Bldg & Fixt	1		26
27	Depreciation--movable equipment			Cap Rel Costs-Mvble Equip	2		27
28	Non-physician anesthetist			Nonphysician Anesthetists	19		28
29	Physicians' assistant						29
30	Adj for occupational therapy costs in excess of limitation (chapter 14)	Wkst A-8-3		Occupational Therapy	67		30
31	Adj for speech pathology costs in excess of limitation (chapter 14)	Wkst A-8-3		Speech Pathology	68		31
32	CAH HIT Adj for Depreciation	A	-76,678	Cap Rel Costs-Mvble Equip	2	9	32
33	VERIZON RENTAL	B	-7,200	Administrative & General	5		33
34	LOBBYING	A	-26,436	Administrative & General	5		34
35							35
36							36
37							37
38							38
39							39
40	LATE FEES	A	-4,290	Administrative & General	5		40
41							41
42	PROVIDER TAX	A	-214,865	Administrative & General	5		42
43	LOBBING PORTION OF DUES	A	-3,648	Administrative & General	5		43
44							44
45							45
46							46
47							47
48							48
49							49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-965,159				50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

KPMG LLP Compu-Max 2552-10

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

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

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

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	31,886		31,886					1
2	30	Adults & Pediatrics AGGREGATE	158,893	158,893						2
3	60	Laboratory AGGREGATE	109,199		109,199					3
4										4
5	91	Emergency AGGREGATE	830,028	404,224	425,804					5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL	1,130,006	563,117	566,889					200

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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							158,893	2
3	60	Laboratory AGGREGATE								3
4										4
5	91	Emergency AGGREGATE							404,224	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
200		TOTAL							563,117	200

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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 visits(s)) (see instructions)						6
7	Standard travel expense rate					5.00	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		751.43				9
10	AHSEA (see instructions)		76.85				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	38.43	38.43				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)			14
15	Therapists (column 2, line 9 times column 2, line 10)	57,747		15
16	Assistants (column 3, line 9 times column 3, line 10)			16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	57,747		17
18	Aides (column 4, line 9 times column 4, line 10)			18
19	Trainees (column 5, line 9 times column 5, line 10)			19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	57,747		20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.			
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	76.85		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	59,943		22
23	Total salary equivalency (see instructions)	59,943		23

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

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

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

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtime hours worked during reporting period (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	59,943	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	59,943	63
64	Total cost of outside supplier services (from provider records)	45,088	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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 visits(s)) (see instructions)						6
7	Standard travel expense rate					5.00	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		368.00				9
10	AHSEA (see instructions)		81.09				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	40.55	40.55				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)			14
15	Therapists (column 2, line 9 times column 2, line 10)	29,841		15
16	Assistants (column 3, line 9 times column 3, line 10)			16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	29,841		17
18	Aides (column 4, line 9 times column 4, line 10)			18
19	Trainees (column 5, line 9 times column 5, line 10)			19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	29,841		20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.			
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	81.09		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	63,250		22
23	Total salary equivalency (see instructions)	63,250		23

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

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

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

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtime hours worked during reporting period (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	63,250	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	63,250	63
64	Total cost of outside supplier services (from provider records)	22,082	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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 visits(s)) (see instructions)						6
7	Standard travel expense rate					5.00	7
8	Optional travel expense rate						8
		Supervisors	Therapists	Assistants	Aides	Trainees	
		1	2	3	4	5	
9	Total hours worked		210.71				9
10	AHSEA (see instructions)		73.85				10
11	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one half of column 3, line 10)	36.93	36.93				11
12	Number of travel hours (provider site) (see instructions)						12
12.01	Number of travel hours (offsite) (see instructions)						12.01
13	Number of miles driven (provider site) (see instructions)						13
13.01	Number of miles driven (offsite) (see instructions)						13.01

PART II - SALARY EQUIVALENCY COMPUTATION

14	Supervisors (column 1, line 9 times column 1, line 10)			14
15	Therapists (column 2, line 9 times column 2, line 10)	15,561		15
16	Assistants (column 3, line 9 times column 3, line 10)			16
17	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)	15,561		17
18	Aides (column 4, line 9 times column 4, line 10)			18
19	Trainees (column 5, line 9 times column 5, line 10)			19
20	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	15,561		20
	If the sum of columns 1 and 2 for respiratory therapy or columns 1 through 3 for physical therapy, speech pathology or occupational therapy, line 9 is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21 through 23.			
21	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 through 3, line 9 for all others)	73.85		21
22	Weighted allowance excluding aides and trainees (line 2 times line 21)	57,603		22
23	Total salary equivalency (see instructions)	57,603		23

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

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

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

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	Assistants	Aides	Trainees	Total	
		1	2	3	4	5	
47	Overtime hours worked during reporting period (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	Overtime rate (see instructions)						48
49	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	Adjusted hourly salary equivalency amount (see instructions)						52
53	Overtime cost limitation (line 51 times line 52)						53
54	Maximum overtime cost (enter the lesser of line 49 or line 53)						54
55	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)						55
56	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	Salary equivalency amount (from line 23)	57,603	57
58	Travel allowance and expense - provider site (from lines 33, 34, or 35)		58
59	Travel allowance and expense - offsite services (from lines 44, 45, or 46)		59
60	Overtime allowance (from column 5, line 56)		60
61	Equipment cost (see instructions)		61
62	Supplies (see instructions)		62
63	Total allowance (sum of lines 57-62)	57,603	63
64	Total cost of outside supplier services (from provider records)	12,644	64
65	Excess over limitation (line 64 minus line 63; if negative enter zero)		65

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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)	ADMINIS- TRATIVE & GENERAL	
		0	1	2	4	4A	5	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	98,524	98,524					1
2	Cap Rel Costs-Mvble Equip	136,376		136,376				2
4	Employee Benefits Department	45,074			45,074			4
5	Administrative & General	2,336,897	13,497	18,683	5,887	2,374,964	2,374,964	5
6	Maintenance & Repairs							6
7	Operation of Plant	381,948	7,841	10,854	1,192	401,835	116,080	7
8	Laundry & Linen Service	60,767	3,535	4,894	325	69,521	20,083	8
9	Housekeeping	145,649			679	146,328	42,271	9
10	Dietary	168,687	3,480	4,817	551	177,535	51,285	10
11	Cafeteria	34,783	1,473	2,039	121	38,416	11,097	11
12	Maintenance of Personnel							12
13	Nursing Administration	111,806	7,765	10,748	687	131,006	37,844	13
14	Central Services & Supply	9,783			62	9,845	2,844	14
15	Pharmacy	211,968	1,547	2,141	547	216,203	62,456	15
16	Medical Records & Library	296,888	4,198	5,811	1,699	308,596	89,146	16
17	Social Service	39,400	691	956	241	41,288	11,927	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,284,517	16,827	23,292	7,403	1,332,039	384,793	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	715,723	5,165	7,150	2,606	730,644	211,065	54
60	Laboratory	1,131,698	2,332	3,229	2,755	1,140,014	329,322	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	131,677	1,547	2,141	747	136,112	39,319	65
66	Physical Therapy	197,161	3,008	4,163	701	205,033	59,229	66
69	Electrocardiology	34,134			218	34,352	9,923	69
71	Medical Supplies Charged to Patients	129,868	1,482	2,052	185	133,587	38,590	71
73	Drugs Charged to Patients	326,060				326,060	94,191	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	1,650,293	17,225	23,839	9,892	1,701,249	491,444	88
90	Clinic	209,566	2,210	3,059	950	215,785	62,335	90
91	Emergency	707,155	4,023	5,569	7,626	724,373	209,253	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	10,596,402	97,846	135,437	45,074	10,594,785	2,374,497	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		371	514		885	256	190
190.0	VENDING MACHINE		307	425		732	211	190.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,596,402	98,524	136,376	45,074	10,596,402	2,374,964	202

