i i i i i i j	orm CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM	
	NO. 0938-0050
	RES 03-31-2022
	sheet S s I-III
To 12/31/2019 Date/	
PART I - COST REPORT STATUS	/2020 10:03 am
Provider 1. [X] Electronically prepared cost report Date: 8/28/2020	Time: 10:03 am
use only 2. [] Manually prepared cost report	TTINE. TO. 03 and
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost r	enort
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.	oport
Contractor 5. [1] Cost Report Status 6. Date Received: 10. NPR Date:	
use only (1) As Submitted 7. Contractor No. 11. Contractor's Vendor Cod	le: 4
 (2) Settled without Audit 8. [N] Initial Report for this Provider CCN 12. [0] If line 5, column (3) Settled with Audit 9. [N] Final Report for this Provider CCN number of times re- 	I IS 4: Enter
(3) Settled with Audit 9. [N]FINAL Report for this provider CCN number of times re- (4) Reopened	openeu = 0-9.
(4) Reopened (5) Amended	
PART II - CERTIFICATION	
MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL	
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS R	
PROVIDED OR PROCURED THROUGH THE PAYMENT DI RECTLY OR INDI RECTLY OF A KI CKBACK 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 accompan	5 5
electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and	
Expenses prepared by PUTNAM COUNTY HOSPITAL (15-1333) for the cost reporting period beginning 01/01/201	
ending 12/31/2019 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 instructio	
except as noted. I further certify that I am familiar with the laws and regulations regarding the provis	
health care services, and that the services identified in this cost report were provided in compliance wi	
laws and regulations.	

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

statement	to be the legally	binding eq	, ui val ent	of my	ori gi nal	si gnature
	(Si gned)	JASON JOHNS	SON			
		Officer or	Adminis	trator	of Provi	der(s)
		CFO				
	Title					
		(5				

(Dated when report is electronically signed.)

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-418, 590	-563, 775	0	-45, 768	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing Bed - SNF	0	-52, 515	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	PUTNAM PEDIATRICS AND INTERNAL MED	0		32, 442		0	10.00
10.01	FAMILY MEDICINE OF CLOVERDALE II	0		71, 659		0	10.01
10. 02	NORTH PUTNAM FAMILY HEALTHCARE III	0		2, 781		0	10.02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.0	0 Total	0	-471, 105	-456, 893	0	-45, 768	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving 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 TAL AND HOSPITAL HEALTH CARE COMPLEX	PUTNAM COUNTY		der CCN: 1	5-1333	Peri od:		of For Workshe		
						From 01/01/ To 12/31/	2019	Part I Date/Ti		
	1.00	2.00		3.00		4	1.00	8/28/20	020 10:	<u>03 am</u>
	Hospital and Hospital Health Care Co			3.00			1.00			
00	Street: 1542 SOUTH BLOOMINGTON ST	P0 Box:								1.0
00	City: GREENCASTLE	State: IN	Zip Cod	le: 46135-	Count	ty: PUTNAM				2.0
		Component Name	CCN	CBSA	Provi der		Payme	nt Syst	em (P,	
			Number	Number	Туре	Certified	Ĵ Т,	0, or	N)	
							V	XVIII	XIX	1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer	nt Identification:					_			
00	Hospi tal	PUTNAM COUNTY HOSPITAL	151333	26900	1	12/31/2005	N	0	0	3.0
00	Subprovider - IPF									4.0
00	Subprovider - IRF									5.0
00	Subprovider - (Other)									6.0
00	Swing Beds - SNF	PUTNAM COUNTY HOSPITAL	15Z333	26900		12/31/2005	N	0	N	7.
00	Swing Beds - NF									8.
00	Hospital-Based SNF									9.
00	Hospital-Based NF									10.
00	Hospital-Based OLTC									11.
00	Hospital-Based HHA									12.
00	Separately Certified ASC									13.
00	Hospital -Based Hospice		150515	2,000		02 /22 /2015	N			14.
00	Hospital -Based Health Clinic - RHC	PPI M	158515	26900		02/23/2015	N	0	N	15.
01	Hospital-Based Health Clinic - RHC	FMC	158513	26900		02/25/2015	N	0	N	15.
02	Hospital-Based Health Clinic - RHC	NPFH	158514	26900		03/17/2015	N	0	N	15.
02			130314	20700		03/17/2013				15.
00	Hospital-Based Health Clinic - FQHC									16.
00	Hospital -Based (CMHC) I									17.
10	Hospital -Based (CORF) I									17.
00	Renal Dialysis									18.
00	Other									19.
						From:		То	:	
						From: 1.00		 2. ({
00	Cost Reporting Period (mm/dd/yyyy)								00	20.
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					1.00		2.0	00	
					1.00	1.00 01/01/20 9		2. (12/31/	00 /2019	
	Type of Control (see instructions)				1.00	1.00 01/01/2		2.0	00 /2019	
00	Type of Control (see instructions)	currently receiving pa	vments fo			1.00 01/01/20 9		2. (12/31/	00 /2019	21.
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00 00 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is ind disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section 8 hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octod or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportin in column 2, "Y" for yes or "N" for	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. ncompensated care paymen mm 1, "Y" for yes or "N eriod occurring prior to " for no for the portion er October 1. (see inst crequires final uncompe aport settlement? (see in " for no, for the portion are cost reporting period nic reclassification from rds for delineating stat column 1, "Y" for yes or g period prior to Octobe no for the portion of the	th 42 CF this endment ts for th 'for no October n of the ructions) nsated ca nstructio on of the , "Y" for on or af m urban t istical a "N" for er 1. Ent ne cost	is for 1. cost rre ms) ter o rreas no er	N	1.00 01/01/20 9 2.00 N		2. (12/31/ 3. (00/2019	21. 22. 22. 22. 22.
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00 00 01 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section 5 hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aff Does this hospital contain at least	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. compensated care paymen umn 1, "Y" for yes or "N eriod occurring prior to "for no for the portio cer October 1. (see inst requires final uncompen- port settlement? (see in "for no, for the porti- per 1. Enter in column 2 he cost reporting period hic reclassification from rds for delineating stat column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see inst 100 but not more than 4	th 42 CF this endment ts for th 'for no October n of the ructions) no of the , "Y" for on or af m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds (R for 1. cost rre ns) ter o yes ter o ureas no er as	N	1.00 01/01/20 9 2.00 N		2. (12/31/ 3. (00/2019	21. 22. 22. 22. 22.
00 00 01 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aff Does this hospital contain at least counted in accordance with 42 CFR 4	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. compensated care paymen umn 1, "Y" for yes or "N eriod occurring prior to "for no for the portio cer October 1. (see inst requires final uncompen- port settlement? (see in "for no, for the porti- per 1. Enter in column 2 he cost reporting period hic reclassification from rds for delineating stat column 1, "Y" for yes or g period prior to Octobe no for the portion of th er October 1. (see inst 100 but not more than 4	th 42 CF this endment ts for th 'for no October n of the ructions) no of the , "Y" for on or af m urban t istical a "N" for er 1. Ent he cost ructions) 99 beds (R for 1. cost rre ns) ter o yes ter o ureas no er as	N	1.00 01/01/20 9 2.00 N		2. (12/31/ 3. (00/2019	21. 22. 22. 22.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting por Enter in column 2, "Y" for yes or "N reporting period occurring on or af- Is this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aff Does this hospital contain at least counted in accordance with 42 CFR 47 yes or "N" for no.	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. ncompensated care paymen mm 1, "Y" for yes or "N eriod occurring prior to "for no for the portio er October 1. (see inst crequires final uncomper aport settlement? (see i "for no, for the portio ber 1. Enter in column 2 ne cost reporting period nic reclassification from ds for delineating stat column 1, "Y" for yes or ng period prior to Octobe no for the portion of ti cre october 1. (see inst column 1, "Y" for yes or ng period prior to Octobe no for the portion of ti cre October 1. (see inst 100 but not more than 4' 2.105)? Enter in column	th 42 CF this endment ts for th 'for no October n of the ructions) hsated ca nstructio on of the . "Y" for on or af m urban t istical a "N" for er 1. Ent ne cost '99 beds (3, "Y" f	R i s for 1. cost rre ns) ves ter o rreas no er as for	N	1.00 01/01/20 9 2.00 N N		2. (12/31/ 3. (00/2019	21. 22. 22. 22. 22. 22.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is individe §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive intering undivide cost reporting period? Enter in column the portion of the cost reporting period occurring on or affils this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N" cost reporting period prior to Octob or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in col for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or affils by this hospital contain at least counted in accordance with 42 CFR 42 yes or "N" for no. Which method is used to determine Metal Mathematical suscession of the cost reporting for no.	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. ncompensated care paymen mm 1, "Y" for yes or "N eriod occurring prior to " for no for the portion er October 1. (see inst crequires final uncompet port settlement? (see in " for no, for the portion per 1. Enter in column 2 ne cost reporting period hic reclassification from rds for delineating stat column 1, "Y" for yes or ng period prior to Octobe no for the portion of the er October 1. (see inst column 1, "Y" for yes or ng period prior to Octobe no for the portion of the er October 1. (see inst 100 but not more than 4 12.105)? Enter in column edicaid days on lines 24	th 42 CF this endment ts for th 'for no October n of the ructions) nsated ca on of the "Y" for on or af m urban t istical a "N" for er 1. Ent ne cost ructions) 99 beds (3, "Y" f	R i s for 1. cost re ms) ter o reas no er as cor	N	1.00 01/01/20 9 2.00 N		2. (12/31/ 3. (00/2019	20. 21. 22. 22. 22. 22. 22. 22. 22.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is individed §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section 5 hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in column the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost refined Enter in column 1, "Y" for yes or "N cost reporting period prior to Octod or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standard adopted by CMS in FY2015? Enter in col for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or aff Does this hospital contain at least counted in accordance with 42 CFR 4 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. ncompensated care paymen mm 1, "Y" for yes or "N eriod occurring prior to " for no for the portion er October 1. (see inst crequires final uncompe aport settlement? (see i " for no, for the portion er 1. Enter in column 2 ne cost reporting period nic reclassification from rds for delineating stat column 1, "Y" for yes or g period prior to Octob no for the portion of the er October 1. (see inst column 1, "Y" for yes or g period prior to Octob no for the portion of the er October 1. (see inst 100 but not more than 4 12.105)? Enter in column edicaid days on lines 24 of admission, 2 if censu	th 42 CF this endment ts for th 'for no October n of the ructions) nsated ca nstructio on of the , "Y" for on or af "N" for er 1. Ent ne cost ructions) 99 beds (3, "Y" f and/or 2 us days,	is for 1. cost rre ms) ter o rreas no er as for 25 or 3	N	1.00 01/01/20 9 2.00 N N		2. (12/31/ 3. (00/2019	21. 22. 22. 22. 22. 22.
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is individe §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive intering undivide cost reporting period? Enter in column the portion of the cost reporting period occurring on or affils this a newly merged hospital that payments to be determined at cost re- Enter in column 1, "Y" for yes or "N" cost reporting period prior to Octob or "N" for no, for the portion of the October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in col for the portion of the cost reporting in column 2, "Y" for yes or "N" for reporting period occurring on or affils by this hospital contain at least counted in accordance with 42 CFR 42 yes or "N" for no. Which method is used to determine Metal Mathematical suscession of the cost reporting for no.	ustment, in accordance w or yes or "N" for no. Is 5412.106(c)(2)(Pickle am or yes or "N" for no. compensated care paymen umn 1, "Y" for yes or "N eriod occurring prior to "for no for the portio cer October 1. (see inst requires final uncompen- port settlement? (see in "for no, for the porti- per 1. Enter in column 2 he cost reporting period hic reclassification from rds for delineating stat column 1, "Y" for yes or ag period prior to Octobe no for the portion of the er October 1. (see inst 100 but not more than 4 (2.105)? Enter in column edicaid days on lines 24 of admission, 2 if censi-	th 42 CF this endment ts for th for no October n of the ructions) nsated ca nstruction on of the , "Y" for on or af m urban t istical a "N" for er 1. Ent tructions) 99 beds (3, "Y" f and/or 2 us days, in this	is for 1. cost rre ms) ter o rreas no er as for 25 or 3	N	1.00 01/01/20 9 2.00 N N		2. (12/31/ 3. (00/2019	21. 22. 22. 22. 22.

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA F	Provider CC	CN: 15-1333	Period:	1 (2010		eet S-2	2
				From 01/0 To 12/3			020 10:	eparec 03 am
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Mee	ther di cai d days	
-	1.00	2.00	3.00	4.00	5.00		5.00	1
 D0 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. D0 If this provider is an IRF, enter the in-state Medicaid eligible unpaid 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 days in column 4, Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid eligible unpaid days in column 4, Medicaid 	0	0	0	0		0	C	24.0
HMO paid and eligible but unpaid days in column 5.								
				Urban/R				-
00 Enter your standard geographic classification (not wa	ane) status	at the be	ainning of	1. (1	2.	00	26.
cost reporting period. Enter "1" for urban or "2" for D0 Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	rural. age) status r"2" for r cation in	at the en ural. If a column 2.	d of the co pplicable,	st	1			27.
00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	> number of	periods S	CH status i	n Begi nr	0 ni na:	Endi	na:	35.
DO Enter applicable beginning and ending dates of SCH st	tatus Subs	crint line	36 for num	1.0		2.		36.
of periods in excess of one and enter subsequent date	es.				0			37.
 10 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period. 11 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" for 	ne MDH tran	sitional p	ayment in	us	0			37.
instructions) D0 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.				Y/	N	Y/	<u>/N</u>	38.
				1.0		2.		1
Do Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)), (ii), or the mileage	(iii)? En requireme	ter in colu nts in	ume N mn		N		39.
20 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	r "Y" for				٢	1	40.
					V	XVIII	XIX	
Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	nt for disp	roporti ona	te share in	accordance	N	N	N	45.
D0 Is this facility eligible for additional payment excer pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	ption for ι. L, Pt. I	extraordin II and Wks	ary circums t. L-1, Pt.	tances I through	N	N	N	46.
00 Is this a new hospital under 42 CFR §412.300(b) PPS c 10 Is the facility electing full federal capital payment					N N	N N	N N	47. 48.
Teaching Hospitals 20 Is this a hospital involved in training residents in		CR 11642						56.
"N" for no in column 1. If column 1 is "Y", are you i								57.
"N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for DI fline 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	no in colu period duri yes or "N th of this Y", complet	ng which r " for no i cost repor e Workshee	n column 1. ting period	lf column ? Enter "Y				
"N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	no in colu period duri yes or "N th of this Y", complet , if appli pursement f	ng which r " for no i cost repor e Workshee cable. or physici	n column 1. ting period t E-4. lf c	lf column ? Enter "Y olumn 2 is				58.

ealth Financial Systems PUTNAM OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Y HOSPITAL Provider C	F	eriod: rom 01/01/2019 o 12/31/2019	u of Form CMS-2 Worksheet S-2 Part I Date/Time Pre 8/28/2020 10:	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	1
0.00 Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent adjustement? Enter "Y" for yes or "N" for no in col	85? (9 umn 1. CR) NAHI	see If column 1	N			60.00
	Y/N	IME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Different the supresent of unrelated primary area 				0.00	0.00	61.00
1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
 1.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 						61.03
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.04
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
1.10 Of the FTEs in line 61.05, specify each new program special ty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.1(
1.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0. 00	61.20
Juit all out and the annotyred count.					1.00	
ACA Provisions Affecting the Health Resources and Se 2.00 Enter the number of FTE residents that your hospital				ciod for which		62.00
your hospital received HRSA PCRE funding (see instru	ctions)					
2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovid	gram. (s	see instructio		o your hospital	0.00	62.01
3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this o			N	63.00

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPI		ATA Provider C		eri od:	u of Form CMS-2 Worksheet S-2	
			Fr	om 01/01/2019 12/31/2019		pared: 03 am
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	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	
period that begins on or after J 54.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facili ber of unweighted no tations occurring in number of unweighte ur hospital. Enter i	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio		0.00	0. 000000	64.00
	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			Site			
	1.00	2.00	3.00	4.00	5.00	1 = =
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 Unweighted	0. 000000 Ratio (col.	65.00
			FTËs Nonprovi der Si te	FTES in Hospital	1/ (col . 1 + col . 2))	
Section 5504 of the ACA Current	Vear FTF Pesidonte i	n Nonnrovider Sottin	1.00	2.00	<u>3.00</u>	
beginning on or after July 1, 20		n Nonprovider Settin	lysLitective i	or cost report	ring perious	
6.00 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-prima ccurring in all nonp unweighted non-prima al. Enter in column	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
 b7.00 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 3 divided by (column 3 + column 4)). (see instructions) 			0.00	0.00	0. 000000	67.00

Heal th	Financial Systems PUTNAM COUNTY HOSPITAL	In Li	eu of Form	n CMS-25	52-10
HOSPI T		eriod: rom 01/01/201 o 12/31/201		me Prepa	ared:
		1.	0 2.00		<u>o an</u>
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sub				70.00
	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teac program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportin (see instructions)	the most no. (see hing no.			71.00
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75.00
76.00	subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes o no. Column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	r "N" for with 42 ,		0	76.00
			1.0	0	
80 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80. 00
	ls this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Ente	•		81.00
	<u>TEFRA Providers</u> Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectic §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 under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
		V 1.00	XI X 2. 0		
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y		90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in	N	Y		91.00
92.00	full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	Ν	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	Ν	N		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	0. 00 N	0. 0 N	-	95.00 96.00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0.00 Y	0. 0 Y		97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	'	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	,	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
105.00	Rural Providers Does this hospital qualify as a CAH?	Y		1	05.00
	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				06.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an	N		1	07.00
	approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				

Health Financial Systems PUTNAM COUNTY	Y HOSPI TAL		In Lieu	of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C			Worksheet S- Part I Date/Time Pr 8/28/2020 10	epared:
			V 1.00	XI X 2.00	_
108.00 is this a rural hospital qualifying for an exception to the	CRNA fee sche	edul e? See 42	N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
109.00 If this hospital qualifies as a CAH or a cost provider, are	1.00 Y	2.00 Y	3.00 Y	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			'	N	109.00
	al Demonstrati	on project (84	104	1.00 N	110.00
Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no. I	f yes,		
			1.00	2.00	_
111.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this c. "Y" for yes or "N" for no in column 1. If the response to contegration prong of the FCHIP demo in which this CAH is participate and the transformed the services; "B" for an for tele-health services.	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N		111.00
		1.00	2.00	3.00	_
112.00 Did this hospital participate in the Pennsylvania Rural Hea demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cen- participation in the demonstration, if applicable.	period? s "Y", enter he	N			112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o	r "N" for no	N			0115.00
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.	B, or E only) 93" percent (includes				
116.00 Is this facility classified as a referral center? Enter "Y" "N" for no.	for yes or	N			116.00
117.00 Is this facility legally-required to carry malpractice insu	rance? Enter	Y			117.00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence po		2			118.00
if the policy is claim-made. Enter 2 if the policy is occur	rence.	Premi ums	Losses	Insurance	
118.01 List amounts of malpractice premiums and paid losses:		1.00 217,630	2.00	3.00	0118.01
The offerst amounts of marphaetree preminants and para rosses.		217,030			
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sche- and amounts contained therein.			1.00 N	2.00	118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified that the Hold Harmless provision in ACA §3121 and applicable amendment	n column 1, "\ ualifies for t	(" for yes or the Outpatient	Ν	Ν	119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost imple	antable device	es charged to	Y		121.00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.			Ν		122.00
Transplant Center Information 125.00Does this facility operate a transplant center? Enter "Y" for	or ves and "N"	for no lf	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below.	-		14		
126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 3		TICATION date			126.00
127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column	ter the certif	fication date			127.00
128.00 If this is a Medicare certified liver transplant center, en	ter the certif	fication date			128.00
in column 1 and termination date, if applicable, in column 1 129.00 If this is a Medicare certified lung transplant center, entrol column 1 and termination date, if applicable, in column 2.		cation date in			129.00

nith Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE	PUTNAM COUN EX IDENTIFICATION DATA	Provider CC	N: 15-1333			u of Form CMS Worksheet S-	2
					1/01/2019 2/31/2019		
						0/20/2020 10	
0.00 f this is a Madisara cartified a	anaroas transplant contor	r optor the cor	tification		1.00	2.00	130.0
0.00 If this is a Medicare certified p date in column 1 and termination			tincation				130.0
1.00 If this is a Medicare certified i			erti fi cati	on			131.0
date in column 1 and termination 2.00If this is a Medicare certified i			ication da	ite			132.0
in column 1 and termination date,							
3.00Removed and reserved 4.00If this is an organ procurement o	rappization (ODO) optor	the ODO number	in column	1			133.0
and termination date, if applicab	5	the oro number		'			134.1
Al I Provi ders					N		
0.00 Are there any related organizatio chapter 10? Enter "Y" for yes or					Ν		140. (
are claimed, enter in column 2 th	<u>e home office chain numbe</u>	er. (see instruc					
<u> </u>		.00 n Linos 141 thro	ugh 142 th	0 nomo on	3.00	of the home	
office and enter the home office			ugn 143 tr	ie name an	iu auuress	of the nome	
1.00Name:	Contractor's Name:		Contra	actor's Nu	mber:		141.0
2.00 Street: 3.00 Ci ty:	PO Box: State:		Zip Co	de.			142.0
				MC.			143.1
						1.00	
4.00 Are provider based physicians' co	sts included in Worksheet	t A?				Y	144.0
					1.00	2.00	-
5.00 If costs for renal services are c							145.
inpatient services only? Enter "Y no, does the dialysis facility in							
period? Enter "Y" for yes or "N"			reporting				
6.00 Has the cost allocation methodolo	av changed from the previ	iously filed cost	t report?		N		146.
					IN		
Enter "Y" for yes or "N" for no i	n column 1. (See CMS Pub.			lf	IN .		
	n column 1. (See CMS Pub.			lf			
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Pub. dd/yyyy) in column 2.	. 15-2, chapter	40, §4020)	If	IV.	1.00	147
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist	n column 1. (See CMS Pub. dd/yyyy) in column 2. ical basis? Enter "Y" for	. 15-2, chapter - r yes or "N" for	40, §4020) no.	lf		1.00 N N	
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Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 3.00 Was there a change in the order o 2.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has c	. 15-2, chapter r yes or "N" for for yes or "N" fr Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N County	no. or no. or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. 3 Ti i cati on o B. (See 4 fferent Cl Zi p Code	itle V 3.00 f the low 2 CFR §41 N N N N N N N BSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N T.00	148.0 149.0 155.0 156.0 157.0 158.0 159.0 161.0 161.0 161.0 165.0
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 2.00 Was there a change in the statist 3.00 Was there a change in the order o 0.00 Was there a change in the order o 0.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 9.00 SNF 9.00 SNF 9.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has c	. 15-2, chapter r yes or "N" for for yes or "N" fr Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N County	no. or no. or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. 3 Ti i cati on o B. (See 4 fferent Cl Zi p Code	itle V 3.00 f the low 2 CFR §41 N N N N N N N BSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N T.00	148. 149. 149. 155. 156. 157. 158. 159. 161. 161. 161. 161. 165. 165. 165. 165. 165. 165. 165. 165. 165. 166. 167. 166. 167. 168. 169.
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Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 2.00 Was there a change in the statist 3.00 Was there a change in the order o 0.00 Was there a change in the order o 0.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 9.00 SNF 9.00 SNF 9.00 HOME HEALTH AGENCY 1.00 CMHC 1.10 CORF Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has c	. 15-2, chapter r yes or "N" for for yes or "N" fr Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N County	no. or no. or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. 3 Ti i cati on o B. (See 4 fferent Cl Zi p Code	itle V 3.00 f the low 2 CFR §41 N N N N N N N BSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N T.00	148. 149. 149. 155. 156. 157. 158. 159. 161. 161. 161. 161. 165. 165. 165. 165. 165. 165. 165. 165. 165. 166. 167. 166. 167. 168. 169.
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 2000 Was there a change in the statist 300 Was there a change in the order o 2000 Was there a change in the order o 2000 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 500 Hospital 500 Subprovider - IPF 200 Subprovider - IRF 300 SUBPROVI DER 500 SUBPROVI DER 500 SNF 500 OMME HEALTH AGENCY 100 CMHC 100 CMHC 100 CMHC 500 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 500 If line 165 is yes, for each 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)	n column 1. (See CMS Pub. dd/yyyy) in column 2. ical basis? Enter "Y" for f allocation? Enter "Y" f ied cost finding method? ider that qualifies for a "N" for no for each compo ampus hospital that has cont Name 0 1) incentive in the Ameri	. 15-2, chapter r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N N N N N N	no. or no. or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. 3 Ti i cati on o B. (See 4 fferent Cl Zi p Code 3. 00	itle V 3.00 f the low 2 CFR §41 N N N N N N N BSAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148. 1 149. 1 155. 1 156. 1 157. 1 158. 1 159. 1 160. 1 161. 1 161. 1 165. 1 00 166. 1
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 2.00 Was there a change in the statist 3.00 Was there a change in the order o 2.00 Was there a change to the simplif Does this facility contain a prov or charges? Enter "Y" for yes or 5.00 Hospital 5.00 Subprovider - IPF 2.00 Subprovider - IRF 3.00 SUBPROVI DER 5.00 SUBPROVI DER 5.00 CMHC 1.10 CORF Multicampus 5.00 If line 165 is yes, for each 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) Heal th Information Technology (HI 7.00 Is this provider a meaningful use	n column 1. (See CMS Pub. dd/yyyy) in column 2. ical basis? Enter "Y" for f allocation? Enter "Y" f ied cost finding method? ider that qualifies for a "N" for no for each compo ampus hospital that has cont Name 0 1) incentive in the Ameri r under §1886(n)? Enter	. 15-2, chapter r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N N N N N N	no. or no. or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. 3 Ti i cati on o B. (See 4 See 4 fferent Cl Zi p Code 3.00	itle V 3.00 f the low 2 CFR §41 N N N N N N BSAs? CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	148.0 149.0 155.0 156.0 157.0 158.0 160.0 161.0 161.0 165.0 165.0 165.0
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 3.00 Was there a change in the order o 9.00 Was there a change in the order o 9.00 Was there a change to the simplif 0.00 Was there a change to the simplif 5.00 Hospital 5.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVI DER 9.00 SNF 9.00 SNF 9.00 HME HEALTH AGENCY 1.00 CMHC 1.10 CORF 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 5.00 If Line 165 is yes, for each 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)	n column 1. (See CMS Pub. dd/yyyy) in column 2. ical basis? Enter "Y" for f allocation? Enter "Y" f ied cost finding method? ider that qualifies for a "N" for no for each compa ampus hospital that has cont Name 0 1) incentive in the Ameri r under \$1886(n)? Enter 05 is "Y") and is a meani	IS-2, chapter r yes or "N" for for yes or "N" for Enter "Y" for ye Part A 1.00 an exemption fro onent for Part A N N N N N N N N N N N N N	no. or no. or no. es or "N" Part E 2.00 m the appl and Part N N N N N N N N N N N N N	for no. 3 Ti i cati on o B. (See 4 See 4 fferent Cl Zi p Code 3.00	itle V 3.00 f the low 2 CFR §41 N N N N N N BSAs? CBSA 4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. (148. (149. (149. (149. (155. (156. (157. (159. (161. (161. (161. (161. (161. (165. (165. (167. (168. (168. (168. (
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Health Financial Systems	PUTNAM COUNTY	In Lieu	u of Form CMS-	2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA		Period:	Worksheet S-2	2
			From 01/01/2019		norod.
			10 12/31/2019	Date/Time Pre 8/28/2020 10:	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending da	te for the reporting			170.00
			1.00	2.00	
171.00 If line 167 is "Y", does this provider hav	e any days for indi	viduals enrolled in	N	(171.00
section 1876 Medicare cost plans reported	on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instr		enter the number of sectio	n		

IOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet S- Part II	
				To 12/31/2019	Date/Time Pr 8/28/2020 10	
		T.		Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NU r	esponses. En	ter all dates in	the	_
	Provider Organization and Operation					_
. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	olumn 2. (see				_
			Y/N 1.00	Date 2.00	<u> </u>	
. 00	Has the provider terminated participation in the Medicare P	Program? If	1.00 N	2.00	3.00	2.0
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	ın 3, "V" for				
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home c or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members c	offices, drug ler or its	N			3.0
	of directors through ownership, control, or family and othe relationships? (see instructions)	er similar				
			Y/N	Туре	Date	_
	Financial Data and Reports		1.00	2.00	3.00	
. 00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	N			4.0
. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.0
				Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities	lf voc ict	ha providor i	IS N		
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	-	në provider i			6.0
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see instructions. N Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. N					7.0
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	IS.				9. (
0.00	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.			N		10. (
1.00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R In an Ap	proved	N	Y/N	11. (
					1. 00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. (13. (
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.0
5.00	Did total beds available change from the prior cost reporti	Par	rt A	Par		15.0
	-	Y/N	Date	Y/N	Date	_
	PS&R Data	1.00	2.00	3.00	4.00	
6. 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	Ν		N		16.0
7.00	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	Y	03/18/2020	Y	03/18/2020	17.
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Ν		N		18.0
9. 00	but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	Ν		Ν		19. (

	Financial Systems PUTNAM COUNTY		01 45 4000		u of Form CM		
HUSPITA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet Part II Date/Time 8/28/2020	Prepared:	
		Descr	iption	Y/N	Y/N		
			0	1.00	3.00		
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			Ν	Ν	20.00	
		Y/N	Date	Y/N	Date		
01.00	We then the second s	1.00	2.00	3.00	4.00	01.00	
	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00	
					1.00		
ľ	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHI LDRENS	HOSPI TALS)				
	Capital Related Cost				N		
	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense			ring the cost	N N	22.00	
23.00	reporting period? If yes, see instructions.		Sal S made du	The cost	IN IN	25.00	
	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost r	eporting period?	Y	24.00	
	Have there been new capitalized leases entered into during instructions.	the cost repo	orting period	?lfyes, see	Y	25.00	
	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	5	Ν	26.00			
ļ	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? I	fyes, submit	N	27.00	
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions						
31.00	Has debt been recalled before scheduled maturity without is instructions.	suance of new	/debt?lfye	s, see	N	31.00	
32.00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through c	ontractual	N	32.00	
33.00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	N	33.00	
	Provider-Based Physicians Are services furnished at the provider facility under an ar	rangement wit	h provider-h	asod physicians?	Y	34.0	
	If yes, see instructions.	0	·				
	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		ents with the		Y	35.0	
				Y/N 1.00	Date 2.00		
	Home Office Costs			N		24.0	
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	epared by the	home office	? N		36.00	
	If yes, see instructions.						
	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			f		38.00	
	If line 36 is yes, did the provider render services to othe see instructions.		5			39.00	
	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see			40.00	
		1.	00	2.	00		
	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	TINA		SEVERS		41.00	
	held by the cost report preparer in columns 1, 2, and 3, respectively.						
	Enter the employer/company name of the cost report	BLUE & CO., LI	_C			42.00	
42.00	preparer.						

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT (QUESTI ONNAI RE	Provider (Period:	Worksheet S-2		
					From 01/01/2019 To 12/31/2019		pared: <u>03 am</u>	
			3.	. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the ti	itle/position	MANAGER				41.00	
	held by the cost report preparer in column	ns 1, 2, and 3,						
	respectively.							
42.00	Enter the employer/company name of the cos	st report					42.00	
	preparer.							
43.00	Enter the telephone number and email addre	ess of the cost					43.00	
	report preparer in columns 1 and 2, respec	cti vel y.						

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PUTNAM COUNTY AL DATA	Provider C	CN: 15-1333	Period:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2019 To 12/31/2019		norod
					To 12/31/2019	8/28/2020 10:	
						I/P Days /	
						0/P Visits /	
						Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number 1.00	2.00	Available 3.00	4.00	5.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	2.00			0	1.0
. 00	8 exclude Swing Bed, Observation Bed and	30.00	17	0, 75	40,010.00	0	1.0
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)						2.0
. 00	HMO IPF Subprovider						3.0
. 00	HMO IRF Subprovider						4.0
. 00	Hospital Adults & Peds. Swing Bed SNF					0	
. 00	Hospital Adults & Peds. Swing Bed NF		10		15 01 (00	0	
. 00	Total Adults and Peds. (exclude observation		19	6, 93	45, 816. 00	0	7.
. 00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	6	2, 19	9, 312. 00	0	8.
. 00	CORONARY CARE UNIT	51.00	0	2, 15	7, 312.00	0	9.
0.00	BURN I NTENSI VE CARE UNI T						10.
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY	43.00				0	13.
4.00	Total (see instructions)		25	9, 12	55, 128. 00	0	14.
5.00	CAH visits					0	15.
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF	41.00	0		0	0	
8.00	SUBPROVIDER	42.00	0		0	0	
9.00	SKILLED NURSING FACILITY						19.
0.00	NURSING FACILITY OTHER LONG TERM CARE						20.
1.00 2.00	HOME HEALTH AGENCY						21.
2.00 3.00	AMBULATORY SURGICAL CENTER (D. P.)						22.
4.00	HOSPI CE						24.
4.10	HOSPICE (non-distinct part)	30, 00					24.
5.00	CMHC - CMHC	00100					25.
5. 10	CMHC - CORF	99.10				0	25.
5.00	PUTNAM PEDIATRICS AND INTERNAL MED	88.00				0	26.
5. 01	FAMILY MEDICINE OF CLOVERDALE	88. 01				0	26.
5. 02	NORTH PUTNAM FAMILY HEALTHCARE	88. 02				0	
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
7.00	Total (sum of lines 14-26)		25			_	27.
3.00	Observation Bed Days					0	
9.00	Ambulance Trips						29.
0. 00 1. 00	Employee discount days (see instruction) Employee discount days - IRF						30. 31.
2.00	Labor & delivery days (see instructions)		0		0		31.
2.00	Total ancillary labor & delivery room		0				32.
2.01	outpatient days (see instructions)						JZ.
3.00	LTCH non-covered days						33.
	LTCH site neutral days and discharges						33.

	Financial Systems FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PUTNAM COUNTY	Provi der CO	N. 15_1222	Period:	u of Form CMS-2 Worksheet S-3	
103P1	AL AND NUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA		JN. 15-1555	From 01/01/2019 To 12/31/2019	Part I	parec
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
I. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 078	49	1, 90		10.00	1. (
	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)	0	29				2.
3.00	HMO I PF Subprovi der	0	0				3.
1.00	HMO I RF Subprovi der	Ő	0				4.
5.00	Hospital Adults & Peds. Swing Bed SNF	309	0	33	35		5.
5.00	Hospital Adults & Peds. Swing Bed NF		0		9		6.
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 387	49	2, 31	3		7.
8.00	I NTENSI VE CARE UNI T	196	0	38	38		8.
. 00	CORONARY CARE UNIT						9.
0.00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY		0		0		13.
4.00	Total (see instructions)	1, 583	49	2, 70		283.69	
5.00	CAH visits	0	0		0		15.
6.00	SUBPROVIDER - IPF						16.
7.00	SUBPROVIDER - IRF	0	0		0 0.00		
8.00	SUBPROVIDER		0		0 0.00	0.00	
9.00	SKILLED NURSING FACILITY						19.
0.00	NURSING FACILITY						20.
2.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						22.
4.00	HOSPICE						23.
4.00	HOSPICE (non-distinct part)				0		24.
5.00	CMHC - CMHC				0		25.
5. 10	CMHC - CORF	o	0		0 0.00	0.00	
6.00	PUTNAM PEDIATRICS AND INTERNAL MED	1,084	3, 130	9, 27			
6.01	FAMILY MEDICINE OF CLOVERDALE	1,657	2, 896	9, 55			
6. 02	NORTH PUTNAM FAMILY HEALTHCARE	1, 353	1, 989	6, 66			
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0, 00	0 0.00		
7.00	Total (sum of lines 14-26)		Ű		0.00		
B. 00	Observation Bed Days		0	1, 30			28
9.00	Ambul ance Trips	0					29.
0.00	Employee discount days (see instruction)				0		30.
1.00	Employee discount days - IRF				0		31.
2.00	Labor & delivery days (see instructions)	0	0		0		32.
2.01	Total ancillary labor & delivery room		-		0		32.
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.
3 01	LTCH site neutral days and discharges	0					33.

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 8/28/2020 10:	pared:
		Full Time		Di sc	harges		
		Equi val ents	T : 11 - 14	T	THE VEY	T. I. J. ALL	
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12.00	13.00	14.00	Patients 15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00			772	1.00
1.00	8 exclude Swing Bed, Observation Bed and		0	57	13	112	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)				0 4		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		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	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	37	5 13	772	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0.00	0		0 0	0	17.00
18.00	SUBPROVIDER	0.00	0		0	0	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 25.10	CMHC – CMHC CMHC – CORF	0.00					25.00 25.10
25.10	PUTNAM PEDIATRICS AND INTERNAL MED	0.00					25.10
		0.00					26.00
26. 01 26. 02	FAMILY MEDICINE OF CLOVERDALE NORTH PUTNAM FAMILY HEALTHCARE	0.00					26.01
26.02	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.02
20.25	Total (sum of lines 14-26)	0.00					20.20
28.00	Observation Bed Days	0.00					28.00
29.00	Ambul ance Trips						28.00
30.00	Employee discount days (see instruction)						30.00
30.00	Employee discount days (see first detron)						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.00	Total ancillary labor & delivery room						32.00
52.01	outpatient days (see instructions)						32.01
33.00	LTCH non-covered days				0		33.00
	LTCH site neutral days and discharges				0		33.01

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 01/01/2019 To 12/31/2019		
					RHC I	Cost	
					1	00	-
	Clinic Address and Identification				1.	00	
1.00	Street				1542 S. BLOOMI	NGTON STREET	1.00
				ty	State	ZIP Code	
2.00	City, State, ZIP Code, County			00	2.00	3.00 46135	2.00
2.00	City, State, Zip Code, County		GREENCASTLE			140133	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for			0	3.00
					<u>Award</u> .00	Date 2.00	
	Source of Federal Funds			<u> </u>	. 00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00 7.00	Health Services for the Homeless (Section 34 Appalachian Regional Commission	U(d), PHS Act)					6.00 7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00		
10.00	Does this facility operate as other than a h	osni tal -based	RHC or EOHC2 E	nter "V" for	1.00 N	2.00	10.00
10.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column	, iv		
			day		nday	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			08: 00	17:00	08: 00	11.00
		•					
12 00	Have you received an approval for an excepti	on to the prod	uctivity ctopd	and?	1.00 N	2.00	12.00
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	С	
				Provi o	ler name	CCN number	
14.00				1	. 00	2.00	14.00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				inty	_		
2.00	City, State, ZIP Code, County		4. PUTNAM	00			2.00
2.00	orty, State, Zri Gode, Gounty	Tuesday		esday	Thur	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	17: 00	08: 00	17:00	08: 00	17:00	11.00
11.00		17.00	00.00	II.7.00	00.00	117.00	1 11.00

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu c						2552-10
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA		Provider C	CN: 15-1333	Period: From 01/01/2019	Worksheet S-8	
		Component	CCN: 15-8515	To 12/31/2019		pared: 03 am
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 01/01/201 To 12/31/201		
					RHC II	Cost	
					1	1.00	-
	Clinic Address and Identification				· · · ·		
1.00	Street				51 E. MARKET		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		CLOVERDALE	00		N 46120	2.00
				-	1		
2.00	UOSDITAL DASED FOUGA ONLY. Dasi gnati an Ent	on "D" for run	al an "II" fan	ushon		1.00	2.00
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er k for run	al or U for		Award	Date	3.00
					00	2.00	
	Source of Federal Funds			1			
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4.00 5.00
6.00	Heal th Services for the Homeless (Section 329(d), Fils A						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)		·				9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	0	10.00
	yes or "N" for no in column 1. If yes, indic. 2.(Enter in subscripts of line 11 the type of						
	hours.)	i other operat		operating			
			iday		nday	Tuesday	
		from 1.00	to 2.00	from 3.00	to 4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	5.00	4.00		
11.00	CLINIC			08: 00	18: 00	08: 00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the prod	uctivitv stand	ard?	1.00	2.00	12.00
	Is this a consolidated cost report as define	d in CMS Pub.	100-04, chapte	r 9, section	Ν	0	
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report. numbers below.	LIST THE Name	s or all provi	ders and			
				Provi d	er name	CCN number	
14.00	DU0 (5010			1.	00	2.00	11.00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.						
	(see instructions)						
				inty			
2.00	City, State, ZIP Code, County		4. PUTNAM	00			2.00
2.00	orty, State, ZFr Coue, County	Tuesday		esday	Thu	ursday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	18: 00	08: 00	18:00	08: 00	18: 00	11.00
			1991 00	1.0.00		1.0.00	1

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of						2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Period: From 01/01/2019	Worksheet S-8	
		Component	CCN: 15-8513	To 12/31/2019		pared: 03 am
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)			_			
11. 00 CLINIC	08: 00	18: 00				11.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
_			Component		rom 01/01/201 o 12/31/201		
			_		RHC III	Cost	
					1	. 00	-
	Clinic Address and Identification						
1.00	Street		Ci	ty	440 E. PAT RA State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		BAI NBRI DGE			N 46105	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "II" for	urban		1.00	3.00
0.00	Theorem is the brock of a non-one in bearging them the				Award	Date	0.00
				1.	00	2.00	
4 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act		1			4.00
4.00 5.00	Migrant Health Center (Section 330(d), PHS A						4.00 5.00
6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
9.00							9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	0	10.00
	yes or "N" for no in column 1. If yes, indic. 2.(Enter in subscripts of line 11 the type of						
	hours.)	other operat		oporating			
			iday		nday	Tuesday	
		from 1.00	to 2.00	from 3.00	to 4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	5.00	4.00	1 5.00	
11.00	CLINIC			08: 00	17:00	08: 00	11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the prod	uctivity stand	ard?	1.00	2.00	12.00
	Is this a consolidated cost report as define				Ν	0	
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report. numbers below.	LIST THE NAME	s of all provi	ders and			
				Provi d	er name	CCN number	
11.00				1.	00	2.00	11.00
14.00	RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all						15.00
	GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.						
	(see instructions)						
				inty			
2.00	City Chata 71D Cada County			00			2.00
2.00	City, State, ZIP Code, County	Tuesday	PUTNAM Wedn	esday	Thu	irsday	2.00
		to	from	to	from	to	
		6. 00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1) CLINIC	17: 00	08: 00	17:00	08: 00	17:00	11.00
11.00		17.00	00.00	J17.00	00.00	117.00	1 11.00

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu o						2552-10
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA		Provi der C	CN: 15-1333	Period: From 01/01/2019	Worksheet S-8	
		Component	CCN: 15-8514	To 12/31/2019	Date/Time Pre 8/28/2020 10:	pared: 03 am
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems PUTNAM COUNT	FY HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-1333	Period: From 01/01/2019	Worksheet S-1	0
				To 12/31/2019	Date/Time Pre 8/28/2020 10:	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column	3 divided by li	ine 202 colum	n 8)	0. 332267	1.00
	Medicaid (see instructions for each line)	· · · · · · · · · · · · · · · · · · ·				
2.00	Net revenue from Medicaid				3, 261, 265	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid					3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or suppl			ai d?		4.00
5.00 6.00	If line 4 is no, then enter DSH and/or supplemental paymen	its from Medicai	d		0 17, 795, 923	
7.00	Medicaid charges Medicaid cost (line 1 times line 6)				5, 912, 998	
8.00	Difference between net revenue and costs for Medicaid prog	ıram (line 7 miı	nus sum of li	nes 2 and 5 [.] if	2, 651, 733	
0.00	< zero then enter zero)				2,001,700	0.00
	Children's Health Insurance Program (CHIP) (see instructio	ns for each lir	ne)			
9.00	Net revenue from stand-alone CHIP				0	
10.00	Stand-al one CHIP charges				0	
11.00 12.00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone C	ULD (Line 11 mi	inus lino 0:	if a zoro thop	0	
12.00	enter zero)		Thus The P,		0	12.00
	Other state or local government indigent care program (see	instructions 1	for each line)		
13.00	Net revenue from state or local indigent care program (Not	included on li	ines 2, 5 or	9)	0	13.00
14.00	Charges for patients covered under state or local indigent	care program	(Not included	in lines 6 or	0	14.00
15 00	10)	no. 14)			0	15.00
15.00 16.00	State or local indigent care program cost (line 1 times li Difference between net revenue and costs for state or loca		e program (li	ne 15 minus line	-	
10.00	13; if < zero then enter zero)	in that gent ear				10.00
	Grants, donations and total unreimbursed cost for Medicaid	, CHIP and stat	te/local indi	gent care progra	ms (see	1
	instructions for each line)				-	
17.00	Private grants, donations, or endowment income restricted				0	
18.00 19.00	Government grants, appropriations or transfers for support Total unreimbursed cost for Medicaid, CHIP and state and			s (sum of lines	2, 651, 733	
17.00	8, 12 and 16)	rocar rhargent	cure program		2,001,700	17.00
			Uni nsured	Insured	Total (col. 1	
			patients 1.00	patients 2.00	+ col. 2) 3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00	
20.00	Charity care charges and uninsured discounts for the entir	e facility	2, 164, 60	07 0	2, 164, 607	20.00
	(see instructions)	,				
21.00	Cost of patients approved for charity care and uninsured d	liscounts (see	719, 22	27 0	719, 227	21.00
22.00	instructions)	ttop off oo		0 0	o	22.00
22.00	Payments received from patients for amounts previously wri charity care	LLEII OTT AS		0 0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)		719, 22	27 0	719, 227	23.00
			•			
		·			1.00	
24.00	Does the amount on line 20 column 2, include charges for p imposed on patients covered by Medicaid or other indigent		yond a length	of stay limit	N	24.00
25 00	If line 24 is yes, enter the charges for patient days beyo		t care progra	m's length of	o	25.00
20.00	stay limit		t care progra	in 3 Fongth of	0	20.00
26.00	Total bad debt expense for the entire hospital complex (se	e instructions))		3, 582, 783	26.00
27.00	Medicare reimbursable bad debts for the entire hospital co	mplex (see ins [.]	tructions)		572, 665	27.00
27.01	Medicare allowable bad debts for the entire hospital compl	ex (see instru	ctions)		881, 023	
28.00	Non-Medicare bad debt expense (see instructions)	±	1	、 、	2,701,760	
29.00 30.00	Cost of non-Medicare and non-reimbursable Medicare bad deb		Instructions)	1, 206, 064	
	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 pl				1, 925, 291 4, 577, 024	
200					., ., ., .,	

