This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 14-1328 Peri od: Worksheet S From 04/01/2022 Parts I-III AND SETTLEMENT SUMMARY 03/31/2023 Date/Time Prepared: 8/28/2023 1: 29 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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 submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by HARDIN COUNTY GENERAL HOSPITAL (14-1328) for the cost reporting period beginning 04/01/2022 and ending 03/31/2023 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.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX					
	1	2	SI GNATURE STATEMENT				
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1			
2	Signatory Printed Name			2			
3	Si gnatory Ti tle			3			
4	Date			4			

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	-414, 211	-310, 166	0	62, 338	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	525, 357	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		16, 094		0	10.00
200.00	TOTAL	0	111, 146	-294, 072	0	62, 338	200.00
The ob	and amounts represent "due to" or "due from"	the engliceble	program for t	ha alamant of	the charte comp	lav indiaatad	

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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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 the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	HARDIN COUNTY GEN		PITAL er CCN:	14-1328	Ir Peri od:	n Lieu	of For Workshe		<u>2552-10</u>
						From 04/01/ To 03/31/	2023	Part I Date/Ti		
	1.00	2. 00		3. 00		4	4. 00	8/28/20	023 1: 2	29 pm
1. 00	Hospital and Hospital Health Care Co Street: 6 FERRELL ROAD	omplex Address: PO Box: 2467								1.00
2. 00	City: ROSICLARE	State: IL	Zip Code			y: HARDIN				2.00
		Component Name	CCN Number	CBSA Number	Provi der Type	Date Certified		nt Syst 0, or		
					J 71		V	XVIII	XIX	
	Hospital and Hospital-Based Componer	1.00 nt Identification:	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	8. 00	
3. 00	Hospi tal	HARDIN COUNTY GENERAL	141328	99914	1	07/09/2003	N	0	0	3.00
4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Subprovi der - IPF Subprovi der - IRF Subprovi der - (Other) Swi ng Beds - SNF Swi ng Beds - NF Hospi tal -Based SNF	HOSPITAL HARDIN COUNTY SWING BED	14Z328	99914		07/09/2003	N	0	N	4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Hospital -Based NF Hospital -Based OLTC Hospital -Based HHA Separately Certified ASC Hospital -Based Hospice Hospital -Based Health Clinic - RHC Hospital -Based Health Clinic - FQHC Hospital -Based (CMHC) I Renal Dialysis	HARDIN COUNTY RHC	143479	99914		04/03/2006	N	0	N	10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
17.00	je triei					From:		То		17:00
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					1. 00 04/01/2 2		03/31/		20.00
21.00	Type or control (see mistractions)				1. 00	2.00		3. 0)O	- 21.00
	Inpatient PPS Information							5. 0	,,,	
22. 00	Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section §	ustment, in accordance wi or yes or "N" for no. Is	th 42 CFI this		N	N				22. 00
22. 01	hospital?) In column 2, enter "Y" for jud this hospital receive interim UC this cost reporting period? Enter in for the portion of the cost reporting. Enter in column 2, "Y" for yes or	or yes or "N" for no. CPs, including supplement or column 1, "Y" for yes on ong period occurring prion	tal UCPs, or "N" foi or to Octol	r no per	N	N				22. 01
22. 02	cost reporting period occurring on c instructions) Is this a newly merged hospital that	or after October 1. (see		ie	N	N				22. 02
22. 02	determined at cost report settlement 1, "Y" for yes or "N" for no, for th period prior to October 1. Enter in	? (see instructions) En ne portion of the cost re	ter in col eporting							22.02
22. 03	for the portion of the cost reportir Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	ng period on or after Ocidic reclassification from the column 1, "Y" for yes or no for the portion of the cotober 1. (see instant)	tober 1. m urban to stical an "N" for n er 1. Ento ne cost ructions) 99 beds (2	reas no er	N	N		N		22. 03
22. 04	yes or "N" for no. Did this hospital receive a geograph rural as a result of the revised OME adopted by CMS in FY 2021? Enter in for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	delineations for statisticolumn 1, "Y" for yes of ag period prior to Octobe no for the portion of the October 1. (see instraction but not more than 400 but not more more more more more more more more	stical are "N" for er 1. Ente ne cost ructions) 99 beds (a	eas no er						22.04
23. 00	yes or "N" for no. Which method is used to determine Mebelow? In column 1, enter 1 if date if date of discharge. Is the method reporting period different from the reporting period? In column 2, enter	of admission, 2 if censuof identifying the days method used in the prior	us days, o in this o cost	or 3		3 N				23. 00

					023 1: 2	9 pm
			Medi cai		ther	
		tate li cai d	HMO day		di cai d days	
		gi bl e		'	aays	
		pai d				
	1.00 2.00 3.00 4	. 00	5. 00	(5. 00	
24. 00	If this provider is an IPPS hospital, enter the 0 0 0	0		0	0	24.00
	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.					
25.00	If this provider is an IRF, enter the in-state 0 0 0	o		o		25.00
	Medicaid paid days in column 1, the in-state					
	Medicaid eligible unpaid days in column 2,					
	out-of-state Medicaid days in column 3, out-of-state					
	Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.					
		 Urban∕Ru	ral S [Date of	Geogr	
	-	1. 00		2.		
26. 00	Enter your standard geographic classification (not wage) status at the beginning of the		2			26.00
	cost reporting period. Enter "1" for urban or "2" for rural.					
27. 00	Enter your standard geographic classification (not wage) status at the end of the cost		2			27. 00
	reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable,					
35 00	enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in		0			35.00
33.00	effect in the cost reporting period.		۷			33.00
	perfect in the cost reporting perfect.	Begi nni	ng:	Endi	ng:	
		1. 00		2.		
36. 00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number					36.00
	of periods in excess of one and enter subsequent dates.					
37. 00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status		0			37.00
27 01	is in effect in the cost reporting period.					27.01
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in					37. 01
	accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					
38. 00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is					38.00
	greater than 1, subscript this line for the number of periods in excess of one and					
-	enter subsequent dates.					
		Y/N		Υ/		
00.00		1.00)	2.		00.00
39. 00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column	N		N	I	39.00
	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), (ii), or (iii)? Enter in column 2 "Y" for yes					
	or "N" for no. (see instructions)					
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or	N		N	I	40.00
	"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)			1		
			V	XVIII		-
	Prospective Payment System (PPS)-Capital		1.00	2. 00	3.00	
45 00	Does this facility qualify and receive Capital payment for disproportionate share in acc	ordance	l N	l N	N	45. 00
10.00	with 42 CFR Section §412.320? (see instructions)	or during	'*	''	"	10.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstanc	es	N	N	N	46.00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I t		1			
	Pt. III.					
	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" fo	r no.	N	N	N	47.00
48. 00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.		N	N	N	48. 00
54 OO	Teaching Hospitals	ortina	T N			E4 00
oo. 00	Is this a hospital involved in training residents in approved GME programs? For cost rep periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column		l in			56.00
	cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2		1			
	the instructions. For column 2, if the response to column 1 is "Y", or if this hospital					
	involved in training residents in approved GME programs in the prior year or penultimate					
	and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction	? Enter	1			
	"Y" for yes; otherwise, enter "N" for no in column 2.					
57.00	For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, i					57.00
	is this the first cost reporting period during which residents in approved GME programs at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did	пагпеd	1			
	residents start training in the first month of this cost reporting period? Enter "Y" fo	r ves or	.			
	"N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N",	, yes or	1			
	complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting peri	ods				
	beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardl	ess of				
	which month(s) of the cost report the residents were on duty, if the response to line 56		1			
	for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet	E-4.			1	

62.01

your hospital received HRSA PCRE funding (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

during in this cost reporting period of HRSA THC program. (see instructions)

Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter

"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

0.00 62.01

63.00

Heal th	ı Financial Systems	HARDIN COL	JNTY GENERAL HOSPITAL		In lia	u of Form CMS-2	2552-10
	TAL AND HOSPITAL HEALTH CARE COMP			CN: 14-1328 Pe	eriod: com 04/01/2022	Worksheet S-2 Part I	pared:
			'	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2. 00	3.00	
	Section 5504 of the ACA Base Yea			-This base year	is your cost	reporti ng	
64. 00	period that begins on or after. Enter in column 1, if line 63 is in the base year period, the nur resident FTEs attributable to resttings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column)	yes, or your facili ber of unweighted non tations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64.00
	. (50.5	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
		-		FTEs Nonprovider Site	FTEs in Hospital	3/ (col. 3 + col. 4))	
		1. 00	2. 00	3. 00	4. 00	5. 00	
65. 00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. 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)			0.00	0.00	0.000000 Ratio (col.	65.00
				FTEs Nonprovider Site	FTEs in Hospital	1/ (col. 1 + col. 2))	
				1. 00	2. 00	3. 00	
	Section 5504 of the ACA Current		n Nonprovider Setting	gsEffective f	or cost report	ing periods	
66. 00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 divided by 1)	unweighted non-priman ccurring in all nonpounweighted non-priman al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2. 00	3. 00	4. 00	5. 00	
67. 00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. 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)			0.00	0.00	0. 000000	67.00

Health Financial Systems HARDIN COUNTY GENERAL HOSPITAL		In	Li eu	of Form	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN:	F	eriod: rom 04/01/2 o 03/31/2	2022	Workshee Part I Date/Tir 8/28/20	me Pre	pared:
			-	1. 0	0	
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-4907. 68.00 For a cost reporting period beginning prior to October 1, 2022, did you obta MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?	ain permissi	on from you		N		68. 00
			1. 00	2.00	3. 00	
Inpatient Psychiatric Facility PPS 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain	n an IPF sub	provi der?	N	Τ		70.00
Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching recent cost report filed on or before November 15, 2004? Enter "Y" for yes 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes Column 3: If column 2 is Y, indicate which program year began during this consideration.	or "N" for n a new tead or "N" for	no. (see chi ng no.			0	71. 00
Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it conf	tain an IRF		N			75. 00
subprovider? Enter "Y" for yes and "N" for no. 76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching recent cost reporting period ending on or before November 15, 2004? Enter "No. Column 2: Did this facility train residents in a new teaching program in CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column indicate which program year began during this cost reporting period. (see in	Y" for yes on accordance olumn 2 is \	or "N" for e with 42 /,			0	76. 00
			-	1. 0	0	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cos "Y" for yes and "N" for no.		period? Er	nter	N N		80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter ' 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	N		85. 00 86. 00			
87.00 Is this hospital an extended neoplastic disease care hospital classified und 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	der section			N		87. 00
		Approved Permaner Adjustme (Y/N) 1.00	nt	Number Appro Permar Adjustm 2.0	ved nent ments	
88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.		<i>y</i>			0	88.00
W	/kst. A Line No.	Effectiv Date	/e	Appro Permar Adjusti Amount Discha	nent ment Per arge	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	1.00	2. 00		3. 0		89. 00
on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period beginning date) for the permanent adjustment to the TEFRA target amount per discharge. Column 3: Enter the amount of the approved permanent adjustment to the						
TEFRA target amount per discharge.		V		XIX	(
Title V and XIX Services		1. 00		2. 0	0	
90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter yes or "N" for no in the applicable column.	er "Y" for	N		Υ		90.00
91.00 Is this hospital reimbursed for title V and/or XIX through the cost report of full or in part? Enter "Y" for yes or "N" for no in the applicable column.	either in	N		Υ		91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column.	n)? (see			N		92.00
93.00 Does this facility operate an ICF/IID facility for purposes of title V and Y "Y" for yes or "N" for no in the applicable column.	XIX? Enter	N		N		93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no i applicable column.	in the	N		N		94.00
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no i applicable column.	in the	0. 00 N		O. O N	0	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0. 0	0	97. 00

		nospital (CAH) no in column 1	N	N	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAI outpatient services cost? Enter "Y" for yes or "N" for no			N	N	98. 04
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add I Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in			N	N	98. 05
column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cose Pts. I through IV? Enter "Y" for yes or "N" for no in column colum	N	N	98. 06		
column 2 for title XIX. Rural Providers					-
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)	l-inclusive met	thod of payment	Y N		105. 00 106. 00
107.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in colum Column 2: If column 1 is Y and line 70 or line 75 is Y, do	N		107. 00		
approved medical education program in the CAH's excluded Enter "Y" for yes or "N" for no in column 2. (see instructions to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	tions)	, ,	N		108. 00
	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 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 no for each therapy.	1.00 e Y	2. 00 Y	3. 00 Y	4.00 N	109. 00
in the fact that age is		1			
110.00 Did this hospital participate in the Rural Community Hospi Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and We applicable.	"Y" for yes or	"N" for no. I	f yes,	1.00 N	110.00
			1. 00	2.00	-
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is pure that apply: "A" for Ambulance services; "B" for a for tele-health services.	cost reporting column 1 is Y, articipating ir	period? Enter enter the n column 2.	1. 00 N	2.00	111.00
Health Integration Project (FCHIP) demonstration for this "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is particular.	cost reporting column 1 is Y, articipating ir	period? Enter enter the n column 2. s; and/or "C"	N		111.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is pure that apply: "A" for Ambulance services; "B" for for tele-health services.	cost reporting column 1 is Y, articipating ir additional beds	period? Enter enter the column 2. s; and/or "C"		2.00	
Health Integration Project (FCHIP) demonstration for this e "Y" for yes or "N" for no in column 1. If the response to e integration prong of the FCHIP demo in which this CAH is p. Enter all that apply: "A" for Ambulance services; "B" for e for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If e "Y", enter in column 2, the date the hospital began partici demonstration. In column 3, enter the date the hospital co- participation in the demonstration, if applicable.	cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the	peri od? Enter enter the col umn 2. s; and/or "C"	N		111.00
Health Integration Project (FCHIP) demonstration for this e "Y" for yes or "N" for no in column 1. If the response to e integration prong of the FCHIP demo in which this CAH is p. Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital coparticipation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide	cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes	peri od? Enter enter the n col umn 2. s; and/or "C"	N	3.00	
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is pure Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost period? Enter "Y" for yes or "N" for no in column 1. If "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital content participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care	cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on	period? Enter enter the n column 2. s; and/or "C"	N	3.00	112.00
Health Integration Project (FCHIP) demonstration for this of "Y" for yes or "N" for no in column 1. If the response to integration prong of the FCHIP demo in which this CAH is pure Enter all that apply: "A" for Ambulance services; "B" for a for tele-health services. 112.00 Did this hospital participate in the Pennsylvania Rural Health (PARHM) demonstration for any portion of the current cost in period? Enter "Y" for yes or "N" for no in column 1. If of "Y", enter in column 2, the date the hospital began participation. In column 3, enter the date the hospital constration. In column 3, enter the date the hospital constrainment on the demonstration, if applicable. Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes of in column 1. If column 1 is yes, enter the method used (A, in column 2. If column 2 is "E", enter in column 3 either for short term hospital or "98" percent for long term care psychiatric, rehabilitation and long term hospitals provide the definition in CMS Pub. 15-1, chapter 22, §2208. 1.	cost reporting column 1 is Y, articipating ir additional beds alth Model reporting column 1 is ipating in the eased or "N" for no B, or E only) "93" percent (includes ers) based on "for yes or	period? Enter enter the n column 2. s; and/or "C"	N	3.00	112.00

132.00 If this is a Medicare-certified islet transplant program, enter the certification date									
in column 1 and termination date, if a	applicable, in column 2.			İ					
133.00 Removed and reserved				İ	133. 00				
134.00 If this is a hospital-based organ prod	curement organization (OPO), enter the (OPO number		İ	134.00				
in column 1 and termination date, if a	applicable, in column 2.								
All Providers									
140.00 Are there any related organization or	home office costs as defined in CMS Pul	o. 15-1,	N	İ	140.00				
chapter 10? Enter "Y" for yes or "N" to	for no in column 1. If yes, and home of	fice costs		İ					
are claimed, enter in column 2 the hor	ne office chain number. (see instruction	ns)							
1. 00	2. 00		3. 00						
If this facility is part of a chain of	rganization, enter on lines 141 through	143 the na	me and address	of the home					
office and enter the home office cont	ractor name and contractor number.								
141.00 Name:	Contractor's Name:	Contractor	's Number:		141. 00				
142.00 Street:	PO Box:				142.00				
143. 00 Ci ty:	State:	Zi p Code:			143.00				
				1.00					
144.00 Are provider based physicians' costs i	ncluded in Worksheet A?			Υ	144.00				
			1. 00	2. 00					
145.00 If costs for renal services are claims	ed on Wkst. A, line 74, are the costs fo	or			145.00				
inpatient services only? Enter "Y" for	yes or "N" for no in column 1. If colu	umn 1 is		İ					
no, does the dialysis facility include	e Medicare utilization for this cost rep	porting		İ					
period? Enter "Y" for yes or "N" for	no in column 2.	3		İ					
146.00 Has the cost allocation methodology ch		eport?	N	İ	146.00				
Enter "Y" for yes or "N" for no in col	umn 1. (See CMS Pub. 15-2, chapter 40,	§4020) If		İ					
yes, enter the approval date (mm/dd/y	yyy) in column 2.	,		İ					
	33,		'						

Health Financial Systems			ERAL HOSPITAL	N 44 400			u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DAT	A	From 04/01/2022			iod: m 04/01/2022 03/31/2023	Worksheet S- Part I Date/Time Pr 8/28/2023 1:	epared:
							1.00	-
147.00 Was there a change in the statist	cal hasis? Enter "Y	" for v	es or "N" for	no.			1.00 N	147.0
148.00 Was there a change in the order of							l N	148. 0
149.00Was there a change to the simplif					for no	ı.	N	149. 0
	<u> </u>		Part A	Part	В	Title V	Title XIX	
			1. 00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or			ent for Part A	and Part		ee 42 CFR §41	3. 13)	
55. 00 Hospi tal			N	N N		N	N	155. C
56. 00 Subprovi der - I PF			N	N N		N	N	156.0
57. 00 Subprovi der - I RF 58. 00 SUBPROVI DER			N	N		N	N	157. C
59. 00 SNF			N	l N		N	N	159. 0
60. OO HOME HEALTH AGENCY			N	l N		N	N N	160.0
61. 00 CMHC				N N	1	N	N N	161.0
				1			1. 00	
Mul ti campus								
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	<u> </u>	has one	<u>'</u>				N	165.0
	Name		County	State	Zip Co		FTE/Campus	_
66.00 If line 165 is yes, for each	0		1. 00	2. 00	3. 00	4.00	5. 00	0 166. 0
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							5.5	
							1.00	
Health Information Technology (HI						Act		
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	05 is "Y") and is a m	meani ng	ful user (lin	"N" for n e 167 is	o. "Y"), e	nter the	Y	167. 0 168. 0
68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful use ? Enter "Y" for yes o	r, does or "N"	this provide for no. (see	instructi	ons)	·		168.0
69.00 If this provider is a meaningful transition factor. (see instruction		") and	is not a CAH	(line 105	is "N"			00169. 0
						Begi nni ng	Endi ng	
70.00 Enter in columns 1 and 2 the EHR	and palma data and i	adir- '	ata for the	onont!		1. 00	2. 00	170.0
period respectively (mm/dd/yyyy)	beginning date and en	naing a	ate for the r	eporting				170. C
						1. 00	2. 00	
71.00 If line 167 is "Y", does this prosection 1876 Medicare cost plans "Y" for yes and "N" for no in column 2. (9)	reported on Wkst. S-3 umn 1. If column 1 is	3, Pt.	I, line 2, co	I. 6? Ent		N		0171.0

	Financial Systems HARDIN COUNTY GEN				u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der Co		Peri od: From 04/01/2022 To 03/31/2023	Worksheet S-2 Part II	epared:
				Y/N	Date	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEN	MENT OHESTION	NALDE	1. 00	2. 00	_
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.			ter all dates in	the	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					4
1. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in co			N S)		1.00
			Y/N	Date	V/I	
2. 00	Has the provider terminated participation in the Medicare Pr	rogram2 lf	1.00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of termination and in column voluntary or "I" for involuntary.	n 3, "V" for				
3.00	Is the provider involved in business transactions, including contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provide officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ffices, drug er or its f the board	N			3.00
			Y/N	Туре	Date	
	Einenial Data and Danasta		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certi Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date avai column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.00
5. 00	Are the cost report total expenses and total revenues differed those on the filed financial statements? If yes, submit reco		N			5. 00
	those on the fired financial Statements: 11 yes, Submit reconcilitation.					
				1. 00	2.00	
6. 00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column 2	2. If ves is	s the provide	er N		6.00
0.00	the legal operator of the program?	2. 11 you, 1.	o the provide			0.00
7. 00 8. 00	Are costs claimed for Allied Health Programs? If "Y" see ins Were nursing programs and/or allied health programs approved cost reporting period? If yes, see instructions.		wed during th	ne N		7. 00 8. 00
9. 00	Are costs claimed for Interns and Residents in an approved (cal education	n N		9. 00
10. 00	program in the current cost report? If yes, see instructions Was an approved Intern and Resident GME program initiated or cost reporting period? If yes, see instructions.		the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.00
					Y/N	
	Bad Debts				1. 00	_
12. 00	Is the provider seeking reimbursement for bad debts? If yes,	, see instruc	ti ons.		Υ	12.00
	If line 12 is yes, did the provider's bad debt collection poperiod? If yes, submit copy.		-		N	13.00
14. 00	If line 12 is yes, were patient deductibles and/or coinsurar instructions. Bed Complement	nce amounts wa	aived? If yes	s, see	N	14.00
15. 00	Did total beds available change from the prior cost reporting			structions.	N	15. 00
	-	Par Y/N	t A Date	Y/N Par	t B Date	
	<u> </u>	1. 00	2.00	3. 00	4. 00	
	PS&R Data					
16. 00	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	Υ	06/09/2023	Y	06/09/2023	16.00
17. 00	instructions) 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		17.00
18. 00	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 this cost report? If yes, see instructions.	N		N		18. 00
19. 00	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. 00

Heal th	Financial Systems HARDIN COUNTY G	ENERAL HOSPITAL	L	In Lie	u of Form CM	S-2552-10
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CCN: 14-1328	Period: From 04/01/2022 To 03/31/2023	Date/Time F 8/28/2023 1	Prepared:
			i pti on	Y/N	Y/N	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20.00
20.00	Report data for Other? Describe the other adjustments:			IN .	IN IN	20.00
	Toport data for other population the other day detimented	Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)		1.00	
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se	e instructions	3		N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense	e due to apprai	sals made du	ring the cost	N	23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost r	eporting period?	Y	24.00
25. 00	Have there been new capitalized leases entered into during	the cost repo	ortina period	7 If ves see	N	25. 00
20.00	instructions.	, the cost repe	iring period	. 11 yes, see	''	20.00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	lf yes, see	N	26.00
	instructions.					
27. 00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? I	f yes, submit	N	27.00
ļ	CODY.					
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	entered into du	iring the cos	t reporting	Y	28.00
20.00	period? If yes, see instructions.	intered Titto de	irring the cos	t reporting	'	20.00
29. 00	Did the provider have a funded depreciation account and/or	bond funds (D	ebt Service	Reserve Fund)	N	29. 00
	treated as a funded depreciation account? If yes, see inst					
30. 00	Has existing debt been replaced prior to its scheduled mat	curity with new	debt? If ye:	s, see	N	30.00
04 00	instructions.		1.1.10.16			24 00
31. 00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If ye	s, see	N	31.00
	instructions. Purchased Services					
	Have changes or new agreements occurred in patient care se	ervices furnish	ed through c	ontractual	N	32.00
02.00	arrangements with suppliers of services? If yes, see instr		.ou till ough o	oner do edd.		02.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to compet	tive bidding? If	N	33.00
	no, see instructions.					
	Provi der-Based Physi ci ans					
34. 00	Were services furnished at the provider facility under an	arrangement wi	th provider-	pased physicians?	Y	34.00
25 00	If yes, see instructions.	detina oaroomo	ntc with the	provider based	N	35.00
35. 00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		ents with the	provider-based	IN IN	35.00
	prigatorians during the cost roporting period. In yes, see i	nstructions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs					
	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p	prepared by the	home office	? N		37.00
20 00	If yes, see instructions.	floo diffore	from that -	e N		20.00
30. UU	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year er			f N		38.00
39. 00	If line 36 is yes, did the provider render services to other			s, N		39.00
	see instructions.					- / / 00
40. 00	If line 36 is yes, did the provider render services to the	e home office?	If yes, see	N		40.00
	instructions.					
			00		00	
	Cost Donort Dronaror Contact Information	1.	. 00	2.	00	
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	MARK		DALLAS		41.00
41.00	held by the cost report preparer in columns 1, 2, and 3,	IMM-MAIN		DALLAS		41.00
	respectively.					
42. 00	Enter the employer/company name of the cost report	KERBER, ECK &			42.00	
	preparer.					
43. 00	Enter the telephone number and email address of the cost	618-529-1040		MARKD@KEBCPA. C	OM	43.00
l	report preparer in columns 1 and 2, respectively.	I				

Heal th	Financial Systems HARDIN COUNTY	GENERAL HOSPITAL				In Lieu of Form CMS-2552-10				
H0SPI	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi der CCN:	14-1328		ri od:	Worksheet S-2			
					To	om 04/01/2022 03/31/2023		pared: 9 pm		
			3. 00							
	Cost Report Preparer Contact Information									
41.00	Enter the first name, last name and the title/position	PA	RTNER					41.00		
	held by the cost report preparer in columns 1, 2, and 3,									
	respecti vel y.									
42.00	Enter the employer/company name of the cost report							42.00		
	preparer.									
43.00	Enter the telephone number and email address of the cost							43.00		
	report preparer in columns 1 and 2, respectively.									