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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 ADMINIS- TRATION	
		7	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant	517,915						7
8	Laundry & Linen Service	30,537	120,141					8
9	Housekeeping		4,065	192,664				9
10	Dietary	30,060	3,582	11,883	274,345			10
11	Cafeteria	12,724		5,030	55,356	122,623		11
12	Maintenance of Personnel							12
13	Nursing Administration	67,065		26,511		2,190	264,616	13
14	Central Services & Supply					335	8,071	14
15	Pharmacy	13,360		5,281		2,564		15
16	Medical Records & Library	36,263		14,335		7,794		16
17	Social Service	5,964		2,358		1,172		17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	145,346	79,307	57,456	201,111	36,291	256,545	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	44,613	8,258	17,636		10,281		54
60	Laboratory	20,146		7,964		11,788		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	13,360		5,281		3,582		65
66	Physical Therapy	25,978	5,849	10,269		2,654		66
69	Electrocardiology					490		69
71	Medical Supplies Charged to Patients	12,803		5,061		1,031		71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic					29,335		88
90	Clinic	19,086	1,610	7,545	17,878	3,131		90
91	Emergency	34,752	17,470	13,738		9,985		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	512,057	120,141	190,348	274,345	122,623	264,616	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	3,207		1,268				190
190.0	VENDING MACHINE	2,651		1,048				190.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	517,915	120,141	192,664	274,345	122,623	264,616	202

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	21,095						14
15	Pharmacy	1,348	301,212					15
16	Medical Records & Library	126		456,260				16
17	Social Service	72			62,781			17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	1,324		421,133	62,781	2,978,126		30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	194		35,127		1,057,818		54
60	Laboratory	13,082				1,522,316		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	249				197,903		65
66	Physical Therapy	65				309,077		66
69	Electrocardiology	40				44,805		69
71	Medical Supplies Charged to Patients	3,085				194,157		71
73	Drugs Charged to Patients		274,052			694,303		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	833	27,160			2,250,021		88
90	Clinic	71				327,441		90
91	Emergency	606				1,010,177		91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	21,095	301,212	456,260	62,781	10,586,144		118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen					5,616		190
190.0	VENDING MACHINE					4,642		190.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	21,095	301,212	456,260	62,781	10,596,402		202

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	2,978,126						30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,057,818						54
60	Laboratory	1,522,316						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	197,903						65
66	Physical Therapy	309,077						66
69	Electrocardiology	44,805						69
71	Medical Supplies Charged to Patients	194,157						71
73	Drugs Charged to Patients	694,303						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	2,250,021						88
90	Clinic	327,441						90
91	Emergency	1,010,177						91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	10,586,144						118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	5,616						190
190.0	VENDING MACHINE	4,642						190.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	10,596,402						202

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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		13,497	18,683	32,180	32,180		5
6	Maintenance & Repairs							6
7	Operation of Plant		7,841	10,854	18,695	1,573	20,268	7
8	Laundry & Linen Service		3,535	4,894	8,429	272	1,195	8
9	Housekeeping					573		9
10	Dietary		3,480	4,817	8,297	695	1,176	10
11	Cafeteria		1,473	2,039	3,512	150	498	11
12	Maintenance of Personnel							12
13	Nursing Administration		7,765	10,748	18,513	513	2,625	13
14	Central Services & Supply					39		14
15	Pharmacy		1,547	2,141	3,688	846	523	15
16	Medical Records & Library		4,198	5,811	10,009	1,208	1,419	16
17	Social Service		691	956	1,647	162	233	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		16,827	23,292	40,119	5,214	5,687	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		5,165	7,150	12,315	2,860	1,746	54
60	Laboratory		2,332	3,229	5,561	4,462	788	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		1,547	2,141	3,688	533	523	65
66	Physical Therapy		3,008	4,163	7,171	802	1,017	66
69	Electrocardiology					134		69
71	Medical Supplies Charged to Patients		1,482	2,052	3,534	523	501	71
73	Drugs Charged to Patients					1,276		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		17,225	23,839	41,064	6,659		88
90	Clinic		2,210	3,059	5,269	845	747	90
91	Emergency		4,023	5,569	9,592	2,835	1,360	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)		97,846	135,437	233,283	32,174	20,038	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		371	514	885	3	126	190
190.0	VENDING MACHINE		307	425	732	3	104	190.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)		98,524	136,376	234,900	32,180	20,268	202

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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ALLOCATION OF CAPITAL-RELATED COSTS
**WORKSHEET B
PART II**

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	9,896						8
9	Housekeeping	335	908					9
10	Dietary	295	56	10,519				10
11	Cafeteria		24	2,122	6,306			11
12	Maintenance of Personnel							12
13	Nursing Administration		125		113	21,889		13
14	Central Services & Supply				17	668	724	14
15	Pharmacy		25		132		46	15
16	Medical Records & Library		68		401		4	16
17	Social Service		11		60		2	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	6,532	269	7,712	1,867	21,221	45	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	680	83		529		7	54
60	Laboratory		38		606		450	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		25		184		9	65
66	Physical Therapy	482	48		136		2	66
69	Electrocardiology				25		1	69
71	Medical Supplies Charged to Patients		24		53		106	71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				1,509		29	88
90	Clinic	133	36	685	161		2	90
91	Emergency	1,439	65		513		21	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	9,896	897	10,519	6,306	21,889	724	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		6					190
190.0	VENDING MACHINE		5					190.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	9,896	908	10,519	6,306	21,889	724	202

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	5,260						15
16	Medical Records & Library		13,109					16
17	Social Service			2,115				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		12,100	2,115	102,881		102,881	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		1,009		19,229		19,229	54
60	Laboratory				11,905		11,905	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy				4,962		4,962	65
66	Physical Therapy				9,658		9,658	66
69	Electrocardiology				160		160	69
71	Medical Supplies Charged to Patients				4,741		4,741	71
73	Drugs Charged to Patients	4,786			6,062		6,062	73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	474			49,735		49,735	88
90	Clinic				7,878		7,878	90
91	Emergency				15,825		15,825	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
113	Interest Expense							113
118	SUBTOTALS (sum of lines 1-117)	5,260	13,109	2,115	233,036		233,036	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen				1,020		1,020	190
190.0	VENDING MACHINE				844		844	190.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)	5,260	13,109	2,115	234,900		234,900	202

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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 SALA RIES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	OPERATION OF PLANT SQUARE FEET	
		1	2	4	5A	5	7	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt	32,103						1
2	Cap Rel Costs-Mvble Equip		32,103					2
4	Employee Benefits Department			6,078,140				4
5	Administrative & General	4,398	4,398	793,804	-2,374,964	8,221,438		5
6	Maintenance & Repairs							6
7	Operation of Plant	2,555	2,555	160,799		401,835	19,538	7
8	Laundry & Linen Service	1,152	1,152	43,794		69,521	1,152	8
9	Housekeeping			91,558		146,328		9
10	Dietary	1,134	1,134	74,271		177,535	1,134	10
11	Cafeteria	480	480	16,304		38,416	480	11
12	Maintenance of Personnel							12
13	Nursing Administration	2,530	2,530	92,585		131,006	2,530	13
14	Central Services & Supply			8,302		9,845		14
15	Pharmacy	504	504	73,713		216,203	504	15
16	Medical Records & Library	1,368	1,368	229,041		308,596	1,368	16
17	Social Service	225	225	32,536		41,288	225	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	5,483	5,483	998,201		1,332,039	5,483	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	1,683	1,683	351,436		730,644	1,683	54
60	Laboratory	760	760	371,446		1,140,014	760	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	504	504	100,676		136,112	504	65
66	Physical Therapy	980	980	94,578		205,033	980	66
69	Electrocardiology			29,400		34,352		69
71	Medical Supplies Charged to Patients	483	483	24,906		133,587	483	71
73	Drugs Charged to Patients					326,060		73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	5,612	5,612	1,334,384		1,701,249		88
90	Clinic	720	720	128,154		215,785	720	90
91	Emergency	1,311	1,311	1,028,252		724,373	1,311	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	31,882	31,882	6,078,140	-2,374,964	8,219,821	19,317	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen	121	121			885	121	190
190.0	VENDING MACHINE	100	100			732	100	190.0
1								1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	98,524	136,376	45,074		2,374,964	517,915	202
203	Unit Cost Multiplier (Wkst. B, Part I)	3.068997	4.248077	0.007416		0.288875	26.508087	203
204	Cost to be allocated (Per Wkst. B, Part II)					32,180	20,268	204
205	Unit Cost Multiplier (Wkst. B, Part II)					0.003914	1.037363	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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 SERV ED	CAFETERIA FTE'S SERV ED	NURSING ADMINIS- TRATION DIRECT NRS ING HRS	CENTRAL SERVICES & SUPPLY COSTED REQ UIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service	80,830						8
9	Housekeeping	2,735	18,386					9
10	Dietary	2,410	1,134	15,760				10
11	Cafeteria		480	3,180	9,518			11
12	Maintenance of Personnel							12
13	Nursing Administration		2,530		170	72,952		13
14	Central Services & Supply				26	2,225	657,636	14
15	Pharmacy		504		199		42,036	15
16	Medical Records & Library		1,368		605		3,927	16
17	Social Service		225		91		2,245	17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics	53,357	5,483	11,553	2,817	70,727	41,287	30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	5,556	1,683		798		6,054	54
60	Laboratory		760		915		407,783	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy		504		278		7,775	65
66	Physical Therapy	3,935	980		206		2,035	66
69	Electrocardiology				38		1,238	69
71	Medical Supplies Charged to Patients		483		80		96,169	71
73	Drugs Charged to Patients							73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic				2,277		25,963	88
90	Clinic	1,083	720	1,027	243		2,220	90
91	Emergency	11,754	1,311		775		18,904	91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	80,830	18,165	15,760	9,518	72,952	657,636	118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen		121					190
190.0	VENDING MACHINE		100					190.0
1								1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	120,141	192,664	274,345	122,623	264,616	21,095	202
203	Unit Cost Multiplier (Wkst. B, Part I)	1.486342	10.478843	17.407678	12.883274	3.627262	0.032077	203
204	Cost to be allocated (Per Wkst. B, Part II)	9,896	908	10,519	6,306	21,889	724	204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.122430	0.049385	0.667449	0.662534	0.300047	0.001101	205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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COST ALLOCATION - STATISTICAL BASIS**WORKSHEET B-1**