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	PUTNAM COUNTY	HOSPITAL		eriod:	u of Form CMS-2 Worksheet A	2552-10
					rom 01/01/2019 0 12/31/2019	Date/Time Pre 8/28/2020 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT		2 270 219	2, 279, 318	520, 545	2 700 942	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	53, 188	2, 279, 318 5, 146, 768		520, 545	2, 799, 863 5, 199, 956	
5.00	00500 ADMI NI STRATI VE & GENERAL	2, 636, 404	5, 962, 352	8, 598, 756	-116, 344	8, 482, 412	5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	322, 811 28, 534	1, 055, 720 164, 168		41, 785 0	1, 420, 316 192, 702	7.00 8.00
9.00	00900 HOUSEKEEPING	424, 432	96, 617		0	521, 049	•
10.00	01000 DI ETARY	377, 984	585, 524		-673, 154	290, 354	•
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION	0 77, 109	0 46, 702	0 123, 811	673, 154 0	673, 154 123, 811	•
	01600 MEDICAL RECORDS & LIBRARY	257, 071	161, 309		0	418, 380	•
	01700 SOCIAL SERVICE	0	0	0	0	0	
17.01	01701 UTI LI ZATI ON REVI EW I NPATI ENT ROUTI NE SERVI CE COST CENTERS	75, 456	6, 691	82, 147	0	82, 147	17.01
30.00	03000 ADULTS & PEDI ATRI CS	1, 899, 350	182, 631	2, 081, 981	0	2, 081, 981	30.00
31.00 41.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	647, 255 0	267, 522 0	914, 777 0	0	914, 777 0	31.00
	04100 SUBPROVI DER – TRF 04200 SUBPROVI DER	0	0	0	0	0	
	04300 NURSERY	0	0	0	0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	676, 029	1, 643, 563	2, 319, 592	23, 929	2, 343, 521	50.00
	05100 RECOVERY ROOM	106, 543	35, 738		23, 727	142, 281	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	832, 046 975, 699	107, 291 396, 419	939, 337 1, 372, 118	0	939, 337 1, 372, 118	53.00 54.00
54.00 54.01	05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	973, 099	131, 744		0	131, 744	•
	03480 ONCOLOGY	323, 400	3, 190, 212		0	3, 513, 612	•
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	174, 884 0	231, 273 0	406, 157 0	0	406, 157 0	57.00 58.00
58.00 59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	•
60.00	06000 LABORATORY	754, 007	1, 455, 252		0	2, 209, 259	60.00
60.01 64.00	06001 BLOOD LABORATORY 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	60.01 64.00
65.00	06500 RESPIRATORY THERAPY	378, 253	76, 869		0	455, 122	•
66.00	06600 PHYSI CAL THERAPY	0	616, 451	616, 451	0	616, 451	•
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	97, 782 49, 904		0	97, 782 49, 904	•
69.00	06900 ELECTROCARDI OLOGY	71, 908	90, 890		0	162, 798	
69.01	06901 CARDI AC REHAB	260, 295	13, 274		0	273, 569	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	12, 527 0	46, 760 0	59, 287 0	-59, 287 35, 358	0 35 358	71.00 72.00
	07300 DRUGS CHARGED TO PATIENTS	272, 539	793, 094		00,000	1, 065, 633	
73.01	03950 ONCOLOGY	0	0	0	0	0	73.01
88.00	OUTPATIENT SERVICE COST CENTERS 08800 PUTNAM PEDIATRICS AND INTERNAL MED	1, 350, 853	414, 585	1, 765, 438	-98, 162	1, 667, 276	88.00
88.01	08801 FAMILY MEDICINE OF CLOVERDALE	1, 119, 240	365, 784	1, 485, 024	-123, 029	1, 361, 995	88.01
88. 02 89. 00	08802 NORTH PUTNAM FAMILY HEALTHCARE 08900 FEDERALLY QUALIFIED HEALTH CENTER	969, 591 0	356, 455 0	1, 326, 046 0	-77, 765	1, 248, 281 0	88.02 89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
	09001 RHEUMATOLOGY	373, 634	69, 664		0	443, 298	•
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 071, 549	1, 149, 376	4, 220, 925	0	4, 220, 925	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
99.10	09910 CORF	0	0	0	0	0	99.10
109 00	SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF	0	0	0	0		113.00 114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	18, 522, 591	27, 287, 702	45, 810, 293	147, 030	45, 957, 323	
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	3, 248, 382	0 929, 192		-144, 558		•
192.01	19201 JOHNSON/NI CHOLS WI C	298, 663	47, 469		-2, 472	343, 660	192.01
		0	0	0	0		192.02 193.00
	19300 NONPAI D WORKERS 19301 DME	0	0	0	0		193.00
193.02	19302 LACTATION CONSULTING	0	0	0	0	0	193. 02
	19303 DI ABETI C COUNSELI NG 07950 VACANT SPACE	0	0	0	0		193.03 194.00
	07950 VACANT SPACE 07951 BOARD OF HEALTH	0	0	-	0		194.00 194.01
	· · ·	-1		-	-		

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provider C		Period: From 01/01/2019	Worksheet A	
					Date/Time Pre 8/28/2020 10:	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	ions (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
194.0207952 PUTNAM/HENRY PRENATAL	0	0		0 0	0	194.02
200.00 TOTAL (SUM OF LINES 118 through 199)	22, 069, 636	28, 264, 363	50, 333, 99	9 0	50, 333, 999	200.00

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C		Provider CCN: 1	I5-1333 Period: From 01/01/ To 12/31/	
				10 12/31/	8/28/2020 10: 03 a
	Cost Center Description	Adjustments (See A-8)	Net Expenses For		
			Allocation		
		6.00	7.00		
	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	-153, 427	2, 646, 436		1
	00400 EMPLOYEE BENEFITS DEPARTMENT	-133, 427 -5, 429			4
	00500 ADMI NI STRATI VE & GENERAL	-2, 419, 581	6,062,831		5
00	00700 OPERATION OF PLANT	-8, 160	1, 412, 156		7
	00800 LAUNDRY & LINEN SERVICE	0	192, 702		8
	00900 HOUSEKEEPI NG	0	521,049		9
	01000 DI ETARY 01100 CAFETERI A	-67, 980	290, 354 605, 174		10
	01300 NURSI NG ADMI NI STRATI ON	0	123, 811		13
	01600 MEDI CAL RECORDS & LI BRARY	-747	417, 633		16
	01700 SOCIAL SERVICE	0	0		17
-	01701 UTI LI ZATI ON REVI EW I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	82, 147		17
	03000 ADULTS & PEDIATRICS	-810, 132	1, 271, 849		30
	03100 I NTENSI VE CARE UNI T	0	914, 777		31
	04100 SUBPROVI DER – I RF	0	0		41
	04200 SUBPROVI DER	0	0		42
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0		43
	05000 OPERATING ROOM	0	2, 343, 521		50
	05100 RECOVERY ROOM	0	142, 281		51
	05200 DELIVERY ROOM & LABOR ROOM	0	0		52
	05300 ANESTHESI OLOGY	-710, 893			53
	05400 RADI OLOGY-DI AGNOSTI C 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	1, 372, 118 131, 744		54
	03480 ONCOLOGY	-2, 943	3, 510, 669		54
	05700 CT SCAN	0	406, 157		57
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0 2, 209, 259		59 60
	06001 BLOOD LABORATORY	0	2,207,237		60
	06400 I NTRAVENOUS THERAPY	0	0		64
	06500 RESPI RATORY THERAPY	0	455, 122		65
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	616, 451		66
	06800 SPEECH PATHOLOGY	0	97, 782 49, 904		68
	06900 ELECTROCARDI OLOGY	0	162, 798		69
	06901 CARDI AC REHAB	-609	272, 960		69
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71
	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0 -35, 966	35, 358 1, 029, 667		72
	03950 ONCOLOGY	-33, 900			73
	DUTPATIENT SERVICE COST CENTERS				
	08800 PUTNAM PEDIATRICS AND INTERNAL MED	-9, 226			88
	08801 FAMILY MEDICINE OF CLOVERDALE 08802 NORTH PUTNAM FAMILY HEALTHCARE	-835 -8, 714			88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	-0, /14	0		89
	09000 CLI NI C	0	0		90
	09001 RHEUMATOLOGY	-270, 341	172, 957		90
	09100 EMERGENCY	-2, 136, 505	2,084,420		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92
- H	09910 CORF	0	0		99
	SPECIAL PURPOSE COST CENTERS				
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	0		109 110
	11100 I SLET ACQUI SI TI ON	0	0		111
	11300 I NTEREST EXPENSE	0	o o		113
	11400 UTI LI ZATI ON REVI EW-SNF	0	0		114
3.00		-6, 641, 488	39, 315, 835		118
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0			192
2. 01	19201 JOHNSON/NI CHOLS WI C	0	343, 660		192
	19203 RHEUMATOLOGY	0	0		192
	19300 NONPALD WORKERS	0	0		193
	19301 DME 19302 LACTATI ON CONSULTI NG	0			193 193
	19303 DI ABETI C COUNSELI NG	0	o		193
3.03		Ű	-		
4. 00	07950 VACANT SPACE 07951 BOARD OF HEALTH	0	0		194 194

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu	of Form CMS	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CO	CN: 15-1333	Period: From 01/01/2019	Worksheet A	
				To 12/31/2019	Date/Time Pr 8/28/2020 10	epared:
Cost Center Description	Adjustments	Net Expenses			0/20/2020 10	
	(See A-8)	For				
		Allocation				
	6.00	7.00				
200.00 TOTAL (SUM OF LINES 118 through 199)	-6, 641, 488	43, 692, 511				200.00

Heal th	Financial Systems		PUTNAM COUNTY	HOSPI TAL		In Lieu	of Form CMS-255	52-10
RECLAS	SI FI CATI ONS			Provider C	CN: 15-1333	Peri od:	Worksheet A-6	
						From 01/01/2019 To 12/31/2019	Date/Time Prepa	rod
						10 12/31/2019	8/28/2020 10:03	am
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - CLINIC RECLASS							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	399, 396				1.00
	FLXT							
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	3, 106				2.00
3.00	OPERATION OF PLANT	7.00	0	41, 785				3.00
4.00		0.00	0	0				4.00
5.00		0.00	0	0				5.00
	TOTALS	T		444, 287				
	C - CAFE RECLASS							
1.00	CAFETERI A	11.00	264, 078	409, 076				1.00
	TOTALS		264,078	409,076				
	D - INSURANCE RECLASS			· .				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	107, 042				1.00
	FLXT							
	TOTALS	T		107,042				
	E - PPO DEPRECIATION							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	14, 107				1.00
	FLXT							
2.00		0.00	0	0				2.00
3.00		0.00	o	0				3.00
4.00		0.00	o	0				4.00
5.00		0.00	О	0				5.00
	TOTALS	T		14, 107				
	F - IMPLANTABLES		·					
1.00	IMPL. DEV. CHARGED TO	72.00	0	35, 358				1.00
	PATI ENT							
	TOTALS			35, 358				
	G - MED SUPPLY COST RECLASS							
1.00	OPERATING ROOM	50.00	12, 527	46, 760				1.00
	TOTALS		12, 527	46, 760				
	H - RHC PHYSICIAN SALARY RECL	ASS	· · · · ·					
1.00	NORTH PUTNAM FAMILY	88. 02	10, 656	0				1.00
	HEALTHCARE							
	TOTALS	+	10, 656	ō				
500.00	Grand Total: Increases		287, 261	1, 056, 630			50	0. 00
				·				

	Cost Center 6.00 CLINIC RECLASS	Decreases Li ne # 7.00		Provider (CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet A-6
	6.00	Line #				10 12/31/2019	Date/Time Prepared: 8/28/2020 10:03 am
	6.00						
		7 00	Sal ary	0ther	Wkst. A-7 Ref		
	CLINIC RECLASS	7.00	8.00	9.00	10.00		
1.00 PUTN							
INTE	AM PEDIATRICS AND RNAL MED	88.00	0	94, 978		9	1.00
	LY MEDICINE OF ERDALE	88. 01	О	108, 318		o	2.00
3.00 NORT	TH PUTNAM FAMILY	88. 02	0	87, 328		o	3.00
	ICIANS' PRIVATE OFFICES	192.00	0	141, 255		0	4.00
	NI STRATI VE & GENERAL	5.00	0	12, 408		0	5.00
			0	444, 287			5.00
	CAFE RECLASS			111,207			
1.00 DIET		10.00	264, 078	409, 076		0	1.00
ТОТА			264,078	409,076			1.00
	I NSURANCE RECLASS		204,070	407, 070			
	NI STRATI VE & GENERAL	5.00	0	107, 042	1	2	1.00
			0	107,042			1.00
	PPO DEPRECIATION		<u>ч</u>	107, 042			
	AM PEDIATRICS AND	88, 00	0	3, 184		9	1.00
	RNAL MED	00.00	Ŭ	0,101		`	1.00
	LY MEDICINE OF	88. 01	0	4,055		0	2.00
	ERDALE	00101	Ŭ	.,			2.00
	H PUTNAM FAMILY	88. 02	0	1, 093		o	3.00
	THCARE			.,		-	
4.00 PHYS	ICIANS' PRIVATE OFFICES	192.00	0	3, 303		o	4.00
5.00 JOHN	SON/NI CHOLS WI C	192.01	o	2, 472		ol	5.00
TOTA	.LS			14, 107		1	
F -	IMPLANTABLES					-1	
1.00 OPER	ATING ROOM	50.00	0	35, 358		0	1.00
TOTA				35, 358		-	
	MED SUPPLY COST RECLASS		-1				
	CAL SUPPLIES CHARGED TO	71.00	12, 527	46, 760		0	1.00
PATI			,	,		-	
TOTA		+	12, 527	46, 760		-	
	RHC PHYSICIAN SALARY RECL	ASS	,	,			
	LY MEDICINE OF	88. 01	10, 656	0		0	1.00
	ERDALE	00.01	,	0		-	1.00
TOTA		+	10, 656		<u> </u>	1	
	d Total: Decreases		287, 261	1,056,630		-	500.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1333	Perio From To	od: 01/01/2019 12/31/2019		pared:
			Acqui si ti on	าร		0/20/2020 101	oo uiii
	Begi nni ng	Purchases	Donati on		Total	Disposals and	
	Bal ances					Retirements	
	1.00	2.00	3.00		4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL A	SSET BALANCES						
1.00 Land	159, 364	23, 138		0	23, 138	0	1.00
2.00 Land Improvements	341, 824	27, 330		0	27, 330	0	2.00
3.00 Buildings and Fixtures	32, 677, 578	499, 310		0	499, 310	0	3.00
4.00 Building Improvements	0	0		0	0	0	4.00
5.00 Fixed Equipment	0	0		0	0	0	5.00
6.00 Movable Equipment	24, 299, 651	291, 279		0	291, 279	0	6.00
7.00 HIT designated Assets	0	0		0	0	0	7.00
8.00 Subtotal (sum of lines 1-7)	57, 478, 417	841, 057		0	841, 057	0	8.00
9.00 Reconciling Items	0	0		0	0	0	9.00
10.00 Total (line 8 minus line 9)	57, 478, 417	841, 057		0	841, 057	0	10.00
	Endi ng	Fully					
	Bal ance	Depreciated					
		Assets					
	6. 00	7.00					
PART I - ANALYSIS OF CHANGES IN CAPITAL A							
1.00 Land	182, 502	0					1.00
2.00 Land Improvements	369, 154	0					2.00
3.00 Buildings and Fixtures	33, 176, 888	0					3.00
4.00 Building Improvements	0	0					4.00
5.00 Fixed Equipment	0	0					5.00
6.00 Movable Equipment	24, 590, 930	0					6.00
7.00 HIT designated Assets	0	0					7.00
8.00 Subtotal (sum of lines 1-7)	58, 319, 474	0					8.00
9.00 Reconciling Items	0	0					9.00
10.00 Total (line 8 minus line 9)	58, 319, 474	0					10.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1333	Peri od:	Worksheet A-7	
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	pared:
					8/28/2020 10:	03 am
		SU	JMMARY OF CAP	TAL		
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			and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	2, 279, 318	0		0 0	0	1.00
3.00 Total (sum of lines 1-2)	2, 279, 318			0 0	0	3.00
	SUMMARY O	F CAPITAL				
Cost Center Description	Other	Total (1)				
	Capi tal -Rel at	(sum of cols.				
	ed Costs (see	9 through 14)				
	instructions)					
	14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	MN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	2, 279, 318				1.00
3.00 Total (sum of lines 1-2)	0	2, 279, 318				3.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
	COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT	33, 176, 888	0	33, 176, 88	8 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	33, 176, 888	0	33, 176, 88			3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	OF CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0		0 2, 692, 821		1.00
3.00 Total (sum of lines 1-2)	0	0		0 2, 692, 821	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)			
		instructions)		ed Costs (see instructions)	9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT	-153, 427	107, 042		0 0	2, 646, 436	1.00
3.00 Total (sum of lines 1-2)	-153, 427	107, 042		0 0	2, 646, 436	3.00

Health Financial Systems	PUTNAM CO
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	Financial Systems MENTS TO EXPENSES		PUTNAM COUNT		eriod:	u of Form CMS-2 Worksheet A-8	
				FI To	rom 01/01/2019 0 12/31/2019	Date/Time Pre 8/28/2020 10:	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00		4.00	5.00	1.0
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)		L	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.0
. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	*** Cost Center Deleted ***	2.00	0	2.0
. 00	Investment income - other (chapter 2)		C		0.00	0	3.0
. 00	Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4.C
. 00 . 00	Refunds and rebates of expenses (chapter 8) Rental of provider space by		C		0. 00 0. 00	0	5. C
. 00	suppliers (chapter 8) Telephone services (pay		C		0.00	0	7.0
	stations excluded) (chapter 21)						
. 00	Television and radio service (chapter 21)		C		0.00	0	
. 00 0. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	-3, 909, 661		0.00	0 0	9. C 10. C
1. 00	Sale of scrap, waste, etc. (chapter 23)		C		0.00	0	11. (
2.00	Related organization transactions (chapter 10)	A-8-1	C			0	12.0
3.00 4.00	Laundry and linen service Cafeteria-employees and guests	В	C -67, 980	CAFETERI A	0.00 11.00	0	14.0
5.00 6.00	Rental of quarters to employee and others Sale of medical and surgical		C C		0. 00 0. 00	0	15. 0 16. 0
0.00	supplies to other than patients				0.00	0	10.0
7.00	Sale of drugs to other than patients		C		0.00	0	17.0
8.00	Sale of medical records and abstracts		C		0.00	0	
9. 00	Nursing and allied health education (tuition, fees,		C		0.00	0	19. (
0.00	books, etc.) Vending machines		C		0.00	0	
1. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		C		0.00	0	21.(
2.00	Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22.0
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23. (
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24.(
5. 00	limitation (chapter 14) Utilization review -		C	UTILIZATION REVIEW-SNF	114.00		25. (
,	physicians' compensation (chapter 21)						
5.00 7.00	Depreciation - NEW CAP REL COSTS-BLDG & FIXT Depreciation CAP REL			NEW CAP REL COSTS-BLDG & FIXT *** Cost Center Deleted ***	1.00	0	
3. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP Non-physician Anesthetist			*** Cost Center Deleted ***	2. 00 19. 00	U	27. 28.
9.00 9.00	Physicians'assistant		C		0.00	0	
0. 00	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30.
). 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		C	ADULTS & PEDI ATRI CS	30. 00		30.

Heal th Financial	Systems	
AD ILICTATINE TO F		

Health Financial Systems		PUTNAM COUNT	Y HUSPITAL	In Lieu of Form CMS-255			
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-1333		Peri od:	Worksheet A-8	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	nared
					10 12/31/2019	8/28/2020 10:	
				Expense Classification o			
				To/From Which the Amount is	to be Adjusted		
	Cont Conton Decemintion	Basi s/Code	A	Cost Costor	1.1	WILLET 0 7	
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		<u>(2)</u> 1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68.00	5.00	31.00
31.00	pathology costs in excess of	A-0-3	0	SPEECH PATHOLOGY	00.00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
52.00	Depreciation and Interest		0		0.00	0	52.00
33.00	MEDICAL RECORDS FEES	В	-747	MEDICAL RECORDS & LIBRARY	16.00	0	33.00
33.01	OTHER ADJUSTMENTS (SPECI FY)	D	, , ,		0.00	0	33.01
50.01	(3)		0		0.00	0	
33. 02	CARDIAC REHAB OTHER MISC INCOM	В	-142	CARDI AC REHAB	69.01	0	33.02
33.03	ADVERTI SI NG OFFSET	А		RHEUMATOLOGY	90.01	0	33.03
33.04	PHARM - MISC REVENUE	В		DRUGS CHARGED TO PATIENTS	73.00	0	33.04
33.05	VEND REBATE/REF	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.05
33.06	PHARMACY REBATES	В		DRUGS CHARGED TO PATIENTS	73.00	0	
33.07	OTHER MISC INCOME	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33.08	NON-ALLOWABLE INTEREST EXPENSE			NEW CAP REL COSTS-BLDG &	1.00	11	
				FLXT			
33.09	LOBBYING OFFSET	А	-906	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	ADVERTI SI NG OFFSET	А	-33, 605	ADMINISTRATIVE & GENERAL	5.00	0	33.10
33. 11	ADVERTI SI NG OFFSET	А	-467	CARDI AC REHAB	69.01	0	33.11
33.12	ADVERTI SI NG OFFSET	А	-2, 943	ONCOLOGY	54.02	0	33.12
33.13	ADVERTI SI NG OFFSET	А	-9, 226	PUTNAM PEDIATRICS AND	88.00	0	33.13
				INTERNAL MED			
33.14	ADVERTI SI NG OFFSET	А	-8, 714	NORTH PUTNAM FAMILY	88. 02	0	33.14
				HEALTHCARE			
33.15	ADVERTI SI NG OFFSET	A	-835	FAMILY MEDICINE OF	88. 01	0	33.15
				CLOVERDALE			
33.16	COMMUNITY RELATIONS OFFSET	A		ADMINISTRATIVE & GENERAL	5.00	0	
33. 17	COMMUNITY RELATIONS OFFSET	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33.19	TELEPHONE WAGES	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.20	TELEPHONE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN		0	33.20
33. 21	TELEPHONE OTHER	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.21
33. 22	TELEVISION OFFSET	A		OPERATION OF PLANT	7.00	0	33.22
33.24	PHYSI CI AN RECRUI TMENT	A	-519	ADMINISTRATIVE & GENERAL	5.00	0	33.24
33.25	OTHER ADJUSTMENTS (SPECIFY)		0	1	0.00	0	33.25
			_			_	
33.26	OTHER ADJUSTMENTS (SPECIFY)		0	1	0.00	0	33.26
aa a -	(3)	٨	45 000		00.01	~	22.07
	PHYSI CI AN RECRUI TMENT	A		RHEUMATOLOGY	90.01	0	
33.28	PHYSI CI AN RECRUI TMENT	A			91.00	0	
33.29	HAF EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	
33.30	INTEREST INCOME	В	-116, 297	NEW CAP REL COSTS-BLDG & FLXT	1.00	11	33.30
33. 31	OTHED AD HISTMENTS (SDECLEV)		0		0.00	0	33.31
JJ. JI	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.31
33. 32	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.32
JJ. JZ	(3)		0		0.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49)		-6, 641, 488				50.00
55.00			5, 071, 400				00.00
	(Transfer to Worksheet A,						

(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.