Heal th	Financial Systems HARDIN COUNTY GENE	RAL HOSPITAL		Non-CMS HFS Wo	orksheet
HFS Su	upplemental Information	Provi der CCN: 14-1328	Peri od: From 04/01/2022 To 03/31/2023	Worksheet S- Part IX Date/Time Pr	epared:
			T: +1 - \/	8/28/2023 1:	29 pm
			Title V	Title XIX	
	TITLES VANDOR VIV FOLLOWING MEDICADE		1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				4
1. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Interstepdown adjustments on W/S B, Part I, column 25? Enter Y/N i and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	n column 1 for Title V	N	N	1.00
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the report Part I (e.g. net of Physician's component)? Enter Y/N in coluin column 2 for Title XIX. (see S-2, Part I, line 98.01)		N	2.00	
3. 00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of the Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for 2 for Title XIX. (see S-2, Part I, line 98.02)		N	3.00	
3. 01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01
	Does Title XIX transfer managed care (HMO) days from Workshee	at C 2 Dant L column 7		Y	
3. 02	sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 267			Y	3. 02
	Suil of Titles 2, 3, and 4 to worksheet E-4, cordiiii 2, Title 20:		Inpatient	Outpati ent	
			1. 00	2. 00	
	CRITICAL ACCESS HOSPITALS		1.00	2.00	_
4. 00	Does Title V follow Medicare (Title XVIII) for Critical Acces	ss Hospitals (CAH) boing	N	N	4.00
4.00	reimbursed 101% of cost? Enter Y or N in column 1 for inpatie for outpatient. (see S-2, Part I, lines 98.03 and 98.04)			IV	4.00
5. 00	Does Title XIX follow Medicare (Title XVIII) for Critical Acc	cass Hospitals (CAH) hair	a N	N	5.00
3.00	reimbursed 101% of cost? Enter Y or N in column 1 for inpatie			IV	3.00
	for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	ent and i or it in cordinii	2		
	To output ent. (see 5 2, full 17, filles 70. 05 and 70. 04)		Title V	Title XIX	
			1.00	2. 00	
	RCE DI SALLOWANCE		1.00	2.00	
6. 00	Do Title V or XIX follow Medicare and add back the RCE Disall	owance on W/S C Part I	N	N	6.00
0.00	column 4? Enter Y/N in column 1 for Title V and Y/N in column S-2, Part I, line 98.05)	n 2 for Title XIX. (see	14	14	0.00
	PASS THROUGH COST				
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payme	ent system is "O") for	N	N	7.00
7.00	worksheets D, parts I through IV? Enter Y/N in column 1 for 1 2 for Title XIX. (see S-2, Part I, line 98.06)			''	7.00
	RHC				
8. 00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Entitle V and Y/N in column 2 for Title XIX.	ter Y/N in column 1 for	N	N	8. 00
	FQHC				
9. 00	For fiscal year beginning on/after 10/01/2014, use M-series 1 XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 for		N	N	9. 00
		Sta	ate		
				00	
	STATE MEDICALD FORMS				
10. 00	Select the state when using state Medicaid forms.				┨ 10. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1328 Peri od: Worksheet S-3 From 04/01/2022 Part I 03/31/2023 Date/Time Prepared: 8/28/2023 1: 29 pm I/P Days / 0/P Visits / Tri ps Bed Days CAH/REH Hours Component Worksheet A No. of Beds Title V Li ne No. Avai I abl e 1.00 2.00 3.00 4.00 5.00 PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 30.00 25 9, 125 25, 392, 00 1.00 0 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 3.00 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 25 9, 125 25, 392. 00 7.00 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 8.00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 25 9.125 25, 392. 00 0 14.00 15.00 CAH visits 15.00 15. 10 REH hours and visits 15.10 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24.00 24. 10 HOSPICE (non-distinct part) 30.00 24.10 CMHC - CMHC 25.00 25.00 RURAL HEALTH CLINIC 88.00 26 00 0 26 00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 89.00 0 26. 25 27.00 Total (sum of lines 14-26) 25 27.00 28.00 Observation Bed Days 28.00

30.00

0

0

0

0

29 00

30.00

31.00

32. 00 32. 01

33.00

33.01

34.00

0

Ambulance Trips

Employee discount days (see instruction)

Labor & delivery days (see instructions)
Total ancillary labor & delivery room

outpatient days (see instructions)

LTCH site neutral days and discharges

34.00 Temporary Expansion COVID-19 PHE Acute Care

Employee discount days - IRF

LTCH non-covered days

29 00

30.00

31.00

32.00

32.01

33.00

In Lieu of Form CMS-2552-10

 Heal th Fi nancial
 Systems
 HARDIN COUNTY
 GENERAL HOSPITAL

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CO
 Peri od: Worksheet S-3 From 04/01/2022 Part I To 03/31/2023 Date/Time Prepared: 8/28/2023 1:20 pm Provider CCN: 14-1328

						8/28/2023 1: 2	9 pm
	·	I/P Days	/ O/P Visits	/ Tri ps	Full Time	Equi val ents	
		,		·		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	671	37	1, 058			1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	175	0				2.00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	934	0				5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	_			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 605	37	2, 083			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1, 605	37	2, 083	0. 00	120. 32	14.00
15.00	CAH visits	0	0	0			15. 00
15. 10	REH hours and visits						15. 10
16.00	SUBPROVI DER - I PF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25.00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	3, 082	0		0. 00		
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00		
27. 00	Total (sum of lines 14-26)				0. 00	142. 22	1
28. 00	Observation Bed Days		28	436			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0				32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0	_	_			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0		l	34.00

| Peri od: | Worksheet S-3 | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared: Health Financial SystemsHARDIN COUHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 14-1328

				To	03/31/2023	Date/Time Pre 8/28/2023 1:2	
		Full Time		Di sch	arges	0/20/2023 1.2) piii
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	DADT I CTATICTICAL DATA	11. 00	12. 00	13. 00	14. 00	15. 00	
4 00	PART I - STATISTICAL DATA			100	ما	004	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		0	180	8	281	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			20	o		2.00
3. 00	HMO IPF Subprovider				ol		3.00
4.00	HMO IRF Subprovider				o		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00 14. 00	NURSERY	0.00	0	180	8	281	13. 00 14. 00
15. 00	Total (see instructions)	0.00	U	100	٩	201	15.00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17.00
18. 00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					26. 25 27. 00
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00		•			28.00
29. 00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room				ļ		32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care				l		34.00

		ARDIN COUNTY GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C)F EXPENSES	Provi der Co		Peri od:	Worksheet A		
					From 04/01/2022 o 03/31/2023	Date/Time Pre		
				T	D 1 161 1	8/28/2023 1: 2	9 pm	
	Cost Center Description	Sal ari es	0ther		Reclassificat	Reclassified		
				+ col . 2)	i ons (See	Trial Balance		
					A-6)	(col. 3 +-		
		1. 00	2. 00	3. 00	4. 00	col . 4) 5.00		
	GENERAL SERVICE COST CENTERS	1.00	2.00	J. 00	4.00	3.00		
1. 00	00100 CAP REL COSTS-BLDG & FLXT		59, 962	59, 962	195	60, 157	1.00	
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		358, 231	358, 231		372, 535	2.00	
3. 00	00300 OTHER CAP REL COSTS		0	(0,2,000	3.00	
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		52, 800	52, 800	4.00	
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 296, 229	2, 524, 848	3, 821, 077			5.00	
6.00	00600 MAINTENANCE & REPAIRS	0	0	(o	0	6.00	
7. 00	00700 OPERATION OF PLANT	211, 598	383, 817	595, 415	-6, 876	588, 539	7.00	
8.00	00800 LAUNDRY & LINEN SERVICE	63, 295	36, 539			99, 834	8.00	
9.00	00900 HOUSEKEEPI NG	155, 814	41, 110	196, 924	ı o	196, 924	9.00	
10.00	01000 DI ETARY	158, 136	152, 253			229, 292	10.00	
11.00	01100 CAFETERI A	0	0		80, 978	80, 978	11.00	
12.00	01200 MAINTENANCE OF PERSONNEL	o	0		o	0	12.00	
13.00	01300 NURSING ADMINISTRATION	o	0		228, 956	228, 956	13.00	
14.00	01400 CENTRAL SERVICES & SUPPLY	40, 862	227, 009	267, 871	-42, 768	225, 103	14.00	
15.00	01500 PHARMACY	87, 647	199, 811	287, 458	-82, 531	204, 927	15.00	
16.00	01600 MEDICAL RECORDS & LIBRARY	224, 036	73, 599	297, 635	o	297, 635	16.00	
17.00	01700 SOCI AL SERVI CE	44, 854	7, 903	52, 757	o o	52, 757	17.00	
19.00	01900 NONPHYSICIAN ANESTHETISTS	o	0	(o	0	19.00	
20.00	02000 NURSI NG PROGRAM	0	0	(o	0	20.00	
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	(0	0	21.00	
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	(0	0	22.00	
23.00	02300 PARAMEDI CAL EDU PROG	0	0	(0	0	23.00	
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDI ATRI CS	1, 545, 464	622, 797	2, 168, 261	-418, 426	1, 749, 835	30.00	
	ANCILLARY SERVICE COST CENTERS							
54.00	05400 RADI OLOGY-DI AGNOSTI C	382, 066	351, 185				1	
54. 01	03630 ULTRA SOUND	111, 270	32, 876				1	
60. 00	06000 LABORATORY	459, 307	577, 303			1, 039, 752	1	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(1	0		
65. 00	06500 RESPI RATORY THERAPY	59, 760	88, 533			80, 158	1	
66. 00	06600 PHYSI CAL THERAPY	119, 283	109, 868			229, 055	1	
67. 00	06700 OCCUPATI ONAL THERAPY	5, 947	2, 781			8, 728	1	
68. 00	06800 SPEECH PATHOLOGY	1, 22,	1, 026			1, 026	1	
69.00	06900 ELECTROCARDI OLOGY	16, 936	1, 600			46, 860		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		,	203, 121	1	
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	215 271	120 520	442 000	372, 124		1	
76. 97 76. 98	07698 HYPERBARI C OXYGEN THERAPY	315, 371	128, 528	443, 899	-35, 665		I	
76. 99	07699 LI THOTRI PSY	0	0			0 0	76. 99	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0			0	ı	
77.00	OUTPATIENT SERVICE COST CENTERS	U U	0		<u>/ </u>	0	77.00	
88 00	08800 RURAL HEALTH CLINIC	1, 403, 241	372, 375	1, 775, 616	15, 517	1, 791, 133	88 00	
	09000 CLINIC	1, 403, 241	372, 373 N	1,775,010	13, 317	1,771,139		
91. 00		1, 348, 064	327, 173	1, 675, 237	-166, 417	_		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,010,001	0277 170	1,0,0,20,	100, 117	1,000,020	92.00	
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	(o	0	93. 99	
	OTHER REIMBURSABLE COST CENTERS	-1			-	_		
95.00	09500 AMBULANCE SERVI CES	105, 613	45, 567	151, 180	-1, 461	149, 719	95.00	
	10200 OPIOID TREATMENT PROGRAM	0	0				102.00	
	SPECIAL PURPOSE COST CENTERS		-				1	
113.00	11300 I NTEREST EXPENSE		12, 489	12, 489	-12, 489	0	113.00	
118.00	1 1	8, 154, 793	6, 739, 183		0			
	NONREI MBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0		190. 00	
	19001 VENDING MACHINE	0	0	(-		190. 01	
200.00	TOTAL (SUM OF LINES 118 through 199)	8, 154, 793	6, 739, 183	14, 893, 976	0	14, 893, 976	200.00	

Provider CCN: 14-1328

Peri od: Worksheet A From 04/01/2022 To 03/31/2023 Date/Time Prepared: 8/28/2023 1:29 pm

				8/28/2023 1: 29 pm	
	Cost Center Description	Adjustments	Net Expenses		
	·	(See A-8)	For		
		, ,	Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1. 00	00100 CAP REL COSTS-BLDG & FLXT	0	60, 157	1 1	00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	-2, 625	369, 910	l l	00
		· ·			
3. 00	00300 OTHER CAP REL COSTS	0	0		00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	52, 800		00
5.00	00500 ADMINISTRATIVE & GENERAL	-511, 664	3, 237, 413	5.0	00
6.00	00600 MAINTENANCE & REPAIRS	0	0	6.0	00
7.00	00700 OPERATION OF PLANT	0	588, 539	7.0	00
8.00	00800 LAUNDRY & LINEN SERVICE	0	99, 834		00
9. 00	00900 HOUSEKEEPI NG	0	196, 924		00
10.00	01000 DI ETARY	0	229, 292		
11.00	01100 CAFETERI A	-2, 909	78, 069		
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	12.0	
13.00	01300 NURSING ADMINISTRATION	0	228, 956	13.0	00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	225, 103	14. (00
15.00	01500 PHARMACY	0	204, 927	15.0	00
16.00	01600 MEDICAL RECORDS & LIBRARY	-1, 310	296, 325	16.0	
17. 00	01700 SOCIAL SERVICE	0	52, 757	17. (
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0 32,737	19.0	
		0	_	l l	
20.00	1	0	0	20.0	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	21.0	
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	22.0	00
23.00	02300 PARAMEDI CAL EDU PROG	0	0	23.0	00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-73, 914	1, 675, 921	30.0	00
00.00	ANCILLARY SERVICE COST CENTERS	, 0, ,	1,0,0,721		00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	730, 096	54.0	$\cap \cap$
		0		54.0	
54. 01	03630 ULTRA SOUND	0	135, 801		
60.00	06000 LABORATORY	0	1, 039, 752		
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.3	
65.00	06500 RESPI RATORY THERAPY	0	80, 158	65.0	00
66.00	06600 PHYSI CAL THERAPY	0	229, 055	66.0	00
67.00	06700 OCCUPATI ONAL THERAPY	0	8, 728	67. (00
68. 00	06800 SPEECH PATHOLOGY	0	1, 026	68.0	
69. 00	06900 ELECTROCARDI OLOGY	0	46, 860	69.0	
71.00		0		71.0	
			203, 121		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	372, 124	73. (
76. 97	07697 CARDI AC REHABI LI TATI ON	-121, 500	286, 734	76.	
76. 98	07698 HYPERBARIC OXYGEN THERAPY	0	0	76. 9	98
76. 99	07699 LI THOTRI PSY	0	0	76.9	99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	77.0	00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0	1, 791, 133	88.0	Ω
90.00	09000 CLINIC	0	1,771,133	90.0	
		(57.00/	050 024		
91.00	09100 EMERGENCY	-657, 996	850, 824		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92.0	
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	93.1	99
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500 AMBULANCE SERVICES	0	149, 719	95.0	00
	10200 OPIOID TREATMENT PROGRAM	0	·	102.0	
	SPECIAL PURPOSE COST CENTERS				
112 0				112	00
	11300 I NTEREST EXPENSE	1 074 010	0	113. (
118.00	3 /	-1, 371, 918	13, 522, 058	118. (UU
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		
	1 19001 VENDING MACHINE	0	0	190. (01
200.00	TOTAL (SUM OF LINES 118 through 199)	-1, 371, 918	13, 522, 058	200. (00
				· '	

| Period: | Worksheet Non-CMS W From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: Health Financial Systems
COST CENTERS USED IN COST REPORT Provider CCN: 14-1328

				To 03/31/2023	Date/Time P 8/28/2023 1	
	Cost Center Description		CMS Code	Standard		. 29 pili
	'			Non-Stand	ard Codes	
		-	1. 00	2. (00	
	GENERAL SERVICE COST CENTERS		1.00	2.	00	
1.00	CAP REL COSTS-BLDG & FIXT		00100			1.00
2.00	CAP REL COSTS-MVBLE EQUIP		00200			2.00
3.00	OTHER CAP REL COSTS		00300			3.00
4.00	EMPLOYEE BENEFITS DEPARTMENT		00400			4.00
5. 00 6. 00	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS		00500 00600			5. 00 6. 00
7. 00	OPERATION OF PLANT		00700			7.00
8. 00	LAUNDRY & LI NEN SERVI CE		00800			8.00
9.00	HOUSEKEEPI NG		00900			9.00
10.00	DI ETARY		01000			10.00
11.00	CAFETERI A		01100			11.00
12. 00 13. 00	MAI NTENANCE OF PERSONNEL NURSI NG ADMI NI STRATI ON		01200 01300			12. 00 13. 00
14. 00	CENTRAL SERVICES & SUPPLY		01400			14.00
15. 00	PHARMACY		01500			15.00
16. 00	MEDICAL RECORDS & LIBRARY		01600			16.00
17.00	SOCI AL SERVI CE		01700			17. 00
19. 00	NONPHYSICIAN ANESTHETISTS		01900			19. 00
20.00	· ·		02000			20.00
21. 00 22. 00	I &R SERVI CES-SALARY & FRI NGES APPRV I &R SERVI CES-OTHER PRGM COSTS APPRV		02100 02200			21.00
23. 00	PARAMEDICAL EDU PROG		02300			23.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		02000			
30.00	ADULTS & PEDIATRICS		03000			30.00
	ANCILLARY SERVICE COST CENTERS					
54.00	RADI OLOGY-DI AGNOSTI C		05400	LIL TO A COUNT		54.00
54. 01 60. 00	ULTRA SOUND LABORATORY		03630 06000	ULTRA SOUND		54. 01 60. 00
62. 30	BLOOD CLOTTING FOR HEMOPHILIACS		06250			62.30
65. 00	RESPIRATORY THERAPY		06500			65.00
66.00	PHYSI CAL THERAPY		06600			66.00
67.00	OCCUPATIONAL THERAPY		06700			67.00
68.00	SPEECH PATHOLOGY		06800			68.00
69. 00 71. 00	ELECTROCARDI OLOGY MEDI CAL SUPPLI ES CHARGED TO PATI ENT		06900 07100			69. 00 71. 00
73.00	DRUGS CHARGED TO PATTENTS		07300			73.00
76. 97	CARDI AC REHABI LI TATI ON		07697	CARDI AC REHABI I	_I TATI ON	76. 97
76. 98	HYPERBARI C OXYGEN THERAPY	İ	07698	HYPERBARI C OXYO	GEN THERAPY	76. 98
76. 99	LI THOTRI PSY		07699	LI THOTRI PSY		76. 99
77. 00	ALLOGENEI C HSCT ACQUI SI TI ON		07700			77. 00
00 NN	OUTPATIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	T	08800			88. 00
90.00	CLINIC		09000			90.00
	EMERGENCY		09100			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART		09200			92.00
93. 99	PARTIAL HOSPITALIZATION PROGRAM		09399			93. 99
05.00	OTHER REIMBURSABLE COST CENTERS		22522			05.00
	AMBULANCE SERVICES		09500 10200			95.00
102.00	OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS		10200			102.00
113. 00	INTEREST EXPENSE		11300			113.00
	SUBTOTALS (SUM OF LINES 1 through 117)					118.00
	NONREI MBURSABLE COST CENTERS			_		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN		19000			190.00
	VENDING MACHINE TOTAL (SUM OF LINES 118 through 199)		19001			190. 01 200. 00
200.00	PITOTAL (SOM OF LINES TO THE OUGH 199)	ı		I		_[] 200.00

| Peri od: | Worksheet A-6 | From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: Provider CCN: 14-1328

					Date/IIme Prepared: 8/28/2023 1:29 pm
		Increases			072072020 1.27 piii
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4. 00	5. 00	
	A - TO RECLASS SUPPLY COST FRO				
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	30, 647	12, 121	1.00
	PATI ENT	+			
	TOTALS		30, 647	12, 121	
1 00	B - TO RECLASS DON COST	10.00	407.070	40. (0)	4.00
1. 00	NURSING ADMINISTRATION	<u>13.</u> 00	18 <u>6, 2</u> 70 186, 270	4 <u>2, 6</u> 86 42, 686	1.00
	D - TO RECLASS SUPPLY COST		180, 270	42, 080	
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	160, 353	1.00
1.00	PATI ENT	71.00	o o	100, 333	1.00
2.00	1711211	0.00	o	o	2.00
3. 00		0.00	Ö	0	3.00
4. 00		0.00	o	Ö	4.00
5. 00		0.00	o	Ö	5. 00
6.00		0.00	O	O	6.00
7.00		0.00	o	0	7.00
8.00		0.00	O	0	8.00
9.00		0.00	O	0	9.00
	TOTALS		0	160, 353	
	E - TO RECLASS INSURANCE EXPE	NSE			
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	2, 688	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	16, 512	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT		•	5 <u>2, 8</u> 00	3.00
	TOTALS		0	72, 000	
4 00	F - TO RECLASS INTEREST	4 00	ما	0.040	4.00
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3, 940	1.00
3.00	RADI OLOGY - DI AGNOSTI C	54.00	0	4, 367	3.00
4. 00	LABORATORY	6000			4.00
	TOTALS G - TO RECLASS CAFE COST		υ	12, 489	
1. 00	CAFETERIA	11. 00	42, 127	38, 851	1.00
1.00	TOTALS	— — 11. 00	$\frac{42,127}{42,127}$	38, 851	1.00
	H - TO RECLASS CARDIAC MONITO	ZING COST	42, 127	30, 031	
1. 00	ELECTROCARDI OLOGY	69.00	24, 107	4, 217	1.00
1.00	TOTALS		24, 107	$-\frac{1}{4},\frac{2}{217}$	1.00
	I - TO RECLASS DRUG COST		= .,	., =	
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	372, 124	1.00
2. 00		0.00	O	0	2.00
3. 00		0.00	o	Ō	3. 00
4.00		0.00	o	0	4.00
5.00		0.00	o	0	5.00
6.00		0.00	O	0	6.00
	TOTALS		0	372, 124	
	J - TO RECLASS CLINIC DEPRECIA				
1.00	RURAL HEALTH CLINIC	88. 00	0	6, 433	1.00
2.00	RURAL HEALTH CLINIC		•	<u>2, 2</u> 08	2.00
	TOTALS		0	8, 641	
	K - TO RECLASS CLINIC COST				
1. 00	RURAL HEALTH CLINIC		3, 829	3,047	1.00
E00.00	TOTALS		3, 829	3, 047	F60 00
500.00	Grand Total: Increases		286, 980	726, 529	500.00

| Peri od: | Worksheet A-6 | From 04/01/2022 | To 03/31/2023 | Date/Time Prepared: Provider CCN: 14-1328

						10 03/31/2023	8/28/2023 1:29 pm
		Decreases					0,20,2020 112, 611
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10.00		
	A - TO RECLASS SUPPLY COST FE	ROM CS					
1.00	CENTRAL SERVICES & SUPPLY	1400	3 <u>0, 6</u> 47	1 <u>2, 1</u> 21			1.
	TOTALS		30, 647	12, 121			
	B - TO RECLASS DON COST						
1.00	ADULTS & PEDIATRICS	<u>30.</u> 00	18 <u>6, 2</u> 70	4 <u>2, 6</u> 86)	1.
	TOTALS		186, 270	42, 686)		
	D - TO RECLASS SUPPLY COST						
1.00	ADULTS & PEDIATRICS	30. 00	0	21, 422			1.
2.00	EMERGENCY	91. 00	0	19, 685			2.
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 522	. C)	3.
4.00	LABORATORY	60.00	0	1, 040	0)	4.
5.00	CARDIAC REHABILITATION	76. 97	0	35, 665	C)	5.
6.00	PHYSI CAL THERAPY	66. 00	0	96	O)	6.
7.00	ULTRA SOUND	54. 01	0	8, 345)	7.
8.00	AMBULANCE SERVICES	95. 00	0	1, 166	C		8.
9.00	RESPI RATORY THERAPY	65. 00	0	65, 412	. c		9.
	TOTALS — — — — —	- $ +$		160, 353		1	
	E - TO RECLASS INSURANCE EXPE	ENSE					
1.00		0. 00	0	С	12		1.
2.00		0. 00	O	0	12		2.
3.00	ADMINISTRATIVE & GENERAL	5. 00	O	72, 000	0		3.
	TOTALS			72,000		1	
	F - TO RECLASS INTEREST						
1.00	INTEREST EXPENSE	113. 00	0	12, 489	11		1.
3.00		0.00	o	0	0		3.
4.00		0.00	0	0			4.
	TOTALS			12, 489		1	
	G - TO RECLASS CAFE COST						
1. 00	DI ETARY	10.00	42, 127	38, 851	C)	1.
	TOTALS		42, 127	38, 851		1	
	H - TO RECLASS CARDIAC MONITO	ORING COST	<u> </u>	•			
1. 00	ADULTS & PEDIATRICS	30.00	24, 107	4, 217	C)	1.
	TOTALS		24, 107	4, 217		1	
	I - TO RECLASS DRUG COST	•			*		
1. 00	ADULTS & PEDIATRICS	30.00	0	139, 724	C)	1.
2. 00	EMERGENCY	91.00	0	146, 732	2		2.
3. 00	PHARMACY	15. 00	0	82, 531	C		3.
4.00	DI ETARY	10.00	o	119			4.
5. 00	RESPI RATORY THERAPY	65. 00	o	2, 723			5.
6. 00	AMBULANCE SERVICES	95. 00	o	295			6.
	TOTALS			372, 124		1	
	J - TO RECLASS CLINIC DEPRECI	ATION	-1	•	•		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	6, 433	9		1.
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	O	2, 208			2.
	TOTALS			8, 641		1	
	K - TO RECLASS CLINIC COST				•	•	
1. 00	OPERATION OF PLANT	7. 00	3, 829	3, 047	·		1.
	TOTALS	— — - 	3, 829	$\frac{1}{3,047}$		1	''
	Grand Total: Decreases		286, 980	726, 529		1	500.