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

	GENERAL SERVICE COST CENTERS							
1	Cap Rel Costs-Bldg & Fixt							1
2	Cap Rel Costs-Mvble Equip							2
4	Employee Benefits Department							4
5	Administrative & General							5
6	Maintenance & Repairs							6
7	Operation of Plant							7
8	Laundry & Linen Service							8
9	Housekeeping							9
10	Dietary							10
11	Cafeteria							11
12	Maintenance of Personnel							12
13	Nursing Administration							13
14	Central Services & Supply							14
15	Pharmacy	358,374						15
16	Medical Records & Library		40,265					16
17	Social Service			2,051				17
19	Nonphysician Anesthetists							19
20	Nursing School							20
21	I&R Services-Salary & Fringes Apprvd							21
22	I&R Services-Other Prgm Costs Apprvd							22
23	Paramed Ed Prgm-(specify)							23
	INPATIENT ROUTINE SERV COST CENTERS							
30	Adults & Pediatrics		37,165	2,051				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic		3,100					54
60	Laboratory							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy							65
66	Physical Therapy							66
69	Electrocardiology							69
71	Medical Supplies Charged to Patients							71
73	Drugs Charged to Patients	326,060						73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic	32,314						88
90	Clinic							90
91	Emergency							91
92	Observation Beds (Non-Distinct Part)							92
	OTHER REIMBURSABLE COST CENTERS							
	SPECIAL PURPOSE COST CENTERS							
118	SUBTOTALS (sum of lines 1-117)	358,374	40,265	2,051				118
	NONREIMBURSABLE COST CENTERS							
190	Gift, Flower, Coffee Shop & Canteen							190
190.0	VENDING MACHINE							190.0
1								1
200	Cross foot adjustments							200
201	Negative cost centers							201
202	Cost to be allocated (Per Wkst. B, Part I)	301,212	456,260	62,781				202
203	Unit Cost Multiplier (Wkst. B, Part I)	0.840496	11.331429	30.609946				203
204	Cost to be allocated (Per Wkst. B, Part II)	5,260	13,109	2,115				204
205	Unit Cost Multiplier (Wkst. B, Part II)	0.014677	0.325568	1.031204				205
206	NAHE adjustment amount to be allocated (per Wkst. B-2)							206
207	NAHE Unit Cost Multiplier (Wkst. D, Parts III and IV)							207

KPMG LLP Compu-Max 2552-10

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

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		AMOUNT	
		CODE	LINE NO.		
	1	2	3	4	

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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COMPUTATION OF RATIO OF COST TO CHARGES**WORKSHEET C
PART I**

				COSTS			
	COST CENTER DESCRIPTIONS	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Dis- allowance	Total Costs	
		1	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30	Adults & Pediatrics	2,978,126		2,978,126			30
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	1,057,818		1,057,818			54
60	Laboratory	1,522,316		1,522,316			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	197,903		197,903			65
66	Physical Therapy	309,077		309,077			66
69	Electrocardiology	44,805		44,805			69
71	Medical Supplies Charged to Patients	194,157		194,157			71
73	Drugs Charged to Patients	694,303		694,303			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	2,250,021		2,250,021			88
90	Clinic	327,441		327,441			90
91	Emergency	1,010,177		1,010,177			91
92	Observation Beds (Non-Distinct Part)	336,286		336,286			92
	OTHER REIMBURSABLE COST CENTERS						
113	Interest Expense						113
200	Subtotal (sum of lines 30 thru 199)	10,922,430		10,922,430			200
201	Less Observation Beds	336,286		336,286			201
202	Total (line 200 minus line 201)	10,586,144		10,586,144			202

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	1,998,607		1,998,607				30
	ANCILLARY SERVICE COST CENTERS							
54	Radiology-Diagnostic	744,201	4,634,514	5,378,715	0.196667			54
60	Laboratory	779,500	3,552,173	4,331,673	0.351438			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
65	Respiratory Therapy	154,274	232,490	386,764	0.511689			65
66	Physical Therapy	404,223	713,287	1,117,510	0.276576			66
69	Electrocardiology	43,741	195,255	238,996	0.187472			69
71	Medical Supplies Charged to Patients	558,877	171,840	730,717	0.265708			71
73	Drugs Charged to Patients	1,350,873	941,062	2,291,935	0.302933			73
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
88	Rural Health Clinic		1,493,744	1,493,744				88
90	Clinic	1,476	484,145	485,621	0.674273			90
91	Emergency	27,716	1,867,654	1,895,370	0.532971			91
92	Observation Beds (Non-Distinct Part)		311,938	311,938	1.078054			92
	OTHER REIMBURSABLE COST CENTERS							
113	Interest Expense							113
200	Subtotal (sum of lines 30 thru 199)	6,063,488	14,598,102	20,661,590				200
201	Less Observation Beds							201
202	Total (line 200 minus line 201)	6,063,488	14,598,102	20,661,590				202

KPMG LLP Compu-Max 2552-10

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.196667		1,632,758			321,110		54
60	Laboratory	0.351438		1,584,494			556,851		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.511689		26,240			13,427		65
66	Physical Therapy	0.276576		152,390			42,147		66
69	Electrocardiology	0.187472		169,814			31,835		69
71	Medical Supplies Charged to Pat	0.265708		171,840			45,659		71
73	Drugs Charged to Patients	0.302933		443,308			134,293		73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.674273		378,789			255,407		90
91	Emergency	0.532971		542,387			289,077		91
92	Observation Beds (Non-Distinct	1.078054		109,678			118,239		92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)			5,211,698			1,808,045		200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)			5,211,698			1,808,045		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.196667							54
60	Laboratory	0.351438							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.511689							65
66	Physical Therapy	0.276576							66
69	Electrocardiology	0.187472							69
71	Medical Supplies Charged to Pat	0.265708							71
73	Drugs Charged to Patients	0.302933							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.674273							90
91	Emergency	0.532971							91
92	Observation Beds (Non-Distinct	1.078054							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

		Capital Related Cost (from Wkst. B, Part II, (col. 26)	Swing Bed Adjust- ment	Reduced Capital Related Cost (col. 1 minus col. 2)	Total Patient Days	Per Diem (col. 3 ÷ col. 4)	Inpatient Program Days	Inpatient Program Capital Cost (col. 5 x col. 6)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)	102,881	40,352	62,529	2,519	24.82	411	10,201	30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	Total (lines 30-199)	102,881		62,529	2,519		411	10,201	200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-1328

WORKSHEET D
PART II

Check
Applicable
Boxes:

☐ Title V

☐ Title XVIII, Part A

☒ Title XIX

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

		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)	
(A)	Cost Center Description	1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
54	Radiology-Diagnostic	19,229	5,378,715	0.003575			54
60	Laboratory	11,905	4,331,673	0.002748			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
65	Respiratory Therapy	4,962	386,764	0.012830			65
66	Physical Therapy	9,658	1,117,510	0.008642			66
69	Electrocardiology	160	238,996	0.000669			69
71	Medical Supplies Charged to Pat	4,741	730,717	0.006488			71
73	Drugs Charged to Patients	6,062	2,291,935	0.002645			73
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
88	Rural Health Clinic	49,735	1,493,744	0.033296			88
90	Clinic	7,878	485,621	0.016223			90
91	Emergency	15,825	1,895,370	0.008349			91
92	Observation Beds (Non-Distinct	11,617	311,938	0.037241			92
	OTHER REIMBURSABLE COST CENTERS						
200	Total (sum of lines 50-199)	141,772	18,662,983				200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjust- ment Amount (see instruct- ions)	Total Costs (sum of cols. 1 through 3 minus col 4.)	
(A)	Cost Center Description	1A	1	2A	2	3	4	5	
	INPATIENT ROUTINE SERVICE COST CENTERS								
30	Adults & Pediatrics General Routine Care)								30
31	Intensive Care Unit								31
32	Coronary Care Unit								32
33	Burn Intensive Care Unit								33
34	Surgical Intensive Care Unit								34
35	Other Special Care (specify)								35
40	Subprovider - IPF								40
41	Subprovider - IRF								41
42	Subprovider I								42
43	Nursery								43
44	Skilled Nursing Facility								44
45	Nursing Facility								45
200	TOTAL (lines 30-199)								200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☐ PPS
☐ TEFRA
☒ Other

		Total Patient Days	Per Diem (col. 5÷ col. 6)	Inpatient Program Days	Inpatient Program Pass- Through Cost (col. 7 x col. 8)	
(A)	Cost Center Description	6	7	8	9	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30	Adults & Pediatrics (General Routine Care)	2,519		411		30
31	Intensive Care Unit					31
32	Coronary Care Unit					32
33	Burn Intensive Care Unit					33
34	Surgical Intensive Care Unit					34
35	Other Special Care (specify)					35
40	Subprovider - IPF					40
41	Subprovider - IRF					41
42	Subprovider I					42
43	Nursery					43
44	Skilled Nursing Facility					44
45	Nursing Facility					45
200	Total (lines 30-199)	2,519		411		200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-1328

WORKSHEET D
PART IV

Check
Applicable
Boxes:

☐ Title V
☐ Title XVIII, Part A
☒ Title XIX

☒ Hospital
☐ IPF
☐ IRF

☐ SUB (Other)
☐ SNF
☐ NF

☐ ICF/IID

☐ PPS
☐ TEFRA
☒ Other

		Non Physician Anesth- etist Cost	Nursing School Post- Stepdown Adjustments	Nursing School	Allied Health Post- Stepdown Adjustments	Allied Health	All Other Medical Education Cost	Total Cost (sum of col. 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3, and 4)	
(A)	Cost Center Description	1	2A	2	3A	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS									
54	Radiology-Diagnostic									54
60	Laboratory									60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS									62.30
65	Respiratory Therapy									65
66	Physical Therapy									66
69	Electrocardiology									69
71	Medical Supplies Charged to Pat									71
73	Drugs Charged to Patients									73
76.97	CARDIAC REHABILITATION									76.97
76.98	HYPERBARIC OXYGEN THERAPY									76.98
76.99	LITHOTRIPSY									76.99
	OUTPATIENT SERVICE COST CENTERS									
88	Rural Health Clinic									88
90	Clinic									90
91	Emergency									91
92	Observation Beds (Non-Distinct									92
	OTHER REIMBURSABLE COST CENTERS									
200	Total (sum of lines 50-199)									200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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 [XX] Hospital [] SUB (Other) [] ICF/IID [] PPS
Applicable [] Title XVIII, Part A [] IPF [] SNF [] TEFRA
Boxes: [XX] Title XIX [] IRF [] NF [XX] Other

		Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass- Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass- Through Costs (col. 9 x col. 12)	
(A)	Cost Center Description	7	8	9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	5,378,715							54
60	Laboratory	4,331,673							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	386,764							65
66	Physical Therapy	1,117,510							66
69	Electrocardiology	238,996							69
71	Medical Supplies Charged to Pat	730,717							71
73	Drugs Charged to Patients	2,291,935							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic	1,493,744							88
90	Clinic	485,621							90
91	Emergency	1,895,370							91
92	Observation Beds (Non-Distinct	311,938							92
	OTHER REIMBURSABLE COST CENTERS								
200	Total (sum of lines 50-199)	18,662,983							200

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

			Program Charges			Program Cost			
		Cost to Charge Ratio (from Wkst C, Part I, col. 9)	PPS Reim-bursed Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	PPS Services (see inst.)	Cost Reim-bursed Subject to Ded. & Coins. (see inst.)	Cost Reim-bursed Not Subject to Ded. & Coins. (see inst.)	
(A)	Cost Center Description	1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
54	Radiology-Diagnostic	0.196667							54
60	Laboratory	0.351438							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
65	Respiratory Therapy	0.511689							65
66	Physical Therapy	0.276576							66
69	Electrocardiology	0.187472							69
71	Medical Supplies Charged to Pat	0.265708							71
73	Drugs Charged to Patients	0.302933							73
76.97	CARDIAC REHABILITATION								76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
88	Rural Health Clinic								88
90	Clinic	0.674273							90
91	Emergency	0.532971							91
92	Observation Beds (Non-Distinct	1.078054							92
	OTHER REIMBURSABLE COST CENTERS								
200	Subtotal (see instructions)								200
201	Less PBP Clinic Lab. Services-Program Only Charges								201
202	Net Charges (line 200 - line 201)								202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1328****WORKSHEET D-1
PART I**

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 I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,157	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,519	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	2,051	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,217	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	406	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	11	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	4	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1,344	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	980	10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	326	11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,978,126	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,327	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	525	25
26	Total swing-bed cost (see instructions)	1,168,075	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,810,051	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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 35 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,810,051	37

KPMG LLP Compu-Max 2552-10

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

1

38	Adjusted general inpatient routine service cost per diem (see instructions)					718.56	38
39	Program general inpatient routine service cost (line 9 x line 38)					965,745	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					965,745	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

1

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					507,882	48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					1,473,627	49

PASS THROUGH COST ADJUSTMENTS

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

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise 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)					704,189	64
65	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)					234,251	65
66	Total Medicare swing-bed SNF inpatient routine costs (title XVIII only. For CAH, see instructions)					938,440	66
67	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67
68	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68
69	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☒ Title XVIII, Part A

☐ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					468	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					718.56	88
89	Observation bed cost (line 87 x line 88) (see instructions)					336,286	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	102,881	2,978,126	0.034546	336,286	11,617	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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COMPUTATION OF INPATIENT OPERATING COST**COMPONENT CCN: 14-1328****WORKSHEET D-1
PART I**

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 I - ALL PROVIDER COMPONENTS**INPATIENT DAYS**

1	Inpatient days (including private room days and swing-bed days, excluding newborn)	4,157	1
2	Inpatient days (including private room days, excluding swing-bed and newborn days)	2,519	2
3	Private room days (excluding swing-bed private room days). If you have only private room days, do not complete this line.		3
4	Semi-private room days (excluding swing-bed private room days)	2,051	4
5	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	1,217	5
6	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	406	6
7	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	11	7
8	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	4	8
9	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	411	9
10	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		10
11	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		11
12	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		12
13	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		13
14	Medically necessary private room days applicable to the program (excluding swing-bed days)		14
15	Total nursery days (title V or XIX only)		15
16	Nursery days (title V or XIX only)		16

SWING-BED ADJUSTMENT

17	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17
18	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18
19	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	120.63	19
20	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	131.13	20
21	Total general inpatient routine service cost (see instructions)	2,978,126	21
22	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		22
23	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		23
24	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	1,327	24
25	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	525	25
26	Total swing-bed cost (see instructions)	1,168,075	26
27	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	1,810,051	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	General inpatient routine service charges (excluding swing-bed and observation bed charges)		28
29	Private room charges (excluding swing-bed charges)		29
30	Semi-private room charges (excluding swing-bed charges)		30
31	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		31
32	Average private room per diem charge (line 29 ÷ line 31)		32
33	Average semi-private room per diem charge (line 30 ÷ line 31)		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 35 x line 35)		36
37	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	1,810,051	37