Heal th	Financial Syste	ems	PUTNAM COUN	ITY H	IOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT			Provider C		Period: From 01/01/2019 To 12/31/2019		epared:
	Wkst. A Line #		Total		ofessi onal	Provi der		Physi ci an/Prov	
		Identifier	Remuneration	Co	omponent	Component		ider Component Hours	
	1.00	2.00	3.00		4.00	5.00	6.00	7.00	
1.00		EMERGENCY	2, 492, 321		2, 136, 368	355, 953			1.00
2.00		NUCLEAR MEDICINE-DIAGNOSTIC	128, 625		2, 100, 000	128, 62	1	0	2.00
3.00		LABORATORY	32,000		0	32,000		0	3.00
4.00		ANESTHESI OLOGY	832, 046		710, 893	121, 153		0	4.00
5.00		ADULTS & PEDIATRICS	810, 132		810, 132	(1	0	5.00
6.00		RHEUMATOLOGY	252, 268		252, 268	(0	6.00
7.00	0, 00		0	1	0	(0	0	7.00
8.00	0.00		0		0	(0 0	0	8.00
9.00	0.00		0		0	(0 0	0	9.00
10.00	0.00		0		0	(0 0	0	10.00
200.00			4, 547, 392		3, 909, 661	637, 73 ⁻		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 P	Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unad	ljusted RCE	Memberships &	Component	of Mal practi ce	
					Limit	Conti nui ng	Share of col.	Insurance	
						Education	12		
	1.00	2.00	8.00		9.00	12.00	13.00	14.00	
1.00		EMERGENCY	0		0		0 0	0	1.00
2.00		NUCLEAR MEDICINE-DIAGNOSTIC	0		0		0	0	2.00
3.00		LABORATORY	0		0		0	0	3.00
4.00		ANESTHESI OLOGY	0		0	(-	0	4.00
5.00		ADULTS & PEDIATRICS	0		0	(-	0	5.00
6.00		RHEUMATOLOGY	0		0	(0	0	6.00
7.00	0.00		0		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	Wkst. A Line #	Cost Center/Physician	0 Provi der	Adi	usted RCE	RCE	Adjustment	0	200.00
	WKSL A LINE #	I denti fi er	Component	Auj	Limit	Di sal l owance	Aujustillent		
		rdentifier	Share of col.		L1 IIII L	DI Sal I Owalice			
			14						
	1.00	2.00	15.00		16.00	17.00	18.00		
1.00	91.00	EMERGENCY	0		0	(2, 136, 368		1.00
2.00	54.01	NUCLEAR MEDICINE-DIAGNOSTIC	0	1	0	(0 0		2.00
3.00	60.00	LABORATORY	0	1	0	(0 0		3.00
4.00	53.00	ANESTHESI OLOGY	0		0	(710, 893		4.00
5.00		ADULTS & PEDIATRICS	0		0	(810, 132		5.00
6.00	90. 01	RHEUMATOLOGY	0		0	(252, 268		6.00
7.00	0.00		0		0	(0 0		7.00
8.00	0.00		0		0	(0 0		8.00
9.00	0.00		0		0	(0 0		9.00
10.00	0.00		0		0	(10.00
200.00			0		0	(3, 909, 661		200.00

	Financial Systems ABBLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS		Y HOSPITAL Provider C	CN: 15-1333	Peri od: From 01/01/2019 To 12/31/2019 Physi cal Therapy	Date/Time Pre 8/28/2020 10:	-3 pared:
						1.00	
	PART I - GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aide	s) (see instru	ctions)			52	•
2.00	Line 1 multiplied by 15 hours per week					780	
3.00	Number of unduplicated days in which supervi					303	
4.00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		on provider si	te but neit	ther supervisor	244	4.00
5.00	Number of unduplicated offsite visits - supe	,	ranists (soo in	nstructions)		0	5.00
6.00	Number of unduplicated offsite visits - ther					0	
0.00	assistant and on which supervisor and/or the						
	instructions)			-			
7.00	Standard travel expense rate					0.00	
8.00	Optional travel expense rate per mile	Company i again	Themeniate	A = = : = + = = +	- A: de -	0.00	8.00
		Supervi sors 1.00	Therapists 2.00	Assi stants 3.00	s Ai des 4.00	Trai nees 5.00	
9.00	Total hours worked	0.00	3, 666. 00				9.00
10.00	AHSEA (see instructions)	0.00	84.94		. 70 0. 00		•
11.00	Standard travel allowance (columns 1 and 2,	42.47	42.47		. 85		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		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12.01 13.00
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00
15.01		0	0	ι	0		13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1					0	
15.00	Therapists (column 2, line 9 times column 2,					311, 390	
16.00 17.00	Assistants (column 3, line 9 times column 3,		notony thorony	. on Linco 1	14 14 for all	203, 330	
17.00	Subtotal allowance amount (sum of lines 14 a others)	nd is for respi	ratory therapy	y or times i	4-10 101 811	514, 720	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					0	
20.00	Total allowance amount (sum of lines 17-19 f	514, 720	20.00				
	If the sum of columns 1 and 2 for respirator						
	occupational therapy, line 9, is greater tha		no entries on	lines 21 an	nd 22 and enter on	line 23 the	
21.00	amount from line 20. Otherwise complete lin Weighted average rate excluding aides and tr		7 dividod by s	m of columr	s 1 and 2 line d	0.00	21.00
21.00	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)			0.00	21.00
22.00	Weighted allowance excluding aides and train					0	22.00
23.00	Total salary equivalency (see instructions)		,			514, 720	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVE	EL EXPENSE COMP	PUTATION - P	ROVIDER SITE		
	Standard Travel Allowance					10.0/0	
24.00						12, 868	1
25.00 26.00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines '	A and 25 for a	all others)		7, 771 20, 639	•
27.00	Standard travel expense (line 7 times line 3				3 and 4 for all	20,037	•
27100	others)	ion roopriato.	j morapj or s				27.00
28.00	Total standard travel allowance and standard	travel expense	e at the provid	der site (su	um of lines 26 and	20, 639	28.00
	27)						
20.00	Optional Travel Allowance and Optional Trave		ad O Line 10 '		1	0	
29.00 30.00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		iu z, tine iz ,)		0	
31.00	Subtotal (line 29 for respiratory therapy or		0				
32.00	Optional travel expense (line 8 times column				apy or sum of	0	
	columns 1-3, line 13 for all others)			, <u>,</u>	1.2	-	
33.00	Standard travel allowance and standard trave	l expense (line	e 28)			20, 639	33.00
34.00	Optional travel allowance and standard trave					0	•
35.00	Optional travel allowance and optional trave					0	35.00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense	ANCE AND TRAVEL	EXPENSE COMPL	JIAIION - SE	RVICES OUTSIDE PR	UVIDER SITE	-
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	
38.00	Subtotal (sum of lines 36 and 37)					0	
39.00	Standard travel expense (line 7 times the su		nd 6)			0	39.00
	Optional Travel Allowance and Optional Trave						
40.00	Therapists (sum of columns 1 and 2, line 12.		n 2, line 10)			0	
41.00 Assistants (column 3, line 12.01 times column 3, line 10)							
42.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su	m of columns 1	3 line 12 01	`		0	
13 00					llowing three lir		- +3.00
43.00	Total Travel Allowance and Travel Expense -	ULISITE SPLVICE					
43.00	Total Travel Allowance and Travel Expense - 46, as appropriate.	Unsite service			in our ng thi oo th		
43.00 44.00							44.00

	BLE COST DETERMINATION FOR THERAPY SERVICES SUPPLIERS	FURNI SHED BY	Provi der C	CN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 10:	pared:
					Physical Therapy	y Cost	
						1.00	
16.00 C	Optional travel allowance and optional travel	expense (sum	of lines 42 a	nd 43 - see i	nstructions)		46.00
	_	Therapi sts	Assi stants	Ai des	Trai nees	Total	
D		1.00	2.00	3.00	4.00	5.00	
	ART V - OVERTIME COMPUTATION Dvertime hours worked during reporting	0.00	0.00	0.	0. 00	0.00	47.00
Ч е с	complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.1		0.00	47.00
	Overtime rate (see instructions)	0.00	0.00				48.00
	Total overtime (including base and overtime	0.00	0.00	0.	0. 00		49.00
	allowance) (multiply line 47 times line 48)						-
	ALCULATION OF LIMIT	0.00	0.00		00 0.00	0.00	
(t	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, ine 47)	0.00	0.00	0.0	00 0.00	0.00	50.00
51.00 A	Allocation of provider's standard work year for one full-time employee times the	0.00	0.00	0.	0. 00	0.00	51.00
	Dercentages on line 50) (see instructions)						-
	Adjusted hourly salary equivalency amount	84.94	63.70	0.1	0. 00		52.00
	(see instructions)	01171	00170		0.00		02.00
	Overtime cost limitation (line 51 times line	0	0		0 0		53.00
5	52)						
	Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
55.00 F	ine 49 or line 53) Portion of overtime already included in nourly computation at the AHSEA (multiply	О	0		0 C		55.00
56.00 0	ine 47 times line 52) Overtime allowance (line 54 minus line 55 -	0	0		o c	0	56.00
t	f 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 A	ND EXCESS COST	ADJUSTMENT			F14 700	
1	Salary equivalency amount (from line 23)	(from Linco 22	24 05 25))			514, 720	
	Fravel allowance and expense - provider site Fravel allowance and expense - Offsite servic					20, 039	
	Overtime allowance (from column 5, line 56)			0)		0	
	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
3.00 1	Fotal allowance (sum of lines 57-62)					535, 359	63.00
	Fotal cost of outside supplier services (from	n your records)				525, 288	
5.00 E	Excess over limitation (line 64 minus line 63	3 - if negative	, enter zero)			0	65.00
	INE 33 CALCULATION						
	ine 26 = line 24 for respiratory therapy or					20, 639	
	ine 27 = line 7 times line 3 for respiratory	/ therapy or su	m of lines 3 a	and 4 for all	others		100. 01
100.02 Line <u>33</u> = line <u>28</u> = sum of lines <u>26</u> and <u>27</u> LINE <u>34</u> CALCULATION							100. 02
101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others							101.00
101. 02 L	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31	sum of lines 2	9 and 30 for a	all others			101. 01 101. 02
	<u>INE 35 CALCULATION</u> ine 31 = line 29 for respiratory therapy or	sum of lines 2	9 and 30 for a	all others		0	102.00
	ine 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102.01
	13 for all others						

	E SUPPLIERS	FURNI SHED BY	/ HOSPITAL Provider CC	CN: 15-1333	Period: From 01/01/2019 To 12/31/2019	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 8/28/2020 10:	-3 pared:
					Occupational Therapy	Cost	
					-	1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	s) (see instruc	tions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week		,			780	2.00
3.00	Number of unduplicated days in which supervi					253 0	3.00
4.00	Number of unduplicated days in which therapy nor therapist was on provider site (see inst		on provider Si	të but nërtr	ler supervisor	0	4.00
5.00	Number of unduplicated offsite visits - supe	rvisors or ther				0	5.00
6.00	Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the					0	6.00
	i nstructi ons)		present during		(300		
7.00	Standard travel expense rate					0.00	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 10.00	Total hours worked AHSEA (see instructions)	0.00 0.00	1, 652. 00 80. 52	0. (0. (0.00 0.00	9. 00 10. 00
11.00	Standard travel allowance (columns 1 and 2,	40.26	40.26	0.0		0.00	11.00
	one-half of column 2, line 10; column 3,						
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	о	o		0		12.00
12.00	Number of travel hours (offsite)	0	0		0		12.00
13.00	Number of miles driven (provider site)	0	0		0		13.00
13.01	Number of miles driven (offsite)	0	0		0		13.01
	L					1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2,					133, 019	
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 respi	ratory therapy	or lines 14	-16 for all	133, 019	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		4h	17 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					133,019 hol.ogy.or	20.00
	occupational therapy, line 9, is greater that	n line 2, make					
21.00	amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr		divided by su	um of columns	1 and 2 line 9	0.00	21.00
21.00	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)			0.00	21.00
22.00	Weighted allowance excluding aides and train	ees (line 2 tim	Des line 21)				
112 00	8					0	
23.00	Total salary equivalency (see instructions)	•	,	UTATION - PR	OVIDER SITE	0 133, 019	
23.00	8	•	,	PUTATION - PR	OVIDER SITE		
24.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11)	•	,	PUTATION - PR	OVIDER SITE	133, 019	23.00 24.00
	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)	NANCE AND TRAVE	L EXPENSE COMP		OVI DER SI TE	133, 019	23.00 24.00 25.00
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	NANCE AND TRAVE	L EXPENSE COMP	II others)		133, 019 10, 186 	23.00 24.00 25.00 26.00
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)	NANCE AND TRAVE sum of lines 2 for respirator	L EXPENSE COMP 4 and 25 for a y therapy or s	ull others) sum of lines	3 and 4 for all	133, 019 10, 186 0 10, 186 0	23.00 24.00 25.00 26.00 27.00
24.00 25.00 26.00 27.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOO 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 2 for respirator travel expense	L EXPENSE COMP 4 and 25 for a y therapy or s	ull others) sum of lines	3 and 4 for all	133, 019 10, 186 0 10, 186 0	23.00 24.00 25.00 26.00 27.00
24. 00 25. 00 26. 00 27. 00 28. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOO 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 2 for respirator travel expense	L EXPENSE COMP 4 and 25 for a by therapy or s at the provid	ull others) sum of lines der site (sum	3 and 4 for all	133, 019 10, 186 0 10, 186 0 10, 186	23.00 24.00 25.00 26.00 27.00 28.00
24.00 25.00 26.00 27.00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOO 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)	WANCE AND TRAVE sum of lines 2 for respirator travel expense Expense of columns 1 ar	L EXPENSE COMP 4 and 25 for a by therapy or s at the provid	ull others) sum of lines der site (sum	3 and 4 for all	133, 019 10, 186 0 10, 186 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00
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	NANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2	L EXPENSE COMP 4 and 25 for a y therapy or s at the provic d 2, line 12) 9 and 30 for a	ull others) sum of lines der site (sum ull others)	3 and 4 for all of lines 26 and	133, 019 10, 186 0 10, 186 0 10, 186 0 10, 186 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 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	NANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2	L EXPENSE COMP 4 and 25 for a y therapy or s at the provic d 2, line 12) 9 and 30 for a	ull others) sum of lines der site (sum ull others)	3 and 4 for all of lines 26 and	133, 019 10, 186 0 10, 186 0 10, 186 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00
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	NANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar, line 12) sum of lines 2 s 1 and 2, line	L EXPENSE COMP 4 and 25 for a by therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir	ull others) sum of lines der site (sum ull others)	3 and 4 for all of lines 26 and	133, 019 10, 186 0 10, 186 0 10, 186 0 10, 186 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
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 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 oumns 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	WANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum	L EXPENSE COMP 4 and 25 for a 5 therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar	ull others) sum of lines der site (sum ull others) ratory therap nd 31)	3 and 4 for all of lines 26 and	133, 019 10, 186 0 10, 186 0 10, 186 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 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 optional trave	WANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	L EXPENSE COMP 4 and 25 for a 5 therapy or s 6 at the provid 10 2, line 12) 19 and 30 for a 6 13 for respir 6 28) of lines 27 ar of lines 31 ar	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	133, 019 10, 186 0 10, 186 0 10, 186 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 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 optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense	WANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	L EXPENSE COMP 4 and 25 for a 5 therapy or s 6 at the provid 10 2, line 12) 19 and 30 for a 6 13 for respir 6 28) of lines 27 ar of lines 31 ar	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	133, 019 10, 186 0 10, 186 0 10, 186 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00 25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 31. 00 33. 00 34. 00 35. 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	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 Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	WANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	L EXPENSE COMP 4 and 25 for a 5 therapy or s 6 at the provid 10 2, line 12) 19 and 30 for a 6 13 for respir 6 28) of lines 27 ar of lines 31 ar	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	133, 019 10, 186 0 10, 186 0 10, 186 0 0 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 33.00 34.00 35.00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00	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 optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense	WANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	L EXPENSE COMP 4 and 25 for a 5 therapy or s 6 at the provid 10 2, line 12) 19 and 30 for a 6 13 for respir 6 28) of lines 27 ar of lines 31 ar	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	133, 019 10, 186 0 10, 186 0 10, 186 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00
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 3 Standard 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 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	WANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum ANCE AND TRAVEL	L EXPENSE COMP 4 and 25 for a 5 therapy or s 6 at the provid 10 2, line 12) 9 and 30 for a 13 for respir 2 28) of lines 27 ar of lines 31 ar EXPENSE COMPU	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	133, 019 10, 186 0 10, 186 0 10, 186 0 0 0 0 0 0 0 0 0 0 0 0 0	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
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 39. 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 Subtotal (line 13 for all others) Standard 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	WANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum expense (sum ANCE AND TRAVEL	L 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 EXPENSE COMPU	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	133, 019 10, 186 0 10, 186 0 10, 186 0 0 10, 186 0 0 0 0 0 0 0 0 0 0 0 0 0	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 39.00
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 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 3 Standard travel allowance and standard trave Optional travel allowance and standard trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense Therapists (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12.	WANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 an , line 12) sum of lines 2 s 1 and 2, line l expense (sum expense (sum expense (sum ANCE AND TRAVEL	L 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 EXPENSE COMPU	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	133, 019 10, 186 0 10, 186 0 10, 186 0 0 0 0 0 0 0 0 0 0 0 0 0	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
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 38. 00 39. 00 40. 00 41. 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 Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard trave Optional travel allowance and standard trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard 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 TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (sum expense (sum expense (sum aNCE AND TRAVEL	L EXPENSE COMP 4 and 25 for a 5 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 EXPENSE COMPU ad 6)	II others) Sum of lines Her site (sum All others) ratory therap Id 31) ITATION - SER	3 and 4 for all of lines 26 and y or sum of	133, 019 10, 186 0 10, 186 0 10, 186 0 0 0 0 0 0 0 0 0 0 0 0 0	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 39.00 40.00 41.00 42.00
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 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 Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard trave Optional travel allowance and standard trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 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 (column 3, line 12.01 times column Subtotal (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su	WANCE AND TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (sum expense (sum expense (sum ANCE AND TRAVEL m of lines 5 ar Expense 01 times column n 3, line 10) m of columns 1-	L EXPENSE COMP 4 and 25 for a 5 y therapy or s 6 at the provid d 2, line 12) 9 and 30 for a 13 for respir 2 28) of lines 27 ar of lines 31 ar EXPENSE COMPU d 6) 1 2, line 10) 3, line 13.01)	II others) sum of lines ler site (sum all others) atory therap ad 31) ad 32) ITATION - SER	3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PR	133, 019 10, 186 0 10, 186 0 10, 186 0 0 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 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00
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 38. 00 39. 00 40. 00 41. 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 Subtotal (line 29 for respiratory therapy or Optional travel allowance and standard trave Optional travel allowance and standard trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW. Standard Travel Expense Therapists (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard 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 TRAVE sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (sum expense (sum expense (sum ANCE AND TRAVEL m of lines 5 ar Expense 01 times column n 3, line 10) m of columns 1-	L EXPENSE COMP 4 and 25 for a 5 y therapy or s 6 at the provid d 2, line 12) 9 and 30 for a 13 for respir 2 28) of lines 27 ar of lines 31 ar EXPENSE COMPU d 6) 1 2, line 10) 3, line 13.01)	II others) sum of lines ler site (sum all others) atory therap ad 31) ad 32) ITATION - SER	3 and 4 for all of lines 26 and y or sum of VICES OUTSIDE PR	133, 019 10, 186 0 10, 186 0 10, 186 0 0 0 0 0 0 0 0 0 0 0 0 0	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 39.00 40.00 41.00 42.00

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) 80 O Overtime rate (see instructions) 90. O Total overtime (including base and overtime allowance), multiply line 47 times line 48) allowance), multiply line 47 times line 48 100. O Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47) 11.00 Allocation of provider's standard work year for one full -time employee times the percentages on line 50) (see instructions) DetERMINATION OF CHETIME ALLOWANCE 22.00 Adjusted hourly salary equivalency amount (see instructions) 33.00 Overtime allowance (line 51 times line 53.00 Overtime allowance (line 53) 11.00 Adjusted hourly computation at the AHSEA (multiply line 47 times line 53) 55.00 Portion of overtime allowance (line 54 minus line 55 - 0 0 0 0 0 0 built end or cline 53) 56.00 Overtime allowance (line 54 minus line 55 - 0 0 0 0 0 built end or cline 53) 57.00 Salary equivalency amount (from line 24) 58.00 Travel allowance and expense - provider is the (from lines 33, 34, or 35)) 50.01 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 50.01 Travel allowance and expense - offsite services (from lines 34, 45, or 46) 50.00 Overtime allowance and expense - offsite services (from lines 34, 45, or 46) 50.00 Overtime allowance (from column 5, 1) 50.01 Travel allowance (from column 5, 1) 50.01 Column allowance from column 5, 1) 50.01 Column	-VI me Pre	Worksheet A-4 Parts I-VI Date/Time Pro 8/28/2020 10 Cost	/01/2019 /31/2019 ati onal	To 12 Occupa	5-1333	CN: 1	Provider C	D BY	FURNI SHED	THERAPY SERVICES	COST DETERMINATION FOR PLIERS			
5:00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions) 6:00 Optional travel allowance and optional travel expense (sum of lines 34 and 43 - see instructions) 16:00 Optional travel allowance and optional travel expense (sum of lines 34 and 43 - see instructions) 17:00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions) 10:0 2:00 3:00 4:00 5:00 10:0 2:00 3:00 4:00 5:00 10:0 2:00 0:00 0:00 0:00 0:00 0:00 10:0 2:00 0:00 0:00 0:00 0:00 0:00 0:00 10:0 2:00 0:00 0:00 0:00 0:00 0:00 0:00 0:00 10:00 0:00 0:00 0:00 0:00 0:00 0:00 0:00 0:00 10:00 0:00 0:00 0:00 0:00 0:00 0:00 0:00 10:00 0:00 0:00 0:00 0:00 0:00 0:00 <th></th> <th></th> <th>rapy</th> <th>The</th> <th></th> <th>-</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>			rapy	The		-								
6.00 Optional travel allowance and optional travel expense (sum of lines 42 and 43 - see instructions)	-					_								
Therapists Assistants Aides Trainees Total PART V - OVERTIME COMPUTATION 1.00 2.00 3.00 4.00 5.00 0 Overtime hours worked during reporting or equal to or greater than 2.080. 0 not complete lines 48-55 and enter zero in each complete lines 48-55 and enter zero in each column of line 50. 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.01 0.02 0.00 0.00 0.00 0.00 0.00 0.01 0.02 0.00 0.00 0.00 0.00 0.00 0.02 0.02 0.00 0.00 0.00 0.00 0.	0 0													
PART V - OVERTIME COMPUTATION 1.00 2.00 3.00 4.00 5.00 7.00 Overtime hours worked during reporting period (if colum no f line 47, is zero or equal to or greater than 2.080, do not complete lines 48-56 and enter zero in each olumn of line 50 0.00 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>0.00</td></td<>													0.00	
7.00 Overtime hours worked during reporting period (f colums, 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	0	5.00												
8.00 Overtime rate (see instructions) 0.00 0.00 0.00 0.00 0.00 9.00 Total overtime (including base and overtime 0.00 0.00 0.00 0.00 0.00 Dercentage of overtime hours by category (divide the hours in each column on line 47) 0.00	0.00	0.00	0.00	00	0. (0.00	0.00		reporting , is zero or 80, do not	ime hours worked durin d (if column 5, line 4 to or greater than 2,0 ete lines 48-55 and en	0 0ve per equ cor	7.00	
al lowance) (multiply line 47 times line 48)			0.00	00	0. (0.00	0.00		ons)			3. 00	
CALCULATION OF LIMIT 0.00 OPERCENTIBLE OUTLINE WORKED - COLUME 5. 101 OLIDITIES OF COLUME ON THE WORKED - COLUME 5. 102 OLIDITIES OF COLUME ON THE WORKED - COLUME 5. 103 OLIDITIES OF COLUME ON THE WORKED - COLUME 5. 104 OLIDITIES OF COLUME 7. STANDARD WORK Year 0.00 0.00 0.00 0.00 105 OPERCENTINE COLUME 7. STANDARD WORKED - COLUME 7. 0.00 0.00 0.00 0.00 0.00 105 OPERCENTINE COLUME 7. STANDARD WORKED - COLUME 7. 0.00 0.00 0.00 0.00 0.00 0.00 105 OPERCENTINE COLUME 7. STANDARD WORKED - COLUME 7. 0.00			0.00	00	0.0		0.00	0.00					9.00	
0.00 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<										times line 48)				
1.00 All ocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) 0.00 0.00 0.00 0.00 0.00 2.00 Adjusted hourly salary equivalency amount (see instructions) 80.52 0.00 0.00 0.00 0.00 2.00 Adjusted hourly salary equivalency amount (see instructions) 80.52 0.00 0.00 0.00 0.00 3.00 Overtime cost limitation (line 51 times line 53) 0	0.00	0.00	0.00	00	0. (0.00	0.00		lumn on line 47	ntage of overtime hours de the hours in each co e total overtime worke) Per (di by	0. 00	
DETERMINATION OF OVERTIVE ALLOWANCE 2:00 Adjusted hourly salary equivalency amount (see instructions) 80.52 0.00 0.00 0.00 3:00 Overtime cost limitation (line 51 times line 52) 0 0 0 0 0 0 1:00 Maximum overtime cost (enter the lesser of 52) 0	0.00	0.00	0.00	00	0.0		0.00	0.00		imes the	ation of provider's sta ne full-time employee) Al I for	I. 00	
(see instructions)														
52) 00 00 0 <td></td> <td></td> <td></td> <td></td> <td>0. (</td> <td></td> <td></td> <td></td> <td></td> <td>5</td> <td>instructions)</td> <td>(se</td> <td></td>					0. (5	instructions)	(se		
i line 49 or line 53) OPortion of overtime al ready included in hourly computation at the AHSEA (multiply line 47 times line 52) O Overtime allowance (line 54 minus line 55 - 0 0 0 0 0 0 0 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.) Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 1.00 Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 1.00 Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 1.00 Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 1.00 Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 1.00 Data cost (see instructions) 1.00 Supplies (see instructions) 1.00 Supplies (see instructions) 1.00 Line 33 CALCULATION 1.00 Line 24 or respiratory therapy or sum of lines 3 and 4 for all others 1.00 LINE 33 CALCULATION 1.00 LINE 34 CALCULATION 1.00 LINE 34 CALCULATION 1.01 LINE 34 CALCULATION 1.02 LINE 35 CALCULATION 1.02 LINE 35 CALCULATION 1.03 1.04 LINE 35 CALCULATION 1.05			0	0			0	0				52)	8. 00	
hourly computation at the ÅHSEA (multiply line 47 times line 52) 0 0 0 0.00 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 for all others.) 0 0 0 1.00 Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 1.00 Salary equivalency amount (from line 23) 00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 100 Overtime allowance (from column 5, line 56) 00 00 Supplies (see instructions) 00 Supplies (see instructions) 00 00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION 00 LINE 33 CALCULATION 00 LINE 34 CALCULATION 00 LINE 34 CALCULATION 00 LINE 34 CALCULATION 00 LINE 34 CALCULATION <td colspan<="" td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>0</td><td>0</td><td></td><td></td><td>49 or line 53)</td><td>lir</td><td>. 00</td></td>	<td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td>49 or line 53)</td> <td>lir</td> <td>. 00</td>							0	0			49 or line 53)	lir	. 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 0.00 Salary equivalency amount (from line 23) 133, 133, 143, 100 Overtime allowance and expense - provider site (from lines 33, 34, or 35)) 100 Travel allowance and expense - offsite services (from lines 44, 45, or 46) 0.00 Vertime allowance (from column 5, line 56) 00 Equipment cost (see instructions) 00 Total allowance (sum of lines 57-62) 143, 101 Tavel allowance (sum of lines 57-62) 111 Total cost of outside supplier services (from your records) 110 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 111 Line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 101 Line 33 = line 28 = sum of lines 26 and 27 102 Line 33 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 102 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 11.00 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 11.00 Line 34 = sum of lines 31 Line 30 11.00 Line 35 CALCULATION 11.00 Line 35 CALCULATION 11.01 Line 34 = sum of lines 3 and 1 11.02 Line 34 = sum of lines 30 mod 1 11.03 Charles 1 11.04 Line 35 CALCULATION 11.05 CALCULATION 11.05 CALCULATION			0	0			0	0			y computation at the A	hou	5. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 7.00 Salary equivalency amount (from line 23) 8.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 9.00 Travel allowance and expense - offsite services (from lines 44, 45, or 46) 0.00 Overtime allowance (from column 5, line 56) 0.00 Equipment cost (see instructions) 0.00 Supplies (see instructions) 0.00 Total allowance (sum of lines 57-62) 0.01 Total cost of outside supplier services (from your records) 0.02 Excess over limitation (line 64 minus line 63 - if negative, enter zero) 1.10 LiNE 33 CALCULATION 0.02 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 0.03 10.04 0.04 Line 33 = line 28 = sum of lines 26 and 27 10.05 LiNE 34 CALCULATION 11.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 10.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 11.00 Line 34 = sum of lines 27 and 31 11.02 Line 34 = sum of lines 27 and 31 LiNE 35 CALCULATION Line 35 CALCULATION	0	C	O	0			0	0		ter in column 5 4 for	gative enter zero) (En um of columns 1, 3, and ratory therapy and colu	if the res	b. 00	
Part VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT 7.00 Salary equivalency amount (from line 23) 8.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 9.00 Travel allowance and expense - offsite services (from lines 44, 45, or 46) 0.00 Overtime allowance (from column 5, line 56) 1.00 Equipment cost (see instructions) 2.00 Supplies (see instructions) 3.00 Total cost of outside supplier services (from your records) 5.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION 10, 00.01 Line 24 for respiratory therapy or sum of lines 24 and 25 for all others 00.02 Line 23 = line 24 for respiratory therapy or sum of lines 3 and 4 for all others 01.00 Line 34 = sum of lines 3 for respiratory therapy or sum of lines 29 and 30 for all others 01.01 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 10,		1.00	_					I		I		1. 2.		
7.00Salary equivalency amount (from line 23)133,8.00Travel allowance and expense - provider site (from lines 33, 34, or 35))10,9.00Travel allowance and expense - Offsite services (from lines 44, 45, or 46)10,9.00Overtime allowance (from column 5, line 56)10,9.00Equipment cost (see instructions)143,9.00Total allowance (sum of lines 57-62)143,9.00Total allowance (sum of lines 57-62)143,9.00Excess over limitation (line 64 minus line 63 - if negative, enter zero)97,9.00Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others10,90.00Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others10,91.00Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others10,91.00Line 24 = 1 ine 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others10,91.00Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others10,91.00Line 34 = sum of lines 27 and 3111,91.01Line 34 = sum of lines 27 and 3111,91.02Line 34 = sum of lines 27 and 3111,91.02Line 35 CALCULATION11,91.02Line 35 CALCULATION11,91.02Line 35 CALCULATION11,	0	1.00					JUSTMENT	S COST	AND EXCESS	RAPY LIMITATION A	/I - COMPUTATION OF THE	Par		
00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 10, 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 10, 00.02 Line 33 = line 28 = sum of lines 26 and 27 10, LINE 34 CALCULATION 10, 10, 01.00 Line 31 = line 29 for respiratory therapy or sum of lines 3 and 4 for all others 10, 01.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 10, 01.01 Line 34 = sum of lines 27 and 31 11,02 LINE 35 CALCULATION 10, 10,	10, 186 0 0 0 0	() () () () () () () () () () () () () (6)	34, or 35)) 4, 45, or 4	nes 33, n lines ecords)	(from lin ces (from m your rea	rom line 23) - provider site - Offsite servid umn 5, line 56) ions) s 57-62) er services (from	y equivalency amount (I allowance and expense I allowance and expense ime allowance (from co ment cost (see instruct ies (see instructions) allowance (sum of line cost of outside suppl s over limitation (line	 Sal Tra Tra 0ve Equ Sup Tot Tot Exc 	 3. 00 7. 00 00 1. 00 2. 00 3. 00 4. 00 	
11.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 11.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 11.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	10, 186 0 10, 186	(others						3 for respiratory	26 = line 24 for respi 27 = line 7 times line 33 = line 28 = sum of	00 Lir 01 Lir 02 Lir	0. 01	
	0 0 0	C		others						atory therapy or	27 = line 7 times line 31 = line 29 for respi 34 = sum of lines 27 an	00 Lir 01 Lir 02 Lir	01. 01	
22.01 Line 32 = line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others	0 0		3, line	umns 1-3							31 = line 29 for respi 32 = line 8 times colu	00 Lir 01 Lir		