Health Financial Systems HARDIN COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 14-1328 Period: Worksheet A-6
From 04/01/2022 To 03/31/2023 Date/Time Prepared:

						To	03/31/2023	Date/Time Pro 8/28/2023 1:2	epared: 29 pm
		Increas	ses			Decrea	ases	0, 20, 2020 111	, p
	Cost Center	Li ne #	Sal ary	Other	Cost Center	Li ne #	Salary	Other	
	2.00	3.00	4. 00	5. 00	6.00	7. 00	8.00	9. 00	
	A - TO RECLASS SUPPLY								
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	30, 647		CENTRAL SERVICES & SUPPLY	14. 00	30, 647	12, 121	1.00
	TOTALS	-	30, 647	_{12, 121}		-	30, 647		
	B - TO RECLASS DON COS	T T	00,017	12, 121	1017/23		30, 017	12, 121	
1. 00	NURSI NG	13. 00	186, 270	42, 686	ADULTS & PEDIATRICS	30.00	186, 270	42, 686	1.00
	ADMI NI STRATI ON			, , , , , ,					
	TOTALS		186, 270	42, 686	TOTALS		186, 270	42, 686	
	D - TO RECLASS SUPPLY	COST							
1. 00	MEDICAL SUPPLIES CHARGED TO PATIENT	71. 00	0	160, 353	ADULTS & PEDIATRICS	30.00	0	21, 422	1.00
2. 00	CHARGED TO PATTENT	0.00	0		EMERGENCY	91.00	o	19, 685	2. 00
3. 00		0.00	0		RADI OLOGY-DI AGNOSTI C	54.00	Ö	7, 522	
4. 00		0.00	0		LABORATORY	60.00	Ö	1, 040	1
5. 00		0.00	0		CARDI AC	76. 97	0	35, 665	1
3.00		0.00	٩		REHABI LI TATI ON	70.77	٩	33, 003	3.00
6. 00		0. 00	0		PHYSI CAL THERAPY	66. 00	0	96	6.00
7. 00		0.00	0	•	ULTRA SOUND	54. 01	o	8, 345	
8. 00		0.00	o		AMBULANCE SERVICES	95. 00	o	1, 166	
9. 00		0.00	o		RESPIRATORY THERAPY	65. 00	o	65, 412	1
7. 00	TOTALS — — —	0.00		160, 353		00.00	— — — ў	160, 353	
	E - TO RECLASS INSURAN	ICE EXPEN		100, 000	1017/25		<u> </u>	100,000	
1. 00	CAP REL COSTS-BLDG &	1. 00	0	2, 688		0.00	0	0	1.00
	FIXT CAP REL COSTS-MVBLE	2.00	0			0.00	0	0	
2. 00	EQUIP	2.00	٥	16, 512		0.00	o o	Ü	2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0		ADMINISTRATIVE & GENERAL	5. 00	0	72, 000	3.00
	TOTALS			72, 000	TOTALS			72, 000	
	F - TO RECLASS INTERES	T							
1. 00	CAP REL COSTS-BLDG &	1. 00	0	3, 940 l	INTEREST EXPENSE	113. 00	0	12, 489	1. 00
3. 00	RADI OLOGY-DI AGNOSTI C	54. 00	0	4, 367		0.00	o	0	3.00
4. 00	LABORATORY	60.00	0	4, 182		0.00	o	0	4.00
1. 00	TOTALS	00.00		12, 489	TOTALS — — —	0.00	— —	12, 489	
	G - TO RECLASS CAFE CO	ST	<u> </u>	12, 107	1017/25		<u> </u>	12, 107	
1. 00	CAFETERI A	11. 00	42, 127	38 851	DI ETARY	10.00	42, 127	38, 851	1.00
1.00	TOTALS	11.00	42, 127	38, 851		10.00	42, 127	38, 851	1.00
	H - TO RECLASS CARDIAC	: MONI TOR		30, 50.			12/12/	00/001	
1.00	ELECTROCARDI OLOGY	69. 00	24, 107	4. 217	ADULTS & PEDIATRICS	30.00	24, 107	4, 217	1.00
	TOTALS		24, 107	4, 217			24, 107	4, 217	
	I - TO RECLASS DRUG CO	ST					, ,	.,	
1. 00	DRUGS CHARGED TO	73. 00	0	372, 124	ADULTS & PEDIATRICS	30.00	0	139, 724	1.00
2 00	PATI ENTS	0.00	0		EMERGENCY	91.00	o	1/4 722	2 00
2.00		0.00	0	•				146, 732	
3.00		0.00	0		PHARMACY	15. 00	0	82, 531	3.00
4.00		0.00	0		DI ETARY	10.00	0	119	1
5. 00		0.00	0	•	RESPIRATORY THERAPY	65. 00	0	2, 723	1
6. 00		0. 00	•		AMBULANCE SERVICES	95. 00	•	295	
	TOTALS	DEDDEOL A	0	372, 124	IUIALS		0	372, 124	ļ
	J - TO RECLASS CLINIC				0.45 BEL 000TO BLDO 0	1 4 00		, ,,,,	
1. 00	RURAL HEALTH CLINIC	88. 00	0		CAP REL COSTS-BLDG &	1. 00	0	6, 433	1.00
2. 00	RURAL HEALTH CLINIC	88. 00	О		FLXT CAP REL COSTS-MVBLE	2. 00	0	2, 208	2.00
		\bot			EQUI P				
	TOTALS		0	8, 641	TOTALS		0	8, 641	
	K - TO RECLASS CLINIC	COST							
1.00	RURAL HEALTH CLINIC	88. 00	3, 829		OPERATION OF PLANT	7. 00	3, 829	3,047	
	TOTALS		3, 829		TOTALS		3, 829	3, 047	
500.00	Grand Total:		286, 980		Grand Total:		286, 980	726, 529	500.00
	Increases			[Decreases				

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 14-1328 Peri od: Worksheet A-7 From 04/01/2022 Part I Date/Time Prepared: 03/31/2023 8/28/2023 1:29 pm Acqui si ti ons Begi nni ng Purchases Total Disposals and Donati on Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 17, 000 1.00 Land 0 0 0 Land Improvements 2.00 256, 674 Ω 2.00 3.00 3.00 Buildings and Fixtures 1, 872, 612 0 257, 454 257, 454 0 4.00 Building Improvements 0 4.00 Fi xed Equi pment 0 0 5.00 0 5.00 0 6.00 Movable Equipment 3, 914, 299 398, 270 398, 270 0 6.00 0 7.00 HIT designated Assets 898, 160 0 7.00 8.00 Subtotal (sum of lines 1-7) 6, 958, 745 655, 724 0 655, 724 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 6, 958, 745 655, 724 655, 724 10.00 10.00 0 0 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 17,000 1.00 2.00 0 2.00 Land Improvements 256, 674 3.00 Buildings and Fixtures 2, 130, 066 0 3.00 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 0 5.00 Movable Equipment 0 6.00 4, 312, 569 6.00 Ol HIT designated Assets 898, 160 7.00 7.00

7, 614, 469

7, 614, 469

0

0

0

8.00

9.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

					In Lieu of Form CMS-2552-10			
<u>Heal</u> th	n Financial Systems H.	ARDIN COUNTY GE	NERAL HOSPITAL		In Lie	2552-10		
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 14-1328	Peri od:	Worksheet A-7		
					From 04/01/2022			
					To 03/31/2023			
				JMMARY OF CAF		8/28/2023 1: 2	9 piii	
			30	JIVIIVIARY OF CAP	1 IAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
		·			(see	instructions)		
					instructions)			
		9. 00	10.00	11. 00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2	<u>'</u>			
1.00	CAP REL COSTS-BLDG & FLXT	59, 962	0		0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	358, 231	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	418, 193	0		0 0	0	3.00	
		SUMMARY OF CAPITAL				-		
	Cost Center Description	Other	Total (1)					
	, , , , , , , , , , , , , , , , , , , ,	Capi tal -Relat						
		ed Costs (see						
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	59, 962				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	l o	358, 231	1			2.00	
	Total (sum of lines 1-2)		/10 102	•			2.00	

0 0

59, 962 358, 231 418, 193

2.00

3.00 Total (sum of lines 1-2)

Heal th	Financial Systems H	ARDIN COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 04/01/2022 To 03/31/2023		pared:
		COMI	PUTATION OF RA	ALLOCATION OF	OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1.00	2.00	col . 2)	4.00	F 00	
	PART III - RECONCILIATION OF CAPITAL COSTS (1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	2, 403, 740		2, 403, 740	0. 315681	0	1. 00
2. 00	CAP REL COSTS-BEDG & TTXT	5, 210, 729				· · · · · · · · · · · · · · · · · · ·	2.00
3. 00	Total (sum of lines 1-2)	7, 614, 469		7, 614, 469			3.00
0.00	10141 (04.11.100 1.2)		TION OF OTHER (F CAPITAL	0.00
		7.220071		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	001111111111111111111111111111111111111		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS (1				
1. 00	CAP REL COSTS-BLDG & FLXT	0		l ~	,	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	000,070	i .	2.00
3. 00	Total (sum of lines 1-2)	0	0	I UMMARY OF CAPIT	406, 927	0	3.00
			St	IMMARY OF CAPIT	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		1	(see	instructions)			
			instructions)	ĺ		9 through 14)	
			,		instructions)	, , , , , , , , , , , , , , , , , , ,	
		11. 00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS (
1. 00	CAP REL COSTS-BLDG & FIXT	3, 940				60, 157	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	.0,0.2				
3. 00	Total (sum of lines 1-2)	3, 940	19, 200	0	0	430, 067	3.00

From 04/01/2022 03/31/2023 Date/Time Prepared: 8/28/2023 1:29 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 di scounts (chapter 8) -187, 203 ADMI NI STRATI VE & GENERAL 5.00 Refunds and rebates of В 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 -3.806 ADMINISTRATIVE & GENERAL 5 00 Α stations excluded) (chapter 8.00 Television and radio service 0.00 0 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 Provi der-based physici an -853, 410 10.00 A - 8 - 2adjustment 11.00 Sale of scrap, waste, etc. 0 0.00 (chapter 23) Related organization 12.00 A-8-1 0 transactions (chapter 10) 13.00 Laundry and linen service 0.00 Cafeteria-employees and guests -2, 909 CAFETERI A 14.00 В 11.00 15.00 Rental of quarters to employee 0.00 and others Sale of medical and surgical 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 pati ents Sale of medical records and -1, 310 MEDICAL RECORDS & LIBRARY 18.00 Α 16.00 abstracts 19.00 Nursing and allied health 0 0.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 21.00 Income from imposition of 0.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol overpayments and borrowings to repay Medicare overpayments

Heal th	Financial Systems	HA	RDIN COUNTY GE	NERAL HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 04/01/2022 To 03/31/2023	Date/Time Pre 8/28/2023 1:2		
				Expense Classification on				
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7		
		(2)				Ref.		
		1. 00	2. 00	3. 00	4. 00	5. 00		
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00	
	pathology costs in excess of							
	limitation (chapter 14)							
32.00	CAH HIT Adjustment for	A	-2, 625	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32.00	
	Depreciation and Interest							
33. 00	OTHER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 00	
24.00	(3)		0	ADMINISTRATIVE & CENEDAL	5. 00	0	24 00	
34.00	LOBBYING	A		ADMINISTRATIVE & GENERAL		0	34.00	
40.00	LATE FEES	A A		ADMINISTRATIVE & GENERAL	5. 00	0	40.00	
42.00	PROVI DER TAX	A		ADMINISTRATIVE & GENERAL	5. 00	0	42.00	
43.00	LOBBING PORTION OF DUES	A A		ADMINISTRATIVE & GENERAL	5. 00	0	43.00	
44. 00	AMBULANCE	Α	0	AMBULANCE SERVICES	95. 00	0	44.00	

-1, 371, 918

50.00

50.00 TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

column 6, line 200.) (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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 14-1328

						To 03/31/2023	B Date/Time Pre 8/28/2023 1:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				'			Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6.00	7.00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	31, 886	(31, 886	0	0	1.00
2.00	30. 00	ADULTS & PEDIATRICS	73, 914	73, 914	4 C	0	0	2.00
3.00	60. 00	LABORATORY	84, 211	(84, 211	0	0	3.00
4.00	91. 00	EMERGENCY	1, 154, 379	657, 996	496, 383	0	0	4.00
5.00	76. 97	CARDIAC REHABILITATION	121, 500	121, 500) (0	0	5.00
6.00	0.00		0	() (0	0	6.00
7.00	0.00		0	() (0	0	7. 00
8. 00	0.00		0	() (0	0	8. 00
9. 00	0.00		0	() (0	0	9. 00
10.00	0. 00		0	() (0	0	10.00
200.00			1, 465, 890				0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE				Physician Cost	
		ldenti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
1 00	1.00	2.00	8. 00	9. 00	12.00	13. 00	14.00	1.00
1.00		ADMI NI STRATI VE & GENERAL	0		-	_		
2.00		ADULTS & PEDIATRICS	0			0	_	
3.00		LABORATORY	0	(0	
4. 00		EMERGENCY	0	9			0	
5.00		CARDIAC REHABILITATION	0	9			0	
6. 00	0.00		0	9			0	0.00
7. 00	0.00		0	9			0	
8. 00	0.00		0	9			0	0.00
9.00	0.00		0	9			0	
10.00	0. 00		0				0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCF	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Aujustillerit		
		rdentrirei	Share of col.	Limit	Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0					1. 00
2.00	30. 00	ADULTS & PEDIATRICS	0			73, 914		2.00
3.00	60.00	LABORATORY	0	(0		3.00
4.00	91. 00	EMERGENCY	0	(657, 996		4.00
5.00	76. 97	CARDIAC REHABILITATION	0	(121, 500		5.00
6. 00	0.00		0		0	0		6.00
7.00	0.00		0	(0	0		7. 00
8. 00	0.00		0	(0	0		8. 00
9. 00	0. 00		0	(0	0		9. 00
10.00	0. 00		0	(0	0		10. 00
200.00			0	(0	853, 410		200.00

		RDIN COUNTY GEN				u of Form CMS-2	
	NABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der CO		Period: From 04/01/2022 To 03/31/2023		
				r	hysical Thorany	8/28/2023 1: 2 Cost	9 pm
				r	Physical Therapy	COST	
	To a control of the c					1. 00	
1. 00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	s) (see instruc	i one)			52	1.00
2. 00	Line 1 multiplied by 15 hours per week	3) (See Thisti de	.1 0113)			780	2.00
3.00							3.00
4. 00	Number of unduplicated days in which therapy assistant was on provider site but neither supervisor nor therapist was on provider site (see instructions)						4. 00
5.00							5. 00
6. 00	Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy						6. 00
	assistant and on which supervisor and/or the instructions)	rapist was not p	present durinç	g the visit(s,	(See		
7. 00	Standard travel expense rate					5. 00	7. 00
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8. 00
		1. 00	2.00	3. 00	4. 00	5. 00	
9. 00	Total hours worked	0.00	440. 70			0.00	9. 00
10. 00 11. 00	,	0. 00 46. 13	92. 26 46. 13			0. 00	10. 00 11. 00
11.00	one-half of column 2, line 10; column 3,	40. 13	40. 13	0.0			11.00
40.00	one-half of column 3, line 10)						40.00
12.00	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12. 00 12. 01
	Number of miles driven (provider site)	Ö	0		0		13. 00
13. 01	Number of miles driven (offsite)	0	0		0		13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
	Supervisors (column 1, line 9 times column 1, line 10)						
	Supervisors (column 1, line 9 times column 1					0 40, 659	14.00
14. 00 15. 00 16. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,	line 10)				0 40, 659 0	
15.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a	line 10) line10)	ratory therapy	y or lines 14	-16 for all	40, 659	15. 00
15. 00 16. 00 17. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others)	line 10) line10) nd 15 for respi	ratory therapy	y or lines 14	-16 for all	40, 659 0 40, 659	15. 00 16. 00 17. 00
15. 00 16. 00 17. 00 18. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others)	line 10) line10) nd 15 for respin	ratory therapy	y or lines 14.	.16 for all	40, 659 0	15. 00 16. 00
15. 00 16. 00 17. 00 18. 00 19. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f	line 10) line10) nd 15 for respir 10) ine 10) or respiratory	therapy or lin	nes 17 and 18	for all others)	40, 659 0 40, 659 0 0 40, 659	15. 00 16. 00 17. 00
15. 00 16. 00 17. 00 18. 00 19. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 fif the sum of columns 1 and 2 for respirators	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col	therapy or linumns 1-3 for	nes 17 and 18 physical ther	for all others) apy, speech pat	40, 659 0 40, 659 0 0 40, 659 hol ogy or	15. 00 16. 00 17. 00 18. 00 19. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator occupational therapy, line 9, is greater that amount from line 20. Otherwise complete line	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make res 21-23.	therapy or linumns 1-3 for one on the control of th	nes 17 and 18 physical ther lines 21 and	for all others) capy, speech pat 22 and enter on	40, 659 0 40, 659 0 40, 659 hol ogy or 1 line 23 the	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
15. 00 16. 00 17. 00 18. 00 19. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater that amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr	line 10) line10) nd 15 for respir 10) ine 10) or respiratory y therapy or col n line 2, make res 21-23. ainees (line 17	therapy or linumns 1-3 for one entries on divided by su	nes 17 and 18 physical ther lines 21 and	for all others) capy, speech pat 22 and enter on	40, 659 0 40, 659 0 40, 659 hol ogy or 1 line 23 the	15. 00 16. 00 17. 00 18. 00 19. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make r es 21-23. ainees (line 17 line 9 for all	therapy or linumns 1-3 formo entries on divided by suothers)	nes 17 and 18 physical ther lines 21 and	for all others) capy, speech pat 22 and enter on	40, 659 0 40, 659 0 40, 659 hol ogy or 1 line 23 the	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than amount from line 20. Otherwise complete line Weighted average rate excluding aides and train Total salary equivalency (see instructions)	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make res 21-23. ainees (line 17 line 9 for all ees (line 2 time	therapy or linumns 1-3 formonentries on divided by sunthers) es line 21)	nes 17 and 18 physical ther lines 21 and um of columns	for all others) Tapy, speech pat 22 and enter on 1 and 2, line 9	40, 659 0 40, 659 0 40, 659 hol ogy or 1 line 23 the	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator; occupational therapy, line 9, is greater that amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make res 21-23. ainees (line 17 line 9 for all ees (line 2 time	therapy or linumns 1-3 formonentries on divided by sunthers) es line 21)	nes 17 and 18 physical ther lines 21 and um of columns	for all others) Tapy, speech pat 22 and enter on 1 and 2, line 9	40, 659 0 40, 659 0 40, 659 hol ogy or 1 li ne 23 the 92. 26 71, 963	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 flf the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater that amount from line 20. Otherwise complete line Weighted average rate excluding aides and train for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make res 21-23. ainees (line 17 line 9 for all ees (line 2 time	therapy or linumns 1-3 formonentries on divided by sunthers) es line 21)	nes 17 and 18 physical ther lines 21 and um of columns	for all others) Tapy, speech pat 22 and enter on 1 and 2, line 9	40, 659 0 40, 659 0 40, 659 hol ogy or 1 li ne 23 the 92. 26 71, 963	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 fl the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater that amount from line 20. Otherwise complete line Weighted average rate excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make r es 21-23. ainees (line 17 line 9 for all ees (line 2 time	therapy or linumns 1-3 for no entries on divided by suothers) es line 21)	nes 17 and 18 physical ther lines 21 and um of columns	for all others) Tapy, speech pat 22 and enter on 1 and 2, line 9	40, 659 0 40, 659 0 40, 659 hol ogy or 1 l i ne 23 the 71, 963 71, 963 0 0	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator occupational therapy, line 9, is greater tha amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make r es 21-23. ainees (line 17 line 9 for all ees (line 2 time	therapy or linumns 1-3 for an entries on divided by sunthers) es line 21) EXPENSE COMP	nes 17 and 18 physical ther lines 21 and um of columns PUTATION - PRO	for all others) rapy, speech pat 22 and enter on 1 and 2, line 9 OVIDER SITE	40, 659 0 40, 659 0 40, 659 hol ogy or 1 line 23 the 71, 963 71, 963 0 0	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator occupational therapy, line 9, is greater tha amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make r es 21-23. ainees (line 17 line 9 for all ees (line 2 time	therapy or linumns 1-3 for an entries on divided by sunthers) es line 21) EXPENSE COMP	nes 17 and 18 physical ther lines 21 and um of columns PUTATION - PRO	for all others) rapy, speech pat 22 and enter on 1 and 2, line 9 OVIDER SITE	40, 659 0 40, 659 0 40, 659 hol ogy or 1 l i ne 23 the 71, 963 71, 963 0 0	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater that amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make res 21-23. ainees (line 17 line 9 for all ees (line 2 time WANCE AND TRAVEL sum of lines 2 for respiratory	cherapy or linumns 1-3 for no entries on divided by suothers) es line 21) EXPENSE COMF	nes 17 and 18 physical theilines 21 and um of columns PUTATION - PRO all others) sum of lines 3	for all others) Tapy, speech pat 22 and enter on 1 and 2, line 9 OVIDER SITE	40, 659 0 40, 659 0 0 40, 659 hol ogy or 1 Li ne 23 the 92. 26 71, 963 71, 963	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater that amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	line 10) line10) nd 15 for respin 10) ine 10) or respiratory y therapy or col n line 2, make r es 21-23. ainees (line 17 line 9 for all ees (line 2 time WANCE AND TRAVEL sum of lines 2 for respiratory travel expense	cherapy or linumns 1-3 for no entries on divided by suothers) es line 21) EXPENSE COMF	nes 17 and 18 physical theilines 21 and um of columns PUTATION - PRO all others) sum of lines 3	for all others) Tapy, speech pat 22 and enter on 1 and 2, line 9 OVIDER SITE	40, 659 0 40, 659 0 0 40, 659 hol ogy or 1 Li ne 23 the 92. 26 71, 963 71, 963	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator; occupational therapy, line 9, is greater tha amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum	line 10) line10) nd 15 for respir 10) ine 10) or respiratory y therapy or col n line 2, make r es 21-23. ainees (line 17 line 9 for all ees (line 2 time WANCE AND TRAVEL sum of lines 2 for respiratory travel expense Expense of columns 1 and	therapy or linumns 1-3 for an entries on divided by substantial others) as line 21) EXPENSE COMF and 25 for any therapy or seat the provided the search of	nes 17 and 18 physical ther lines 21 and um of columns PUTATION - PRO all others) sum of lines 3 der site (sum	for all others) Tapy, speech pat 22 and enter on 1 and 2, line 9 OVIDER SITE	40, 659 0 40, 659 0 40, 659 hol ogy or 1 line 23 the 71, 963 71, 963 0 0 0 0	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator occupational therapy, line 9, is greater that amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and Standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3	line 10) line10) nd 15 for respir 10) ine 10) or respiratory y therapy or col n line 2, make r es 21-23. ainees (line 17 line 9 for all ees (line 2 time WANCE AND TRAVEL sum of lines 2 for respiratory travel expense Expense of columns 1 and line 12)	cherapy or linumns 1-3 for no entries on divided by su others) es line 21) EXPENSE COMF and 25 for a therapy or set the provided by su others)	physical ther lines 21 and um of columns PUTATION - PRO all others) sum of lines 3 der site (sum	for all others) Tapy, speech pat 22 and enter on 1 and 2, line 9 OVIDER SITE	40, 659 0 40, 659 0 40, 659 hol ogy or 1 line 23 the 92. 26 71, 963 71, 963 0 0 0 0	15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00
15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator; occupational therapy, line 9, is greater tha amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum	line 10) line10) nd 15 for respir 10) ine 10) or respiratory y therapy or col n line 2, make res 21-23. ainees (line 17 line 9 for all lees (line 2 time WANCE AND TRAVEL sum of lines 2 for respiratory travel expense Expense of columns 1 and line 12) sum of lines 20 sum of lines 20 sum of lines 20 sum of lines 20	cherapy or linumns 1-3 for no entries on divided by suothers) es line 21) EXPENSE COMF and 25 for a therapy or suat the provided 12, line 12 (2) and 30 for a sum of the provided 20 and 30 for a sum of the provided 25	nes 17 and 18 physical ther lines 21 and um of columns PUTATION - PRO all others) sum of lines 3 der site (sum	for all others) Tapy, speech pat 22 and enter on 1 and 2, line 9 OVIDER SITE B and 4 for all of lines 26 and	40, 659 0 40, 659 0 40, 659 hol ogy or 1 line 23 the 71, 963 71, 963 0 0 0 0	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00

	occupational therapy, The 7, 13 greater than the 22 and effect of		
	amount from line 20. Otherwise complete lines 21-23.		
	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9	92. 26	21.0
	for respiratory therapy or columns 1 thru 3, line 9 for all others)		
	Weighted allowance excluding aides and trainees (line 2 times line 21)	71, 963	
	Total salary equivalency (see instructions)	71, 963	23.0
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE		
	Standard Travel Allowance		
4.00	Therapists (line 3 times column 2, line 11)	0	24.0
5. 00	Assistants (line 4 times column 3, line 11)	0	25. (
6.00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	0	26. (
7. 00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all	ol	27. (
	others)		
	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and	0	28.0
3. 00	27)	ا ا	20.
İ	Optional Travel Allowance and Optional Travel Expense		
	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29. (
	Assistants (column 3, line 10 times column 3, line 12)	ő	
	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	7	31.
	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	0	-
. 00	columns 1-3, line 13 for all others)	۷	32.
			22
	Standard travel allowance and standard travel expense (line 28)	0	
	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	
	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.0
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PRO	OVIDER SITE	
	Standard Travel Expense		
	Therapists (line 5 times column 2, line 11)	0	
7.00	Assistants (line 6 times column 3, line 11)	0	
3. 00	Subtotal (sum of lines 36 and 37)	0	38. (
9. 00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39. (
Ī	Optional Travel Allowance and Optional Travel Expense		
	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40. (
	Assistants (column 3, line 12.01 times column 3, line 10)	0	41. (
	Subtotal (sum of lines 40 and 41)		42. (
	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)		
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line		10. (
	46. as appropriate.	23 44, 45, 61	
	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44. (
	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)		45. (
15.00	optional travel arrowance and Standard travel expense (Sum of Tries 39 and 42 - See Instructions)	υĮ	45.0