KPMG LLP Compu-Max 2552-10

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

1

38	Adjusted general inpatient routine service cost per diem (see instructions)					718.56	38
39	Program general inpatient routine service cost (line 9 x line 38)					295,328	39
40	Medically necessary private room cost applicable to the Program (line 14 x line 35)						40
41	Total Program general inpatient routine service cost (line 39 + line 40)					295,328	41
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1	2	3	4	5	
42	Nursery (Titles V and XIX only)						42
	Intensive Care Type Inpatient Hospital Units						
43	Intensive Care Unit						43
44	Coronary Care Unit						44
45	Burn Intensive Care Unit						45
46	Surgical Intensive Care Unit						46
47	Other Special Care (specify)						47

1

48	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48
49	Total program inpatient costs (sum of lines 41 through 48)(see instructions)					295,328	49

PASS THROUGH COST ADJUSTMENTS

50	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					10,201	50
51	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51
52	Total Program excludable cost (sum of lines 50 and 51)					10,201	52
53	Total Program inpatient operating cost excluding capital related, nonphysician anesthetist and medical education costs (line 49 minus line 52)						53

TARGET AMOUNT AND LIMIT COMPUTATION

54	Program discharges						54
55	Target amount per discharge						55
56	Target amount (line 54 x line 55)						56
57	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57
58	Bonus payment (see instructions)						58
59	Lesser of line 53 ÷ line 54 or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket.						59
60	Lesser of line 53 ÷ line 54 or line 55 from prior year cost report, updated by the market basket.						60
61	If line 53 ÷ 54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (line 54 x 60), or 1% of the target amount (line 56), otherwise 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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-1328

WORKSHEET D-1
PARTS III & IV

Check
Applicable
Boxes:

☐ Title V - I/P

☐ Title XVIII, Part A

☒ Title XIX - I/P

☒ Hospital

☐ IPF

☐ IRF

☐ SUB (Other)

☐ SNF

☐ NF

☐ ICF/IID

☐ PPS

☐ TEFRA

☒ Other

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	Total observation bed days (see instructions)					468	87
88	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					718.56	88
89	Observation bed cost (line 87 x line 88) (see instructions)					336,286	89
		Cost	Routine Cost (from line 21)	col. 1÷col. 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost col. 3 x col. 4) (see instructions)	
		1	2	3	4	5	
90	Capital-related cost	102,881	2,978,126	0.034546	336,286	11,617	90
91	Nursing School						91
92	Allied Health						92
93	Other Medical Education						93

KPMG LLP Compu-Max 2552-10

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics		1,209,600		30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.196667	337,849	66,444	54
60	Laboratory	0.351438	396,648	139,397	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.511689	67,365	34,470	65
66	Physical Therapy	0.276576	36,185	10,008	66
69	Electrocardiology	0.187472	25,560	4,792	69
71	Medical Supplies Charged to Patients	0.265708	271,687	72,189	71
73	Drugs Charged to Patients	0.302933	590,297	178,820	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.674273			90
91	Emergency	0.532971	3,306	1,762	91
92	Observation Beds (Non-Distinct Part)	1.078054			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,728,897	507,882	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,728,897		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.196667	66,002	12,980	54
60	Laboratory	0.351438	95,018	33,393	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.511689	48,997	25,071	65
66	Physical Therapy	0.276576	302,797	83,746	66
69	Electrocardiology	0.187472	2,739	513	69
71	Medical Supplies Charged to Patients	0.265708	186,476	49,548	71
73	Drugs Charged to Patients	0.302933	334,274	101,263	73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.674273	1,476	995	90
91	Emergency	0.532971			91
92	Observation Beds (Non-Distinct Part)	1.078054			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)		1,037,779	307,509	200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)		1,037,779		202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

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

		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
(A)	COST CENTER DESCRIPTION	1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	Adults & Pediatrics				30
	ANCILLARY SERVICE COST CENTERS				
54	Radiology-Diagnostic	0.196667			54
60	Laboratory	0.351438			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
65	Respiratory Therapy	0.511689			65
66	Physical Therapy	0.276576			66
69	Electrocardiology	0.187472			69
71	Medical Supplies Charged to Patients	0.265708			71
73	Drugs Charged to Patients	0.302933			73
76.97	CARDIAC REHABILITATION				76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
88	Rural Health Clinic				88
90	Clinic	0.674273			90
91	Emergency	0.532971			91
92	Observation Beds (Non-Distinct Part)	1.078054			92
	OTHER REIMBURSABLE COST CENTERS				
200	Total (sum of lines 50-94, and 96-98)				200
201	Less PBP Clinic Laboratory Services-Program only charges (line 61)				201
202	Net Charges (line 200 minus line 201)				202

(A) Worksheet A line numbers

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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)	1,808,045			1
2	Medical and other services reimbursed under OPPTS (see instructions)				2
3	OPPS payments				3
4	Outlier payment (see instructions)				4
4.01	Outlier reconciliation amount (see instructions)				4.01
5	Enter the hospital specific payment to cost ratio (see instructions)				5
6	Line 2 times line 5				6
7	Sum of lines 3, 4, and 4.01, divided by line 6				7
8	Transitional corridor payment (see instructions)				8
9	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200				9
10	Organ acquisition				10
11	Total cost (sum of lines 1 and 10) (see instructions)	1,808,045			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	Ancillary service charges				12
13	Organ acquisition charges (from Wkst. D-4, Part III, col. 4, line 69)				13
14	Total reasonable charges (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	Aggregate amount actually collected from patients liable for payment for services on a charge basis				15
16	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)				16
17	Ratio of line 15 to line 16 (not to exceed 1.000000)				17
18	Total customary charges (see instructions)				18
19	Excess of customary charges over 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 (see instructions)	1,826,125			21
22	Interns and residents (see instructions)				22
23	Cost of physicians' services in a teaching hospital (see instructions)				23
24	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	Deductibles and coinsurance (see instructions)	13,397			25
26	Deductibles and coinsurance relating to amount on line 24 (see instructions)	749,976			26
27	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1,062,752			27
28	Direct graduate medical education payments (from Wkst. E-4, line 50)				28
29	ESRD direct medical education costs (from Wkst. E-4, line 36)				29
30	Subtotal (sum of lines 27 through 29)	1,062,752			30
31	Primary payer payments	397			31
32	Subtotal (line 30 minus line 31)	1,062,355			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	Composite rate ESRD (from Wkst. I-5, line 11)				33
34	Allowable bad debts (see instructions)	257,818			34
35	Adjusted reimbursable bad debts (see instructions)	167,582			35
36	Allowable bad debts for dual eligible beneficiaries (see instructions)	237,869			36
37	Subtotal (see instructions)	1,229,937			37
38	MSP-LCC reconciliation amount from PS&R				38
39	Other adjustments (specify) (see instructions)				39
39.50	Pioneer ACO demonstration payment adjustment (see instructions)				39.50
40	Subtotal (see instructions)	1,229,937			40
40.01	Sequestration adjustment (see instructions)	24,599			40.01
40.02	Demonstration payment adjustment amount after sequestration				40.02
41	Interim payments	1,332,691			41
42	Tentative settlement (for contractors use only)				42
43	Balance due provider/program (see instructions)	-127,353			43
44	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				44

TO BE COMPLETED BY CONTRACTOR

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

KPMG LLP Compu-Max 2552-10

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

			INPATIENT PART A		PART B	
			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
DESCRIPTION			1	2	3	4
1	Total interim payments paid to provider			1,670,240		1,552,708
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					
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51	11/02/2017	11/02/2017	3.51
		Provider	.52	03/22/2018		3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99	-361,757		-220,017
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)			1,308,483		1,332,691
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determined net settlement amount (balance due)		.01			6.01
	based on the cost report (1)		.02	-84,388		-127,353
7	Total Medicare program liability (see instructions)			1,224,095		1,205,338
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED**COMPONENT CCN: 14-Z328****WORKSHEET E-1
PART I**

Check ☐ Hospital ☐ SUB (Other)
Applicable ☐ IPF ☐ SNF
Boxes: ☐ IRF ☒ Swing Bed SNF