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	PUTNAM COUNTY FURNI SHED BY	HOSPI TAL Provi der CC	CN: 15-1333	In Lie Period: From 01/01/2019 To 12/31/2019 Speech Pathology	Date/Time Pre 8/28/2020 10:	-3 pared:
						1.00	
	PART I – GENERAL INFORMATION					1.00	
1.00 2.00 3.00 4.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	sor or therapist assistant was c	was on provi			52 780 161 0	2.00 3.00
5.00 6.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	rvisors or thera apy assistants (include only	visits made	by therapy	0	5.00 6.00
7.00	Standard travel expense rate					0.00	•
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	s Ai des	0.00 Trai nees	8.00
		1.00	2.00	3.00	4.00	5.00	
9. 00 10. 00 11. 00	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0.00 0.00 38.70	1, 000. 00 77. 39 38. 70	0.	00 0.00 00 0.00 00		
12.00 12.01 13.00 13.01	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite)	0 0 0 0	0 0 0 0		0 0 0		12.00 12.01 13.00 13.01
		·			·	1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1	
14.00 15.00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,					0 77 390	14.00 15.00
16. 00 17. 00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a others)	line10)	atory therapy	y or lines 1	4-16 for all	0	1
18. 00 19. 00 20. 00	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 than	erapy, speech pat	thology or	19.00			
	amount from line 20. Otherwise complete lin Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,	es 21-23. ainees (line 17	divided by su			1	21.00
22. 00 23. 00	Weighted allowance excluding aides and train Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO	ees (line 2 time	es line 21)			0 77, 390	22.00 23.00
	Standard Travel Allowance	WANCE AND TRAVEL	EXPENSE COMP	PUTATION - P	ROVIDER SITE		
	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					6, 231 0	24.00 25.00
26.00 27.00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)				3 and 4 for all	6, 231 0	26.00
28.00	Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave	· .	at the provid	der site (su	m of lines 26 and	6, 231	28.00
29.00 30.00 31.00 32.00	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	of columns 1 and , line 12) sum of lines 29	and 30 for a	all others)	py or sum of	0 0 0 0	30.00 31.00
33.00 34.00 35.00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and optional trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW.	l expense (sum c l expense (sum c	of lines 27 ar of lines 31 ar	nd 32)	RVICES OUTSIDE PF	6, 231 0 0 ROVI DER SI TE	34.00
24 00	Standard Travel Expense					1	24 00
36.00 37.00 38.00 39.00	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	m of lines 5 and	1 6)			0 0 0 0	37.00 38.00
40.00 41.00	Optional Travel Allowance and Optional Trave Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum	I Expense 01 times column				0	40.00
41.00 42.00 43.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su Total Travel Allowance and Travel Expense - 0	m of columns 1-3			llowing three lir	0	42.00
44.00 45.00	46, as appropriate. Standard travel allowance and standard trave Optional travel allowance and standard trave						44. 00 45. 00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
REASONABLE COST DETERMINATION FOR THERAPY SERVICES OUTSIDE SUPPLIERS	FURNI SHED BY	Provider CO		Period: From 01/01/2019 To 12/31/2019		pared:
			5	Speech Pathology	Cost	
					1.00	
46.00 Optional travel allowance and optional trave						46.00
	Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
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 0.00	0. 00	47.00
 48.00 Overtime rate (see instructions) 49.00 Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT 	0.00 0.00	0.00 0.00	0.0			48.00 49.00
50.00 Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	0.0	0 0.00	0. 00	50.00
<pre>1 line 47) 51.00 Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)</pre>	0.00	0.00	0.0	0 0.00	0.00	51.00
DETERMINATION OF OVERTIME ALLOWANCE 52.00 Adjusted hourly salary equivalency amount	77.39	0.00	0.0	0 0.00		52.00
(see instructions) 53.00 [Overtime cost limitation (line 51 times line		0.00		0 0		53.00
52) 54.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
<pre>line 49 or line 53) 55.00 Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)</pre>	О	0		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 for all others.)	0	0		0 0	0	56.00
	<u> </u>				1.00	
Part VI - COMPUTATION OF THERAPY LIMITATION	AND EXCESS COST	ADJUSTMENT			1.00	
 57.00 Salary equivalency amount (from line 23) 58.00 Travel allowance and expense - provider site 59.00 Travel allowance and expense - Offsite servi 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) 64.00 Total cost of outside supplier services (fro 65.00 Excess over limitation (line 64 minus line 6 LINE 33 CALCULATION 	(from lines 33 ces (from lines m your records)	, 34, or 35)) 44, 45, or 40	5)		6, 231 0 0 0 83, 621 49, 754	59.00 60.00 61.00 62.00
100.00 Line 26 = line 24 for respiratory therapy or 100.01 Line 27 = line 7 times line 3 for respirator				others	6, 231 0	100. 00 100. 01
100.02 Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					6, 231	100. 02
101.00 Line 27 = line 7 times line 3 for respirator 101.01 Line 31 = line 29 for respiratory therapy or 101.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101.00 101.01 101.02
102.00 Line 31 = line 29 for respiratory therapy or 102.01 Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line		102. 00 102. 01
102.02 Line 35 = sum of lines 31 and 32					0	102.02

CEST ALLOCATION EDIFICIC Der Local Per Local Per Local Der Local <thder local<="" th=""></thder>	Health Financial Systems	PUTNAM COUNT				u of Form CMS-2	2552-10
Cost Center Description Cost Center Description <thcost center="" des<="" td=""><td>COST ALLOCATION - GENERAL SERVICE COSTS</td><td></td><td>Provider CC</td><td>F</td><td></td><td></td><td>pared:</td></thcost>	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F			pared:
Understand Description Net Encode Correst tor correst (reg correst) Description Subtrail (reg correst) Description ADM INISTRATIV E & ENCODE 1.00 Correst Correst Contrement (reg correst) 3.00 4.00 64.00 5.00			CAPI TAI				
FIAT DESCRIPTION FIAT DEVENTION E & DEMENL 100 CLIMINAL SEGUCE COST CENTERS 0 1.00 4.00 5.00 1.00 4.00 5.00 7.01 7.0			RELATED COSTS				
All location (Trom #43:1) DEFARTMENT DEFARTMENT 0 000000 HPV CAP RET_COSTS_BIDD & FLAT 0.000000 HPV CAP RET_COSTS_BIDD & FLAT 0.0000000 HPV CAP RET_COSTS_BIDD & FLAT 0.00000000000000000000000000000000000	Cost Center Description				Subtotal		
coll 7.0 4.00			11.71				
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1.00 00100 [NET GAP REL COSTS RELICE X FIX 2, 644, 436 5, 100, 400 1,	GENERAL SERVICE COST CENTERS	0	1.00	4.00	4A	5.00	
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0.1000 OPE MATT (MO F PLANT 1.412, 1ss 266, 537 76, 271 1.74, 914 1.33, 748 7.00 0.00000 PUBLIC MORTY & LINES SEVICE 152, 1649 11, 283 1100, 216 637, 548 122, 711 6, 854 11.00 1100, 01100 CONTENING AUMINISTRATION 123, 811 11, 71, 714 18, 207 19, 60 166, 60 156, 60 156, 60 156, 60 156, 60 156, 60 156, 60 156, 60 156, 60 110, 60 110, 60 110, 60 110, 60 110, 60 110, 60 110, 60 110, 60 111, 65, 61 10, 60 17, 71 178, 36, 30 300, 62 30, 00 150, 01 152, 199 1, 81, 81, 82, 83 30, 60 150, 01 152, 199 1, 81, 81, 83 30, 60 150, 01 152, 199 1, 81, 83, 36, 30 300, 62 30, 01 100 100, 111, 81, 92, 91 181, 81, 91 110, 91, 91, 91, 91, 91, 91, 91, 91, 91, 91							•
0.00 000000 LAUNDRY ALLINEN SERVICE 102, 702 17, 417 6, 727 27, 66, 856 41, 725 8, 00 0.00 000000 DETARY 200, 359 90, 1000 20, 895 647, 548 722, 017 90 0.00 000000 DETARY 200, 359 90, 1000 20, 895 647, 548 722, 701 90, 1000 10.00 010000 DETARY 111 17, 114 62, 727 200, 511 101, 623 60, 699 580, 105 111, 651 10, 00 100 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td>•</td></t<>							•
9.00. 00900 MUSECEPING 57.648 122.701 9.00 11.00 01000 DETARY 200.356 90.100 2.6,665 007.37.648 172.701 9.00 11.00 01000 DETARY 10.01 DETAR TON 16.05.774 41.7.27 62.645 708,855 136.424 11.00 11.00 01000 DETARY 10.01 DETAR TON 16.05.774 41.7.27 62.645 708,855 136.424 11.00 17.00 01700 SOCIAL SERVICE 10.057 CENTERS 10.02 10.02 10.00 000 000 000 000 000 000 000 000 0							•
11.00 01100 CAFETERIA 005, 174 41.227 62.354 709, 855 136, 424 11.00 13.00 01300 MENIS MARINA MARINA STRATION 72.3, 811 17.134 18.90 159.90 159.91 336, 630 15.00 150.00							
13.00 01300 UNEN INC ADM IN STRATION 123, a11 17, 134 18, 207 150, 152 30, 630 18, 60 17, 00 01700 OCI AL, SERVICE 0							•
16.00 01600 HETICLAL RECORDS & LIBRARY 417, 63 101, 823 60, 699 580, 155 111, 65 16, 00 17, 01 17.00 10701 UTLLZATION REVIEW 82, 147 6, 580 17, 817 106, 544 20, 890 17, 01 1000 10701 UTLLZATION REVIEW 12, 21, 847 16, 304 444, 471 1, 873, 203 360, 552 30, 00 01000 00000 NITERS ROUTE GENEROUS COST CENTERS 0 0 0 40, 00 42, 00 31, 00 440, 471 1, 873, 203 360, 552 30, 00 42, 00 31, 00 440, 00 22, 00 1, 400, 800 24, 00 41, 00 42, 00 41, 00 42, 00 41, 00 42, 00 41, 00 42, 00 41, 00 42, 00 41, 400 52, 40, 00 41, 400 52, 40, 00 41, 400 52, 40, 00 41, 400, 57, 74, 53, 50, 44, 40 196, 461 44, 44, 90 81, 77, 78, 53, 00 50, 00, 60, 50, 51, 50, 00, 51, 50, 50, 64, 44, 50, 50, 50, 50, 50, 50, 50, 50, 50, 50							•
17.00 01700 SOCIAL SERVICE 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>							•
INPART ENT_ROUTINE_SERVICE_COST_CENTERS 1.271,649 448,471 1.673,363 3.60,542 3.0.0 31.00 003000 INTERS VE_CARE_UNIT 914,777 73,198 152,829 1,140,804 219,556 31.00 440,00 44		· · · ·					•
30.00 03000 ADULTS & PEDLATELCS 1, 271, 849 152, 043 448, 471 1, 873, 363 360, 542 30.00 41.00 04100 SUBFROVICER - 1 RF 914, 77 73, 196 0 0 0 0 41.00 0		82, 147	8, 580	17, 817	108, 544	20, 890	17.01
11. 00 03100 INTERS VE CARE UNIT 914, 777 73, 198 152, 829 1, 140, 804 219, 558 31, 00 41. 00 04200 SUBPROVIDER 0 <		1 071 040	152.042	440 471	1 070 0/0	2/0 5/0	1 20 00
41.00 04100 SUBPROV DER 1 FF 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>							•
12. 00 01/200 LUBSERY 0							•
MACILLARY SERVICE COST CONTERS 90.00 05000 (PERATIN ROM 2,343,521 210,782 162,580 2.716,883 552,08 552,00 51.00 05000 RECOVERY ROM 142,281 59,130 25,157 226,568 43,605 51.00 53.00 05300 AMESTHESIOLOGY 228,444 0 196,461 424,905 81,776 53.00 54.01 05401 NUCLEAR MEDICINE - HARDSTIC 137,118 78,097 20,313,351 22,049 54.01 50.00 05700 CT,SCAN ARONSTIC 131,744 3.607 0 135,351 22,049 54.01 50.00 05700 CT,SCAN ARONSTIC 131,744 3.607 0		0	0	0	0 0	0	42.00
50.00 05000 0FECATING ROOM 2,343,521 210,782 126,280 2,716,883 50.00 51.00 51.00 05100 0FCOVERY ROOM 142,281 59,130 25,157 226,564 43,605 51.00 52.00 05300 RESTMESILOGY 137,374 18 78,033 230,380 1.680,591 323,442 54.00 54.00 05400 RADIOLOGY-DIAGNOSTIC 1.31,744 3,607 0 153,351 26,649 54.01 54.00 03480 ORCLORY 3,510,669 125,100 41,233 54.02 0 </td <td></td> <td>0</td> <td>0</td> <td>(</td> <td>0 0</td> <td>0</td> <td>43.00</td>		0	0	(0 0	0	43.00
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52. 00 0 GS200 DELL VERY NOM & LABOR ROOM 0							
54:00 05400 RADIOLGGY-DIAGNOSTIC 1,372,118 78,093 230,380 1,680.591 322,442 54.00 54:00 Construction 3,510,669 125,140 76,361 3,712,170 714,433 54.02 57:00 DS700 CTOCO CTSCAN 406,157 34,010 41,293 481,460 92,666 57.00 58:00 DS600 MARCHITC RESONANCE I MAGI NG (MRI) 0 0 0 0 0 58.00 59:00 DS600 MARCHITERER ZATION 0 <td></td> <td></td> <td></td> <td>C</td> <td>0 0</td> <td></td> <td>52.00</td>				C	0 0		52.00
94 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 131, 744 3, 607 0 135, 351 20, 049 54 01 54 02 03400 ONCOLOCY 3, 510, 669 125, 140 76, 361 371, 21, 707 714, 433 54, 02 2360 658, 00 57, 00 0<							•
54.02 03480 (NCUCOY) 3,510,669 125,140 76,361 3,712,170 714,433 54,02 57,00 58,00 58,00 58,00 58,00 58,00 58,00 58,00 58,00 58,00 58,00 58,00 59,00 50,00 56,00 50,00 56,00 50,00 56,00 57,00 56,00 50,00 56,00 57,00 56,00 57,00 56,00 57,00 50,00 56,00 57,00 50,01 10,00 0 0							•
57.00 CST200 (T SCAN 448.460 92.660 57.00 58.00 CSB00 MAGKETT C RESONANCE IMAGING (MRI) 0				-			•
59:00 0 <td>57.00 05700 CT SCAN</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>•</td>	57.00 05700 CT SCAN						•
60. 00 0cc00 LABORATORY 2, 209, 259 64, 670 178, 035 2, 451, 964 471, 896 60. 00 71. 00 72. 756 70. 01 71. 00 72. 756 70. 01 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 00 73. 01 73. 01		0	0			-	•
Co. 01 Docol LABORATORY Docol Docol <thdocol< th=""> Docol Docol</thdocol<>		2 200 250	0		0	-	•
64.00 [Action] INTRAVENOUS THERAPY 0		2,209,239	04,070	178,030	0 2,431,904		•
66.00 06600 PHYSICAL THERAPY 616,451 43,903 0 660,354 127,090 66.00 67.00 06700 0CUPATIONAL THERAPY 97,782 0 0 97,782 18,819 67.00 68.00 69.00 97,782 0 0 49,904 9,064 68.00 68.00 69.01 69010 6001 6800 25,576 16,979 182,353 35,095 69.01 69.01 67.00 0		0	0	(0	0	•
67:00 OCOUPATIONAL THERAPY 97,782 0 0 97,782 18,819 67.00 68:00 06600 SPECET PATHOLOCY 162,798 2,576 16,979 182,353 35,095 69.00 69:00 06900 ELECTROCARDIOLOGY 162,798 2,576 16,979 182,353 35,095 69.00 71:00 07100 MEL DEV. CHARGED TO PATIENT 0 0 0 0 0 0 73.01 73:00 07300 DURDICALARGED TO PATIENTS 1,029,667 23.085 64,351 1,117,103 214,994 73.00 73:01 0350 07300 07300 0,00 0 0 0 73.01 88:00 08300 PUTNAM FEDIATIENT SAND INTERNAL MED 1,658,050 124,599 318,961 2,101,610 404,470 88.00 88:00 08300 PUTNAM FAULY HEALTHCARE 1,361,160 64,283 261,757 1,66,695 311,144 88.00 88:00 089000 0 <							•
68.00 06800 SPECH PATHOLOGY 49,904 0 49,904 0,00 49,904 0,00 49,904 0,00 49,904 0,00 49,904 0,00 49,904 0,00 49,904 0,00 49,904 0,00 49,904 0,00 49,904 0,00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 69.00 67.00 16.072,057 69.01 71.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.01				-			
69.00 06900 ELECTROCARDI OLOGY 162, 798 2, 576 16, 979 182, 353 35, 095 69.00 69.01 06900 CARDI AC REHAB 272, 960 41, 636 61, 460 376, 056 72, 375 69.01 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 35, 358 0 0 35, 358 68.05 72.00 073.00 73.00 73.00 73.00 73.00 73.00 0 73.00 0 73.00 0 0 0 0 0 0 0 0 0 73.00 0 73.00 0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>•</td>				-			•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 <t< td=""><td></td><td></td><td></td><td>16, 979</td><td></td><td></td><td>•</td></t<>				16, 979			•
72.00 07200 MPL_DEV. CHARGED TO PATI ENT 35,358 0 0 35,358 6,805 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 1,029,667 23,085 64,351 1,117,103 214,994 73.00 0017300 DRUGS CHARGED TO PATI ENTS 1,029,667 23,085 64,351 1,117,103 214,994 73.00 001700 DRUGS CHARGED TO PATI ENTS 1,029,667 23,085 64,351 1,117,103 214,994 73.00 001700 DRUGS CHARGED TO PATI ENTS 1,029,667 124,599 318,961 2,101,610 404,470 88.00 88.00 08800 PUTNAM PEDI ATRI CS AND INTERNAL MED 1,658,050 124,599 318,961 2,101,610 404,470 88.00 88.01 08801 FAMILY MEDI CINC OF CLOVERDALE 1,361,160 64,283 261,757 1,687,200 324,713 88.01 89.00 09000 CLINI C 0 0 0 0 90.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00 99.00		272, 960		61, 460	376, 056		•
73.00 07300 DRUGS CHARGED TO PATIENTS 1,029,667 23,085 64,351 1,117,103 214,994 73.00 73.01 03950 ONCOLOGY 0		25 250	-))) ()		
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88.00 08800 PUTNAM PEDI ATRI CS AND INTERNAL MED 1, 658, 050 124, 599 318, 961 2, 101, 610 404, 470 88.00 88.01 08801 FAMI LY MEDI CI NE OF CLOVERDALE 1, 361, 160 64, 283 261, 757 1, 687, 200 324, 713 88.01 88.02 08802 NORTH PUTNAM FAMI LY HEALTHCARE 1, 239, 567 145, 674 231, 454 1, 616, 695 311, 148 80.0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 90.01 09000 CLINIC 0 4, 174 803 90.00 90.01 09000 EMERGENCY 2, 084, 420 149, 591 725, 248 2, 959, 259 569, 530 91.00 91.00 09010 EMERGENCY 2, 084, 420 149, 591 725, 248 2, 959, 259 569, 530 91.00 92.00 DSECI AL PURPOSE COST CENTERS 0 0 0 0 0 0 0 109.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 111.00 111.00 111.00 <td></td> <td></td> <td></td> <td>(</td> <td></td> <td></td> <td></td>				(
88.01 08801 FAMILLY MEDICINE OF CLOVERDALE 1, 361, 160 64, 283 261, 757 1, 687, 200 324, 713 88.01 88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE 1, 239, 567 145, 674 231, 454 1, 616, 695 311, 144 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0					· · · · · · · · · · · · · · · · · · ·		
88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE 1, 239, 567 145, 674 231, 454 1, 616, 695 311, 144 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0							
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0							•
90.01 09001 RHEUMATOLOGY 172,957 12,135 88,222 273,314 52,601 90.01 91.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 2,084,420 149,591 725,248 2,959,259 569,530 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 92.00 OTHER REI MBURSABLE COST CENTERS 99.10 SPECI AL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 109.00 111.00 INTOST INAL ACQUI SI TI ON 0 0 0 0 0 111.00 113.00 INTERST INAL ACQUI SI TI ON 0 0 0 0 111.0		0	0	(0 0		•
91.00 09100 EMERGENCY 2,084,420 149,591 725,248 2,959,259 569,530 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 92.00 09100 OPTHER REIMBURSABLE COST CENTERS 0 0 0 0 99.10 SPECI AL PURPOSE COST CENTERS 0 0 0 0 0 0 99.10 110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 110.00 111.00 INTERST EXPENSE 0 0 0 0 0 111.00 </td <td></td> <td>0</td> <td></td> <td>C</td> <td></td> <td></td> <td>•</td>		0		C			•
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS 99. 10 0 0 0 0 0 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 0 <							•
OTHER REI MBURSABLE COST CENTERS 99. 10 09910 CORF 0		2,084,420	149, 591	125, 248		509, 530	•
SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUI SI TI ON 0 111.00 1111.00 1111.00 1111.00 1111.00 1113.00 1114.00 114.00							/2:00
109:00 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 109:00 110:00 INTESTI NAL ACQUI SI TI ON 0		0	0	(0 0	0	99.10
110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 ISLET ACQUISITION 0 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 113.00 114.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>100.00</td>							100.00
111.00 1SET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00			0				
114.00 11400 UTI LI ZATI ON REVIEW-SNF 39, 315, 835 2, 360, 936 4, 360, 959 38, 192, 825 5, 993, 315 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 12, 290 0 12, 290 2, 365 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 4, 033, 016 255, 355 766, 990 5, 055, 361 972, 934 192.00 192.01 JOHNSON/NI CHOLS WI C 343, 660 0 70, 520 414, 180 79, 712 192.01 192.02 J2020 RHEUMATOLOGY 0 0 0 0 192.02 193.00 19300 NONREIRS 0 0 0 192.02 193.01 J9301 DME 00 0 0 0 193.01		0	0	(0 0		
Image: 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 39, 315, 835 2, 360, 936 4, 360, 959 38, 192, 825 5, 993, 315 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 118.00 12, 290 0 12, 290 2, 365 190.00 192.00 192.00 PHYSI CI ANS' PRI VATE OFFICES 4, 033, 016 255, 355 766, 990 5, 055, 361 972, 934 192.00 192.01 JOHNSON/NI CHOLS WI C 343, 660 0 70, 520 414, 180 79, 712 192.01 192.02 JOUNPAI D WORKERS 0 0 0 0 192.00 193.00 193.00 193.01 0 0 0 192.02 192.02 192.03 192.02 192.02 192.03 192.02 1							•
NONRE I MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP 2,365 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 4,033,016 255,355 766,990 5,055,361 972,934 192. 00 192. 01 19201 JOHNSON/NI CHOLS WI C 343,660 0 70,520 414,180 79,712 192. 01 192. 02 19203 RHEUMATOLOGY 0 0 0 0 192. 02 193. 00 19300 NORKERS 0 0 0 0 0 193. 01 193. 01 DME 0 0 0 0 0 193. 01		20 215 025	2 2 4 0 0 2 4	4 3/0 05/	20 102 025	F 002 01F	•
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 12, 290 0 12, 290 2, 365 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 4, 033, 016 255, 355 766, 990 5, 055, 361 972, 934 192.00 192.01 JOHNSON/NI CHOLS WI C 343, 660 0 70, 520 414, 180 79, 712 192.01 192.02 19203 RHEUMATOLOGY 0 0 0 0 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.01 193.01 DME 0 0 0 0 193.01		39, 315, 835	2, 360, 936	4, 360, 959	38, 192, 825	5, 993, 315	118.00
192.00PHYSI CI ANS' PRI VATE OFFICES4,033,016255,355766,9905,055,361972,934192.00192.01JOHNSON/NI CHOLS WI C343,660070,520414,18079,712192.01192.0219203RHEUMATOLOGY0000192.02193.0019300NONPAI D WORKERS00000193.00193.0119301DME0000193.01		0	12, 290	(12, 290	2, 365	190.00
192.02 19203 RHEUMATOLOGY 0 0 0 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 193.01 19301 DME 0 0 0 0 193.01							
193.00 NONPAI D WORKERS 0 0 0 193.00 193.01 19301 DME 0 0 0 0 193.01		343, 660	0	70, 520	414, 180		
193.01 19301 DME 0 0 0 193.01			0				•
		0	0		0 0		
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Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1333	Period: From 01/01/2019 To 12/31/2019		pared:
					8/28/2020 10:	<u>03 am</u>
		CAPI TAL RELATED COSTS				
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
	for Cost	FLXT	BENEFITS		E & GENERAL	
	Allocation		DEPARTMENT			
	(from Wkst A					
	<u>col. 7)</u>	1.00	4,00	4A	5.00	
193. 03 19303 DI ABETI C COUNSELI NG	0	1.00	4.00	4A 0		193.03
194. 00107950 VACANT SPACE	0	0				193.03
194. 01 07951 BOARD OF HEALTH	0	17, 855		0 17,855		194.00
194. 02 07952 PUTNAM/HENRY PRENATAL	0	17,000		0 0		194.02
200.00 Cross Foot Adjustments		Ű		0		200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118 through 201)	43, 692, 511	2, 646, 436	5, 198, 4	43, 692, 511	7, 051, 762	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	PUTNAM COUNT			eriod: com 01/01/2019	u of Form CMS-: Worksheet B Part I Date/Time Pre 8/28/2020 10:	pared:
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	1					1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	2, 092, 659					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	18, 138					8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	16, 957 93, 827			617, 426		9.00 10.00
11.00	01100 CAFETERI A	43, 036			017,420	905, 151	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	17, 842	0	6, 980	0	3, 435	13.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	106, 035		,	0	43, 548	
	01700 SOCIAL SERVICE 01701 UTILIZATION REVIEW	0 8, 935	-	-	0	0 6, 260	17.00
17.01	INPATIENT ROUTINE SERVICE COST CENTERS	0, 733		5,475	U U	0,200	17.01
30.00	03000 ADULTS & PEDIATRICS	159, 374	60, 200	62, 349	513, 133	130, 066	30.00
31.00	03100 I NTENSI VE CARE UNI T	76, 226			104, 293	57, 845	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	-	, i i i i i i i i i i i i i i i i i i i	0	0	41.00 42.00
	04300 NURSERY	0			0	0	42.00
	ANCILLARY SERVICE COST CENTERS	-	-				
	05000 OPERATING ROOM	219, 502			0	66, 858	50.00
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	61, 576			0	8, 723	51.00 52.00
52.00 53.00	05300 ANESTHESI OLOGY	0		-	0	0 18, 939	
54.00	05400 RADI OLOGY-DI AGNOSTI C	81, 324	, s	-	0	103, 954	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	3, 756		1, 470	0	0	54.01
54.02	03480 ONCOLOGY	130, 317	8, 895		0	33, 691	54.02
57.00 58.00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	35, 416 0		13, 855 0	0	18, 388 0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	-	0	0	0	59.00
60.00	06000 LABORATORY	67, 345	-	26, 346	0	106, 489	60.00
60.01	06001 BLOOD LABORATORY	0	-	0	0	0	60.01
64.00	06400 I NTRAVENOUS THERAPY	0	-	-	0	0	64.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	18, 781 45, 719	0 7,642	.,	0	35, 558 0	65.00 66.00
67.00	06700 OCCUPATI ONAL 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	2, 683		1, 050	0	7, 352	69.00
69. 01 71. 00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	43, 358 0		16, 962 0	0	22, 269 0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	-	-	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	24,040	0	9, 405	0	26, 174	
73.01	03950 ONCOLOGY	0	0	0	0	0	73.01
88.00	OUTPATIENT SERVICE COST CENTERS 08800 PUTNAM PEDIATRICS AND INTERNAL MED	129, 753	6, 194	50, 761	0	0	88.00
88.01	08801 FAMILY MEDICINE OF CLOVERDALE	66, 943		0	0	0	88.01
88.02	08802 NORTH PUTNAM FAMILY HEALTHCARE	151, 701		59, 347	0	0	88.02
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90. 00 90. 01	09000 CLINIC 09001 RHEUMATOLOGY	4, 347		1, 700 4, 944	0	0 25 409	90.00
90.01 91.00	09100 EMERGENCY	12, 637 155, 779			0	25, 408 148, 403	90.01 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,777	07, 302	00, 743	0	140, 403	92.00
	OTHER REIMBURSABLE COST CENTERS	1	1				
99.10	09910 CORF	0	0	0	0	0	99.10
100 00	SPECIAL PURPOSE COST CENTERS	0	C	0	0	0	109.00
	11000 INTESTINAL ACQUISITION	0		0	0		110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0		111.00
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF	1 705 047	2/2 720	(10.445	(17 40)	0/2 2/0	114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 795, 347	263, 739	662, 445	617, 426	863, 360	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 798	C	5,007	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	265, 920	12, 990	104, 033	0		192.00
	19201 JOHNSON/NI CHOLS WI C	0	0	0	0		192.01
	19203 RHEUMATOLOGY 19300 NONPAID WORKERS	0		0	0		192. 02 193. 00
	19300 NONPALD WORKERS						193.00 193.01
	19302 LACTATION CONSULTING	0	0	0	0		193.02
193.03	19303 DI ABETI C COUNSELI NG	0	0	0	0	0	193.03
	07950 VACANT SPACE	0	0	0	0		194.00
	07951 BOARD OF HEALTH 07952 PUTNAM/HENRY PRENATAL	18, 594		7, 274	0		194.01 194.02
200.00					0	0	200.00
	1 1	1	1	1			