EASONABLE COST DETERMINATION FOR THERAPY SERVICES UTSIDE SUPPLIERS	FURNI SHED BY	Provi der CC	CN: 14-1328	Peri od: From 04/01/2022 To 03/31/2023	Worksheet A-8 Parts I-VI Date/Time Pre 8/28/2023 1:2	pared:
				Physical Therapy	Cost	
					1. 00	
6.00 Optional travel allowance and optional trave	l expense (sum o	f lines 42 ar	nd 43 - see i	nstructions)	0	46.00
		Assi stants	Ai des	Trai nees	Total	
DADT W. OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
PART V - OVERTIME COMPUTATION 7.00 Overtime hours worked during reporting	0.00	0. 00	0. 0	0. 00	0.00	 47. 00
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	0.00	0.00	0. 0	0.00	0.00	47.00
column of line 56)	0.00	0.00	0.0	0.00		40.00
8.00 Overtime rate (see instructions) 9.00 Total overtime (including base and overtime	0. 00 0. 00	0. 00 0. 00	0. 0 0. 0			48. 00 49. 00
allowance) (multiply line 47 times line 48)	0.00	0.00	0. 0	0.00		49.00
CALCULATION OF LIMIT						1
0.00 Percentage of overtime hours by category	0.00	0.00	0.0	0. 00	0.00	50.00
(divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)						
1.00 Allocation of provider's standard work year	0.00	0. 00	0.0	0.00	0.00	51.00
for one full-time employee times the	0.00	0.00	0.0		0.00	000
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE						
2.00 Adjusted hourly salary equivalency amount	92. 26	0. 00	0.0	0. 00		52.00
(see instructions)						F0 0
3.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.00
52) 4.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
line 49 or line 53)		U				34.00
5.00 Portion of overtime already included in	0	0		0 0		55.00
hourly computation at the AHSEA (multiply						
line 47 times line 52)						
6.00 Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56.00
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.)						
					1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION	AND EXCESS COST	ADJUSTMENT			1.00	
7.00 Salary equivalency amount (from line 23)					71, 963	57.0
8.00 Travel allowance and expense - provider site	(from lines 33,	34, or 35))			0	58.0
9.00 Travel allowance and expense - Offsite servi			5)		0	59.0
0.00 Overtime allowance (from column 5, line 56)					0	60.0
					0	
1.00 Equipment cost (see instructions)						62.0
2.00 Supplies (see instructions)					0	
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62)					71, 963	
2.00 Supplies (see instructions)3.00 Total allowance (sum of lines 57-62)4.00 Total cost of outside supplier services (fro		onton zono)			71, 963 26, 442	64.0
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro 5.00 Excess over limitation (line 64 minus line 6		enter zero)			71, 963 26, 442	64.0
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION	3 - if negativé,		all others		71, 963 26, 442 0	64.00 65.00
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or	3 - if negative, sum of lines 24	and 25 for a		others	71, 963 26, 442 0	64. 00 65. 00 100. 00
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or 00.01 Line 27 = line 7 times line 3 for respiratory	3 - if negative, sum of lines 24	and 25 for a		others	71, 963 26, 442 0	64. 00 65. 00 100. 00 100. 0
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or	3 - if negative, sum of lines 24	and 25 for a		others	71, 963 26, 442 0	
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or 00.01 Line 27 = line 7 times line 3 for respirator 00.02 Line 33 = line 28 = sum of lines 26 and 27	3 - if negative, sum of lines 24 y therapy or sum	and 25 for a of lines 3 a	and 4 for all		71, 963 26, 442 0	64. 00 65. 00 100. 00 100. 0
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or 1.00 Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 27 = line 7 times line 3 for respirator 1.01 Line 31 = line 29 for respiratory therapy or 1.01 Line 31 = line 29 for respiratory therapy or 1.01 Line 31 = line 29 for respiratory therapy or 1.00 Line 20 Total Line 20 Total Line 31 = line 29 for respiratory therapy or 1.00 Line 27 = line 29 for respiratory therapy or 1.01 Line 31 = line 29 for respiratory therapy or 1.01 Line 31 = line 29 for respiratory therapy or 1.01 Line 31 = line 29 for respiratory therapy or 1.01 Line 31 = line	3 - if negative, sum of lines 24 y therapy or sum y therapy or sum	and 25 for a of lines 3 a	and 4 for all		71, 963 26, 442 0 0 0 0 0 0	64. 00 65. 00 100. 00 100. 00 101. 00 101. 00
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or 00.01 Line 27 = line 7 times line 3 for respirator 100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 27 = line 7 times line 3 for respirator	3 - if negative, sum of lines 24 y therapy or sum y therapy or sum	and 25 for a of lines 3 a	and 4 for all		71, 963 26, 442 0 0 0 0 0 0	64. 00 65. 00 100. 00 100. 00 101. 00 101. 00
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or 00.01 Line 27 = line 7 times line 3 for respirator 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 27 = line 7 times line 3 for respirator 01.01 Line 31 = line 29 for respiratory therapy or 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	3 - if negative, sum of lines 24 y therapy or sum y therapy or sum sum of lines 29	and 25 for a of lines 3 a of lines 3 a and 30 for a	and 4 for all and 4 for all all others		71, 963 26, 442 0 0 0 0 0 0	64. 00 65. 00 100. 00 100. 02 101. 00 101. 02
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or 00.01 Line 27 = line 7 times line 3 for respirator 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 27 = line 7 times line 3 for respirator 01.01 Line 31 = line 29 for respiratory therapy or 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or 01.01 Line 31 = line 29 for respiratory therapy or 02.00 Line 31 = line 29 for respiratory therapy or 02.00 Line 31 = line 29 for respiratory therapy or	3 - if negative, sum of lines 24 y therapy or sum y therapy or sum sum of lines 29	and 25 for a of lines 3 a of lines 3 a and 30 for a	and 4 for all	others	71, 963 26, 442 0 0 0 0 0 0 0	100. 00 100. 00 100. 0 100. 0 101. 0 101. 0 101. 0
2.00 Supplies (see instructions) 3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (fro Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or 00.01 Line 27 = line 7 times line 3 for respirator 00.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION 01.00 Line 27 = line 7 times line 3 for respirator 01.01 Line 31 = line 29 for respiratory therapy or 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	3 - if negative, sum of lines 24 y therapy or sum y therapy or sum sum of lines 29	and 25 for a of lines 3 a of lines 3 a and 30 for a	and 4 for all	others	71, 963 26, 442 0 0 0 0 0 0 0	100. 0 100. 0 100. 0 100. 0 101. 0 101. 0

	IABLE COST DETERMINATION FOR THERAPY SERVICES SUPPLIERS	FURNI SHED BY	Provi der CC	CN: 14-1328	Peri od: From 04/01/2022 To 03/31/2023 Occupati onal Therapy		pared:		
						1. 00			
	PART I - GENERAL INFORMATION								
1.00 2.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instruct	ti ons)			52 780	1. 00 2. 00		
3. 00	Number of unduplicated days in which supervi	sor or therapist	t was on provi	der site (se	ee instructions)	0	3.00		
1. 00	Number of unduplicated days in which therapy		on provider si	te but neit	ner supervisor	0	4.00		
5. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		anists (see ir	nstructions)		0	5. 00		
5. 00	Number of unduplicated offsite visits - ther				by therapy	Ö	6. 00		
	assistant and on which supervisor and/or the instructions)	rapist was not p	oresent durinç	the visit(s)) (see				
7. 00	Standard travel expense rate					0.00	7.00		
3. 00	Optional travel expense rate per mile	C	Th	A: -++	A: -l	0.00	8.00		
		Supervi sors 1.00	Therapi sts 2.00	Assi stants 3.00	Ai des 4.00	Trai nees 5. 00			
9. 00	Total hours worked	0.00	46. 35	0.	0. 00	0. 00	9. 00		
10. 00 11. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 43. 72	87. 43 43. 72		00 0. 00 00	0.00	10. 00 11. 00		
1.00	one-half of column 2, line 10; column 3,	43.72	43. 72	0.	00		11.00		
	one-half of column 3, line 10)						40.00		
12. 00 12. 01	Number of travel hours (provider site) Number of travel hours (offsite)	0	0		0		12. 00 12. 01		
	Number of miles driven (provider site)	o o	0		0		13.00		
13. 01	Number of miles driven (offsite)	0	0		0		13. 01		
						1. 00			
14.00	Part II - SALARY EQUIVALENCY COMPUTATION	1: 10)				0	14.00		
14. 00 15. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					0 4, 052	14. 00 15. 00		
16. 00	Assistants (column 3, line 9 times column 3,					0	16.00		
17. 00	Subtotal allowance amount (sum of lines 14 a others)	nd 15 for respir	ratory therapy	or lines 1	4-16 for all	4, 052	17. 00		
18. 00	Aides (column 4, line 9 times column 4, line	10)				0	18. 00		
19.00	Trainees (column 5, line 9 times column 5, l	ine 10)				0	19.00		
20. 00	Total allowance amount (sum of lines 17-19 f If the sum of columns 1 and 2 for respirator						20.00		
	occupational therapy, line 9, is greater tha								
1 00	amount from line 20. Otherwise complete lin		di vi dod by si	ım of column	and a line of	87. 42	04 00		
.1.00	for respiratory therapy or columns 1 thru 3,	line 9 for all	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line						
22. 00	Weighted allowance excluding aides and train	for respiratory therapy or columns 1 thru 3, line 9 for all others) Weighted allowance excluding aides and trainees (line 2 times line 21)							
		ees (line 2 time				68, 188	22. 00		
23. 00	Total salary equivalency (see instructions)		es line 21)	PUTATION - PI	ROVIDER SITE		22. 00		
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance		es line 21)	PUTATION - PI	ROVI DER SITE	68, 188	22. 00 23. 00		
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11)		es line 21)	PUTATION - PI	ROVI DER SI TE	68, 188 68, 188	22. 00 23. 00 24. 00		
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance	WANCE AND TRAVEL	es line 21) _ EXPENSE COMF		ROVI DER SI TE	68, 188 68, 188	22. 00 23. 00 24. 00 25. 00		
23. 00 24. 00 25. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3	WANCE AND TRAVEL	es line 21) EXPENSE COMF 4 and 25 for a	all others)		68, 188 68, 188 0 0	22. 00 23. 00 24. 00 25. 00 26. 00		
23. 00 24. 00 25. 00 26. 00 27. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)	sum of lines 24	EXPENSE COMP 4 and 25 for a 4 therapy or s	all others) sum of lines	3 and 4 for all	68, 188 68, 188 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00		
23. 00 24. 00 25. 00 26. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	sum of lines 24 for respiratory	EXPENSE COMP 4 and 25 for a 4 therapy or s	all others) sum of lines	3 and 4 for all	68, 188 68, 188 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00		
23. 00 24. 00 25. 00 26. 00 27. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave	sum of lines 24 for respiratory travel expense	EXPENSE COMP 4 and 25 for a y therapy or s at the provio	all others) sum of lines der site (su	3 and 4 for all	68, 188 68, 188 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00		
23. 00 24. 00 25. 00 26. 00 27. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	sum of lines 24 for respiratory travel expense I Expense of columns 1 and	EXPENSE COMP 4 and 25 for a y therapy or s at the provio	all others) sum of lines der site (su	3 and 4 for all	68, 188 68, 188 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	sum of lines 24 for respiratory travel expense of columns 1 and 1, line 12) sum of lines 25 sum of lines 25	EXPENSE COMP 4 and 25 for a therapy or s at the provided 2, line 12) 9 and 30 for a	all others) sum of lines der site (sum all others)	3 and 4 for all m of lines 26 and	68, 188 68, 188 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column	sum of lines 24 for respiratory travel expense of columns 1 and 1, line 12) sum of lines 25 sum of lines 25	EXPENSE COMP 4 and 25 for a therapy or s at the provided 2, line 12) 9 and 30 for a	all others) sum of lines der site (sum all others)	3 and 4 for all m of lines 26 and	68, 188 68, 188 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 27. 00 28. 00 29. 00 30. 00 31. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel allowance and standard travel	sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line)	EXPENSE COMP 4 and 25 for a y therapy or s at the provio	all others) sum of lines der site (sum all others) ratory thera	3 and 4 for all m of lines 26 and	68, 188 68, 188 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 31. 00 33. 00 34. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave	sum of lines 24 for respiratory travel expense I Expense of columns 1 and I line 12) sum of lines 29 s 1 and 2, line I expense (line	EXPENSE COMP 4 and 25 for a y therapy or s at the provice d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar	all others) sum of lines der site (sum all others) ratory thera	3 and 4 for all m of lines 26 and	68, 188 68, 188 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel	wance and travel sum of lines 24 for respiratory travel expense I Expense of columns 1 and I line 12) sum of lines 29 s 1 and 2, line I expense (sum of lines (sum of lin	EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 31 ar	all others) sum of lines der site (sum all others) ratory therap and 31) and 32)	3 and 4 for all m of lines 26 and by or sum of	68, 188 68, 188 0 0 0 0 0 0 0 0 0 0 0			
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense	wance and travel sum of lines 24 for respiratory travel expense I Expense of columns 1 and I line 12) sum of lines 29 s 1 and 2, line I expense (sum of lines (sum of lin	EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 31 ar	all others) sum of lines der site (sum all others) ratory therap and 31) and 32)	3 and 4 for all m of lines 26 and by or sum of	68, 188 68, 188 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	wance and travel sum of lines 24 for respiratory travel expense I Expense of columns 1 and I line 12) sum of lines 29 s 1 and 2, line I expense (sum of lines (sum of lin	EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 31 ar	all others) sum of lines der site (sum all others) ratory therap and 31) and 32)	3 and 4 for all m of lines 26 and by or sum of	68, 188 68, 188 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 31. 00 33. 00 34. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense	wance and travel sum of lines 24 for respiratory travel expense I Expense of columns 1 and I line 12) sum of lines 29 s 1 and 2, line sl expense (sum of lines (sum of li	EXPENSE COMP 4 and 25 for a y therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 31 ar	all others) sum of lines der site (sum all others) ratory therap and 31) and 32)	3 and 4 for all m of lines 26 and by or sum of	68, 188 68, 188 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	wance and travel sum of lines 24 for respiratory travel expense I Expense of columns 1 and I line 12) sum of lines 29 s 1 and 2, line I expense (sum of lexpense (sum of lines AND TRAVEL m of lines 5 and	EXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMPLEXPENSE COMP	all others) sum of lines der site (sum all others) ratory therap and 31) and 32)	3 and 4 for all m of lines 26 and by or sum of	68, 188 68, 188 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard Travel Allowance and Optional Travel Optional Travel Allowance (line 7 times the su	wance and travel sum of lines 24 for respiratory travel expense I Expense of columns 1 and I line 12) sum of lines 29 s 1 and 2, line I expense (sum of lexpense (sum of lines ANCE AND TRAVEL m of lines 5 and 1 Expense	EXPENSE COMPLEXPEN	all others) sum of lines der site (sum all others) ratory therap and 31) and 32)	3 and 4 for all m of lines 26 and by or sum of	68, 188 68, 188 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 35. 00 36. 00 37. 00 38. 00 39. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column 3 Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column	wance and travel sum of lines 24 for respiratory travel expense I Expense of columns 1 and I line 12) sum of lines 29 s 1 and 2, line I expense (sum of lexpense (sum of lines ANCE AND TRAVEL m of lines 5 and Expense Of times column	EXPENSE COMPLEXPEN	all others) sum of lines der site (sum all others) ratory therap and 31) and 32)	3 and 4 for all m of lines 26 and by or sum of	68, 188 68, 188 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00		
23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00 43. 00 44. 00 44. 00 45. 00 46. 00 47. 00 47. 00 48. 00 49. 00 40. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41)	wance and travel sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line le expense (sum of e	EXPENSE COMP 4 and 25 for a y therapy or s at the provio d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 31 ar EXPENSE COMPL d 6) 2, line 10)	all others) sum of lines der site (sum all others) ratory thera and 31) and 32) UTATION - SE	3 and 4 for all m of lines 26 and by or sum of	68, 188 68, 188 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 25. 00 26. 00 27. 00 28. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00		
44. 00 45. 00 47. 00 48. 00 49. 00 40. 00 41. 00 42. 00 44. 00 45. 00 47. 00 48. 00 49. 00 40. 00 41. 00 41. 00 42. 00 43. 00 44. 00 45. 00 47. 00 47. 00 48. 00 49. 00 40. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum Subtotal (sum of lines 40 and 41)	wance and travel sum of lines 24 for respiratory travel expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lexpense (sum of lines 5 and lexpense	EXPENSE COMP 4 and 25 for a y therapy or s at the provio d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 31 ar EXPENSE COMPL d 6) 2, line 10) 3, line 13.01)	all others) sum of lines der site (sum all others) ratory thera and 31) and 32) JTATION - SE	3 and 4 for all m of lines 26 and by or sum of	68, 188 68, 188 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00		

Heal th	Financial Systems HA	RDIN COUNTY GEN	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FURNI SHED BY	Provi der C		Period: From 04/01/2022 To 03/31/2023		pared:
					Occupati onal Therapy	Cost	
						1. 00	
45. 00 46. 00	Optional travel allowance and standard travel Optional travel allowance and optional trave					0	45. 00 46. 00
10.00	, , , , , , , , , , , , , , , , , , ,	Therapi sts	Assi stants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
47. 00	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)	0.00	0. 00	0.0	0.00	0.00	47. 00
48. 00 49. 00	Overtime rate (see instructions) Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0. 00 0. 00	0. 00 0. 00	•			48. 00 49. 00
	CALCULATION OF LIMIT						
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.0	0.00	0.00	50.00
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52. 00	Adjusted hourly salary equivalency amount (see instructions)	87. 43	0. 00				52.00
53. 00	Overtime cost limitation (line 51 times line 52)		0		0		53.00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00 55. 00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)		U		0 0		55.00
56. 00	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	0	0		0 0	0	56.00
	for all others.)						
	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND FYCESS COST	ΔD IIISTMENT			1. 00	
57. 00	Salary equivalency amount (from line 23)	AND EXCESS COST	ADJUSTIMENT			68, 188	57. 00
62. 00 63. 00 64. 00	58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 60.00 Overtime allowance (from column 5, line 56) 61.00 Equipment cost (see instructions) 62.00 Supplies (see instructions) 63.00 Total allowance (sum of lines 57-62)					0 0 0 0 0 68, 188 2, 781	63.00 64.00
100. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respirator Line 33 = line 28 = sum of lines 26 and 27				others	0	100. 00 100. 01 100. 02
101. 01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respirator Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or					0	102. 00
	Line 32 = line 8 times columns 1 and 2, line 13 for all others	13 for respira	itory therapy (or sum of col	umns 1-3, line		102.01
102. 02	PLine 35 = sum of lines 31 and 32					l O	102. 02

Health Financial Systems HARDIN COUNTY GENERAL HOSPITAL In Lieu					2552-10
		Provi der CCN: 14-1328	Peri od: Worksheet A-8-3 From 04/01/2022 Parts I-VI Date/Time Prepa 8/28/2023 1: 29		pared:
			Speech Pathology	Cost	
				1. 00	
PART I - GENERAL IN	IFORMATI ON	<u> </u>			
1.00 Total number of wee	eks worked (excluding aides) (see instruct	i ons)		52	1.00

		PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) (see instructions) 52 1.								
	00	OO Total number of weeks worked (excluding aides) (see instructions)								
2.	00	Line 1 multiplied by 15 hours per week					780	2. 00		
3.	00	Number of unduplicated days in which supervi	sor or therapi:	st was on provi	der site (see	instructions)	0	3.00		
4.	00	Number of unduplicated days in which therapy	assistant was	on provider si	te but neither	supervi sor	0	4.00		
		nor therapist was on provider site (see inst	ructions)							
5.	00	Number of unduplicated offsite visits - supe	rvisors or the	rapists (see ir	nstructions)		0	5.00		
6.	00	Number of unduplicated offsite visits - ther	apy assistants	(include only	visits made by	therapy	0	6. 00		
		assistant and on which supervisor and/or the	rapist was not	present during	g the visit(s))	(see				
		instructions)				•				
7.	00	Standard travel expense rate					5. 00	7. 00		
8.	00	Optional travel expense rate per mile					0.00	8. 00		
			Ai des	Trai nees						
			5. 00							
9.	00	Total hours worked	1.00	2. 00 17. 10	3. 00	4. 00		9. 00		
	. 00	AHSEA (see instructions)	0.00			0. 00				
	. 00	Standard travel allowance (columns 1 and 2,	42. 01	42. 01				11.00		
		one-half of column 2, line 10; column 3,								
		one-half of column 3, line 10)								
12	00	Number of travel hours (provider site)	0	0	o			12.00		
	. 01	Number of travel hours (offsite)	i o	Ö	_			12. 01		
		Number of miles driven (provider site)	0	Ö				13.00		
	. 01	Number of miles driven (offsite)	0	0				13. 01		
13	. 01	Number of mires driven (orrsite)	0	U	U			13.01		
							1.00			
		Part II - SALARY EQUIVALENCY COMPUTATION					1.00			
1.1	00		1: 10)					14.00		
		Supervisors (column 1, line 9 times column 1					0			
	. 00						1, 437			
	. 00	Assistants (column 3, line 9 times column 3,	,				0	16.00		
17	. 00	Subtotal allowance amount (sum of lines 14 a	nd 15 for resp	iratory therapy	y or lines 14-1	6 for all	1, 437	17. 00		
		others)								
	. 00	Aides (column 4, line 9 times column 4, line					0	18. 00		
	. 00						0	19. 00		
20	. 00	Total allowance amount (sum of lines 17-19 f						20.00		
		If the sum of columns 1 and 2 for respirator	y therapy or co	olumns 1-3 for	physical thera	py, speech pat	:hology or			
		occupational therapy, line 9, is greater tha	n line 2, make	no entri es on	lines 21 and 2	2 and enter or	ıline 23 the			
		amount from line 20. Otherwise complete lin	es 21-23.							
21	. 00	Weighted average rate excluding aides and tr	ainees (line 1	7 divided by su	um of columns 1	and 2, line 9	84. 04	21.00		
		for respiratory therapy or columns 1 thru 3,	line 9 for al	l others)						
22	. 00	Weighted allowance excluding aides and train	ees (line 2 tii	mes line 21)			65, 551	22.00		
23	. 00	Total salary equivalency (see instructions)					65, 551	23. 00		
		PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVE	EL EXPENSE COMP	PUTATION - PROV	I DER SI TE				
		Standard Travel Allowance								
24	. 00						0	24.00		
	. 00	Assistants (line 4 times column 3, line 11)					l ol	25. 00		
	. 00	Subtotal (line 24 for respiratory therapy or	sum of lines	24 and 25 for a	all others)		l ol	26. 00		
	. 00	Standard travel expense (line 7 times line 3				and 4 for all	0	27. 00		
2,	. 00	others)	Tor respirato	ry therapy or s	Sum of Triles 5	and 4 for all	į	27.00		
28	. 00	Total standard travel allowance and standard	travel evnens	e at the provid	der site (sum o	flines 26 and	0	28. 00		
20	. 00	27)	traver expens	c at the provid	aci site (sum o	1 TITICS 20 dife	į	20.00		
		Optional Travel Allowance and Optional Trave	I Evnense							
20	00	Therapists (column 2, line 10 times the sum		nd 2 line 12 `	١		0	29. 00		
		Assistants (column 3, line 10 times column 3		nu z, Tine iz ,	,					
		Subtotal (line 29 for respiratory therapy or		20 and 20 for a	all others)		0	31.00		
						or cum of				
32	. 00	Optional travel expense (line 8 times column	is I and 2, Time	e is for respir	atory therapy	or Sulli or	0	32. 00		
2.2	00	columns 1-3, line 13 for all others)	L avnance (Lin	. 20)				22.00		
	. 00	Standard travel allowance and standard trave			01)		0	33.00		
	. 00	Optional travel allowance and standard trave					0	34.00		
35	. 00	1				050 0UTOLDE DE	0	35. 00		
		Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	_ EXPENSE COMPL	JIAIION - SERVI	CES OUTSTDE PE	ROVIDER SITE			
		Standard Travel Expense								
	. 00	Therapists (line 5 times column 2, line 11)					0	36.00		
	. 00	Assistants (line 6 times column 3, line 11)					0	37.00		
	. 00	Subtotal (sum of lines 36 and 37)					0	38. 00		
39	. 00	Standard travel expense (line 7 times the su		nd 6)			0	39. 00		
		Optional Travel Allowance and Optional Trave								
	. 00	Therapists (sum of columns 1 and 2, line 12.		n 2, line 10)			0	40.00		
41	. 00	Assistants (column 3, line 12.01 times colum	n 3, line 10)				0	41.00		
42	. 00	Subtotal (sum of lines 40 and 41)					0	42.00		
43	. 00	Optional travel expense (line 8 times the su	m of columns 1	-3, line 13. ₀₁))		0	43.00		
		Total Travel Allowance and Travel Expense -	Offsite Service	es; Complete or	ne of the follo	wing three lir	nes 44, 45, or			
		46, as appropriate.								
44	. 00	Standard travel allowance and standard trave	l expense (sum	of lines 38 ar	nd 39 - see ins	tructions)	0			
45	. 00	Optional travel allowance and standard trave	l expense (sum	of lines 39 ar	nd 42 - see ins	tructions)	0	45.00		

alth Financial Systems HA ASONABLE COST DETERMINATION FOR THERAPY SERVICES TSIDE SUPPLIERS	RDIN COUNTY GENI FURNI SHED BY	Provider Co	CN: 14-1328	Period: From 04/01/2022 To 03/31/2023	Date/Time Pre 8/28/2023 1:2	-3 pared:
				Speech Pathology	1. 00	
.00 Optional travel allowance and optional travel	expense (sum o	of Lines 42 au	nd 43 - see i	nstructions)		46.00
Too oper onal traver arremance and oper onal traver	Therapi sts	Assi stants	Ai des	Trainees	Total	10.00
	1. 00	2.00	3. 00	4. 00	5. 00	
PART V - OVERTIME COMPUTATION						
.00 Overtime hours worked during reporting	0.00	0.00	0. (0. 00	0.00	47.00
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)						
.00 Overtime rate (see instructions)	0.00	0.00	0. (0. 00		48.00
.00 Total overtime (including base and overtime	0.00	0.00				49.00
allowance) (multiply line 47 times line 48)	0.00	0.00	0. (0.00		17.00
CALCULATION OF LIMIT						i
.00 Percentage of overtime hours by category	0.00	0.00	0. (0.00	0.00	50.00
(divide the hours in each column on line 47	0.00	0.00	0. 0	0.00	0.00] 50. 00
by the total overtime worked - column 5,						
line 47)						
.00 Allocation of provider's standard work year	0.00	0.00	0. (0.00	0.00	51.00
for one full-time employee times the	0.00	0.00	0. 0	0.00	0.00] 31.00
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE						1
. 00 Adjusted hourly salary equivalency amount	84. 02	0.00	0. 0	0.00		52.00
(see instructions)	04. 02	0.00	0. 0	0.00		32.00
.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.00
52)		O				33.00
.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
line 49 or line 53)	o o	O				34.00
.00 Portion of overtime already included in	0	0		0		55.00
hourly computation at the AHSEA (multiply	o o	O				33.00
line 47 times line 52)						
.00 Overtime allowance (line 54 minus line 55 -	0	0		0	0	56.00
if negative enter zero) (Enter in column 5	o o	O			O	30.00
the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3						
for all others.)						
Tot art others.)						
					1. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
.00 Salary equivalency amount (from line 23)					65, 551	57.0
.00 Travel allowance and expense - provider site	(from lines 33,	34, or 35))			0	58.00
.00 Travel allowance and expense - Offsite service			5)		0	59.0
.00 Overtime allowance (from column 5, line 56)	,		•		0	60.0
.00 Equipment cost (see instructions)					0	
.00 Supplies (see instructions)					0	62.0
.00 Total allowance (sum of lines 57-62)					65, 551	
.00 Total cost of outside supplier services (from	vour records)				1, 026	1
.00 Excess over limitation (line 64 minus line 63		enter zero)				65.0
LINE 33 CALCULATION	o - II negative,	enter zero)				05.0
0.00 Line 26 = line 24 for respiratory therapy or	sum of lines 2/	l and 25 for s	all others		0	100. 0
0.00 Line 20 = Time 24 for respiratory therapy of 0.01 Line 27 = line 7 times line 3 for respiratory				othors		100.0
0.02 Line 33 = line 28 = sum of lines 26 and 27	therapy or sun	i di Tines 5 d	and 4 ron arr	Other 3		100. 0
					0	1100.0.
LINE 34 CALCULATION	, +bananı, an aıı	of Linco 2	and 1 for all	a+hara		1 101. 00
1.00 Line 27 = line 7 times line 3 for respiratory				others		
1.01 Line 31 = line 29 for respiratory therapy or	Sull of Titles 29	and 30 ror a	arr others			101.0
1.02 Line 34 = sum of lines 27 and 31					0	101. 0
LINE 35 CALCULATION 2.00 Line 31 = line 29 for respiratory therapy or			11 11			100 -
2 HOLLING 31 - Line 29 for resniratory therapy or	sum of lines 29	and 30 for a				102.0
						1:1 (1) A
2.01 Line 32 = line 8 times columns 1 and 2, line		ory therapy of	or sum of col	umns 1-3, line	0	102.0
		ory therapy o	or sum of col	umns 1-3, line		102. 0

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Period: Worksheet B From 04/01/2022 Part I Provider CCN: 14-1328

COST Center Description					Fr To	om 04/01/2022 0 03/31/2023	Part I Date/Time Pre	
BEMERAL SERVICE COST CENTERS				CAPI TAL REI	LATED COSTS		8/28/2023 1: 2	9 pm
BEMERAL SERVICE COST CENTERS				DI DO A FLVT	L 10/D) 5 50// D	EMBI 0)/EE		
CEMERAL SERVICE COST CENTERS 0 1.00 2.00 4.00 4A 1.00 1.00 2.00 4.00 4A 1.00 1.00 2.00 4.00 4A 1.00 1.00 2.00 4.00 4A 1.00 1.00 2.00 4		Cost Center Description		BLDG & FIXI	MARTE EGOLD		Subtotal	
SENDRAL SERVICE COST CENTERS								
GENERAL SERVICE COST CENTERS								
ENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLIGS & FIXT				1. 00	2.00	4. 00	4A	
2 00 00200 CAP REL COSTS-WELE EQUIP 369, 910 369, 910 52, 800 4.00 5000 CAP REL COSTS-WELE EQUIP 5.02 80, 910 52, 800 4.00 5000 CAP WILE SERVICES SERVICES 5.02 80, 910 52, 800 4.00 5000 CAP WILE SERVICES 5.02 80, 910 6.00 6.00 6.00 6.00 6.00 6.00 6.00 6.						,		
4.00 OOKOO LEMELOVEE BENEFITS DEPARTMENT 52,800 0 0 0 22,800 0 0 0 0 0 0 0 0 0				60, 157	1			1
0.000 0.0000 0.00000 0.00000 0.000000 0.00000000		•		0		52, 800		1
7.00 000000 (DeERATION OF PLANT \$588, 539 \$5,711 \$13,515 \$1,345 \$630,710 7.00 9.00 00000 (LAUNDRY & LINN SERVICE \$9,834 \$2,575 \$15,833 \$400 \$118,662 \$8.00 9.00 00 (9000) (HOUSEKEEPING 196,924 0 0 0 10,090 \$197,933 9.00 11.00 01 (1000) (CAFETERIA) 78,069 1,073 6,597 227 86,012 11.10 13.00 01 (3000) (MINES NIGA CARTERIA) 78,069 1,171 1,200 626,022 13.00 13.00 01 (3000) (MINES NIGA CARTERIA) 228,032 3,000 0 66 225,169 14.00 15.00 01 (1500) (PHARMACY) 204,977 1,126 6,927 55.68 213,548 15.00 15.00 01 (1500) (PHARMACY) 296,522 2,494 15,338 1,461 315,000 16.00 15.00 01 (1500) (PHARMACY) 296,222 2,494 15,338 1,461 315,000 16.00 15.00			3, 237, 413	9, 859				1
0.000 0.0000 LANDRY & LINEN SERVICE			500 520	0 5 711		-1	-	1
10.00 0 10000 DIETARY 229, 292 2, 535 15, 585 751 248, 163 10.00 10.00 CAFETERIA 78, 069 1, 073 6, 597 273 86, 012 11.00 10.00 CAFETERIA 78, 069 1, 073 6, 597 773 86, 012 11.00 10.00 10.00 0 0 0 0 0 0 0 0 12.00 10.00 1	1	ł	1		1			
11.00	9.00 00900	HOUSEKEEPI NG		0	0			1
12 00 01200 MAINTENANCE OF PERSONNEL 0 0 0 0 0 0 0 12 00								1
13. 00 01300 NURSIN & ADMINISTRATION 228, 956 5,069 31, 171 1,206 266, 402 31, 00 15:00 0 66 225, 169 14:00 15:00 015:00 PHARMACY 204, 927 1,126 6,927 5:68 213, 548 15:00 10:00 PHARMACY 204, 927 1,126 6,927 5:68 213, 548 15:00 17:00 017:00 SOCI AL SERVICE 52,757 5:03 3,092 290 5:6,642 17:00 10:00 0100 000 000 00 00		1	78,009					1
15. 00 01500 PHAMMACY 204, 927 1, 126 6, 927 5.68 213, 548 15. 00 17. 00 01700 SOCIAL SERVI CE 52, 757 5.03 3, 0.92 290 56, 642 17. 00 19. 00 11900 01900 000 000 00 0	13.00 01300	NURSING ADMINISTRATION	228, 956	5, 069	31, 171	1, 206	266, 402	1
16 00 01-000 MEDICAL RECORDS & LIBRARY 296, 325 2, 494 15, 338 1, 451 315, 608 16, 00 19 00 01-900 00-1900 00-				_	_			1
17. 00 017						ı		1
20.00 02000 NURSI NG PROGRAM 0 0 0 0 0 0 21.00	1							
22.00 02100 IAS SERVICES-SALARY & FRINCES APPRV 0 0 0 0 0 0 0 22.00		l e e e e e e e e e e e e e e e e e e e	0	0	_	0		1
22.00 02200 LAR SERVICES-OTHER PRGM COSTS APPRV 0 0 0 0 0 0 0 0 22.00			0	0	0	0		1
23.00			0	0	Ö	o		1
30.00	23. 00 02300	PARAMEDI CAL EDU PROG	0	0	0	0	0	23. 00
ANCILLARY SERVICE COST CENTERS			1 475 001	12 254	75 254	0 445	1 770 174	20.00
54.01 03630 ULTRA SOUND 135,801 563 3,463 720 140,547 54.01 60.00 06000 LABDRATORY 1,039,752 1,433 8,810 2,974 1,052,969 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1,075, 921	12, 254	75, 350	8, 045[1, 772, 170	30.00
60.00 06000 LABORATORY 1,039,752 1,433 8,810 2,974 1,052,969 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 80,158 1,126 6,927 387 88,589 65.00 66.00 06600 PHYSI CAL THERAPY 229,055 3,934 24,189 772 257,950 66.00 67.00 06700 OCCUPATIONAL THERAPY 8,728 0 0 39 8,767 67.00 68.00 06800 SPEECH PATHOLOGY 1,026 0 0 0 0 0 1,026 68.00 69.00 06900 ELECTROCARDIOLOGY 46,860 0 0 0 266 47,126 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 203,121 1,080 6,638 198 211,037 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 372,124 0 0 0 372,124 73.00 74.97 07697 CARDIA CR EHABILITATION 286,734 563 3,463 2,042 292,802 76.97 76.98 07699 LITHOTIP PSY 0 0 0 0 0 0 0 0 0 0 76.99 77.00 07690 LITHOTIP PSY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54.00 05400	RADI OLOGY-DI AGNOSTI C						1
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		•						1
65.00 06500 RESPIRATORY THERAPY 80,158 1,126 6,927 387 88,598 65.00 66.00 06600 O6500 CHAPTIONAL THERAPY 229,055 3,934 24,189 772 257,950 67.00 06700 OCCUPATIONAL THERAPY 8,728 0			1,039,752					1
67. 00 06700 OCCUPATIONAL THERAPY 8, 728 0 0 39 8, 767 67. 00 68. 00 OSBOO SPEECH PATHLOGY 1, 1026 0 0 0 0 69. 00 OSPEECH PATHLOGY 46, 860 0 0 0 71. 00 O7100 MEDI CAL SUPPLIES CHARGED TO PATIENT 203, 121 1,080 6,638 198 211, 037 71. 00 73. 00 O7300 DRUGS CHARGED TO PATIENTS 372, 124 0 0 0 372, 124 73. 00 O7300 DRUGS CHARGED TO PATIENTS 372, 124 0 0 0 0 372, 124 75. 97 O7697 CARDI AC REHABI LI TATI ON 286, 734 563 3, 463 2, 042 292, 802 76. 97 76. 98 O7698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 99 O7699 LI THOTRI PSY 0 0 0 0 0 0 77. 00 O7700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 77. 00 O7700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 79. 00 O9000 CLI NI C 0 0 0 0 0 79. 00 O9000 CLI NI C 0 0 0 0 79. 00 O9000 CLI NI C 0 0 0 0 79. 00 O9000 OBERGENCY 850, 824 3, 064 18, 843 8, 729 881, 460 91. 00 79. 00 O9000 OBERGENCY 850, 824 3, 064 18, 843 8, 729 881, 460 91. 00 79. 00 O9000 OBERGENCY 850, 824 3, 064 18, 843 8, 729 881, 460 91. 00 79. 00 O9000 OBERGENCY 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 0 79. 00 O9000 OBERGENCY 0 0 0 0 0 0	65.00 06500	RESPI RATORY THERAPY			1			65.00
68.00		•						1
69.00 66900 ELECTROCARDIOLOGY 46, 860 0 0 266 47, 126 69, 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 203, 121 1,080 6,638 198 211, 037 71. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 372, 124 0 0 0 0 372, 124 73. 00 76. 97 07697 CARDI AC REHABILLITATION 286, 734 563 3, 463 2,042 292, 802 76, 97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 88. 00 08800 RURAL HEALTH CLINIC 1,791, 133 0 0 0 9, 108 1,800, 241 89. 00 09000 CLINIC 0 0 0 0 0 0 0 91. 00 09000 CLINIC 850, 824 3,064 18,843 8,729 881,460 91.00 92. 00 09200 08SERVATI ON BEDS (NON-DI STINCT PART 90,399 PARTI AL HOSPI TALI ZATI ON PROGRAM 0 0 0 0 0 0 93. 99 07490 AMBULANCE SERVI CES 149,719 939 5,772 684 157,114 95.00 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 0 118. 00 SPECI AL PURPOSE COST CENTERS 149,719 939 5,763 366,873 52,800 13,518,527 118.00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 13,522,058 59,663 366,873 52,800 13,518,527 118.00 190. 00 19000 OFT, FLOWER, COFFEE SHOP & CANTEEN 0 224 1,374 0 1,598 190.00 190. 01 19001 VENDI NG MACHI NE 0 224 1,374 0 1,598 190.00 200. 00 Nonet Medical Research 0 0 0 0 0 0 0 201. 00 Nogeti we Cost Centers 0 0 0 0 0 0 201. 00 Nogeti we Cost Centers 0 0 0 0 0 0 201. 00 Nogeti we Cost Centers 0 0 0 0 0 201. 00 Nogeti we Cost Centers 0 0 0 0 0 201. 00 00 00 00 00 0 0 201. 00 00 00 00 00 00 0 201. 00 00 00 00 00 00 0 201. 00 00 00 00 00 00 0 201. 00 00 00 00 00 00 201. 00 00 00 00 00 00 201. 00 00 00 00 00 00 201. 00				0				1
73. 00 07300 DRUGS CHARGED TO PATIENTS 372, 124 0 0 0 372, 124 73. 00 76. 97 76. 97 76. 97 76. 97 76. 98 76. 98 76. 98 76. 98 76. 98 76. 98 76. 99 76. 99 76. 99 76. 99 76. 99 76. 99 77. 00 77. 0				0	0	266		1
76. 97 07697 CARDI AC REHABILITATION 286, 734 563 3, 463 2, 042 292, 802 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 99 77. 00 0700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0 0 0						1		1
76. 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 0 0 0 76. 99 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 1, 791, 133 0 0 0 0 9, 108 1, 800, 241 88. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 90. 00 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 93. 99 OTHER REI MBURSABLE COST CENTERS 113. 00 11320 OP101 D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				_	_	-1		1
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 0 0 0 0 0 0 0 0		1	0					1
SECOND CONTROL CONTR			0	_		-1		
88. 00			0	0	0	<u></u> 0	0	77.00
91. 00			1, 791, 133	0	0	9, 108	1, 800, 241	88. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 93. 99 09399 PARTI AL HOSPITALIZATI ON PROGRAM 0 0 0 0 0 0 0 93. 99 0THER REI MBURSABLE COST CENTERS 149, 719 939 5, 772 684 157, 114 95. 00 10200 0PI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0			0					
93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM 0 0 0 0 0 0 93. 99			850, 824	3, 064	18, 843	8, 729		
95. 00 09500 AMBULANCE SERVI CES 149, 719 939 5, 772 684 157, 114 95. 00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 13, 522, 058 59, 663 366, 873 52, 800 13, 518, 527 118. 00 118. 00 119. 00			0	0	О	o		1
102. 00 10200 OPI 0I D TREATMENT PROGRAM O O O O O 102. 00					II			
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 13, 522, 058 59, 663 366, 873 52, 800 13, 518, 527 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 270 1, 663 0 1, 933 190. 00 190. 01 19001 VENDI NG MACHI NE 0 224 1, 374 0 1, 598 190. 01 200. 00 Cross Foot Adjustments 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 201. 00			1			1		
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 13, 522, 058 59, 663 366, 873 52, 800 13, 518, 527 118. 00			U	0			0	102.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 270 1,663 0 1,933 190.00 190.01 19001 VENDI NG MACHI NE 0 224 1,374 0 1,598 190.01 200.00 Cross Foot Adjustments 0 0 0 0 0 201.00 0 0 0 0 0 0 0 0 0			40 500 050	50 ((0	044.070	50.000	10 510 507	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 270 1,663 0 1,933 190. 00 190. 01 19001 VENDI NG MACHI NE 0 224 1,374 0 1,598 190. 01 200. 00 Cross Foot Adjustments 0 0 0 0 0 201. 00 0 0 0 0 0 0 0 0 0			13, 522, 058	59, 663	366, 873	52, 800	13, 518, 527	Ji 18. 00
200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 0	190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	270	1, 663	0	1, 933	190. 00
201.00 Negative Cost Centers 0 0 0 0 201.00			0	224	1, 374	0		
		,		0	0	Ω		
			13, 522, 058			- 1		

Provider CCN: 14-1328

Peri od: Worksheet B
From 04/01/2022 Part I
To 03/31/2023 Date/Time Prepared: 8/28/2023 1: 29 pm

						8/28/2023 1: 2	9 pm
	Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL	3, 316, 288					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7. 00	00700 OPERATION OF PLANT	204, 944	0	835, 654			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	38, 555	0	48, 257	205, 464		8.00
9. 00	00900 HOUSEKEEPI NG	64, 317	0	0	9, 572	271, 822	9. 00
10.00	01000 DI ETARY	80, 639	0	1		16, 399	1
11. 00	01100 CAFETERI A	27, 949	0	20, 107	0, 417	6, 941	1
12. 00	01200 MAINTENANCE OF PERSONNEL	27, 747	0		_	0, 741	
	01300 NURSING ADMINISTRATION	86, 565	0		_	36, 442	1
			_		0		1
	01400 CENTRAL SERVICES & SUPPLY	73, 167	0		0	7 200	14.00
15.00	01500 PHARMACY	69, 391	0	21, 112		7, 288	1
	01600 MEDICAL RECORDS & LIBRARY	102, 554	0	46, 749		16, 138	1
17. 00	01700 SOCIAL SERVICE	18, 405	0	9, 425	0	3, 254	1
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
20. 00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
	02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23.00	02300 PARAMEDI CAL EDU PROG	0	0	0	0	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	575, 854	0	229, 678	119, 222	79, 289	30.00
	ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADI OLOGY-DI AGNOSTI C	246, 781	0	70, 500	17, 755	24, 338	54.00
54. 01	03630 ULTRA SOUND	45, 670	0			3, 644	1
60.00	06000 LABORATORY	342, 154	0		0	9, 269	1
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0 12, 101	0		0	0	
65. 00	06500 RESPIRATORY THERAPY	28, 789	0		0	7, 288	1
66. 00	06600 PHYSI CAL THERAPY	83, 819	0			25, 451	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 849	0	75,720	14, 320	23, 431	67.00
68. 00	06800 SPEECH PATHOLOGY	333	0		0	0	68.00
	1 1		0	0	0	0	1
69.00	06900 ELECTROCARDI OLOGY	15, 313	_	20 222	0	_	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	68, 575	0	20, 233	0	6, 985	1
	07300 DRUGS CHARGED TO PATIENTS	120, 919	0	0	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	95, 144	0		0	0	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	·	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0		0	0	76. 99
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	_					
88. 00	08800 RURAL HEALTH CLINIC	584, 979	0	0	2, 293	0	88. 00
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	286, 423	0	57, 431	35, 879	19, 826	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	0	0	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS			•			1
95.00	09500 AMBULANCE SERVI CES	51, 053	0	17, 594	0	6, 074	95.00
	10200 OPIOID TREATMENT PROGRAM	0					102.00
	SPECIAL PURPOSE COST CENTERS	-		_			1
113 00	11300 I NTEREST EXPENSE						113.00
118. 00		3, 315, 141	0	826, 396	205, 464	268, 626	1
110.00	NONREI MBURSABLE COST CENTERS	3, 313, 141	0	020, 390	203, 404	200, 020	11 10.00
100.00		400	0	E 0/0		1 750	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	628				1, /50	100.00
	19001 VENDING MACHINE	519	0	4, 189	0	1, 446	190. 01
200.00			_	_		_	200.00
201.00		0	0		-		201.00
202.00	TOTAL (sum lines 118 through 201)	3, 316, 288	0	835, 654	205, 464	271, 822	1202.00

Provider CCN: 14-1328

Peri od: Worksheet B From 04/01/2022 Part I To 03/31/2023 Date/Time Prepared: 8/28/2023 1: 29 pm