			INPATIENT PART A		PART B	
DESCRIPTION			mm/dd/yyyy 1	AMOUNT 2	mm/dd/yyyy 3	AMOUNT 4
1	Total interim payments paid to provider			1,562,439		1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary for services rendered in the cost reporting period. If none, write 'NONE' or enter a zero					2
3	List separately each retroactive lump sum adjustment		.01			3.01
	amount based on subsequent revision of the interim		.02			3.02
	rate for the cost reporting period. Also show date of	Program	.03			3.03
	each payment. If none, write 'NONE' or enter a zero. (1)	to	.04			3.04
		Provider	.05			3.05
			.06			3.06
			.07			3.07
			.08			3.08
			.09			3.09
			.10			3.10
			.50			3.50
			.51	11/02/2017	187,846	3.51
		Provider	.52	03/22/2018	138,928	3.52
		to	.53			3.53
		Program	.54			3.54
			.55			3.55
			.56			3.56
			.57			3.57
			.58			3.58
			.59			3.59
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99	-326,774		3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)			1,235,665		4
TO BE COMPLETED BY CONTRACTOR						
5	List separately each tentative settlement payment		.01			5.01
	after desk review. Also show date of each payment.		.02			5.02
	If none, write 'NONE' or enter a zero. (1)	Program	.03			5.03
		to	.04			5.04
		Provider	.05			5.05
			.06			5.06
			.07			5.07
			.08			5.08
			.09			5.09
			.10			5.10
			.50			5.50
			.51			5.51
		Provider	.52			5.52
		to	.53			5.53
		Program	.54			5.54
			.55			5.55
			.56			5.56
			.57			5.57
			.58			5.58
			.59			5.59
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99			5.99
6	Determined net settlement amount (balance due)		.01			6.01
	based on the cost report (1)		.02	-90,697		6.02
7	Total Medicare program liability (see instructions)			1,144,968		7
8	Name of Contractor		Contractor Number		NPR Date (Month/Day/Year)	

(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.

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS

COMPONENT CCN: 14-Z328

WORKSHEET E-2

Check ☐ Title V
 Applicable ☒ Title XVIII
 Boxes: ☐ Title XIX

☒ Swing Bed - SNF
☐ Swing Bed - NF

COMPUTATION OF NET COSTS OF COVERED SERVICES

		PART A	PART B	
		1	2	
1	Inpatient routine services - swing bed-SNF (see instructions)	947,824		1
2	Inpatient routine services - swing bed-NF (see instructions)			2
3	Ancillary services (from Wkst. D-3, col. 3, line 200 for Part A, and sum of Wkst. D, Pt. V, cols. 6 and 7, line 202 for Part B) (For CAH, see instructions)	310,584		3
4	Per diem cost for interns and residents not in approved teaching program (see instructions)			4
5	Program days	1,306		5
6	Interns and residents not in approved teaching program (see instructions)			6
7	Utilization review - physician compensation - SNF optional method only			7
8	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	1,258,408		8
9	Primary payer payments (see instructions)	16,367		9
10	Subtotal (line 8 minus line 9)	1,242,041		10
11	Deductibles billed to program patients (exclude amounts applicable to physician professional services)			11
12	Subtotal (line 10 minus line 11)	1,242,041		12
13	Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services)	86,002		13
14	80% of Part B costs (line 12 x 80%)			14
15	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1,156,039		15
16	Other Adjustments (specify) (see instructions)			16
16.50	Pioneer ACO demonstration payment adjustment (see instructions)			16.50
17	Allowable bad debts (see instructions)	18,917		17
17.01	Adjusted reimbursable bad debts (see instructions)	12,296		17.01
18	Allowable bad debts for dual eligible beneficiaries (see instructions)	18,917		18
19	Total (see instructions)	1,168,335		19
19.01	Sequestration adjustment (see instructions)	23,367		19.01
19.02	Demonstration payment adjustment amount after sequestration			19.02
20	Interim payments	1,235,665		20
21	Tentative settlement (for contractor use only)			21
22	Balance due provider/program (line 19 minus lines 19.01, 19.02, 20 and 21)	-90,697		22
23	Protested amounts (nonallowable cost report items) in accprdamce with CMS Pub. 15-2, chapter 1, §115.2			23

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	1,473,627	1
2	Nursing an dallied health managed care payment (see instructions)		2
3	Organ acquisition		3
4	Subtotal (sum of lines 1-3)	1,473,627	4
5	Primary payer payments		5
6	Total cost (see instructions)	1,488,363	6
	COMPUTATION OF LESSER OF COST OR CHARGES		
	REASONABLE CHARGES		
7	Routine service charges		7
8	Ancillary service charges		8
9	Organ acquisition charges, net of revenue		9
10	Total reasonable charges		10
	CUSTOMARY CHARGES		
11	Aggregate amount actually collected from patients liable for payment for services on a charge basis		11
12	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		12
13	Ratio of line 11 to line 12 (not to exceed 1.000000)	0.000000	13
14	Total customary charges (see instructions)		14
15	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)		15
16	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions)		16
17	Cost of physicians' services in a teaching hospital (see instructions)		17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18	Direct graduate medical education payments		18
19	Cost of covered services (sum of lines 6 and 17)	1,488,363	19
20	Deductibles (exclude professional component)	289,263	20
21	Excess reasonable cost (from line 16)		21
22	Subtotal (line 19 minus the sum of lines 20 and 21)	1,199,100	22
23	Coinsurance		23
24	Subtotal (line 22 minus line 23)	1,199,100	24
25	Allowable bad debts (exclude bad debts for professional services) (see instructions)	76,888	25
26	Adjusted reimbursable bad debts (see instructions)	49,977	26
27	Allowable bad debts for dual eligible beneficiaries (see instructions)	70,770	27
28	Subtotal (sum of lines 24 and 26)	1,249,077	28
29	Other adjustments (specify) (see instructions)		29
29.50	Pioneer ACO demonstration payment adjustment (see instructions)		29.50
30	Subtotal (see instructions)	1,249,077	30
30.01	Sequestration adjustment (see instructions)	24,982	30.01
30.02	Demonstration payment adjustment amount after sequestration		30.02
31	Interim payments	1,308,483	31
32	Tentative settlement (for contractor use only)		32
33	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31 and 32)	-84,388	33
34	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		34

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	295,328		1
2	Medical and other services			2
3	Organ acquisition (certified transplant centers only)			3
4	Subtotal (sum of lines 1, 2 and 3)	295,328		4
5	Inpatient primary payer payments			5
6	Outpatient primary payer payments			6
7	Subtotal (line 4 less sum of lines 5 and 6)	295,328		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	Routine service charges			8
9	Ancillary service charges			9
10	Organ acquisition charges, net of revenue			10
11	Incentive from target amount computation			11
12	Total reasonable charges (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	Amount actually collected from patients liable for payment for services on a cahрге basis			13
14	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			14
15	Ratio of line 13 to line 14 (not to exceed 1.000000)	1.000000	1.000000	15
16	Total customary charges (see instructions)			16
17	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)			17
18	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)			18
19	Interns and residents (see instructions)			19
20	Cost of physicians' services in a teaching hospital (see instructions)			20
21	Cost of covered services (lesser of line 4 or line 16)	295,328		21
	PROSPECTIVE PAYMENT AMOUNT			
22	Other than outlier payments			22
23	Outlier payments			23
24	Program capital payments			24
25	Capital exception payments (see instructions)			25
26	Routine and ancillary service other pass through costs			26
27	Subtotal (sum of lines 22 through 26)			27
28	Customary charges (Titles V or XIX PPS covered services only)			28
29	Titles V or XIX (sum of lines 21 and 27)	295,328		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	Excess of reasonable cost (from line 18)			30
31	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	295,328		31
32	Deductibles			32
33	Coinsurance			33
34	Allowable bad debts (see instructions)			34
35	Utilization review			35
36	Subtotal (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	295,328		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	Subtotal (line 36 ± line 37)	295,328		38
39	Direct graduate medical education payments (from Wkst. E-4)			39
40	Total amount payable to the provider (sum of lines 38 and 39)	295,328		40
41	Interim payments	249,234		41
42	Balance due provider/program (line 40 minus line 41)	46,094		42
43	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			43