Health Fir	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLO	CATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2019	Worksheet B Part I		
					To 12/31/2019			
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A		
		PLANT	LINEN SERVICE					
		7.00	8.00	9.00	10.00	11.00		
201.00	Negative Cost Centers	0	0		0 0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	2, 092, 659	276, 729	778, 75	9 617, 426	905, 151	202.00	

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL			In Lieu	ı of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1333	Perio		Worksheet B Part I	
				То	12/31/2019	Date/Time Pre 8/28/2020 10:	pared: 03 am
Cost Center Description	NURSI NG ADMI NI STRATI O	MEDI CAL RECORDS &	SOCI AL SERVI CE	TU	I LI ZATI ON REVI EW	Subtotal	
	N 13.00	LI BRARY 16. 00	17.00		17.01	24.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION	218, 039						1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	0	882, 875 0		0			16.00 17.00
17.01 01701 UTILIZATION REVIEW	0	0		0	148, 124		17.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	84, 324	386, 058		0	123, 103	3, 752, 512	30.00
31.00 03100 INTENSI VE CARE UNI T 41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER - 4 RF 43.00 04300 NURSERY - ANCI LLARY SERVI CE COST CENTERS	37, 502 0 0	0 0 0 0		0 0 0 0	25, 021 0 0	1, 737, 554 0 0	30.00 31.00 41.00 42.00 43.00
50. 00 05000 OPERATI NG ROOM	0	312, 392		0	0	3, 963, 725	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	368, 766 0	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	0	525, 620	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0		0 0	0	2, 241, 827 166, 626	54.00 54.01
54. 02 03480 ONCOLOGY	0	0		0	0	4, 650, 488	
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	641, 779 0	57.00 58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	0		0	0	3, 124, 042 0	60.00 60.01
64.00 06400 INTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	732, 407	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0 0	858, 691 116, 601	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	0	59, 508	68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	0		0	0	228, 533 531, 020	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS	0	0		0	0	42, 163	
73. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 01 03950 ONCOLOGY	0	0		0	0	1, 391, 716 0	
OUTPATIENT SERVICE COST CENTERS				-		0 (00 700	
88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED 88.01 08801 FAMILY MEDICINE OF CLOVERDALE	0	0		0	0	2, 692, 788 2, 078, 856	
88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE	0	0		0	0	2, 138, 887	88.02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0		0	0	0 11, 024	89.00 90.00
90. 01 09001 RHEUMATOLOGY	0	0		0	0	368, 904	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	96, 213	184, 425		0	0	4, 241, 934	91.00 92.00
OTHER REIMBURSABLE COST CENTERS							92.00
99.10 09910 CORF	0	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE	0	0		0	0	0	111.00 113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF							114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	218, 039	882, 875		0	148, 124	36, 665, 971	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	32, 460	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0	0	6, 411, 238	
192. 01 19201 JOHNSON/NI CHOLS WI C 192. 02 19203 RHEUMATOLOGY	0	0		0	0	535, 683 0	192.01 192.02
193. 00 19300 NONPAI D WORKERS	o o	Ő		0	0	0	193.00
193. 01 19301 DME 193. 02 19302 LACTATI ON CONSULTI NG	0	0		0	0		193. 01 193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	0		õ	0	0	193.03
194.00 07950 VACANT_SPACE 194.01 07951 BOARD_OF_HEALTH	0	0		0	0		194. 00 194. 01
194. 0107951 BOARD OF HEALTH 194. 02 07952 PUTNAM/HENRY_PRENATAL	0	0		0	0		194.01 194.02

Heal th Financ	ial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATI	ON - GENERAL SERVICE COSTS		Provider C	CN: 15-1333	Peri od:	Worksheet B	
					From 01/01/2019		
					To 12/31/2019	Date/Time Pre	pared:
						8/28/2020 10:	<u>03 am</u>
C	Cost Center Description	NURSI NG	MEDI CAL	SOCI AL	UTI LI ZATI ON	Subtotal	
		ADMI NI STRATI O	RECORDS &	SERVI CE	REVIEW		
		Ν	LI BRARY				
		13.00	16.00	17.00	17.01	24.00	
200. 00 C	Cross Foot Adjustments					0	200.00
201.00 N	Negative Cost Centers	0	0		0 0	0	201.00
202.00 T	FOTAL (sum lines 118 through 201)	218, 039	882, 875		0 148, 124	43, 692, 511	202.00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	PUTNAM COUNTY	HOSPITAL Provider CCN: 15-1333	In Lieu of Form Period: Workshee	
CUST ALLOCATION - GENERAL SERVICE CUSTS		Provider CCN: 15-1333	From 01/01/2019 Part I	
			To 12/31/2019 Date/Tin 8/28/202	me Prepared: 20 10:03 am
Cost Center Description	Intern & Residents	Total		
	Cost & Post			
	Stepdown			
	Adjustments	26.00		
GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT				5.00
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 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION				11.00
16. 00 01600 MEDICAL RECORDS & LIBRARY				16.00
17. 00 01700 SOCIAL SERVICE				17.00
17.01 01701 UTILIZATION REVIEW				17.01
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	3, 752, 512		30.00
31. 00 03100 I NTENSI VE CARE UNI T	0	1, 737, 554		31.00
41. 00 04100 SUBPROVI DER – I RF	0	0		41.00
42. 00 04200 SUBPROVI DER	0	0		42.00
43.00 04300 NURSERY	0	0		43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	3, 963, 725		50.00
51. 00 05100 RECOVERY ROOM	0	368, 766		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53. 00 05300 ANESTHESI OLOGY	0	525, 620		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	2, 241, 827 166, 626		54.00 54.01
54. 02 03480 0NCOLOGY	0	4, 650, 488		54.02
57.00 05700 CT SCAN	0	641, 779		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	3, 124, 042		59.00 60.00
60. 01 06001 BLOOD LABORATORY	0	0		60.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	732, 407		65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	858, 691 116, 601		66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	59, 508		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	228, 533		69.00
69. 01 06901 CARDI AC REHAB	0	531, 020		69.01
71.0007100MEDI CALSUPPLIESCHARGEDTOPATI ENTS72.0007200I MPL.DEV.CHARGEDTOPATI ENT	0	0 42, 163		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 391, 716		73.00
73. 01 03950 ONCOLOGY	0	0		73.01
OUTPATIENT SERVICE COST CENTERS	1 -1			
88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED 88.01 08801 FAMILY MEDICINE OF CLOVERDALE	0	2, 692, 788 2, 078, 856		88.00 88.01
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE	0	2, 138, 887		88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90. 00 09000 CLINIC	0	11, 024		90.00
90. 01 09001 RHEUMATOLOGY 91. 00 09100 EMERGENCY	0	368, 904 4, 241, 934		90.01 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	4,241,734		92.00
OTHER REIMBURSABLE COST CENTERS				
99. 10 09910 CORF	0	0		99.10
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION		0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111.00
113. 00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTILIZATION REVIEW-SNF 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	36, 665, 971		114.00 118.00
NONREI MBURSABLE COST CENTERS		00,000,771		110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32, 460		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	6, 411, 238		192.00
192. 01 19201 JOHNSON/NI CHOLS WI C 192. 02 19203 RHEUMATOLOGY	0	535, 683		192.01 192.02
192. 02 19203 RHEUMATOLOGY 193. 00 19300 NONPALD WORKERS	0	0		192.02
193. 01 19301 DME	0	ŏ		193.01
193. 02 19302 LACTATI ON CONSULTI NG	0	0		193.02
193. 03 19303 DI ABETI C COUNSELI NG	0	0		193.03
194. 00 07950 VACANT SPACE	0	0		194.00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-1333	Period:	Worksheet B		
				From 01/01/2019 To 12/31/2019		epared:	
					Date/Time Pre 8/28/2020 10:	03 am	
Cost Center Description	Intern &	Total					
	Residents						
	Cost & Post						
	Stepdown						
	Adjustments						
	25.00	26.00					
194.0107951 BOARD OF HEALTH	0	47, 159				194.01	
194.0207952 PUTNAM/HENRY PRENATAL	0	0				194.02	
200.00 Cross Foot Adjustments	0	0				200.00	
201.00 Negative Cost Centers	0	0				201.00	
202.00 TOTAL (sum lines 118 through 201)	0	43, 692, 511				202.00	

	inancial Systems ON OF CAPITAL RELATED COSTS	PUTNAM COUNT	Y HOSPITAL Provider CO	Fr	eriod: com 01/01/2019	u of Form CMS-2 Worksheet B Part II	
	Cost Center Description	Di rectly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS NEW BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI V E & GENERAL	pared: 03 am
G	ENERAL SERVICE COST CENTERS	0	1.00	2A	4.00	5.00	
$\begin{array}{c cccc} 1.\ 00 & 0 \\ 4.\ 00 & 0 \\ 5.\ 00 & 0 \\ 7.\ 00 & 0 \\ 8.\ 00 & 0 \\ 9.\ 00 & 0 \\ 10.\ 00 & 0 \\ 11.\ 00 & 0 \\ 13.\ 00 & 0 \\ 16.\ 00 & 0 \\ 17.\ 00 & 0 \\ 17.\ 01 & 0 \\ \end{array}$	0100 NEW CAP REL COSTS-BLDG & FIXT 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DI ETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1600 MEDICAL RECORDS & LIBRARY 1700 SOCIAL SERVICE 1701 UTILIZATION REVIEW		3, 942 366, 429 266, 537 17, 417 16, 283 90, 100 41, 327 17, 134 101, 823 0 8, 580	3, 942 366, 429 266, 537 17, 417 16, 283 90, 100 41, 327 17, 134 101, 823 0 8, 580	3, 942 472 58 5 76 20 47 14 46 0 14	366, 901 17, 572 2, 171 6, 384 4, 079 7, 098 1, 594 5, 809 0 1, 087	8.00 9.00 10.00 11.00 13.00 16.00 17.00
30.00 0 31.00 0 41.00 0 42.00 0 43.00 0	NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT 4100 SUBPROVIDER - IRF 4200 SUBPROVIDER 4300 NURSERY	0 0 0 0 0	153, 043 73, 198 0 0 0	153, 043 73, 198 0 0 0	340 116 0 0 0	18, 758 11, 423 0 0 0	31.00 41.00 42.00
$\begin{array}{c ccccc} & & & & & & \\ \hline & & & & \\ \hline & & & \\ 51, 00 & 0 \\ \hline & & & \\ 51, 00 & 0 \\ \hline & & & \\ 52, 00 & 0 \\ \hline & & & \\ 54, 01 & 0 \\ \hline & & \\ 54, 02 & 0 \\ \hline & & \\ 57, 00 & 0 \\ \hline & & \\ 57, 00 & 0 \\ \hline & & \\ 57, 00 & 0 \\ \hline & & \\ 57, 00 & 0 \\ \hline & & \\ 57, 00 & 0 \\ \hline & & \\ 57, 00 & 0 \\ \hline & & \\ 60, 00 & 0 \\ \hline & & \\ 60, 00 & 0 \\ \hline & & \\ 60, 00 & 0 \\ \hline & & \\ 61, 00 & 0 \\ \hline & $	NCI LLARY SERVI CE COST CENTERS 5000 OPERATI NG ROOM 5100 RECOVERY ROOM 5200 DELI VERY ROOM & LABOR ROOM 5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C 5401 NUCLEAR MEDI CI NE-DI AGNOSTI C 3480 ONCOLOGY 5700 CT SCAN 5800 MAGNETI C RESONANCE I MAGI NG (MRI) 5900 CARDI AC CATHETERI ZATI ON 6000 LABORATORY 6001 BLODD LABORATORY 6400 I NTRAVENOUS THERAPY 6500 RESPI RATORY THERAPY 6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY 6600 DELECTROCARDI OLOGY 6900 ELECTROCARDI OLOGY 6900 CARDI AC REHAB 7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 7200 IMPL. DEV. CHARGED TO PATI ENTS 7200 IMPL. DEV. CHARGED TO PATI ENTS 7305 ONCOLOGY UTPATI ENT SERVI CE COST CENTERS 8800 PUTNAM PEDI ATRI CS AND I NTERNAL MED 8801 FAMI LY MEDI CI NE OF CLOVERDALE 8822 NORTH PUTNAM FAMI LY HEALTHCARE 8900 FLERALLY QUALI FIED HEALTH CENTER 9000 CLI NI C 9001 RHEUMATOLOGY 9100 EMERGENCY 9200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		210, 782 59, 130 0 78, 093 3, 607 125, 140 34, 010 0 64, 670 0 64, 670 0 18, 035 43, 903 0 0 2, 576 41, 636 0 0 23, 085 0 124, 599 64, 283 145, 674 0 4, 174 12, 135 149, 591	$\begin{array}{c} 210, 782 \\ 59, 130 \\ 0 \\ 0 \\ 78, 093 \\ 3, 607 \\ 125, 140 \\ 34, 010 \\ 0 \\ 64, 670 \\ 0 \\ 64, 670 \\ 0 \\ 0 \\ 18, 035 \\ 43, 903 \\ 0 \\ 0 \\ 2, 576 \\ 41, 636 \\ 0 \\ 0 \\ 23, 085 \\ 0 \\ 0 \end{array}$	123 19 0 149 175 0 58 31 0 0 135 0 0 0 135 0 0 0 0 135 0 0 0 0 135 0 0 0 0 133 0 0 0 0 133 0 0 0 0 0 133 13 9 0 0 0 0 0 0 133 13 0 0 0 0 135 0 0 0 0 149 175 0 0 0 0 149 175 0 0 0 0 0 0 149 175 0 0 0 0 0 0 175 0 0 0 0 0 0 0 0 0 0 0 0 0 0 135 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27, 204 2, 269 0 4, 255 16, 828 1, 355 37, 170 4, 821 0 24, 552 6, 612 979 500 1, 826 3, 765 0 354 11, 186 0 21, 043 16, 894 16, 188 0 42 2, 737	50.00 51.00 52.00 53.00 54.01 54.02 57.00 58.00 59.00 60.01 64.00 65.00 66.00 67.00 68.00 69.01 71.00 73.00 73.01 88.02 89.00 90.01
99.10 0	THER REIMBURSABLE COST CENTERS 9910 CORF	0	0	0	0	0	99.10
109.001 110.001 111.001 113.001 114.001 118.00	PECIAL PURPOSE COST CENTERS 0900 PANCREAS ACQUISITION 1000 INTESTINAL ACQUISITION 1100 ISLET ACQUISITION 1300 INTEREST EXPENSE 1400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117) ONREIMBURSABLE COST CENTERS	000000000000000000000000000000000000000	0 0 0 2, 360, 936	0 0 0 2, 360, 936	0 0 0 3, 307	0	109.00 110.00 111.00 113.00 114.00 118.00
190. 00 1 192. 00 1 192. 01 1 192. 02 1 193. 00 1 193. 01 1 193. 02 1	UNIXEL MIDURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9200 PHYSI CIANS' PRIVATE OFFICES 9201 JOHNSON/NI CHOLS WI C 9203 RHEUMATOLOGY 9300 NONPAID WORKERS 9301 DME 9302 LACTATION CONSULTING 9303 DI ABETIC COUNSELING		12, 290 255, 355 0 0 0 0 0 0 0 0	12, 290 255, 355 0 0 0 0 0 0 0 0	0 582 53 0 0 0 0 0	50, 634 4, 147 0 0 0 0 0	190. 00 192. 00 192. 01 192. 02 193. 00 193. 01 193. 02 193. 03