					8/28/2023 1: 2	9 pm
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	
	10. 00	11. 00	12.00	13.00	14. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL 6. 00 00600 MAI NTENANCE & REPAIRS 7. 00 00700 OPERATI ON OF PLANT 8. 00 00800 LAUNDRY & LI NEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY 16. 00 01600 MEDICAL RECORDS & LI BRARY 17. 00 01700 SOCIAL SERVICE 19. 00 01900 NURSING PROGRAM 21. 00 02100 LAR SERVICES-OTHER PRGM COSTS APPRV 22. 00 02200 LAR SERVICES-OTHER PRGM COSTS APPRV	399, 121 106, 314 0 0 0 0 0 0 0	247, 323 0 5, 720 721 4, 825 10, 221 2, 363 0 0	0 0 0 0	500, 691 16, 326 0 0 0	9, 577 2, 541 272 0 0 0 0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 20. 00 21. 00 22. 00
23. 00 02300 PARAMEDI CAL EDU PROG	0	0	<u> </u>	0	0	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	292, 807	79, 232		484, 365	34, 022	30. 00
ANCILLARY SERVICE COST CENTERS	272,007	17, 232		404, 303	34,022	30.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O	15, 792	C	0	9, 176	54.00
54. 01 03630 ULTRA SOUND	o	4, 427	ĺ		1, 009	54. 01
60. 00 06000 LABORATORY	O	21, 910	C	o	142, 242	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	. 0	l c	ol	0	62.30
65. 00 06500 RESPI RATORY THERAPY	o	12, 037		o	7, 552	65.00
66. 00 06600 PHYSI CAL THERAPY	0	5, 670	l d	أم	5, 040	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o o	0, 0, 0		-	0,010	67. 00
68. 00 06800 SPEECH PATHOLOGY	o o	0			ő	68. 00
69. 00 06900 ELECTROCARDI OLOGY		2, 338			673	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		2, 188			69, 891	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		2, 100			0,,0,1	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0			Ö	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0			Ö	76. 77
76. 99 07699 LI THOTRI PSY	Ö	0		-	Ö	76. 76
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	o	0			Ö	77. 00
OUTPATIENT SERVICE COST CENTERS	<u> </u>			,		77.00
88. 00 08800 RURAL HEALTH CLINIC	0	54, 463	С	o	14, 699	88. 00
90. 00 09000 CLINIC	o	0			0	90.00
91. 00 09100 EMERGENCY	o	21, 785			11, 442	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					,	92.00
93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM	o	0	l c	o	0	93. 99
OTHER REIMBURSABLE COST CENTERS	-,		<u>-</u>			
95. 00 09500 AMBULANCE SERVI CES	0	3, 631	C	0	7, 247	95.00
102.00 10200 OPIOID TREATMENT PROGRAM	o	0			0	102.00
SPECIAL PURPOSE COST CENTERS	-1	_	<u>-</u>			
113. 00 11300 NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	399, 121	247, 323	l c	500, 691	315, 383	
NONREI MBURSABLE COST CENTERS	21171=1		<u>-</u>		2.27.222	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	С	0	0	190. 00
190. 01 19001 VENDI NG MACHI NE	o	0	C			190. 01
200.00 Cross Foot Adjustments		_]			200.00
201.00 Negative Cost Centers	o	0	C	o	0	201.00
202.00 TOTAL (sum lines 118 through 201)	399, 121	247, 323	C	500, 691	315, 383	202.00
	·					

Provider CCN: 14-1328

| Peri od: | Worksheet B | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared:

					0 03/31/2023	8/28/2023 1: 2	
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	NONPHYSI CI AN	NURSI NG	
			RECORDS &	SERVI CE	ANESTHETI STS	PROGRAM	
		15. 00	16. 00	17. 00	19. 00	20.00	
	GENERAL SERVICE COST CENTERS	13.00	10.00	17.00	17.00	20.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11. 00
	01200 MAI NTENANCE OF PERSONNEL						12.00
	01300 NURSI NG ADMINI STRATI ON						13.00
	01400 CENTRAL SERVI CES & SUPPLY	005 744					14.00
	01500 PHARMACY	325, 741	400 044				15.00
	01600 MEDICAL RECORDS & LIBRARY	0	493, 811	00.271			16.00
	01700 SOCI AL SERVI CE	0	0	90, 361			17.00
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM	0	0			0	19.00
	02100 I&R SERVICES-SALARY & FRINGES APPRV		0			l	21.00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		0				22.00
	02300 PARAMEDI CAL EDU PROG		0				23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		· · · · · ·	1		23.00
30.00	03000 ADULTS & PEDIATRICS	0	487, 031	90, 361	0	0	30.00
	ANCILLARY SERVICE COST CENTERS	-1			_		1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 780	C	0	0	54.00
54. 01	03630 ULTRA SOUND	0	0	0	0	0	54. 01
	06000 LABORATORY	0	0	0	0	0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
	06500 RESPI RATORY THERAPY	0	0	0	0	0	1
	06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
	06800 SPEECH PATHOLOGY	0	0		0		68.00
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0		0		
	07300 DRUGS CHARGED TO PATTENT	292, 427	0		0		1
	07697 CARDI AC REHABI LI TATI ON	2,2,42,	Ö		0	ĺ	
	07698 HYPERBARI C OXYGEN THERAPY		0		0	0	
	07699 LI THOTRI PSY	o	0		0	l o	
	07700 ALLOGENEIC HSCT ACQUISITION	o	0	l c	0	0	1
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	33, 314	0	C	0	0	88. 00
	09000 CLI NI C	0	0	0	0	0	
	09100 EMERGENCY	0	0	0	0	0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	_	_	_	_	_	92.00
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0	0	0	0	93. 99
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES	O	0	О	0	0	95.00
	10200 OPI OI D TREATMENT PROGRAM		0				102.00
102.00	SPECIAL PURPOSE COST CENTERS	٩	U ₁		0		1102.00
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		325, 741	493, 811	90, 361	0	0	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
	19001 VENDI NG MACHI NE	0	0	O	_		190. 01
200.00					0		200.00
201.00		0	0	0	0		201.00
202. 00	TOTAL (sum lines 118 through 201)	325, 741	493, 811	90, 361	0	, O	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 04/01/2022 | Part I | To 03/31/2023 | Date/Time Prepared: Provider CCN: 14-1328

					To 03/31/2023	Date/Time Pre 8/28/2023 1:2	
		INTERNS &	RESIDENTS			0/20/2023 1.2	27 DIII
		7.11.2.11.10 u					
Cost Center Descripti	on	SERVI CES-SALA	SERVI CES-OTHE	PARAMEDI CAL	Subtotal	Intern &	
		RY & FRINGES	R PRGM COSTS	EDU PROG		Resi dents	
		APPRV	APPRV			Cost & Post	
						Stepdown	
						Adjustments	
OFNEDAL CEDILLOS COCT OFNED	6	21. 00	22. 00	23. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTER 1.00 00100 CAP REL COSTS-BLDG &				l		1	1.00
2. 00 00200 CAP REL COSTS-BLDG &							2.00
4. 00 00400 EMPLOYEE BENEFITS DEP							4.00
5. 00 00500 ADMI NI STRATI VE & GENE						•	5.00
6.00 00600 MAI NTENANCE & REPAI RS							6.00
7. 00 00700 OPERATION OF PLANT							7. 00
8.00 00800 LAUNDRY & LINEN SERVI	CE						8.00
9. 00 00900 HOUSEKEEPI NG							9.00
10. 00 01000 DI ETARY							10.00
11. 00 01100 CAFETERI A							11.00
12.00 01200 MAINTENANCE OF PERSON							12.00
13. 00 01300 NURSI NG ADMINI STRATI 0							13. 00
14. 00 01400 CENTRAL SERVICES & SUI	PPLY						14.00
15. 00 01500 PHARMACY	DADY						15.00
16. 00 01600 MEDI CAL RECORDS & LI BI	RARY						16.00
17. 00 01700 SOCIAL SERVICE	LCTC						17.00
19. 00 O1900 NONPHYSI CLAN ANESTHET 20. 00 O2000 NURSI NG PROGRAM	1313						19. 00 20. 00
21. 00 02100 1 &R SERVICES-SALARY &	EDINGES ADDDV	0					21.00
22. 00 02200 1 &R SERVICES-OTHER PR		U	0				22.00
23. 00 02300 PARAMEDI CAL EDU PROG	OW COSTS ATTIC		J		0		23. 00
INPATIENT ROUTINE SERVICE C	OST CENTERS				<u> </u>		20.00
30. 00 03000 ADULTS & PEDIATRICS		0	0		0 4, 244, 037	0	30.00
ANCILLARY SERVICE COST CENT	ERS						
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0	0		0 1, 150, 585	l .	1
54. 01 03630 ULTRA SOUND		0	0	•	0 205, 853	l .	
60. 00 06000 LABORATORY	MODILL I A 00	0	0		0 1, 595, 395	l .	
62. 30 06250 BLOOD CLOTTI NG FOR HEI 65. 00 06500 RESPI RATORY THERAPY	MOPHI LI ACS	0	0		0 145 374	_	
66. 00 06600 PHYSI CAL THERAPY		0	0		0 165, 376 0 465, 982	l .	1
67. 00 06700 OCCUPATI ONAL THERAPY		0	0		0 405, 402	l e	
68. 00 06800 SPEECH PATHOLOGY		0	0		0 1, 359		
69. 00 06900 ELECTROCARDI OLOGY		0	0		0 65, 450	l .	1
71.00 07100 MEDICAL SUPPLIES CHAR	GED TO PATIENT	0	0		0 378, 909	l .	1
73.00 07300 DRUGS CHARGED TO PATI		0	0		0 785, 470	l .	73.00
76. 97 07697 CARDIAC REHABILITATIO	N	0	0		0 387, 946	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THE	RAPY	0	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY		0	0		0		
77. 00 07700 ALLOGENEI C HSCT ACQUI		0	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CEN	TERS	0	0		0 400 000	1	00.00
88. 00 08800 RURAL HEALTH CLINIC		0	0		0 2, 489, 989		1
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY		0	0		0 0 1, 314, 246	·	
92. 00 09200 OBSERVATION BEDS (NON	DISTINCT DART	U	U		1, 314, 240		1
93. 99 09399 PARTI AL HOSPI TALI ZATI		0	0		0		
OTHER REIMBURSABLE COST CEN			<u> </u>		0		73. 77
95. 00 09500 AMBULANCE SERVICES		0	0		0 242, 713	0	95.00
102.00 10200 OPI OI D TREATMENT PROG	RAM	0	0		0 0	0	102.00
SPECIAL PURPOSE COST CENTER	S						
113.00 11300 INTEREST EXPENSE							113. 00
118.00 SUBTOTALS (SUM OF LIN		0	0		0 13, 504, 926	0	118. 00
NONREI MBURSABLE COST CENTER				ı	al - · · ·	1	
190. 00 19000 GIFT, FLOWER, COFFEE	SHUP & CANTEEN	0	0		9, 380		190.00
190. 01 19001 VENDI NG MACHI NE		0	0		0 7, 752		190. 01
200.00 Cross Foot Adjustment: 201.00 Negative Cost Centers		0	0		0		200. 00 201. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118		0	0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		201.00
202.00 TOTAL (Suil TITIES 110	1111 Jugii 201)	U	0	I	0 13, 522, 030	1	1202.00

| Peri od: | Worksheet B | From 04/01/2022 | Part I | To 03/31/2023 | Date/Ti me Prepared: 8/28/2023 1: 29 pm Provider CCN: 14-1328

			/2023 1: 29 pm
	Cost Center Description	Total	•
		26. 00	
	GENERAL SERVICE COST CENTERS		
1.00	00100 CAP REL COSTS-BLDG & FLXT		1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL		5. 00
6.00	00600 MAINTENANCE & REPAIRS		6. 00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8. 00
9.00	00900 HOUSEKEEPI NG		9. 00
10.00	01000 DI ETARY		10.00
11. 00	01100 CAFETERI A		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSI NG ADMI NI STRATI ON		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING PROGRAM		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300 PARAMEDICAL EDU PROG		23.00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	
30.00	03000 ADULTS & PEDIATRICS	4, 244, 037	30.00
	ANCILLARY SERVICE COST CENTERS		
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 150, 585	54.00
54. 01	03630 ULTRA SOUND	205, 853	54. 01
60.00	06000 LABORATORY	1, 595, 395	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62. 30
65.00	06500 RESPI RATORY THERAPY	165, 376	65.00
66.00	06600 PHYSI CAL THERAPY	465, 982	66.00
67.00	06700 OCCUPATI ONAL THERAPY	11, 616	67.00
68.00	06800 SPEECH PATHOLOGY	1, 359	68.00
69.00	06900 ELECTROCARDI OLOGY	65, 450	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	378, 909	71.00
73.00	07300 DRUGS CHARGED TO PATIENTS	785, 470	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	387, 946	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	76. 98
76. 99	07699 LI THOTRI PSY	O	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	О	77. 00
	OUTPATIENT SERVICE COST CENTERS		
88. 00	08800 RURAL HEALTH CLINIC	2, 489, 989	88. 00
90.00	09000 CLI NI C	О	90.00
91.00	09100 EMERGENCY	1, 314, 246	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM	0	93. 99
	OTHER REIMBURSABLE COST CENTERS	<u> </u>	
95.00	09500 AMBULANCE SERVICES	242, 713	95.00
102.00	10200 OPIOID TREATMENT PROGRAM	0	102.00
	SPECIAL PURPOSE COST CENTERS	<u>'</u>	
113.00	11300 INTEREST EXPENSE		113.00
118.00		13, 504, 926	118.00
	NONREI MBURSABLE COST CENTERS		
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 380	190. 00
	19001 VENDI NG MACHI NE	7, 752	190. 01
200.00		0	200.00
201.00	1 1	o	201.00
202.00		13, 522, 058	202. 00
		. ,	1

			8/28/2023 1:	29 pm
	Cost Center Description	Statistics	Statistics Description	
		Code		
		1. 00	2. 00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	1	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALA RIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM COST	5.00
6.00	MAINTENANCE & REPAIRS	3	SQUARE FEET	6.00
7.00	OPERATION OF PLANT	4	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	5	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPI NG	4	SQUARE FEET	9.00
10.00	DI ETARY	6	MEALS SERV ED	10.00
11.00	CAFETERI A	7	FTE'S SERV ED	11.00
12.00	MAINTENANCE OF PERSONNEL	8	NUMBER HOUSED	12.00
13.00	NURSI NG ADMI NI STRATI ON	9	DIRECT NRS ING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	10	COSTED REQ UIS.	14.00
15.00	PHARMACY	11	COSTED REQ UIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	12	TIME SPENT	16.00
17.00	SOCI AL SERVI CE	13	PATIENT DA YS	17.00
19.00	NONPHYSI CI AN ANESTHETI STS	14	ASSIGNED TIME	19.00
20.00	NURSI NG PROGRAM	15	ASSIGNED TIME	20.00
21.00	I&R SERVICES-SALARY & FRINGES APPRV	16	ASSIGNED TIME	21.00
22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	17	ASSIGNED TIME	22.00
23.00	PARAMEDI CAL EDU PROG	18	ASSIGNED TIME	23.00

Heal th	Fi nan	cial Systems HA	ARDIN COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
COST A	LLOCAT	TION - STATISTICAL BASIS		Provi der C	CN: 14-1328	Peri od:	Worksheet B-1	
						From 04/01/2022 To 03/31/2023	Date/Time Pre	pared:
			CAPITAL REL	L LATED COSTS			8/28/2023 1: 2	.9 pm
			ON TIME REE					
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
			(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
					DEPARTMENT (GROSS SALA		(ACCUM COST)	
					RIES)			
			1. 00	2.00	4.00	5A	5. 00	
4 00		AL SERVICE COST CENTERS	0, 015	1	1		Г	
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	26, 915	26, 915				1.00
4. 00		EMPLOYEE BENEFITS DEPARTMENT	0		i	3		4.00
5. 00		ADMINISTRATIVE & GENERAL	4, 411				10, 205, 770	
6. 00		MAINTENANCE & REPAIRS	0	C		0	0	
7. 00		OPERATION OF PLANT	2, 555					1
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	1, 152				118, 652 197, 933	1
10. 00		DI ETARY	1, 134	_	1		248, 163	1
		CAFETERI A	480			-	86, 012	
12.00	1	MAINTENANCE OF PERSONNEL	0	C		0	0	
		NURSING ADMINISTRATION	2, 268	2, 268				
		CENTRAL SERVICES & SUPPLY PHARMACY	504	504	10, 215 87, 64		225, 169	1
	1	MEDICAL RECORDS & LIBRARY	1, 116		1		213, 548 315, 608	1
		SOCIAL SERVICE	225				56, 642	
19. 00		NONPHYSICIAN ANESTHETISTS	0	C		0	0	19. 00
20. 00		NURSI NG PROGRAM	0	C		0	0	
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0				0	
		PARAMEDICAL EDU PROG	0	_	1		l	1
20.00		ENT ROUTINE SERVICE COST CENTERS				5		20.00
30.00		ADULTS & PEDIATRICS	5, 483	5, 483	1, 335, 08	7 0	1, 772, 176	30.00
F4 00		LARY SERVICE COST CENTERS	1 (02	1 (02	202.04	, ,	750 4/2	1 54 00
		RADI OLOGY-DI AGNOSTI C ULTRA SOUND	1, 683 252					
60.00		LABORATORY	641	641			1, 052, 969	
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
65.00		RESPI RATORY THERAPY	504	l .	1		88, 598	1
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	1, 760 0				257, 950 8, 767	1
68. 00		SPEECH PATHOLOGY	0	-	3, 74		1, 026	1
69.00	06900	ELECTROCARDI OLOGY	0	C	41, 043	3 0	47, 126	
		MEDICAL SUPPLIES CHARGED TO PATIENT	483	l .	30, 64		211, 037	
		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	0 252		215 27	0 1 0	372, 124 292, 802	
		HYPERBARIC OXYGEN THERAPY	252	252	315, 37	0	292, 802	
		LI THOTRI PSY	0	C		0	1	
77. 00		ALLOGENEIC HSCT ACQUISITION	0	C	(0	0	77. 00
00.00		TIENT SERVICE COST CENTERS			1 407 07		1 000 241	1 00 00
		RURAL HEALTH CLINIC CLINIC	0		1, 407, 070	0 0	,	1
		EMERGENCY	1, 371	1, 371	1, 348, 06		l	1
	1	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93. 99		PARTIAL HOSPITALIZATION PROGRAM	0	<u>C</u>		0	0	93. 99
95. 00		REIMBURSABLE COST CENTERS AMBULANCE SERVICES	420	420	105, 613	3 0	157, 114	95 00
		OPIOID TREATMENT PROGRAM	0	l .				102.00
		AL PURPOSE COST CENTERS						Ī
		INTEREST EXPENSE			0 454 70	0.01/.000	40.000.000	113.00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117) MBURSABLE COST CENTERS	26, 694	26, 694	8, 154, 793	3 -3, 316, 288	10, 202, 239	1118.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	121	121		0	1, 933	190. 00
	1	VENDING MACHINE	100	l .	1	0		190. 01
200.00	1	Cross Foot Adjustments						200.00
201. 00 202. 00		Negative Cost Centers Cost to be allocated (per Wkst. B,	60, 157	369, 910	52, 800		3, 316, 288	201.00
202.00	1	Part 1)	00, 137	309, 910	52, 800		3, 310, 200	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	2. 235073	13. 743637	0. 00647	5	0. 324942	
204.00		Cost to be allocated (per Wkst. B,				D	70, 482	204.00
205.00		Part II) Unit cost multiplier (Wkst. B, Part			0. 000000		0. 006906	205 00
205. 00	1	II)			0.00000		0.000906	203.00
206.00		NAHE adjustment amount to be allocated						206.00
207.00		(per Wkst. B-2)						207. 00
207. 00	1	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00
	•	•		•	•	•	•	-

Provider CCN: 14-1328

			T	0 03/31/2023	Date/Time Pre 8/28/2023 1:2	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERV ED)	
	(040/2 121)	, ,	LAUNDRY)			
CENEDAL CEDILICE COCT CENTEDO	6. 00	7. 00	8. 00	9. 00	10. 00	
GENERAL SERVICE COST CENTERS 1.00 O0100 CAP REL COSTS-BLDG & FLXT		I				1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6. 00 00600 MAI NTENANCE & REPAI RS	0					6.00
7. 00 00700 OPERATION OF PLANT	0	19, 949				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	1, 152 0				8. 00 9. 00
10. 00 01000 DI ETARY	0	1, 134	3, 844 2, 577	1, 134	11, 882	10.00
11. 00 01100 CAFETERI A	0	480		480	3, 165	11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	0	2, 520	0	2, 520	0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15. 00 01500 PHARMACY	0	504	0	504	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	1, 116		1, 116	0	16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	225	0	225	0	17. 00 19. 00
20. 00 02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV	Ö	Ö	0	Ö	0	22. 00
23. 00 02300 PARAMEDI CAL EDU PROG	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	5, 483	47, 876	5, 483	8, 717	30. 00
ANCILLARY SERVICE COST CENTERS		1 4 (00	7 400	4 (00		E 4 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0				0	54.00
54. 01 03630 ULTRA SOUND 60. 00 06000 LABORATORY	0		0	252 641	0	54. 01 60. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	041	0	041	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0	504	0	504	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 760	5, 753		0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	483	0	483	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON 76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 97 76. 98
76. 99 07699 LI THOTRI PSY		0	0	0	0	76. 99
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0		Ö	o	0	77. 00
OUTPATIENT SERVICE COST CENTERS	-	-				
88. 00 08800 RURAL HEALTH CLINIC	0	0	921	0	0	88. 00
90. 00 09000 CLI NI C	0		0	0	0	90.00
91. 00 09100 EMERGENCY	0	1, 371	14, 408	1, 371	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
93. 99 O9399 PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS	0	0	0	l O	0	93. 99
95. 00 09500 AMBULANCE SERVICES	0	420	0	420	0	95. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM		l .	0			102.00
SPECIAL PURPOSE COST CENTERS				<u> </u>		.02.00
113.00 11300 INTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	19, 728	82, 509	18, 576	11, 882	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			l .		190. 00
190. 01 19001 VENDI NG MACHI NE	0	100	0	100	0	190. 01
200.00 Cross Foot Adjustments						200. 00 201. 00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	0	835, 654	205, 464	271, 822	399, 121	
Part I)		033, 034	203, 404	271,022	377, 121	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	41. 889518	2. 490201	14. 460925	33. 590389	203. 00
204.00 Cost to be allocated (per Wkst. B,	0	45, 182			23, 228	
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	2. 264875	0. 264650	0. 126829	1. 954890	205. 00
NAUE adjustment amount to be all control						20/ 22
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207. 00
Parts III and IV)						
			,	,		

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1328 Peri od: Worksheet B-1 From 04/01/2022 03/31/2023 Date/Time Prepared: 8/28/2023 1: 29 pm Cost Center Description CAFETERI A MAI NTENANCE NURSI NG CENTRAL **PHARMACY** ADMI NI STRATI O (FTE'S SERV OF PERSONNEL SERVICES & (COSTED REQ ED) (NUMBER **SUPPLY** UIS.) Ν (DIRECT NRS HOUSED) (COSTED REO ING HRS) UIS.) 11.00 12.00 13.00 14.00 15.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 9, 945 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 74, 309 13.00 230 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 29 2, 423 723, 589 14.00 15.00 01500 PHARMACY 194 0 21, 973 322, 453 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 411 0 5, 829 0 16.00 01700 SOCIAL SERVICE 0 17 00 95 C 625 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 02000 NURSING PROGRAM 0 20.00 0 0 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 C 0 0 0 22.00 23.00 02300 PARAMEDICAL EDU PROG 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 3, 186 0 71, 886 78 058 n 30.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 635 21, 052 0 54.00 Ω 0 54.01 03630 ULTRA SOUND 178 0 0 2, 315 0 54.01 06000 LABORATORY 60 00 881 0 0 60 00 326, 350 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 0 0 62.30 06500 RESPIRATORY THERAPY 484 0 0 17, 326 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 228 0 0 11, 563 0 66,00 06700 OCCUPATI ONAL THERAPY 0 67 00 Ω 67 00 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 68.00 06900 ELECTROCARDI OLOGY 69.00 94 1,544 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 88 0 0 160, 353 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 289, 475 73.00 0 C 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76.97 76 98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 0 76.98 07699 LI THOTRI PSY 0 0 76.99 76.99 0 0 0 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 2, 190 32, 978 88.00 C 33, 724 88.00 90 00 09000 CLI NI C C 0 0 90.00 91.00 09100 EMERGENCY 876 C 0 26, 251 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 93.99 0 0 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 146 0 16,626 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 9,945 0 74, 309 723, 589 322, 453 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 Ω 0 0 190. 01 19001 VENDING MACHINE 0 0 0 0 190.01 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201.00 325, 741 202. 00 202.00 Cost to be allocated (per Wkst. B, 247, 323 500, 691 315, 383 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 24.869080 0.000000 6.737959 0. 435859 1. 010197 203. 00 Cost to be allocated (per Wkst. B, 204.00 15, 599 44.468 3.050 11, 130 204. 00 Part II) 0.000000 0.004215 0. 034517 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 1.568527 0.598420 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 207 00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1328 Peri od: Worksheet B-1 From 04/01/2022 03/31/2023 Date/Time Prepared: 8/28/2023 1:29 pm INTERNS & **RESI DENTS** MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG SERVI CES-SALA Cost Center Description RY & FRINGES RECORDS & SERVI CE **ANESTHETLSTS PROGRAM** (ASSI GNED **APPRV** LI BRARY (PATIENT DA (ASSI GNED (TIME SPENT) TIME) TIME) (ASSI GNED YS) TIME) 16. 00 17. 00 19.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 18, 208 16.00 17.00 01700 SOCIAL SERVICE 1,088 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 02000 NURSING PROGRAM 0 20 00 C 0 20 00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 22.00 23.00 02300 PARAMEDICAL EDU PROG 0 C 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17, 958 1, 088 0 0 0 30.00 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 250 C 0 0 54.00 0 03630 ULTRA SOUND 54.01 0 C 0 0 54.01 60.00 06000 LABORATORY 0 0 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 0 62.30 06500 RESPIRATORY THERAPY 000000000 0 0 0 0 0 0 0 65.00 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 C 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 0 0 68.00 06800 SPEECH PATHOLOGY 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 69.00 C 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT C 0 71.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 76.97 0 07698 HYPERBARIC OXYGEN THERAPY 0 76.98 0 76.98 0 76. 99 0 07699 LI THOTRI PSY 0 C 0 0 76.99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 0 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 90.00 09000 CLI NI C 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 0 0 93.99 93.99 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 0 0 0 ol 102.00 10200 OPIOID TREATMENT PROGRAM C 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 088 118.00 18, 208 0 0 0 1 1 8 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 0 190. 01 190. 01 19001 VENDING MACHINE 0 0 ol 200 00 Cross Foot Adjustments lana an 201.00 Negative Cost Centers 201.00 493, 811 0 202.00 202.00 Cost to be allocated (per Wkst. B, 90, 361 Part I) 0.000000 203.00 Unit cost multiplier (Wkst. B, Part I) 27. 120551 0.000000 0.000000 203.00 83.052390 204.00 Cost to be allocated (per Wkst. B, 23, 352 4,677 0 204.00 Part II) 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part 1. 282513 4. 298713 0.000000 0.000000 II) 206.00 206.00 NAHE adjustment amount to be allocated 0 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 Parts III and IV)