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	260,634				1
2	Temporary investments					2
3	Notes receivable					3
4	Accounts receivable	2,662,018				4
5	Other receivables					5
6	Allowances for uncollectible notes and accounts receivable	-1,090,967				6
7	Inventory	203,208				7
8	Prepaid expenses	13,340				8
9	Other current assets					9
10	Due from other funds					10
11	Total current assets (sum of lines 1-10)	2,048,233				11
FIXED ASSETS						
12	Land	17,000				12
13	Land improvements	256,674				13
14	Accumulated depreciation	-146,257				14
15	Buildings	1,796,754				15
16	Accumulated depreciation	-1,355,772				16
17	Leasehold improvements					17
18	Accumulated depreciation					18
19	Fixed equipment					19
20	Accumulated depreciation					20
21	Automobiles and trucks					21
22	Accumulated depreciation					22
23	Major movable equipment	3,745,979				23
24	Accumulated depreciation	-3,224,294				24
25	Minor equipment depreciable					25
26	Accumulated depreciation					26
27	HIT designated assets					27
28	Accumulated depreciation					28
29	Minor equipment-nondepreciable					29
30	Total fixed assets (sum of lines 12-29)	1,090,084				30
OTHER ASSETS						
31	Investments					31
32	Deposits on leases					32
33	Due from owners/officers					33
34	Other assets					34
35	Total other assets (sum of lines 31-34)					35
36	Total assets (sum of lines 11, 30 and 35)	3,138,317				36
	Liabilities and Fund Balances (Omit Cents)	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1	2	3	4	
CURRENT LIABILITIES						
37	Accounts payable	259,295				37
38	Salaries, wages and fees payable	719,764				38
39	Payroll taxes payable					39
40	Notes and loans payable (short term)	112,351				40
41	Deferred income	83,446				41
42	Accelerated payments					42
43	Due to other funds					43
44	Other current liabilities	319,579				44
45	Total current liabilities (sum of lines 37 thru 44)	1,494,435				45
LONG TERM LIABILITIES						
46	Mortgage payable					46
47	Notes payable	234,033				47
48	Unsecured loans					48
49	Other long term liabilities					49
50	Total long term liabilities (sum of lines 46 thru 49)	234,033				50
51	Total liabilities (sum of lines 45 and 50)	1,728,468				51
CAPITAL ACCOUNTS						
52	General fund balance	1,409,849				52
53	Specific purpose fund					53
54	Donor created - endowment fund balance - restricted					54
55	Donor created - endowment fund balance - unrestricted					55
56	Governing body created - endowment fund balance					56
57	Plant fund balance - invested in plant					57
58	Plant fund balance - reserve for plant improvement, replacement, and expansion					58

KPMG LLP Compu-Max 2552-10

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

	Assets	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	(Omit Cents)	1	2	3	4	
59	Total fund balances (sum of lines 52 thru 58)	1,409,849				59
60	Total liabilities and fund balances (sum of lines 51 and 59)	3,138,317				60

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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		1,020,124		1
2	Net income (loss) (from Worksheet G-3, line 29)		388,693		2
3	Total (sum of line 1 and line 2)		1,408,817		3
4	Additions (credit adjustments) (specify)				4
5	PRIOR YEAR ADJUSTMENTS				5
6					6
7					7
8					8
9					9
10	Total additions (sum of lines 4-9)				10
11	Subtotal (line 3 plus line 10)		1,408,817		11
12	Deductions (debit adjustments) (specify)				12
13					13
14					14
15					15
16					16
17					17
18	Total deductions (sum of lines 12-17)				18
19	Fund balance at end of period per balance sheet (line 11 minus line 18)		1,408,817		19

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES**WORKSHEET G-2
PARTS I & II****PART I - PATIENT REVENUES**

	REVENUE CENTER	INPATIENT 1	OUTPATIENT 2	TOTAL 3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	Hospital	2,452,284		2,452,284	1
2	Subprovider IPF				2
3	Subprovider IRF				3
5	Swing Bed - SNF	1,059,707		1,059,707	5
6	Swing Bed - NF				6
7	Skilled nursing facility				7
8	Nursing facility				8
9	Other long term care				9
10	Total general inpatient care services (sum of lines 1-9)	3,511,991		3,511,991	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	Intensive Care Unit				11
12	Coronary Care Unit				12
13	Burn Intensive Care Unit				13
14	Surgical Intensive Care Unit				14
15	Other Special Care (specify)				15
16	Total intensive care type inpatient hospital services (sum of lines 11-15)				16
17	Total inpatient routine care services (sum of lines 10 and 16)	3,511,991		3,511,991	17
18	Ancillary services	4,983,578	11,650,233	16,633,811	18
19	Outpatient services	558,497	1,543,955	2,102,452	19
20	Rural Health Clinic (RHC)		1,493,744	1,493,744	20
21	Federally Qualified Health Center (FQHC)				21
22	Home health agency				22
23	Ambulance				23
25	ASC				25
26	Hospice				26
27	Other (specify)				27
28	Total patient revenues (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	9,054,066	14,687,932	23,741,998	28

PART II - OPERATING EXPENSES

		1	2	
29	Operating expenses (per Worksheet A, column 3, line 200)		11,561,561	29
30	Add (specify)			30
31				31
32				32
33				33
34				34
35				35
36	Total additions (sum of lines 30-35)			36
37	Deduct (specify)			37
38				38
39				39
40				40
41				41
42	Total deductions (sum of lines 37-41)			42
43	Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		11,561,561	43

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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)	23,741,998	1
2	Less contractual allowances and discounts on patients' accounts	12,143,009	2
3	Net patient revenues (line 1 minus line 2)	11,598,989	3
4	Less total operating expenses (from Worksheet G-2, Part II, line 43)	11,561,561	4
5	Net income from service to patients (line 3 minus line 4)	37,428	5

OTHER INCOME

6	Contributions, donations, bequests, etc.	2,528	6
7	Income from investments	23,346	7
8	Revenues from telephone and other miscellaneous communication services		8
9	Revenue from television and radio service		9
10	Purchase discounts		10
11	Rebates and refunds of expenses	101,994	11
12	Parking lot receipts		12
13	Revenue from laundry and linen service		13
14	Revenue from meals sold to employees and guests	3,313	14
15	Revenue from rental of living quarters		15
16	Revenue from sale of medical and surgical supplies to otehr than patients		16
17	Revenue from sale of drugs to other than patients		17
18	Revenue from sale of medical records and abstracts	4,855	18
19	Tuition (fees, sale of textbooks, uniforms, etc.)		19
20	Revenue from gifts, flowers, coffee shops and canteen		20
21	Rental of vending machines		21
22	Rental of hosptial space		22
23	Governmental appropriations		23
24	Other (MISCELLANOUS)	7,200	24
24.01	Other (GRANTS)	131,351	24.01
24.02	Other (DEFERRED REVENUE)	76,678	24.02
24.03	Other (SITE FEES)		24.03
24.04	Other (EHR INCENTIVE)		24.04
25	Total other income (sum of lines 6-24)	351,265	25
26	Total (line 5 plus line 25)	388,693	26
29	Net income (or loss) for the period (line 26 minus line 28)	388,693	29

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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
190.0	VENDING MACHINE							190.0
1								1
200	Cross Foot Adjustments							200
201	Negative Cost Centers							201
202	TOTAL (sum of lines 118-201)							202