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS	Provider C		Period:	Worksheet B			
				From 01/01/2019 To 12/31/2019		narod	
				10 12/31/2019	8/28/2020 10:	03 am	
		CAPI TAL					
		RELATED COSTS					
Cost Center Description	Di rectl y	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V		
	Assigned New	FLXT		BENEFI TS	E & GENERAL		
	Capi tal			DEPARTMENT			
	Related Costs						
	0	1.00	2A	4.00	5.00		
194.0007950 VACANT SPACE	0	0		0 0	0	194.00	
194.0107951BOARD OF HEALTH	0	17, 855	17,85	5 0	179	194.01	
194.0207952 PUTNAM/HENRY PRENATAL	0	0		0 0	0	194.02	
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	0	2, 646, 436	2, 646, 43	6 3, 942	366, 901	202.00	

	nancial Systems N OF CAPITAL RELATED COSTS	PUTNAM COUNT	Y HOSPITAL Provider C	CN: 15-1333 Pe	In Lieu eriod:	ı of Form CMS-: Worksheet B	2552-10
					rom 01/01/2019	Part II Date/Time Pre	pared:
	Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	8/28/2020 10: CAFETERI A	
		PLANT 7. 00	LINEN SERVICE 8.00	9.00	10.00	11.00	
GEN	IERAL SERVI CE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
	00 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00 EMPLOYEE BENEFITS DEPARTMENT 00 ADMINISTRATIVE & GENERAL						4.00 5.00
	OO OPERATION OF PLANT	284, 167					7.00
	300 LAUNDRY & LINEN SERVICE	2, 463	22, 056				8.00
	200 HOUSEKEEPI NG 200 DI ETARY	2, 303 12, 741	124 91	25, 170 1, 186	108, 217		9.00 10.00
	00 CAFETERI A	5, 844	0		108, 217	54,860	
13.00 013	BOO NURSING ADMINISTRATION	2, 423	0	226	0	208	
	000 MEDICAL RECORDS & LIBRARY	14, 399	0	1, 341	0	2,639	
	700 SOCIAL SERVICE 701 UTILIZATION REVIEW	0 1, 213	0	0 113	0	0 379	17.00 17.01
I NP	ATIENT ROUTINE SERVICE COST CENTERS	.,					
	000 ADULTS & PEDIATRICS	21, 642	4, 798		89, 937	7,883	30.00
	00 INTENSIVE CARE UNIT 00 SUBPROVIDER - IRF	10, 351 0	3, 705 0		18, 280 0	3, 506 0	31.00 41.00
	200 SUBPROVI DER	0	0		0	0	42.00
	300 NURSERY	0	0	0	0	0	43.00
	ILLARY SERVICE COST CENTERS	29, 807	3, 135	2, 775	0	4, 052	50.00
	OO RECOVERY ROOM	8, 362	335		0	529	51.00
	200 DELIVERY ROOM & LABOR ROOM	0	0	-	0	0	52.00
	300 ANESTHESI OLOGY 100 RADI OLOGY-DI AGNOSTI C	0 11, 043	0 1, 650	0 1, 028	0	1, 148 6, 301	53.00 54.00
	01 NUCLEAR MEDICINE-DIAGNOSTIC	510	0		0	0, 301	54.00
	80 ONCOLOGY	17, 696	709		0	2,042	
	700 CT SCAN 300 MAGNETIC RESONANCE IMAGING (MRI)	4, 809 0	0	448	0	1, 114 0	57.00 58.00
	CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
	DOO LABORATORY	9, 145	0	852	0	6, 454	60.00
	001 BLOOD LABORATORY 100 I NTRAVENOUS THERAPY	0	0	0	0	0	60.01 64.00
	500 RESPIRATORY THERAPY	2, 550	0	-	0	2, 155	
66.00 066	00 PHYSI CAL THERAPY	6, 208	609		0	0	66.00
	000 OCCUPATI ONAL THERAPY 300 SPEECH PATHOLOGY	0	0	0	0	0	67.00 68.00
	200 ELECTROCARDI OLOGY	364	0	34	0	446	69.00
69.01 069	01 CARDI AC REHAB	5, 888	0	548	0	1, 350	•
	00 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	200 I MPL. DEV. CHARGED TO PATIENT 300 DRUGS CHARGED TO PATIENTS	0 3, 264	0	0 304	0	0 1, 586	72.00 73.00
73.01 039	250 ONCOLOGY	0	0	0	0	0	
		17 (10	494	1 (4 1	0	0	
	BOO PUTNAM PEDIATRICS AND INTERNAL MED BOI FAMILY MEDICINE OF CLOVERDALE	17, 619 9, 090		1, 641 0	0	0	88.00 88.01
88. 02 088	302 NORTH PUTNAM FAMILY HEALTHCARE	20, 600	0	1, 918	0	0	88. 02
	POO FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
	000 CLI NI C 001 RHEUMATOLOGY	590 1, 716	0	55 160	0	0 1, 540	90.00 90.01
91.00 091	OO EMERGENCY	21, 154	5, 371	1, 970	0	8, 995	91.00
	000 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
99.10 099	IER REIMBURSABLE COST CENTERS	0	0	0	0	0	99.10
SPE	CIAL PURPOSE COST CENTERS	-					
	200 PANCREAS ACQUISITION 200 INTESTINAL ACQUISITION	0	0	0	0		109.00
	00 I SLET ACQUISITION	0	0	0	0		110.00 111.00
113.00113	300 INTEREST EXPENSE	_	-	_			113.00
	UTILIZATION REVIEW-SNF	040 704	04.004	01.411	100 017	50 007	114.00
118.00 NON	SUBTOTALS (SUM OF LINES 1 through 117) REIMBURSABLE COST CENTERS	243, 794	21, 021	21, 411	108, 217	52, 327	118.00
190.00190	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 738		162	0	0	190.00
	200 PHYSI CI ANS' PRI VATE OFFI CES	36, 110	1, 035		0		192.00
	201 JOHNSON/NI CHOLS WI C 203 RHEUMATOLOGY	0	0	0	0		192. 01 192. 02
	BOO NONPAI D WORKERS	0	0	0	0		193.00
193.01193		0	0	0	0		193.01
	302 LACTATION CONSULTING 303 DIABETIC COUNSELING		0	0	0		193. 02 193. 03
194.00079	250 VACANT SPACE	0	0	0	0		193.03
194.01079	51 BOARD OF HEALTH	2, 525	0	235	0		194.01
194. 02 079 200. 00	252 PUTNAM/HENRY PRENATAL Cross Foot Adjustments	0	0	0	0	0	194. 02 200. 00
200.00	10.000 FOUL AUJ USTINOTES	1					

Health Fir	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATI O	N OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2019	Worksheet B Part II	
					To 12/31/2019		
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7.00	8.00	9.00	10.00	11.00	
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	284, 167	22, 056	25, 17	0 108, 217	54, 860	202.00

Cost Centrer Description NUSTING Example 2012/001 (2012) Solution Example 2012/001 (2012) Solution Example 2012/001 (2012) Solution Example 2012/001 (2012) Solution Example 2012 (2012)	Health Financial Systems	PUTNAM COUNT			1	In Lieu	u of Form CMS-	2552-10
COST Center Jeson (pt) on N.I.I. BURKIN, N.I.I. BURKIN, N.I.I. BURKIN, S.I.N.C. Science, S.I.I. S.I.N.C. ULL Lation (S.I.I.I.I.I.I.I.I.I.I.I.I.I.I.I.I.I.I.I	ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1333				
ADDIT STRATO PERCENT SPRVICT PERVICT					To 12	/31/2019	Date/Time Pre 8/28/2020 10:	epared: 03 am
CHERAL SERVICE OST CENTERS 12.00 16.00 17.00 1	Cost Center Description	ADMI NI STRATI O	RECORDS &		-		Subtotal	
1.00 DOTOD NEW CAP REL COSTS-BLOG A FIXI 1.1 0.00 DOTOD NEW CAP REL COSTS-BLOG A FIXI 1.1 0.00 DOTOD NEW CAP REL COSTS-BLOG A FIXI 5.1 0.00 DOTOD NEW CAP REL COSTS-BLOG A FIXI 5.1 0.00 DOTOD NEW CAP REVECTES 5.1 0.00 DOTOD NEW CAP REVECTES 5.1 0.00 DOTOD NEWS AL LINE SERVICE 1.3 1.00 DOTOD NEWS AL LINE SERVICE 1.3 1.00 DOTOD NEWS AL LINE SERVICE 1.3 1.00 DOTOD NEWSING AND INSTRATION 2.7, 599 1.2 1.00 DOTOD NEWSING AND INSTRATION 2.7, 599 1.2 0.9 0.01700 NOCAL RECORDS TO CONT CONTENTS 0 0.1, 9.23 1.3 1.3 0.0000 AULTS 4 FED ATERS 8, 5.35 5.5, 1.22 0 9, 4.64 371, 344 0.0 0.0000 AULTS 4 FED ATERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				17.00	1	7.01	24.00	
4.00 Opendo EMPLAYEE BERKET TS DEPARTMENT 4 5.00 Opendo MINISTRATIVE AS CONFIRMATION 7 7.000 OPENDO MINISTRATIVE AS CONFIRMATION 7 10.00 DITAGE OF PLANT 9 11.00 DITAGE OF PLANT 9								1.00
5.00 DODOCI JANNINI STATUTUE & GAREBAL 5.00 DODOCI JANNINI STATUTUE & GAREBAL 5.00 6.00 DODOCI JANNINI STATUTUE 5.00 DODOCI JANNINI STATUTUE 5.00 6.00 DODOCI JANNINI STATUTUE 5.00 DODOCI JANNINI STATUTUE 5.00 1.00 DITAGO MERSINI MINI NISTATUTUE 5.00 DODOCI JANNINI STATUTUE 5.00 1.00 DITAGO MERSINI MINI NISTATUTUE 0 0 11.360 11.360 1.00 DITAGO MERSINI MINI NISTATUTUE 0 0 0 11.380 15.00 1.00 DITAGO MERSINI MINI NISTATUTUE 0 0 0 11.380 16.00 1.000 DITAGO MERSINI MINI NISTATUTUE 0 0 0 0 12.00 13.00 1.000 DITAGO MERSINI MINI NISTATUTUE 0 0 0 12.00 13.00 12.00 13.00 12.00 13.00 12.00 13.00 12.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00								4.00
8.00 00000 (LAURENY & LINER SERVICE 0 0 00000 (LAURENY ALTINE SERVICE 0 0 00000 11.00 11.00 11.100 10 10 10 10 10 10 10 10 10 10 10 10								5.00
0.00 00000 HOUSENCEPING 0								7.00
10.00 DITODO DETRAFY 0								8.00 9.00
13.00 01300 MURSING ADMINISTRATION 21,599 126,037 0 16 17.00 1700 DICAL ALESCORES & LIBBARY 0 0 11,380 16 17.00 1700 DICAL ALESCORES & LIBBARY 0 0 17,384 16 17.00 1700 DICAL ALESCORE & LIBBARY 0 0 17,384 17 30.00 DISCORE ALESCORE & LIBBARY 0 0 1,328 17,1384 17 30.00 DISCORE ANTIESS & CARRES & LIBBARY 0								10.00
10.00 01000 DED (CARL SPRIVE) 0 126,057 1,386 11,386 11,386 11,386 11,386 11,386 11,386 11,386 31,00 31,00 20,000 21,00								11.00
12.00 01700 SOCIAL SERVICE 0 0 0 17.00 10.00 01700 SOCIAL SERVICE 0 0 17.00 10.00 00000 CURS & PEDIATR(S) 8,532 55,122 0 0,463 271,345 10.00 00000 CURS & PEDIATR(S) 8,532 55,122 0 0 0 0 10.00 00000 CURS & PEDIATR(S) 8,532 55,122 0 0 0 0 11.00 00000 CURS & PEDIATR(S) 8,532 55,122 0 0 0 0 11.00 00000 CURS & PEDIATR(S) 0 0 0 0 0 0 12.00 00000 CURS & PEDIATR(S) 0 0 0 0 0 0 12.00 00000 CURS & PEDIATR(S) 0 0 0 0 0 0 13.00 DSHOD AVESTHES ROUGE 0 0 0 0 0 0 0 13.00 DSHOD AVESTHES ROUGE 0 0 0 0 0 0 0 0 0 14.00 CARDER AVESTHES 0 0 0 0 0 0 0 0 0 0 14.00 CARDER AVESTH		1	126 057					13.00
17.01 DITOI UTIL LZATION REVIEW 0 0 11.380 17.380 INVERTIGATION REVIGE COST CENTERS 8.363 55,122 0 9.463 571,354 30.01 10.01 03000 ADULTS & PEDIATRICS 8.353 55,122 0 9.463 571,354 30.01 10.01 04100 SUPROVIDER - IAF 0		-			0			17.00
30.00 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 00000 000000 000000 000000 000000 0000000 000000000000000000000000000000000000	17.01 01701 UTILIZATION REVIEW	0	0		0	11, 386		17.01
31 00 00 3070 INTENSIVE CARE UNIT 3, 715 0 0 1, 923 127, 181 3 42.00 04200 SUBPROVIDER 0 </td <td></td> <td>0.050</td> <td>FF 400</td> <td></td> <td></td> <td>0.440</td> <td>074 054</td> <td>1 00 00</td>		0.050	FF 400			0.440	074 054	1 00 00
41.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 41. 42.00 04200 URSDAW 0 0 0 0 43. 50.00 DESDDQ OFFRATI NER ROW 0 0 0 0 322.461 50. 50.00 DESDDQ OFFRATI NER ROW 0 0 0 0 17.01 52. 53. 53.00 0 53.00 0 0 0 0 0 17.01 52. 53.00 0 0 0 0 15.115 54.01 054.00 0 0 0 0 15.115 54.01 054.00 0 0 0 18.4.62 34.5.7 55.00 0 0.00 0<					-			1
41.00 0 <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>1</td>					-			1
MACLILARY SERVICE COST CENTRES			-		-		0	
50. 00 65000 0PECOMENT NOR ROAM 0 44, 663 0 0 322. 461 00. 51. 00 65100 65100 65100 65100 65100 65100 65100 65100 65100 65100 65100 65200 65200 65200 65200 65100 65000 <		0	0		0	0	0	43.00
51. 00 05100 RECOVERY ROM LABOR ROM 0 0 0 0 0 0 52. 05200 S2000		0	44,603		0	0	322, 481	50.00
53. 00 09300 AMESTRESIOLOGY 0 0 0 5,52 83. 54. 00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 0 115,118 54. 54. 00 05400 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 0 154.463 54. 57. 00 05700 CT SCAN 0 0 0 184.463 54. 50. 00 05900 CARDIAC CATHETERI ZATION 0		-						
54.00 06400 [RADILOGY-DI AGNOSTI C 0 0 0 115.118 54.02 54.00 06400 [NUCLEAR VEID INE-DI AGNOSTI C 0 0 0 0 15.118 54.02 54.00 05400 [NUCLEAR VEID INE-DI AGNOSTI C 0		0	0		-			
54. 01 05401 NUCLEAR WEDIC IN E-DI AGNOSTIC 0 0 0 15. 519 54. 54. 02 03480 NORCLOSY 0 0 0 164.45 54. 57. 00 05700 CT SCAN 0 0 0 0 164.45 54. 59. 00 05900 CARDIAC CATHETER IZATION 0 0 0 0 0580 60. 00 06001 LABORATORY 0		0	0		0			
54. 02 03480 (NACLOGY 0 0 184. 463 54. 57. 00 05700 (0570) (CT SCAN 0		0	0		0			
58. 00 05800 (MAGNETIC RESONANCE IMAGING (MRI) 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0		0	0		
59.00 65000 CARDIA C CATHETERIZATION 0		0	0		0			
60.00 0000 LABORATORY 0 0 0 105,808 0.00 60.01 06001 INTRAVENUUS THERAPY 0		0	0		0	-		
64.00 06400 INTRAVENUES THERAPY 0<		0	0		0	-		1
65.00 06500 PHATORY THERAPY 0 0 0 28,677 65. 66.00 06600 PHYSICAL THERAPY 0 0 0 57,910 66. 67.00 000 0 0 0 0 57,910 66. 68.00 06900 PHYSICAL THERAPY 0 0 0 0 0 57,910 66. 69.01 06901 CARDIAL RERAPH 0 0 0 0 52.59 69. 10.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71. 73.01 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 94.47 73. 03950 NCOLOGY 0 0 0 0 0 0 94.47 73. 03950 NCOLOGY 0 0 0 0 0 94.47 73. 03950 NCOLOGY 0 0 0 0<		0	0		0	0		60.01
66.00 06600 PHYSICAL THERAPY 0 0 0 57.910 66. 67.00 06700 OCUPATIONAL THERAPY 0 0 0 979 67. 68.00 06800 SPEECH PATHOLOGY 0 0 0 53.236 68. 69.01 06901 CARDI AC REHAB 0 0 0 53.234 69. 71.00 0700 IMPL DEV. CHARGED TO PATIENTS 0 0 0 39.474 73. 0 07300 INCLE CV. CHARGED TO PATIENTS 0 0 0 0 0 0 73. 0 07300 PUICS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 0 08000 PUITAM PERT LATT SERVICE COST CENTRES 0 0 0 0 0 0 165.538 88. 88.00 08800 POLONO 0 0 0 0 163.255 89. 90.00 0 0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>°</td><td></td><td></td></td<>		0	0		0	°		
67.00 0COUPATI ONAL THERAPY 0 0 0 97.9 67. 68.00 06000 SPEECH PATHOLOCY 0 0 0 0.0<		0	0		0	-		
69:00 06900 ELECTROCARDIOLOGY 0 0 0 0 5,259 69,21 69:01 64901 CARDIA C REHAB 0 0 0 0 71.00 0 0 0 71.00 0 0 0 0 71.00 0 0 0 0 0 0 0 71.00 0 0 0 0 0 0 0 0 0 0 0 0 71.72.00 0		0	0		0	Ő		
69.01 06901 CARDIAC REHAB 0 0 0 53, 234 69, 71, 72, 71, 72, 72, 73, 70, 72, 73, 70, 72, 73, 70, 72, 73, 70, 72, 72, 70, 74, 74, 74, 74, 74, 74, 74, 74, 74, 74		0	0		0			
11.00 OT100 DICAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 0 7 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 39,474 73,73 73.01 03950 ONCOLOGY 0 0 0 0 0 0 0 0 0 39,474 73,73 73,01 03950 ONCOLOGY 0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>-</td><td></td><td></td></td<>		0	0		0	-		
72.00 07200 IMPL DEV. CHARGED TO PATIENT 0 0 0 354 72.7 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.7 73.01 03950 ONCOLOGY 0 0 0 0 73.7 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 0 73.7 0UTPATIENT SERVICE COST CENTERS 0 0 0 0 165.638 88.8 88.01 08800 PUTNAM PEDIATRICS AND INTERNAL MED 0 0 0 184,555 88.8 99.00 0 0 184,555 88.8 99.00 0 0 184,555 88.9 90.00 0 0 0 185,55 90.9 91.00 0 0 0 186,355 90.9 92.00 0 0 0 0 185,355 90.9 92.00 0 0 0 0 0 186,355 90.9 92.0 92.0 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td></td><td></td></t<>		0	0		0	0		
73.01 03950 0x0cuogy 0 0 0 0 0 73.02 88.00 08800 PUTNAM FEDIATRICS AND INTERNAL MED 0 0 0 0 90.05 688.06 0 0 0 0 0 90.06 88.02 08800 PUTNAM FEDIATRICS AND INTERNAL MED 0 0 0 90.06 0 0 90.06 0 0 0 90.06 0 0 0 0 90.06 0		0	0		0	0		
OUTPATIENT SERVICE COST CENTERS 88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED 0 0 165,638 88. 88.01 08801 FAMILY MEDICINE OF CLOVERALE 0 0 0 90,465 88. 88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE 0 0 0 184,555 88. 80.00 08900 FODERALLY OUALIFIED HEALTH CENTER 0 0 0 0 89. 90.00 09000 CLINIC 0 0 0 0 89. 91.00 09100 EMEGRICY 9,531 26,332 0 183,55 91. 92.00 092010 DESERVATI ON BEDS (NON-DI STI NCT PART) 95. 92. 0		0	0		0			
88 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED 0 0 0 145,638 88.81 88 01 08801 FAMILY MEDICINE OF CLOVERDALE 0 0 0 90,0465 88.82 88 02 08802 NORTH PUTNAM FAMILY HEALTHCARE 0 0 0 184,555 88. 90,00 09000 CLINIC 0 0 0 4,861 90. 90,01 09001 RHEUMATOLOGY 0 0 0 4,861 90. 90,01 09001 RHERCENCY 9,531 26,332 0 0 253,125 91. 91,00 09010 CRERCENCY 9,531 26,332 0 0 0 0 92. 014120 ORTHER REIMBURSABLE COST CENTERS 91.0 0		0	0		U	U	0	13.01
88. 02 08802 INORTH PUTNAM FAMILY HEALTHCARE 0 0 184, 555 88. 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 90. 00 09000 CLINIC 0 0 0 0 89. 90. 01 09000 CLINIC 0 0 0 48.451 90. 01 09000 EMERGENCY 9,531 26,332 0 0 253,125 91. 91. 00 09200 DESECIAL DIBURSABLE COST CENTERS 92. 9910 CORF 99. 99. 9910 00900 PARCREAS ACQUISITION 0 0 0 0 100. 10.00 11000 INTEREST EXPENSE 1 113. 113. 113. 113. 113. 113. 114. 118. 114. 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 21,599 126,057 11,386 2,257,518 118. 192.00		0	0		0	0	165, 638	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0		0	0		0	0		
90.00 09000 CLINIC 0 0 0 4,861 90. 90.01 09001 RHEUMATOLOGY 0 0 0 18,355 90. 91. 91.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 91.33 26,332 0 0 253,125 91. 92. 92.00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 92.01 0 09200 DBSERVATION BEDS (NON-DISTINCT PART) 92.01 0 92.01 0 0 0 0 0 92.01 92.01 0 92.01 0 90.01 0 0 0 0 97.01		0	0		0	0		1
91.00 09100 EMERGENCY 9, 531 26, 332 0 0 253, 125 91. 92.00 DBSERVATI ON BEDS (NON-DI STINCT PART) 0 0 0 92. 99. 99.00 00000 0 0 0 92. 99. 0 09910 CORF 0 0 0 0 99. SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 109.00 PANCREAS ACQUI SI TI ON 0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td></td><td></td></td<>		0	0		0	0		
92.00 OP200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. OTHER REIMBURSABLE COST CENTERS 0 0 0 0 99. 99.10 OP910 CORF 0 0 0 0 99. 99.10 OP910 CORF 0 0 0 0 99. 109.00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 109. 110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110. 111.00 1SLET ACQUI SI TI ON 0 0 0 0 111. 113.00 INTERST EXPENSE 113. 114. 114.00 114.00 UTI LI ZATI ON REVI EW-SNF 114. 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 21,599 126,057 0 11,386 2,257,518 118. 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 114. 114. 114. 114. 114. 114. 114. 114. 114. 1192.01 192.01		0	0		0	0		
OTHER REI MBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 0 0 99.5 109.00 10900 PANCREAS ACQUI SI TI ON 0 <t< td=""><td></td><td>9, 531</td><td>26, 332</td><td></td><td>0</td><td>0</td><td>253, 125</td><td></td></t<>		9, 531	26, 332		0	0	253, 125	
99.10 OP910 CORF O </td <td></td> <td> </td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>92.00</td>								92.00
109.00 10900 PANCREAS ACQUI SI TI ON 0 <th< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td>99.10</td></th<>		0	0		0	0	0	99.10
110.00 1NTESTI NAL ACQUI SI TI ON 0 0 0 0 110. 111.00 1SLET ACQUI SI TI ON 0 0 0 0 0 111. 113.00 11300 INTEREST EXPENSE 111. 113. 114.00 11401 UTI LI ZATI ON REVIEW-SNF 113. 114.00 114.00 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.01 114.00 114.01								100.00
111.00 11100 I SLET ACQUI SI TI ON 0 0 0 0 111. 113.00 11300 INTEREST EXPENSE 113. 113. 114. 114.00 114.00 114.00 114.01 114.00 114.00 114.00 114.01 111.1. 113.01 114.00 <td< td=""><td></td><td>0</td><td>-</td><td></td><td>-</td><td></td><td></td><td></td></td<>		0	-		-			
114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 21,599 126,057 0 11,386 2,257,518 118. NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 14,313 190. 192.00 19201 JOHNSON/NI CHOLS WI C 0 0 0 347,078 192. 192.01 JOHNSON/NI CHOLS WI C 0 0 0 0 192. 192.02 19201 JOHNSON/NI CHOLS WI C 0 0 0 0 192. 192.02 19203 RHEUMATOLOGY 0 0 0 192. 193.00 19300 NONPAI D WORKERS 0 0 0 0 193. 193.01 19302 LACTATI ON CONSULTI NG 0 0 0 0 193. 193.02 19303 DI ABETI C COUNSELI NG 0 0 0 0 193. <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td></td> <td>111.00</td>		0	0		0	0		111.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 21,599 126,057 0 11,386 2,257,518 118. NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 14,313 190. 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 347,078 192. 192.01 JOHNSON/NI CHOLS WI C 0 0 0 6,733 192. 192.02 19203 RHEUMATOLOGY 0 0 0 0 192. 193.00 19300 NONPAI D WORKERS 0 0 0 0 192. 193.02 19301 DME 0 0 0 0 193. 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 0 193. 193.02 19303 DI ABETI C COUNSELI NG 0 0 0 0 193. 193.03 19303 DI ABETI C COUNSELI NG 0								113.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 14, 313 190. 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 347, 078 192. 192.01 19201 JOHNSON/NI CHOLS WI C 0 0 0 6, 733 192. 192.02 19203 RHEUMATOLOGY 0 0 0 0 192. 193.00 19300 NONPAI D WORKERS 0 0 0 193. 193.01 DME 0 0 0 0 193. 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 193. 193.03 19303 DI ABETI C COUNSELI NG 0 0 0 193. 194.00 07950 VACANT SPACE 0 0 0 0 194. 194.01 07951 BOARD OF HEALTH 0 0 0 0 20, 794 194.		21 500	10/ 057		0	11 20/	0 057 510	114.00
190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 14, 313 190. 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 347, 078 192. 192.01 19201 JOHNSON/NI CHOLS WI C 0 0 0 0 6, 733 192. 192.02 19203 RHEUMATOLOGY 0 0 0 0 192. 193.00 19300 NONPAI D WORKERS 0 0 0 0 193. 193.01 19301 DME 0 0 0 0 0 193. 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 0 193. 193.03 19303 DI ABETI C COUNSELI NG 0 0 0 0 193. 194.00 07950 VACANT SPACE 0 0 0 0 194. 194.01 07951 BOARD OF HEALTH 0 0 0 0 20, 794 194.		21, 599	126, 057	<u> </u>	0	11, 386	2, 257, 518	118.00
192.01 19201 JOHNSON/NI CHOLS WI C 0 0 0 6,733 192. 192.02 19203 RHEUMATOLOGY 0 0 0 0 192. 193.00 19300 NONPAI D WORKERS 0 0 0 0 193. 193.01 19301 DME 0 0 0 0 193. 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 193. 193.03 19303 DI ABETI C COUNSELI NG 0 0 0 193. 194.00 07950 VACANT SPACE 0 0 0 0 194. 194.01 07951 BOARD OF HEALTH 0 0 0 0 20, 794 194.		0	0		0	0	14, 313	190.00
192.02 19203 RHEUMATOLOGY 0 0 0 192. 193.00 19300 NONPAI D_WORKERS 0 0 0 0 193. 193.01 19300 DME 0 0 0 0 193. 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 193. 193.03 19303 DI ABETI C_COUNSELI NG 0 0 0 193. 194.00 07950 VACANT SPACE 0 0 0 0 194. 194.01 07951 BOARD OF HEALTH 0 0 0 0 20, 794 194.		0	0		0	0		
193.00 19300 NONPAID WORKERS 0 0 0 193. 193.01 19301 DME 0 0 0 0 193. 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 0 193. 193.03 19303 DLABETIC COUNSELING 0 0 0 0 193. 194.00 07950 VACANT SPACE 0 0 0 0 194. 194.01 07951 BOARD OF HEALTH 0 0 0 20, 794 194.		0	0		0	0		
193.01 193.01 DME 0 0 0 193. 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 0 193. 193.03 19303 DLABETI C COUNSELI NG 0 0 0 0 193. 194.00 07950 VACANT SPACE 0 0 0 0 194. 194.01 07951 BOARD OF HEALTH 0 0 0 0 20, 794 194.		0	0		0	0		192.02
193.03 19303 DI ABETI C COUNSELI NG 0 0 0 193. 194.00 07950 VACANT SPACE 0 0 0 0 194. 194.01 07951 BOARD OF HEALTH 0 0 0 0 20, 794 194.	193. 01 19301 DME	0	0		0	Ő	0	193.01
194. 00 07950 VACANT SPACE 0 0 0 0 194. 194. 01 07951 BOARD OF HEALTH 0 0 0 0 20, 794 194.		0	0		0	0		193.02
194. 01 07951 BOARD OF HEALTH 0 0 0 0 20, 794 194.		0	0		0	0		
		0	0		0	0		
	194.0207952 PUTNAM/HENRY PRENATAL	0	0		0	0		194.02