Health Financial Systems HARDIN COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 14-1328 Peri od: Worksheet B-1 From 04/01/2022 03/31/2023 Date/Time Prepared: 8/28/2023 1: 29 pm INTERNS & **RESI DENTS** SERVI CES-OTHE PARAMEDI CAL Cost Center Description R PRGM COSTS FDU PROG (ASSI GNED **APPRV** (ASSI GNED TIME) TIME) 22. 00 23. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 6.00 00600 MAINTENANCE & REPAIRS 7.00 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 8 00 9.00 00900 HOUSEKEEPI NG 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 01200 MAINTENANCE OF PERSONNEL 12 00 13.00 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 19.00 02000 NURSING PROGRAM 20 00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 02300 PARAMEDICAL EDU PROG INPATIENT ROUTINE SERVICE COST CENTERS 23.00 30.00 03000 ADULTS & PEDIATRICS 0 0 ANCILLARY SERVICE COST CENTERS 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 0 03630 ULTRA SOUND 54.01 0 60.00 06000 LABORATORY 0 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 06500 RESPIRATORY THERAPY 000000000 0 65.00 06600 PHYSI CAL THERAPY 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 68.00 06800 SPEECH PATHOLOGY 0 69.00 06900 ELECTROCARDI OLOGY 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 07300 DRUGS CHARGED TO PATIENTS 0 76. 97 07697 CARDIAC REHABILITATION 0 07698 HYPERBARIC OXYGEN THERAPY 76.98 0 0 76.99 07699 LI THOTRI PSY 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 0 08800 RURAL HEALTH CLINIC 0 90.00 09000 CLI NI C 0 0 91.00 09100 EMERGENCY 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92 00 93.99 09399 PARTIAL HOSPITALIZATION PROGRAM 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0 0 102.00 10200 OPIOID TREATMENT PROGRAM 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 0 0 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 01 19001 VENDING MACHINE 0 0 200 00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, C Part I)

MCRI F32 - 21. 1. 177. 1

	<u> </u>	ARDIN COUNTY GE				u of Form CMS-	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 04/01/2022	Worksheet C Part I	
					To 03/31/2023	Date/Time Pre 8/28/2023 1:2	pared:
			Title	XVIII	Hospi tal	Cost	, p
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	4, 244, 037		4, 244, 03	7 0	0	30.00
	ANCILLARY SERVICE COST CENTERS		1				
	05400 RADI OLOGY-DI AGNOSTI C	1, 150, 585		1, 150, 58		0	0 00
	03630 ULTRA SOUND	205, 853	l .	205, 85		0	01.01
	06000 LABORATORY	1, 595, 395		1, 595, 39		0	00.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	_		0 0	0	02.00
	06500 RESPI RATORY THERAPY	165, 376		165, 37		0	00.00
	06600 PHYSI CAL THERAPY	465, 982		465, 98		0	00.00
	06700 OCCUPATI ONAL THERAPY	11, 616		11, 61		0	07.00
	06800 SPEECH PATHOLOGY	1, 359	l .	1, 35		0	68.00
	06900 ELECTROCARDI OLOGY	65, 450		65, 45		0	07.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	378, 909	l .	378, 90		0	,
	07300 DRUGS CHARGED TO PATIENTS	785, 470		785, 47		0	,
	07697 CARDI AC REHABI LI TATI ON	387, 946		387, 94	6	0	1 . 0
	07698 HYPERBARI C OXYGEN THERAPY	0			0	0	76. 98
	07699 LI THOTRI PSY	0			0 0	0	76. 99
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
00 00	OUTPATIENT SERVICE COST CENTERS	2 400 000	I	2 400 00		0	00 00
	08800 RURAL HEALTH CLINIC	2, 489, 989	l .	2, 489, 98	9 0	0	88.00

1, 314, 246

734, 577

242, 713

14, 239, 503

13, 504, 926

734, 577

1, 314, 246 734, 577

242, 713

14, 239, 503

734, 577 13, 504, 926

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202.00

09000 CLI NI C

09100 EMERGENCY

92. 00 | 09200 | 0BSERVATI ON BEDS (NON-DI STI NCT PART 93. 99 | 09399 | PARTI AL HOSPI TALI ZATI ON PROGRAM

OTHER REIMBURSABLE COST CENTERS

Less Observation Beds

Total (see instructions)

95. 00 09500 AMBULANCE SERVICES
102. 00 10200 OPI 0I D TREATMENT PROGRAM
SPECIAL PURPOSE COST CENTERS

113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions)

Health Financial Systems HARDIN COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 14-1328 Period: From 04/01/2022 From 04/01/2022 To 03/31/2023 Date/Time Prepare 8/28/2023 1: 29 pr	
From 04/01/2022 Part I To 03/31/2023 Date/Time Prepare 8/28/2023 1:29 pi	52-10
	red:
Title XVIII Hospital Cost	
Charges	
Cost Center Description Inpatient Outpatient Total (col. 6 Cost or Other TEFRA	
+ col. 7) Ratio Inpatient	
Ratio	
6.00 7.00 8.00 9.00 10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	

				7(1111	nospi tai	0031	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
				_		Rati o	
		6. 00	7. 00	8. 00	9, 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	71.00	0.00	7. 00	101.00	
30.00	03000 ADULTS & PEDIATRICS	1, 166, 840		1, 166, 840			30.00
00.00	ANCILLARY SERVICE COST CENTERS	1, 100, 010		17 1007010			
54.00	05400 RADI OLOGY-DI AGNOSTI C	516, 763	5, 384, 865	5, 901, 628	0. 194961	0. 000000	54.00
54. 01	03630 ULTRA SOUND	98, 242	759, 091			0. 000000	
60.00	06000 LABORATORY	653, 776	4, 283, 089		I I	0. 000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		l .	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	120, 349	134, 524	-	I I	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	133, 006	757, 574			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	18, 704	26, 061			0. 000000	
68. 00	06800 SPEECH PATHOLOGY	1, 534	184			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	24, 534	207, 795			0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	267, 467	124, 223			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	993, 875	1, 033, 782			0. 000000	
	07697 CARDI AC REHABI LI TATI ON	0	276, 863		I I	0. 000000	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0. 000000	0.000000	
	07699 LI THOTRI PSY	0	0	0	0. 000000	0. 000000	
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0. 000000	0. 000000	
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	1, 284, 583	1, 284, 583			88. 00
90.00	09000 CLI NI C	0	0		0. 000000	0.000000	
91.00	09100 EMERGENCY	74, 540	3, 194, 092	3, 268, 632	I I	0.000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	279, 842		l I	0.000000	
	09399 PARTI AL HOSPI TALI ZATI ON PROGRAM	0	0			0. 000000	
	OTHER REIMBURSABLE COST CENTERS	-1	-	-			
95.00	09500 AMBULANCE SERVI CES	0	285, 030	285, 030	0. 851535	0.000000	95.00
	10200 OPI OI D TREATMENT PROGRAM	0	0		l .		102.00
	SPECIAL PURPOSE COST CENTERS	-1	-	-			
113.00	11300 I NTEREST EXPENSE						113.00
200.00		4, 069, 630	18, 031, 598	22, 101, 228			200.00
201.00		1, 221, 000	, , 0 , 0	,, 220			201.00
202.00		4, 069, 630	18, 031, 598	22, 101, 228			202.00
		.,,	-,,	, , , , , , , , , , , , , , , , , , , ,	1		

Health Financial Systems	HARDIN COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 14-1328	Peri od: From 04/01/2022 To 03/31/2023	Worksheet C Part I Date/Time Prepared: 8/28/2023 1:29 pm
	Title XVIII	Hospi tal	Cost

NPATIENT ROUTINE SERVICE COST CENTERS 11.00			Title XVIII	Hospi tal	Cost
INPATIENT ROUTINE SERVICE COST CENTERS 11.00	Cost Center Description	PPS Inpatient			
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 30.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADIOLOCY-DIAGNOSTIC 0.000000 54.00 65.400 65.00 05400 RADIOLOCY-DIAGNOSTIC 0.000000 54.00 66.00 06000 LABORATORY 0.000000 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 65.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 RESPI RATORY THERAPY 0.000000 66.00 0600 RESPI RATORY THERAPY 0.000000 66.00 0600 RESPI RATORY THERAPY 0.000000 66.00 0600 RESPI RATORY THERAPY 0.000000 67.00 06.00 0600 RESPI RATORY THERAPY 0.000000 67.00 06.00	·				
30.00		11. 00			
ANCI LLARY SERVICE COST CENTERS					
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 54.01 0.000000 62.30 0.000000 62.30 0.000000 62.30 0.000000 62.30 0.000000 62.30 0.000000 62.30 0.000000 62.30 0.000000 62.30 0.000000 62.30 0.000000 62.30 0.000000 62.30 0.000000 65.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000					30.00
54. 01 03630 ULTRA SOUND 0.000000 54. 01					
60. 00 06000 LABORATORY 0. 000000 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 06. 00 06600 PHYSI CAL THERAPY 0. 000000 06. 00 06600 PHYSI CAL THERAPY 0. 000000 06. 00 06600 PHYSI CAL THERAPY 0. 000000 06. 00 06600 PHYSI CAL THERAPY 0. 000000 06. 00 06600 PHYSI CAL THERAPY 0. 000000 06. 00 06600 PHYSI CAL THERAPY 0. 000000 06. 00 06600 PHYSI CAL THERAPY 0. 000000 06. 00 06600 SPEECH PATHOLOGY 0. 000000 06. 00 06600 SPEECH PATHOLOGY 0. 000000 071. 00 06900 ELECTROCARDI OLOGY 0. 000000 071. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 076. 97 07697 CARDI AC REHABI LITATI ON 0. 000000 076. 99 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 076. 99 07699 LI THOTRI PSY 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 0000000 0. 00000000		1			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.5000000 0.5000000 0.5000000 0.50000000 0.50000000 0.50000000 0.500000000 0.500000000 0.500000000 0.50000000000					
65. 00 06500 RESPI RATORY THERAPY 0.000000 06500 06600 PHYSI CAL THERAPY 0.000000 06700 06CUPATI ONAL THERAPY 0.000000 06700 06700 06CUPATI ONAL THERAPY 0.000000 06800 SPEECH PATHOLOGY 0.000000 068. 00 06900 ELECTROCARDI OLOGY 0.000000 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0.000000 07100 DRUGS CHARGED TO PATI ENTS 0.000000 073. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 076. 97 07697 CARDI AC REHABI LITATI ON 0.000000 076. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 076. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 076. 99 07699 LI THOTRI PSY 0.000000 076. 99 07699 LI THOTRI PSY 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000					
66. 00 06600 PHYSICAL THERAPY 0.000000 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 06800 SPECEP PATHOLOGY 0.000000 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 73. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0.000000 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0.000000 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 76. 99 76. 99 07699 LI THOTRI PSY 0.000000 77. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0.000000 77. 00 000000 CLIN C 0.000000 0.000000 77. 00 09000 CLIN C 0.000000 0.000000 77. 00 09000 CLIN C 0.000000 0.000000 79. 00 09000 DEBERVATI ON BEDS (NON-DI STINCT PART 0.000000 79. 00 09500 AMBULANCE SERVI CES 0.000000 70 000000 0000000 0000000000		1			
67. 00 06700 0CCUPATI ONAL THERAPY 0.000000 67. 00 68. 00 6800 SPECH PATHOLOGY 0.000000 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0.000000 69. 00 69					
68. 00					
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0. 000000 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0. 000000 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 76. 98 76. 99 07699 LI THOTRI PSY 0. 000000 76. 98 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0. 000000 77. 00 00000 00000 CLI NI C 0. 000000 77. 00 00000 CLI NI C 0. 000000 99. 00 99. 00 09000 CLI NI C 0. 000000 99. 00 99. 00 09000 EMERGENCY 0. 000000 99. 00 99. 00 09000 DESERVATI ON BEDS (NON-DI STI NCT PART 0. 000000 93. 99 0000 09000 DESERVATI ON BEDS (NON-DI STI NCT PART 0. 000000 93. 99 0000 OND OND OND OND OND OND OND OND OND OND					
71. 00					
73. 00					
76. 97 07697 CARDI AC REHABILITATION 0.000000 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 76. 99 77. 00 07700 ALLOGENEIC HSCT ACQUI SI TI ON 0.000000 0.000000 88. 00 08800 RURAL HEALTH CLINI C 88. 00 90. 00 09000 CLI NI C 0.000000 91. 00 91. 00 09100 EMERGENCY 0.000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0.000000 93. 99 93. 99 09399 PARTI AL HOSPI TALI ZATI ON PROGRAM 0.000000 95. 00 102. 00 10200 OPI OI D TREATMENT PROGRAM 102. 00 SPECI AL PURPOSE COST CENTERS 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00		0. 000000			
76. 98		0. 000000			
76. 99 07699 LI THOTRI PSY 0. 000000 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0. 000000 77. 00 000000 00000 00000 00000 00000 00000	76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 88. 00 90. 00 09000 CLINIC 0.000000 99. 00 91. 00 09100 EMERGENCY 0.000000 99. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.000000 97. 00 93. 99 09399 PARTIAL HOSPITALIZATION PROGRAM 0.000000 97. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 0.000000 95. 00 102. 00 09500 OPIOID TREATMENT PROGRAM 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 Less Observation Beds		0. 000000			
SECOND S	76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
88. 00		0. 000000			77. 00
90. 00					
91. 00					
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0. 000000 93. 99 09399 PARTI AL HOSPITALIZATI ON PROGRAM 0. 000000 93. 99 07HER REIMBURSABLE COST CENTERS 0. 000000 095. 00					
93. 99		0. 000000			
OTHER REIMBURSABLE COST CENTERS	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			
95. 00		0. 000000			93. 99
102. 00					
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 200.00 Subtotal (see instructions) 200.00 Less Observation Beds 201.00		0. 000000			
113. 00					102. 00
200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00					
201.00 Less Observation Beds 201.00					
202.00 Total (see instructions) 202.00					
	202.00 Total (see instructions)				202.00

Health Financial Systems	HARDIN COUNTY GENER	RAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-1328	Peri od:	Worksheet D

From 04/01/2022 Part V
To 03/31/2023 Date/Time Prepared: 8/28/2023 1: 29 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Part I, col. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 194961 54.00 2, 366, 377 03630 ULTRA SOUND 0. 240109 0 54.01 54.01 0 0 06000 LABORATORY 0 60.00 0. 323160 1, 686, 508 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 0 0 0 0 0 0 62.30 65.00 06500 RESPIRATORY THERAPY 0.648856 21, 671 65.00 06600 PHYSI CAL THERAPY 288, 407 66.00 0.523234 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 259488 14, 624 0 67.00 68.00 06800 SPEECH PATHOLOGY 0. 791036 68.00 69.00 06900 ELECTROCARDI OLOGY 0. 281713 138, 230 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 967370 93, 541 71.00 71.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.387378 774,609 0 73.00 07697 CARDIAC REHABILITATION 1. 401220 45, 732 0 76. 97 76.97 0 0 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 76. 98 76 98 0 0 76. 99 07699 LI THOTRI PSY 0.000000 0 0 0 76. 99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0.000000 90.00 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 0.402078 0 596, 759 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 2.624971 0 87, 251 0 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0.000000 0 93.99 0 0 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 851535 95.00 0 200.00 Subtotal (see instructions) 0 6, 113, 709 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 6, 113, 709 0 202.00

From 04/01/2022 To 03/31/2023 Part V Date/Time Prepared: 8/28/2023 1:29 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 461, 351 03630 ULTRA SOUND 54.01 0 54.01 06000 LABORATORY 0 60.00 545, 012 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 65.00 06500 RESPIRATORY THERAPY 14,061 0 65.00 150, 904 06600 PHYSI CAL THERAPY 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 3, 795 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 0 69.00 06900 ELECTROCARDI OLOGY 38, 941 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 90, 489 71.00 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 300,066 0 73.00 07697 CARDIAC REHABILITATION 64, 081 0 76. 97 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 76. 99 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 09000 CLI NI C 90.00 0 0 90.00 91.00 09100 EMERGENCY 239, 944 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 229, 031 0 92.00 09399 PARTIAL HOSPITALIZATION PROGRAM 93.99 0 93.99 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Subtotal (see instructions) 0 200.00 2, 137, 675 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

2, 137, 675

0

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	HARDIN COUNTY GENERAL HOSPITAL	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 14-1328	Peri od: From 04/01/2022	Worksheet D-1	
			Date/Time Pre 8/28/2023 1:2	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				
			1 00	

		Title XVIII	Hospi tal	8/28/2023 1: 2 Cost	9 piii
	Cost Center Description		110001 (41	3331	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed day	s. excluding newborn)		2, 519	1.00
2. 00	Inpatient days (including private room days, excluding swing-	,		1, 494	2.00
3.00	Private room days (excluding swing-bed and observation bed da		ivate room days,	0	3. 00
	do not complete this line.		-		
4.00	Semi-private room days (excluding swing-bed and observation b			1, 058	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	769	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	256	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber	or or the cost	200	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	o the Program (excluding	swing_hed and	671	9. 00
7. 00	newborn days) (see instructions)	o the rrogram (exertaining	3 SWITING DEG GITG	071	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	701	10.00
	through December 31 of the cost reporting period (see instruc				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	233	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00
12.00	through December 31 of the cost reporting period	A only (Therauling privat	.e room days)	0	12.00
13.00	1 91	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y				
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
16.00	SWING BED ADJUSTMENT			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	of the cost		17. 00
	reporting period	3			
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through Docombor 21 of	the cost	120. 63	19. 00
17.00	reporting period	3 thi dagii becember 31 di	the cost	120.03	17.00
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	131. 13	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing ported (line	4, 244, 037 9 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost report	ing period (inte		22.00
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23. 00
	x line 18)				
24. 00	1 3 11 31	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	neriod (line 8	0	25. 00
25.00	x line 20)	or the cost reporting	perrou (Trie o	O	23.00
26.00	Total swing-bed cost (see instructions)			1, 726, 930	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 517, 107	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abaserustion had al	argoa)	0	20.00
29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cr	iai yes)	0	28. 00 29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34.00	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		37.00
57.00	27 minus line 36)	pato 100m 003t ui		2,317,107	000
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				00.5-
38.00	,			1, 684. 81	38.00
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•		1, 130, 508 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	,		1, 130, 508	
		,	,		•

		ARDIN COUNTY GEN				u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der 0		Period: From 04/01/2022 To 03/31/2023	Worksheet D-1 Date/Time Pre	pared:
				e XVIII	Hospi tal	8/28/2023 1: 2 Cost	9 pili
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00	NURSERY (title V & XIX only)	1. 00	2. 00	3. 00	4. 00	5. 00	42.00
	Intensive Care Type Inpatient Hospital Units			1] 42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00
44. 00 45. 00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
49.00	Program inpatient ancillary service cost (Wk	rc+ D 2 col 2	Line 200)			1. 00	49.00
	Program inpatient cellular therapy acquisiti			III, line 10,	column 1)	452, 286 0	1
49. 00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instru	ctions)		1, 582, 794	49.00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	patient routine	services (fro	m Wkst. D. sur	m of Parts I and	0	50. 00
	111)						
51. 00	Pass through costs applicable to Program inpand IV)	oatient ancillar	y services (f	rom Wkst. D, s	sum of Parts II 	0	51.00
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	ıated, non-ph	ysician anesth	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	<u></u> /					
	Program di scharges Target amount per di scharge					0 00	54. 00 55. 00
55. 01	Permanent adjustment amount per discharge						55. 01
	Adjustment amount per discharge (contractor						55. 02
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		rget amount (line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	· ·			·	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		the cost rep	orting period	endi ng 1996,	0. 00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54,		m prior year	cost report, ι	updated by the	0. 00	60.00
61. 00	<pre>market basket) Continuous improvement bonus payment (if lin</pre>	ne 53 ÷ line 54	is less than	the lowest of	lines 55 nlus	0	61. 00
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	he amount by	which operation	ng costs (line	Ü	000
	Relief payment (see instructions)					-	62.00
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctrons)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	sts through Dece	mber 31 of th	e cost reporti	ng period (See	1, 181, 052	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after Decemb	er 31 of the	cost reporting	g period (See	392, 561	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi					1, 573, 613	44 00
00.00	CAH, see instructions	ne costs (Title	04 prus rine	os)(ti tie xvii	i on y), roi	1, 573, 013	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through	December 31	of the cost re	eporting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after D	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY	, AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of)		70.00 71.00
72. 00	Program routine service cost (line 9 x line	71)					72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv		•				73.00 74.00
75. 00	Capital-related cost allocated to inpatient				Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi den rocer	ds)			78.00 79.00
	Total Program routine service costs for comp				nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
86.00							1 -0.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions						 87. 00

Health Financial Systems HA	ARDIN COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 04/01/2022 To 03/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			734, 577	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
				·	instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	218, 728	4, 244, 037	0. 05153	8 734, 577	37, 859	90.00
91.00 Nursing Program cost	0	4, 244, 037	0.00000	0 734, 577	0	91.00
92.00 Allied health cost	0	4, 244, 037	0.00000	0 734, 577	o	92.00
93.00 All other Medical Education	o	4, 244, 037	0. 00000	0 734, 577	, o	93.00

I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 14-1328	Peri od: From 04/01/2022 To 03/31/2023	Worksheet D-3 Date/Time Pre 8/28/2023 1:2	pared:
		Title	XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	PATIENT ROUTINE SERVICE COST CENTERS					
	000 ADULTS & PEDIATRICS CILLARY SERVICE COST CENTERS			705, 768		30.00
	400 RADI OLOGY-DI AGNOSTI C		0. 1949		37, 624	
	630 ULTRA SOUND		0. 24010		0	
	000 LABORATORY		0. 3231		92, 872	
	250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	1
	500 RESPI RATORY THERAPY		0. 6488!		28, 689	
	600 PHYSI CAL THERAPY		0. 5232		6, 338	
	700 OCCUPATI ONAL THERAPY		0. 25948		891	67.00
	800 SPEECH PATHOLOGY		0. 7910		583	
	900 ELECTROCARDI OLOGY		0. 2817		4, 526	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 9673		104, 757	
	300 DRUGS CHARGED TO PATIENTS		0. 3873		171, 419	
	697 CARDI AC REHABI LI TATI ON		1. 4012		0	
	698 HYPERBARIC OXYGEN THERAPY		0.00000		0	
	699 LI THOTRI PSY		0.00000		0	
	700 ALLOGENEIC HSCT ACQUISITION		0. 00000	00 0	0	77.0
	TPATIENT SERVICE COST CENTERS					
	800 RURAL HEALTH CLINIC		0.0000		0	
	000 CLINIC		0. 00000		0	
	100 EMERGENCY		0. 4020		4, 587	
	200 OBSERVATION BEDS (NON-DISTINCT PART		2. 6249		0	
	399 PARTIAL HOSPITALIZATION PROGRAM HER REIMBURSABLE COST CENTERS		0.0000	00 0	0	93. 9
	500 AMBULANCE SERVICES		1			95.0
200. 00	Total (sum of lines 50 through 94 and 96 through	98)		1, 119, 139	452, 286	1
200.00	Less PBP Clinic Laboratory Services-Program only of			1, 117, 139	·	200. 0
201.00	Net charges (line 200 minus line 201)	marges (Title 01)		1, 119, 139		201.0