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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	597,880	66,966	664,846		664,846		664,846	1
2	Physician Assistant								2
3	Nurse Practitioner	217,702	21,414	239,116		239,116		239,116	3
4	Visiting Nurse								4
5	Other Nurse	229,318	41,654	270,972		270,972		270,972	5
6	Clinical Psychologist								6
7	Clinical Social Worker								7
8	Laboratory Techincian								8
9	Other Facility Health Care Staff Costs	289,484	46,772	336,256		336,256		336,256	9
10	Subtotal (sum of lines 1 through 9)	1,334,384	176,806	1,511,190		1,511,190		1,511,190	10
	COSTS UNDER AGREEMENT								
11	Physician Services Under Agreement								11
12	Physician SUpervision Under Agreement								12
13	Other Costs Under Agreement								13
14	Subtotal (sum of lines 11 through 13)								14
	OTHER HEALTH CARE COSTS								
15	Medical Supplies		1,470	1,470		1,470		1,470	15
16	Transportation (Health Care Staff)		218	218		218		218	16
17	Deperciation-Medical Equipment								17
18	Professional Liability Insurance								18
19	Other Health Care Costs		76,964	76,964		76,964		76,964	19
20	Allowable GME Costs								20
21	Subtotal (sum of lines 15 through 20)		78,652	78,652		78,652		78,652	21
22	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	1,334,384	255,458	1,589,842		1,589,842		1,589,842	22
	COSTS OTHER THAN RHC/FQHC SERVICES								
23	Pharmacy								23
24	Dental								24
25	Optometry								25
25.01	Telehealth								25.01
25.02	Chronic Care Management								25.02
26	All other nonreimbursable costs								26
27	Nonallowable GME costs								27
28	Total Nonreimbursable Costs (sum of lines 23 through 27)								28
	FACILITY OVERHEAD								
29	Facility Costs		52,788	52,788		52,788		52,788	29
30	Administrative Costs				7,663	7,663		7,663	30
31	Total Facility Overhead (sum of lines 29 and 30)		52,788	52,788	7,663	60,451		60,451	31
32	Total faciltiy costs (sum of lines 22, 28 and 31)	1,334,384	308,246	1,642,630	7,663	1,650,293		1,650,293	32

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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ALLOCATION OF OVERHEAD TO RHC/FQHC SERVICES

COMPONENT CCN: 14-3479

WORKSHEET M-2

Check applicable box: ☒ RHC ☐ FQHC**VISITS AND PRODUCTIVITY**

		Number of FTE Personnel	Total Visits	Productivity Standard (1)	Minimum Visits (col. 1 x col. 3)	Greater of col. 2 or col. 4	
	Positions	1	2	3	4	5	
1	Physicians	1.75	7,598	4,200	7,350		1
2	Physician Assistants			2,100			2
3	Nurse Practitioners	1.86	4,720	2,100	3,906		3
4	Subtotal (sum of lines 1 through 3)	3.61	12,318		11,256	12,318	4
5	Visiting Nurse						5
6	Clinical Psychologist						6
7	Clinical Social Worker						7
7.01	Medical Nutrition Therapist (FQHC only)						7.01
7.02	Diabetes Self Management Training (FQHC only)						7.02
8	Total FTEs and Visits (sum of lines 4 through 7)	3.61	12,318			12,318	8
9	Physician Services Under Agreements						9

DETERMINATION OF ALLOWABLE COST APPLICABLE TO RHC/FQHC SERVICES

10	Total costs of health care services (from Wkst. M-1, col. 7, line 22)		1,589,842	10
11	Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28)			11
12	Cost of all services (excluding overhead) (sum of lines 10 and 11)		1,589,842	12
13	Ratio of RHC/FQHC services (line 10 divided by line 12)		1.000000	13
14	Total facility overhead (from Wkst. M-1, col. 7, line 31)		60,451	14
15	Parent provider overhead allocated to facility (see instructions)		599,728	15
16	Total overhead (sum of lines 14 and 15)		660,179	16
17	Allowable Direct GME overhead (see instructions)			17
18	Subtotal (see instructions)		660,179	18
19	Overhead applicable to RHC/FQHC services (line 13 x line 18)		660,179	19
20	Total allowable cost of RHC/FQHC services (sum of lines 10 and 19)		2,250,021	20

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES

COMPONENT CCN: 14-3479

WORKSHEET M-3

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

DETERMINATION OF RATE FOR RHC/FQHC SERVICES

1	Total allowable cost of RHC/FQHC services (from Wkst. M-2, line 20)	2,250,021	1
2	Cost of vaccines and their administratino (from Wkst. M-4, line 15)	17,726	2
3	Total allowable cost excluding vaccine (line 1 minus line 2)	2,232,295	3
4	Total visits (from Wkst. M-2, col. 5, line 8)	12,318	4
5	Physicians visits under agreement (from Wkst. M-2, col. 5, line 9)		5
6	Total adjusted visits (line 4 plus line 5)	12,318	6
7	Adjusted cost per visit (line 3 divided by line 6)	181.22	7

		Calculation of Limit (1)			
		Prior to January 1	On or after January 1	(See instr.)	
		1	2	3	
8	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.6 or your contractor)				8
9	Rate for program covered visits (see instructions)	181.22	181.22	181.22	9
CALCULATION OF SETTLEMENT					
10	Program covered visits excluding mental health services (from contractor records)		4,590		10
11	Program cost excluding costs for mental health services (line 9 x line 10)		831,800		11
12	Program covered visits for mental health services (from contractor records)				12
13	Program covered cost from mental health services (line 9 x line 12)				13
14	Limit adjustment for mental health services (see instructions)				14
15	Graduate Medical Education pass-through cost (see instructions)				15
16	Total Program cost (see instructions)		831,800		16
16.01	Total program charges (see instructions)(from contractor's records)		599,100		16.01
16.02	Total program preventive charges (see instructions)(from provider's records)		1,996		16.02
16.03	Total program preventive costs (see instructions)		2,772		16.03
16.04	Total program non-preventive costs (see instructions)		607,800		16.04
16.05	Total program cost (see instructions)		610,572		16.05
17	Primary payer payments		107		17
18	Less: Beneficiary deductible for RHC only (see instructions)(from contractor records)		69,278		18
19	Less: Beneficiary coinsurance for RHC/FQHC services (see instructions) (from contractor records)		97,565		19
20	Net Medicare cost excluding vaccines (see instructions)		610,465		20
21	Program cost of vaccines and their administration (from Wkst. M-4, line 16)		13,260		21
22	Total reimbursable Program cost (line 20 plus line 21)		623,725		22
23	Allowable bad debts (see instructions)		46,688		23
23.01	Adjusted reimbursable bad debts (see instructions)		30,347		23.01
24	Allowable bad debts for dual eligible beneficiaries (see instructions)		46,688		24
25	Other adjustments (specify) (see instructions)				25
26	Net reimbursable amount (see instructions)		654,072		26
26.01	Sequestration adjustment (see instructions)		13,081		26.01
26.02	Demonstration payment adjustment amount after sequestration				26.02
27	Interim payments		598,857		27
28	Tentative settlement (for contractor use only)				28
29	Balance due component/program (line 26 minus lines 26.01, 27 and 28)		42,134		29
30	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2				30

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

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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)	1,511,190	1,511,190	1
2	Ratio of pneumococcal and influenza vaccine staff time to total health care staff time	0.000221	0.001994	2
3	Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)	334	3,013	3
4	Medical supplies cost - pneumococcal and influenza vaccine (from your records)	1,699	7,479	4
5	Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)	2,033	10,492	5
6	Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)	1,589,842	1,589,842	6
7	Total overhead (from Wkst. M-2, line 16)	660,179	660,179	7
8	Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6)	0.001279	0.006599	8
9	Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8)	844	4,357	9
10	Total pneumococcal and influenza vaccine costs and their administration costs (sum of lines 5 and 9)	2,877	14,849	10
11	Total number of pneumococcal and influenza vaccine injections (from your records)	56	506	11
12	Cost per pneumococcal and influenza vaccing injection (line 10/line 11)	51.38	29.35	12
13	Number of pneumococcal and influenza vaccine injections administered to program beneficiaries	41	380	13
14	Program cost of pneumococcal and influenza vaccines and their administration costs (line 12 x line 13)	2,107	11,153	14
15	Total cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)		17,726	15
16	Total Program cost of pneumococcal and influenza vaccines and their administration costs (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3, line 21)		13,260	16

KPMG LLP Compu-Max 2552-10

HARDIN COUNTY GENERAL HOSPITAL Provider CCN: 14-1328	In Lieu of Form CMS-2552-10	Period : From: 04/01/2017 To: 03/31/2018	Run Date: 08/13/2018 Run Time: 13:13 Version: 2018.04 (07/10/2018)
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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		
				mm/dd/yyyy	Amount	
DESCRIPTION				1	2	
1	Total interim payments paid to provider				510,836	1
2	Interim payments payable on individual bills, either submitted or to be submitted to the intermediary, for services rendered in the cost reporting period. If none, write 'NONE' or enter zero					2
3	List separately each retroactive lump sum adjustment 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	11/02/2017	88,021	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		88,021	3.99
4	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. M-3, line 27)				598,857	
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		42,134	6.01
			.02			6.02
7	Total Medicare program liability (see instructions)				640,991	
8	Name of Contractor	Contractor Number	NPR Date (Month/Day/Year)			8

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