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	,
		Component	CCN: 14-Z328	From 04/01/2022 To 03/31/2023	8/28/2023 1: 2	
		Title	: XVIII	Swing Beds - SNF	Cost	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
	ANCILLARY SERVICE COST CENTERS					4
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 19496			
54. 01	03630 ULTRA SOUND		0. 24010		0	
60.00	06000 LABORATORY		0. 32316			
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
65.00	06500 RESPI RATORY THERAPY		0. 64885		29, 626	
66.00	06600 PHYSI CAL THERAPY		0. 52323		61, 043	
67.00	06700 OCCUPATI ONAL THERAPY		0. 25948		3, 573	
68. 00	06800 SPEECH PATHOLOGY		0. 79103		485	
	06900 ELECTROCARDI OLOGY		0. 2817			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 96737			
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 38737	·	100, 005	
	07697 CARDI AC REHABI LI TATI ON		1. 40122		0	
	07698 HYPERBARI C OXYGEN THERAPY		0.00000		0	
	07699 LI THOTRI PSY		0.00000		0	
77.00	07700 ALLOGENEIC HSCT ACQUISITION		0.00000	00 0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS		0.0000	20		
88. 00	08800 RURAL HEALTH CLINIC		0.00000		0	
90.00	09000 CLINIC		0.00000		0	
	09100 EMERGENCY		0. 40207	·	533	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		2. 62497		0	
93. 99	09399 PARTIAL HOSPITALIZATION PROGRAM OTHER REIMBURSABLE COST CENTERS		0.00000	00 0	0	93. 99
95. 00	O9500 AMBULANCE SERVICES		I			95.00
				700 0/0	241 441	
200.00	Total (sum of lines 50 through 94 and 96 through 98)	o (line (1)		722, 363	341, 441	
201.00		s (Tine 61)		722, 363		201. 00 202. 00
202.00				1// 363		

Health Financial Systems	HARDIN COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1328	Peri od: Worksheet E From 04/01/2022 Part B To 03/31/2023 Date/Ti me Prepared: 8/28/2023 1:29 pm

	Title William Hearth	8/28/2023 1: 2	9 pm
	Title XVIII Hospital	Cost	
		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1. 00	Medical and other services (see instructions)	2, 137, 675	•
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3. 00 4. 00	OPPS or REH payments Outlier payment (see instructions)	0	
4. 01	Outlier reconciliation amount (see instructions)		4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	1
6.00	Line 2 times line 5	0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	1
8. 00 9. 00	Transitional corridor payment (see instructions)	0	
10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 Organ acquisitions	0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions)	2, 137, 675	
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) Total reasonable charges (sum of lines 12 and 13)	0	
14.00	Customary charges		14.00
15. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	18. 00 19. 00
17.00	instructions)		17.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
	instructions)		
	Lesser of cost or charges (see instructions)	2, 159, 052	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	25, 651	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	900, 366	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	1, 233, 035	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28. 00
	REH facility payment amount		28. 50
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29. 00
	Subtotal (sum of lines 27, 28, 28.50 and 29)	1, 233, 035	•
	Primary payer payments	831	
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1, 232, 204	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	291, 867	34.00
	Adjusted reimbursable bad debts (see instructions)	189, 714	ı
	Allowable bad debts for dual eligible beneficiaries (see instructions)	1 421 010	1
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R	1, 421, 918	1
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	Ö	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)		39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)	0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	0	39. 97
	Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION	0	39. 98 39. 99
	Subtotal (see instructions)	1, 421, 918	
40. 01	Sequestration adjustment (see instructions)	24, 884	1
40.02	Demonstration payment adjustment amount after sequestration	0	40. 02
	Sequestration adjustment-PARHM pass-throughs		40. 03
	Interim payments	1, 707, 200	
41.01	Interim payments-PARHM Tentative settlement (for contractors use only)	0	41. 01 42. 00
	Tentative settlement-PARHM (for contractor use only)		42.00
43. 00	Balance due provider/program (see instructions)	-310, 166	1
43. 01	Balance due provider/program-PARHM (see instructions)		43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44. 00
	\$115.2		
90. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0	90.00
	Outlier reconciliation adjustment amount (see instructions)	0	
92.00	The rate used to calculate the Time Value of Money	0.00	1
	Time Value of Money (see instructions)	0	
94.00	Total (sum of lines 91 and 93)	0	94.00

Health Financial Systems	HARDIN COUNTY GENERAL	HOSPI TAL	In Lieu	of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pr	rovi der CCN: 14-1328	Peri od:	Worksheet E	
			From 04/01/2022		
			To 03/31/2023		pared:
				8/28/2023 1: 2	9 pm
		Title XVIII	Hospi tal	Cost	
				Overri des	
				1. 00	
WORKSHEET OVERRIDE VALUES					
112.00 Override of Ancillary service charges (lin	ne 12)			0	112.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

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 Systems
 HARDIN

 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 | Peri od: | Worksheet E-1 | From 04/01/2022 | Part | To 03/31/2023 | Date/Time Prepared: Provi der CCN: 14-1328

				10 03/31/2023	8/28/2023 1: 29	
		Ti tl e	e XVIII	Hospi tal	Cost	
		I npati er	nt Part A	Par	rt B	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1. 00	Total interim payments paid to provider	1.00	1, 391, 30		2, 057, 542	1.00
2. 00	Interim payments payable on individual bills, either			0	2,057,542	2.00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			ol	1 0	3. 01
3. 02	ADJUST MENTS TO TROVIDER			0		3. 02
3. 03		03/22/2023	469, 27	<u> ۲</u>	l ő	3. 03
3. 04				o	0	3. 04
3. 05				O	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	10/19/2022	20, 66	4 10/19/2022	277, 159	3.50
3. 51				0	0	3. 51
3. 52				0 03/22/2023	73, 183	3. 52
3. 53				0	0 0	3. 53 3. 54
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		448, 60	<u> </u>	-350, 342	3. 54
3. 77	3. 50-3. 98)		440,00	7	-350, 342	3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 839, 91	4	1, 707, 200	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02			l	Ö	0	5. 02
5.03				0	0	5.03
	Provider to Program		,	_		
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51			1	0	0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1	0	0 0	5. 52 5. 99
5. 99	5. 50-5. 98)			U .		5. 99
6. 00	Determined net settlement amount (balance due) based on	•				6.00
3. 00	the cost report. (1)					5. 50
6. 01	SETTLEMENT TO PROVIDER		1	О	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		414, 21	1	310, 166	6.02
7. 00	Total Medicare program liability (see instructions)		1, 425, 70		1, 397, 034	7. 00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		U	1.00	2.00	8. 00
5. 00	Maile of Contractor	1		Ţ	1	0.00

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 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	JUN. 14-Z320 10	03/31/2023	8/28/2023 1: 29	
		Title	XVIII Sw	ing Beds - SNF		
	<u> </u>	I npati en	t Part A	Par	t B	
				,,,,		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1. 00	Total interim payments paid to provider	1.00	2. 00 1, 751, 146	3. 00	4. 00	1. 00
2. 00	Interim payments payable on individual bills, either		1, 751, 140			2. 00
2.00	submitted or to be submitted to the contractor for		o o			2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	l				
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02			0		0	3.02
3. 03			0		0	3.03
3.04			0		0	3.04
3. 05			0		0	3. 05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM	10/19/2022	12 (10		0	2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM	10/19/2022	12, 610 0			3. 50 3. 51
3. 52		03/22/2023	425, 549			3. 52
3. 53		007 227 2020	0		ő	3. 53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		-438, 159		0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 312, 987		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR	L				
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provi der				_	
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02 5. 03			0		0 0	5. 02 5. 03
5.05	Provider to Program		<u> </u>		0	5.05
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					, 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		525, 357		o	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		o o	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 838, 344		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	()	1. 00	2. 00	8. 00
0.00	Inallie of Contractor	I	ļ		l l	0.00

Heal th	Financial Systems HARDIN COUNTY GENER	RAI HOSPITAI	In lie	u of Form CMS-:	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 14-1328 Period: From 04/01/2022				
			To 03/31/2023	Date/Time Pre 8/28/2023 1:2	
	<u> </u>	Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				-
4 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		. 44		4 00
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I COI. 15 IIIn	e 14		1.00 2.00
2. 00 3. 00	Medicare days (see instructions) Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4. 00	Total inpatient days (see instructions)				4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c		Wkst S-2 Pt I		7.00
,, ,,	line 168	ie. trii ed iii i teeliiie. egy			,,,,,
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instructio	ns)		32.00
				Overri des	
	I			1. 00	
400.00	CONTRACTOR OVERRIDES				
108.00	Override of HIT payment		l		108. 00

Health Financial Systems	HARDIN COUNTY GENER	RAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 14-1328		Worksheet E-2
			From 04/01/2022	
		Component CCN: 14-Z328	To 03/31/2023	Date/Time Prepared:
		·		8/28/2023 1 29 pm

		Component CCN: 14-Z328	To 03/31/2023	Date/Time Pre 8/28/2023 1:2	pared:
		Title XVIII	Swing Beds - SNF		9 рііі
		<u> </u>	Part A	Part B	
	COMPUTATION OF NET COOT OF COVERED OFFINIORS		1.00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		1 500 240	0	1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		1, 589, 349	U	1. 00 2. 00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A. and sum of Wkst. D.	344, 855	0	3.00
0.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi			Ü	0.00
	instructions)	3 1			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4. 00	Per diem cost for interns and residents not in approved teach	ing program (see		0. 00	4. 00
5. 00	instructions) Program days		934	0	5. 00
6. 00	Interns and residents not in approved teaching program (see i	nstructions)	701	0	
7.00	Utilization review - physician compensation - SNF optional me		o		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 934, 204	0	
9.00	Primary payer payments (see instructions)		0	0	
10. 00 11. 00	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts appli	cable to physician	1, 934, 204	0	10.00 11.00
11.00	professional services)	cable to physician		U	11.00
12.00	Subtotal (line 10 minus line 11)		1, 934, 204	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (excl ude coi nsurance	73, 104	0	13.00
44.00	for physician professional services)				
	80% of Part B costs (line 12 x 80%)		1 041 100	0	
	Subtotal (see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		1, 861, 100	0	•
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		O	16.50
16. 55	Rural community hospital demonstration project (§410A Demonst		o		16. 55
	adjustment (see instructions)				
16. 99	Demonstration payment adjustment amount before sequestration		15 244	0	16. 99
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		15, 366 9, 988	0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	7, 760	0	•
	Total (see instructions)	,	1, 871, 088	0	l
19. 01	Sequestration adjustment (see instructions)		32, 744	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03 19. 25	Sequestration adjustment-PARHM pass-throughs Sequestration for non-claims based amounts (see instructions)			0	19. 03 19. 25
	Interim payments		1, 312, 987	0	20.00
	Interim payments-PARHM		1, 0.12, 707	· ·	20. 01
21.00	Tentative settlement (for contractor use only)		O	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21.01
	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	525, 357	0	22.00
22. 01 23. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	0	0	22. 01 23. 00
23.00	chapter 1, §115.2	rice with GMS rub. 13-2,		O	23.00
	Rural Community Hospital Demonstration Project (§410A Demonst				
200.00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				
201 00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst D-1 Pt II line			201. 00
2011.00	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, lin	е		202. 00
202.00	200 (title XVIII swing-bed SNF))				202 00
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				203. 00 204. 00
201.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	201.00
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	,			206. 00
207 00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbur Program reimbursement under the §410A Demonstration (see inst				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	*	1		207.00
	and 3)	, , , , , , , , , , , , , , , , , , , ,			
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
210. 00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
2.0.00	instructions)	(3000 210)			

Health Financial Systems	HARDIN COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 14-1328	From 04/01/2022	Worksheet E-3 Part V Date/Time Prepared: 8/28/2023 1:29 pm
	T: +1 - \0.0111	Hanni Ani	C+

				8/28/2023 1: 2	9 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1. 00	Inpatient services			1, 582, 794	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
3.00	Organ acquisition			0	3. 00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4.00	Subtotal (sum of lines 1 through 3.01)			1, 582, 794	4.00
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 598, 622	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7. 00	Routine service charges			0	7.00
8. 00	Ancillary service charges			0	8.00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
44 00	Customary charges				144.00
11.00	Aggregate amount actually collected from patients liable for			0	
12. 00	Amounts that would have been realized from patients liable for		on a charge basis	0	12.00
13. 00	had such payment been made in accordance with 42 CFR 413.13(e Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13.00
14. 00	` ` '				14.00
15. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	Ly if line 14 exceeds li	no 6) (coo	0	15.00
13.00	instructions)	Ty IT TITLE 14 exceeds IT	ne o) (see	U	15.00
16. 00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds lin	na 14) (saa	0	16.00
10.00	instructions)	Ty IT Time of exceeds ITI	16 14) (366		10.00
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	. 401. 0.1.0)			17.00
18. 00	Direct graduate medical education payments (from Worksheet E-	4. line 49)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	,		1, 598, 622	19.00
20.00	Deductibles (exclude professional component)			194, 220	
21.00	Excess reasonable cost (from line 16)			0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 404, 402	22.00
23.00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			1, 404, 402	24.00
25.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		71, 838	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	, ,		46, 695	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	ŕ		1, 451, 097	28. 00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			1, 451, 097	30.00
30. 01	Sequestration adjustment (see instructions)			25, 394	30. 01
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30.03
31.00	Interim payments			1, 839, 914	31.00
31.01	Interim payments-PARHM				31.01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0	2, 31, and 32)		-414, 211	33.00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m	inus lines 30.03, 31.01,	and 32.01)		33. 01
34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
	§115. 2				

Heal th	Financial Systems HA	ARDIN COUNTY GE	NERAL HOSPITAL	=	In Lie	eu of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 14-1328	Peri od:	Worksheet M-1	
					From 04/01/2022		
			Component	CCN: 14-3479	To 03/31/2023	Date/Time Pre 8/28/2023 1:2	
					RHC I	Cost	.7 PIII
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat		
		oomponoa er on	011101 00010	+ col . 2)	ions	Tri al Balance	
				<u> </u>		(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	421, 516	52, 174			1,0,0,0	
2.00	Physician Assistant	0	0	1	0	1	
3. 00	Nurse Practitioner	239, 941	34, 809	274, 75	0	274, 750	
4. 00	Visiting Nurse	0	0)	0	0	
5. 00	Other Nurse	291, 144	87, 770	378, 91	4 0	378, 914	1
6. 00	Clinical Psychologist	0	0)	0	0	
7. 00	Clinical Social Worker	0	0)	0	0	
8. 00	Laboratory Technician	450 (40	70.070	500.04	0	0	
9.00	Other Facility Health Care Staff Costs	450, 640				530, 010	1
10.00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	1, 403, 241	254, 123	1, 657, 36	4	1, 657, 364	1
11. 00 12. 00	Physician Supervision Under Agreement	0				0	
13. 00	Other Costs Under Agreement	0			0		
14. 00	Subtotal (sum of lines 11 through 13)	0			0		
15. 00	Medical Supplies	0	2, 207	2, 20	7 0	2, 207	
16. 00	Transportation (Health Care Staff)	0	2,207	2,20	0	2,207	1
17. 00	Depreciation-Medical Equipment	0			0	Ö	1
18. 00	Professional Liability Insurance	0	Ö		0	o o	18.00
19. 00		0	54, 843	54, 84	3 0	54, 843	
20. 00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	57, 050	57, 05	0	57, 050	21.00
22.00	Total Cost of Health Care Services (sum of	1, 403, 241	311, 173	1, 714, 41	4 0	1, 714, 414	22.00
	lines 10, 14, and 21)]
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0	1	0	1	
24. 00	Dental	0	0)	0	1	
25. 00	Optometry	0	0)	0	0	20.00
25. 01	Tel eheal th	0	0)	0	0	
25. 02		0	0)	0	0	
26.00	All other nonreimbursable costs	0	0	7	0	0	20.00
27. 00	Nonallowable GME costs		_				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0		'	0	0	28. 00
	EACLLITY OVERHEAD						1

0

1, 403, 241

61, 202

61, 202

372, 375

61, 202

61, 202

1, 775, 616

61, 202 15, 517

76, 719

1, 791, 133

15, 517

15, 517

15, 517

29.00

30.00

31.00

32.00

FACILITY OVERHEAD
29.00 Facility Costs

30.00 Administrative Costs

31.00 Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	HARDIN COUNTY GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 14-1328	Peri od: From 04/01/2022	Worksheet M-1
	Component CCN: 14-3479		Date/Time Prepared:

			Component	CCN: 14-3479	То	03/31/2023	Date/Time Pro 8/28/2023 1::	epared: 29 pm
						RHC I	Cost	<u> </u>
	·	Adjustments	Net Expenses	5				
			for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	473, 69	90				1.00
2.00	Physician Assistant	0		0				2.00
3.00	Nurse Practitioner	0	274, 7	50				3.00
4.00	Visiting Nurse	0		0				4.00
5.00	Other Nurse	0	378, 9°	14				5. 00
6.00	Clinical Psychologist	0		0				6. 00
7.00	Clinical Social Worker	0		0				7. 00
8.00	Laboratory Techni ci an	0		0				8. 00
9.00	Other Facility Health Care Staff Costs	0	530, 0°	10				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	1, 657, 30	54				10.00
11. 00	Physician Services Under Agreement	0		0				11.00
12.00	Physician Supervision Under Agreement	0		0				12.00
13.00	Other Costs Under Agreement	0		0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0		0				14.00
15.00	Medical Supplies	o	2, 20	07				15.00
16.00	Transportation (Health Care Staff)	o		0				16.00
17.00	Depreciation-Medical Equipment	o		0				17.00
18.00	Professional Liability Insurance	o		0				18. 00
19.00	Other Health Care Costs	o	54, 84	43				19.00
20.00	Allowable GME Costs							20.00
21.00	Subtotal (sum of lines 15 through 20)	o	57, 0	50				21.00
22.00	Total Cost of Health Care Services (sum of	o	1, 714, 4°	14				22.00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0		0				23. 00
24.00	Dental	0		0				24.00
25.00	Optometry	0		0				25. 00
25. 01	Tel eheal th	0		0				25. 01
25. 02	Chronic Care Management	0		0				25. 02
26.00	All other nonreimbursable costs	0		0				26. 00
27.00	Nonallowable GME costs							27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	0		0				28. 00
	through 27)							╛
	FACILITY OVERHEAD							
29. 00	Facility Costs	0	61, 20	02				29. 00
30.00	Administrative Costs	0	15, 5°					30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	76, 7	19				31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	0	1, 791, 13	33				32.00
	and 31)							

Heal th	n Financial Systems H	ARDIN COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		Period: From 04/01/2022	Worksheet M-2 Date/Time Pre	
	Component CCN: 14-3479 To 03/31/2023 D 8						
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	1.04					1.00
2. 00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	2. 03				0.057	3.00
4.00	Subtotal (sum of lines 1 through 3)	3. 07			8, 631	9, 057	4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	3. 07	9, 057			9, 057	8. 00
8.00	through 7)	3.07	7,037			9,037	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	Thysrerain services under Agreements					O	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SEI	RVICES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			1, 714, 414	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			1, 714, 414	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13.00
14.00	14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					76, 719	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			698, 856	15.00
16.00	Total overhead (sum of lines 14 and 15)					775, 575	16.00
17. 00						0	
	Enter the amount from line 16					775, 575	
	Overhead applicable to hospital-based RHC/FC					775, 575	
20. 00	Total allowable cost of hospital-based RHC/F	FQHC services (sum of lines 10	0 and 19)		2, 489, 989	20.00

	Financial Systems HARDIN COUNTY GENER			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 14-1328	Peri od: From 04/01/2022	Worksheet M-3	
SERVI C	E2	Component CCN: 14-3479	To 03/31/2023	Date/Time Pre	pared:
				8/28/2023 1: 2	9 pm
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1.00	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		2, 489, 989	1.00
2.00	Cost of injections/infusions and their administration (from W			9, 991	2.00
3.00	Total allowable cost excluding injections/infusions (line 1 m	ninus line 2)		2, 479, 998	
4.00	Total Visits (from Wkst. M-2, column 5, line 8)	1:50 0)		9, 057	4.00
5. 00 6. 00	Physicians visits under agreement (from Wkst. M-2, column 5, Total adjusted visits (line 4 plus line 5)	Title 9)		0 9, 057	
7. 00	Adjusted cost per visit (line 3 divided by line 6)			273. 82	
7.00	That district cost per visit (Time o di vided by Time o)		Cal cul ati on		7.00
			Rate Period 1		
			(04/01/2022	(01/01/2023	
			through 12/31/2022)	through 03/31/2023)	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	204. 57	212. 35	8.00
9. 00	Rate for Program covered visits (see instructions)		204. 57	212. 35	9.00
	CALCULATION OF SETTLEMENT				
10.00	Program covered visits excluding mental health services (from		2, 310	772	
11.00	Program cost excluding costs for mental health services (line	*	472, 557	163, 934	
12. 00 13. 00	Program covered visits for mental health services (from contr Program covered cost from mental health services (line 9 x li		0	0	12.00 13.00
14. 00	Limit adjustment for mental health services (see instructions	•	0	0	
15. 00	Graduate Medical Education Pass Through Cost (see instruction			o .	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	2 and 3) *	0	636, 491	1
16. 01	Total program charges (see instructions)(from contractor's re	ecords)		440, 287	16. 01
16. 02	Total program preventive charges (see instructions) (from prov	•		1, 524	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		2, 203	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		461, 098	16.04
16. 05	Total program cost (see instructions)		0	463, 301	16. 05
17. 00	Pri mary payer amounts			0	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		57, 915	18.00
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		75, 472	19.00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			463, 301	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		8, 031	1
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		471, 332	
23. 00	Allowable bad debts (see instructions)			29, 132	23.00
23. 01	Adjusted reimbursable bad debts (see instructions)			18, 936	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY))		0	
25. 50 25. 99	Pioneer ACO demonstration payment adjustment (see instruction Demonstration payment adjustment amount before sequestration	15)		0	l
26. 00	Net reimbursable amount (see instructions)			490, 268	
26. 01	Sequestration adjustment (see instructions)			8, 580	1
26. 02	Demonstration payment adjustment amount after sequestration			0	26. 02
27. 00	Interim payments			465, 594	
28. 00	Tentative settlement (for contractor use only)	00 07		0	
29.00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda			16, 094	
30.00	chapter I, §115.2	IIICE WI LII CWS PUD. 15-11	,	0	30.00

		NERAL HOSPITAL			u of Form CMS-2	
COMPUI	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provider CO	CN: 14-1328	Peri od: From 04/01/2022	Worksheet M-4	
		'	CCN: 14-3479	To 03/31/2023	Date/Time Pre 8/28/2023 1:2	
			XVIII	RHC I	Cost	
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
		1.00	2.00	2. 01	PRODUCTS 2. 02	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1, 657, 364			1, 657, 364	1.00
2. 00	Ratio of injection/infusion staff time to total health	0. 000084			0. 000000	ł
	care staff time					
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	139	3, 4	49 2, 755	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	366	1:	25 44	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	505	3, 5	74 2, 799	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 714, 414	1, 714, 4	1, 714, 414	1, 714, 414	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	775, 575	775, 5	75 775, 575	775, 575	7. 00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 000295	0. 0020	0. 001633	0. 000000	8. 00
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	229		·	0	
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	734				
11. 00	Total number of injections/infusions (from your records)	15		73 298	-	
12.00	Cost per injection/infusion (line 10/line 11)	48. 93			0.00	
13. 00	Number of injection/infusion administered to Program beneficiaries	13	30	236	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14.00	Program cost of injections/infusions and their	636	4, 1	76 3, 219	0	14.00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
					N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administratio		f columns 1,		9, 991	15. 00
16. 00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		e (sum of		8, 031	16. 00
10.00	5.00 Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)					10.00

Health Financial Systems	HARDIN COUNTY GENEI	RAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 14-1328 Component CCN: 14-3479	Peri od: From 04/01/2022 To 03/31/2023	
			D110 1	0 1

RHC Cost Part B mm/dd/yyyy Amount 1.00 2.00 1.00 1.00			Component CCN: 14-3479	10 03/31/2023	8/28/2023 1: 29	
1.00				RHC I		
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