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1333	Peri od:	Worksheet B	
				From 01/01/2019	Part II	
				To 12/31/2019	Date/Time Pre	epared:
					8/28/2020 10:	
Cost Center Description	NURSI NG	MEDI CAL	SOCI AL	UTI LI ZATI ON	Subtotal	
	ADMI NI STRATI O	RECORDS &	SERVI CE	REVI EW		
	N	LI BRARY				
	13.00	16.00	17.00	17.01	24.00	
200.00 Cross Foot Adjustments					C	200.00
201.00 Negative Cost Centers	0	0		0 0	C	201.00
202.00 TOTAL (sum lines 118 through 201)	21, 599	126, 057		0 11, 386	2, 646, 436	202.00

	Financial Systems	PUTNAM COUNTY		In Lieu of Form CM	
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CCN: 15-133	From 01/01/2019 Part II	
				To 12/31/2019 Date/Time F 8/28/2020 1	Prepared: 10:03 am
	Cost Center Description	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments			
		25.00	26.00		
1 00	GENERAL SERVICE COST CENTERS				1.00
1.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT				1.00
5.00	00500 ADMI NI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE				8.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
	01100 CAFETERI A				11.00
	01300 NURSI NG ADMI NI STRATI ON				13.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE				16.00
	01701 UTI LI ZATI ON REVI EW				17.00
17.01	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	l		- 17.01
30.00	03000 ADULTS & PEDIATRICS	0	371, 354		30.00
31.00	03100 I NTENSI VE CARE UNI T	0	127, 181		31.00
41.00	04100 SUBPROVI DER – I RF	0	0		41.00
	04200 SUBPROVI DER	0	0		42.00
43.00		0	0		43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	322, 481		50.00
	05100 RECOVERY ROOM	0	71, 423		51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300 ANESTHESI OLOGY	0	5, 552		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	115, 118		54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	5, 519		54.01
	03480 ONCOLOGY	0	184, 463		54.02
57.00	05700 CT SCAN	0	45, 233		57.00
58.00 59.00	05800 MAGNETIC RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0		58.00 59.00
60.00	06000 LABORATORY	0	105, 808		60.00
60.01	06001 BLOOD LABORATORY	0	0		60.01
64.00	06400 I NTRAVENOUS THERAPY	0	o		64.00
65.00	06500 RESPI RATORY THERAPY	0	28, 677		65.00
66.00	06600 PHYSI CAL THERAPY	0	57, 910		66.00
	06700 OCCUPATI ONAL THERAPY	0	979		67.00
	06800 SPEECH PATHOLOGY	0	500		68.00
	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	5, 259 53, 234		69.00 69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	354		72.00
	07300 DRUGS CHARGED TO PATIENTS	Ő	39, 474		73.00
73.01	03950 ONCOLOGY	0	0		73.01
	OUTPATIENT SERVICE COST CENTERS	II	1		
	08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	165, 638		88.00
	08801 FAMILY MEDICINE OF CLOVERDALE	0	90, 465 184 555		88.01
	08802 NORTH PUTNAM FAMILY HEALTHCARE 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	184, 555 0		88. 02 89. 00
	09000 CLINIC	0	4, 861		90.00
	09001 RHEUMATOLOGY	0	18, 355		90.00
	09100 EMERGENCY	0	253, 125		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92.00
	OTHER REIMBURSABLE COST CENTERS	[]			
99.10	09910 CORF	0	0		99.10
100 00	SPECIAL PURPOSE COST CENTERS	~	0		109.00
	11000 INTESTINAL ACQUISITION	0	0		1109.00
	11100 I SLET ACQUI SI TI ON	0	ő		111.00
	11300 I NTEREST EXPENSE				113.00
114.00	11400 UTILIZATION REVIEW-SNF				114.00
118.00		0	2, 257, 518		118. 00
100 07	NONREI MBURSABLE COST CENTERS	-1	14.040		100.07
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14, 313		190.00 192.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 JOHNSON/NI CHOLS WI C	0	347, 078 6, 733		192.00
	19203 RHEUMATOLOGY	0	0, 733		192.01
	19300 NONPALD WORKERS	0	o		192.02
	19301 DME	o	ő		193.01
193.02	19302 LACTATION CONSULTING	0	0		193.02
102 02	19303 DI ABETI C COUNSELI NG	0	0		193.03
	07950 VACANT SPACE	0	0		194.00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1333	Period:	Worksheet B		
				From 01/01/2019 To 12/31/2019		epared:	
					8/28/2020 10:	03 am	
Cost Center Description	Intern &	Total					
	Residents						
	Cost & Post						
	Stepdown						
	Adjustments						
	25.00	26.00					
194.0107951 BOARD OF HEALTH	0	20, 794				194.01	
194.0207952 PUTNAM/HENRY PRENATAL	0	0				194.02	
200.00 Cross Foot Adjustments	0	0				200.00	
201.00 Negative Cost Centers	0	0				201.00	
202.00 TOTAL (sum lines 118 through 201)	0	2, 646, 436				202.00	

	Financial Systems LLOCATION - STATISTICAL BASIS	PUTNAM COUNT		CN: 15-1333 F	Period:	u of Form CMS-2 Worksheet B-1	
				F	rom 01/01/2019 o 12/31/2019	Date/Time Pre	epared:
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	Reconciliatio	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	8/28/2020 10: OPERATION OF PLANT (SQUARE FEET)	<u>03 am</u>
		1.00	4.00	5A	5.00	7.00	
00	GENERAL SERVICE COST CENTERS	102 715		1		1	1 1 00
1.00 3.00 6.00 7.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 UTILIZATION REVIEW	102, 715 153 14, 222 10, 345 676 632 3, 497 1, 604 665 3, 952 0 3333	22, 016, 448 2, 636, 404 322, 811 28, 534 424, 432 113, 906 264, 078 77, 109 257, 071 0 75, 456	-7,051,762	1, 754, 914 216, 856 637, 548 407, 349 708, 855 159, 152 580, 155 0	77, 995 676 632 3, 497 1, 604 665 3, 952 0 333	8.00 9.00 10.00 11.00 13.00 16.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	5, 940	1, 899, 350		1, 873, 363	5, 940	30.00
1.00 2.00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER 04300 NURSERY	2, 841 0 0 0	647, 255 0 0 0		0 1, 140, 804 0 0 0 0	2, 841 0 0	31.00 41.00 42.00
50.00	ANCI LLARY SERVI CE COST CENTERS	8, 181	688, 556		2, 716, 883	8, 181	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	2, 295 0	106, 543 0 832, 046		226, 568 0 0	2, 295 0	51.00 52.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 031	975, 699		,	3, 031	
	05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	140	0	-		140	
	03480 ONCOLOGY 05700 CT SCAN	4, 857 1, 320	323, 400 174, 884		3, 712, 170 481, 460	4, 857 1, 320	
58.00 59.00 50.00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0 0 2, 510	0 0 754, 007		0 0 0 0	0 0 2, 510	58.00 59.00
4.00	06001 BLOOD LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 0 700	0 0 378, 253		0 0 0 0 562,469	0 0 700	64.00
6.00 7.00 8.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 704 0 0	0 0 0		0 660, 354 97, 782 49, 904	1, 704 0 0	67.00
	06900 ELECTROCARDI OLOGY	100	71, 908		182, 353		69.00
	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 616 0	260, 295 0		0,0,000		69.0 [°] 71.00
2.00 3.00	07200 I MPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0 896 0	0 272, 539 0) 35, 358) 1, 117, 103	0 896	72.00 73.00 73.0
3.01	03950 ONCOLOGY OUTPATIENT SERVICE COST CENTERS		0	<u>1 (</u>	0	0	13.0
	08800 PUTNAM PEDIATRICS AND INTERNAL MED	4, 836	1, 350, 853		2/ 101/ 010		
38. 02	08801 FAMILY MEDICINE OF CLOVERDALE 08802 NORTH PUTNAM FAMILY HEALTHCARE	2, 495 5, 654 0	1, 108, 584 980, 247		1, 687, 200 1, 616, 695	5, 654	88. 02
90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 162	0) 0 4,174	0 162	
	09001 RHEUMATOLOGY	471	373, 634		273, 314	471	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 806	3, 071, 549		2, 959, 259	5, 806	91.00 92.00
9. 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0) 0	0	99.10
00 00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	0				0	109.00
10. 00 11. 00	11000 FARERES ACCUISTION 11000 INTESTINAL ACQUISTION 11100 ISLET ACQUISTION 11300 INTEREST EXPENSE	0	0			0	1109.00 110.00 111.00
14. 00 18. 00	11400 UTILIZATION REVIEW-SNF	91, 634	18, 469, 403	-7, 051, 762	2 31, 141, 063	66, 914	114.00
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	477	0		12, 290		190. 00
92.01	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 JOHNSON/NI CHOLS WI C 19203 RHEUMATOLOGY	9, 911 0 0	3, 248, 382 298, 663 0		5, 055, 361 414, 180 0 0	0	192.00 192.01 192.02
93.00	19300 NONPALD WORKERS 19301 DME	0	0			0	192.02 193.00 193.01
	19302 LACTATION CONSULTING	0	0				193.02

Health Fina	ancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 10:	
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
		FLXT	BENEFITS	n	E & GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE FEET)	
		FEET)	(GROSS		COST)		
		1.00	SALARI ES)		F 00	7 00	
100 00 1000		1.00	4.00	5A	5.00	7.00	100.00
	3 DI ABETI C COUNSELI NG	0	0		0		193.03
	O VACANT SPACE	0	0		J U		194.00
	1 BOARD OF HEALTH	693	0		0 17,855		194.01
	2 PUTNAM/HENRY PRENATAL	0	0		5 0		194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		- 400 440		7 054 7/0		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 646, 436	5, 198, 469		7, 051, 762	2, 092, 659	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	25. 764844	0. 236118		0. 192457	26. 830681	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		3, 942		366, 901	284, 167	204.00
205.00	Unit cost multiplier (Wkst. B, Part		0. 000179		0. 010013	3. 643400	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	PUTNAM COUNT	Y HOSPITAL Provider CO	^N· 15_1333 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
				om 01/01/2019		pared:
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERIA (MANHOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	
	8.00	9.00	10.00	11.00	13.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 009000 HOUSEKEEPING	178, 565					1.00 4.00 5.00 7.00 8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE 17. 01 01701 UTILIZATION REVIEW INPATIENT ROUTINE SERVICE COST CENTERS	1, 002 740 0 0 0 0 0	74, 192 3, 497 1, 604 665 3, 952 0 333	2, 297	302, 488 1, 148 14, 553 0 2, 092	112, 391 0 0 0	9.00 10.00 11.00 13.00 16.00 17.00 17.01
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNI T	38, 845 29, 996	5, 940 2, 841	1, 909 388	43, 466 19, 331	43, 466 19, 331	30.00 31.00
41.00 04100 SUBPROVI DER - I RF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY	000000000000000000000000000000000000000	0 0 0	0 0 0	0 0	0 0 0	41.00 42.00 43.00
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM	25, 382 2, 713 0	8, 181 2, 295 0	0 0 0	22, 343 2, 915 0	0 0	50.00 51.00 52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0 13, 358 0	0 3, 031 140	0 0 0	6, 329 34, 740 0	0	53.00 54.00 54.01
54. 02 03480 ONCOLOGY 57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 740 0 0	4, 857 1, 320 0	0 0 0	11, 259 6, 145 0	0	54.02 57.00 58.00
59.00 05900 CARDI AC CATHETERI ZATI ON 60.00 06000 LABORATORY 60.01 06001 BLOOD LABORATORY 64.00 06400 I NTRAVENOUS THERAPY		0 2, 510 0 0	0 0 0 0	0 35, 587 0 0	0 0 0 0	59.00 60.00 60.01 64.00
65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY	0 4, 931 0	700 1, 704 0	0 0 0	11, 883 0 0	0 0 0	65.00 66.00 67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	0 100 1, 616		0 2, 457 7, 442	0 0 0	68.00 69.00 69.01
71.0007100MEDICAL SUPPLIES CHARGED TO PATIENTS72.0007200I MPL. DEV. CHARGED TO PATIENT73.0007300DRUGS CHARGED TO PATIENTS73.0103950ONCOLOGY	000000000000000000000000000000000000000	0 0 896 0	0 0 0	0 0 8, 747 0	0 0 0 0	73.00
OUTPATI ENT SERVI CE COST CENTERS		-	-	0		73.01
88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED 88.01 08801 FAMILY MEDICINE OF CLOVERDALE 88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE	3, 997 0 0	4, 836 0 5, 654	0	0 0 0	0 0 0	88.00 88.01 88.02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 90. 01 09001 RHEUMATOLOGY	000000000000000000000000000000000000000	0 162 471	0 0 0	0 0 8, 491	0 0 0	89.00 90.00 90.01
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REI MBURSABLE COST CENTERS	43, 479	5, 806	0	49, 594	49, 594	91.00 92.00
99. 10 09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99.10
109.00 10900 PANCREAS ACQUI SI TI ON 110.00 11000 I NTESTI NAL ACQUI SI TI ON 111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 I NTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF	000000000000000000000000000000000000000	0 0 0	0 0 0	0 0 0	0	109.00 110.00 111.00 113.00 114.00
114. 00 T1400 0TELZATION REVIEW-SNF 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	170, 183	63, 111	2, 297	288, 522	112, 391	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 JOHNSON/NI CHOLS WI C	0 8, 382 0	477 9, 911 0	0 0 0	0 0 13, 966	0	190. 00 192. 00 192. 01
192. 02 19203 RHEUMATOLOGY 193. 00 19300 NONPALD WORKERS 193. 01 19301 DME	000000000000000000000000000000000000000	0	0 0 0	0 0 0	0 0	192. 02 193. 00 193. 01
193. 02 19302 LACTATI ON CONSULTI NG 193. 03 19303 DI ABETI C COUNSELI NG 194. 00 07950 VACANT SPACE	0	0	0 0 0	0 0 0	0 0	193. 02 193. 03 194. 00

Health Fi	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALL	DCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019		pared: <u>03 am</u>
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERIA (MANHOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	
		8.00	9.00	10.00	11.00	13.00	
194.0107	951 BOARD OF HEALTH	0	693	(0 0	0	194.01
194.0207	952 PUTNAM/HENRY PRENATAL	0	0	(0 0	0	194.02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	276, 729	778, 759	617, 420	905, 151	218, 039	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 549738	10. 496536	268. 79669 [.]	1 2. 992353	1. 940004	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	22, 056	25, 170	108, 21	7 54, 860	21, 599	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 123518	0. 339255	47. 112320	0. 181363	0. 192177	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

	Financial Systems	PUTNAM COUNTY		01 45 4000	In Lieu of Form C	
COST A	LLOCATION - STATISTICAL BASIS		Provider C		Period: Worksheet From 01/01/2019 To 12/31/2019 Date/Time	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE (PATI ENT	UTI LI ZATI ON REVI EW (PATI ENT	8/28/2020	10: 03 am
		(TIME SPENT) 16.00	DAYS) 17.00	DAYS) 17.01		
1.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00 5.00 7.00 8.00 9.00 10.00 11.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	129, 196				4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 16.00
17.00	01700 SOCIAL SERVICE 01701 UTILIZATION REVIEW	0	0			17.00
17.01	INPATIENT ROUTINE SERVICE COST CENTERS		0	2,25		17.01
30.00 31.00 41.00 42.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	56, 494 0 0 0 0	0 0 0 0	38		30. 00 31. 00 41. 00 42. 00 43. 00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	45, 714	0		0	50.00
51.00 52.00 53.00 54.00 54.01	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0 0 0 0	0 0 0 0 0		0 0 0 0 0	51.00 52.00 53.00 54.00 54.01
54.02 57.00	03480 ONCOLOGY 05700 CT SCAN	0	0 0		0 0	54.02 57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0		0	58.00 59.00
60.00	06000 LABORATORY	0	0		0	60.00
60. 01 64. 00	06001 BLOOD LABORATORY 06400 I NTRAVENOUS THERAPY	0	0		0	60. 01 64. 00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0 0		0	65.00 66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	67.00 68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	69.00
69.01 71.00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	69.01 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03950 ONCOLOGY	0	0		0	73.00 73.01
88.00	OUTPATIENT SERVICE COST CENTERS 08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	0		0	88.00
88.01	08801 FAMILY MEDICINE OF CLOVERDALE	0	0		0	88.01
88. 02 89. 00	08802 NORTH PUTNAM FAMILY HEALTHCARE 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	88. 02 89. 00
90. 00 90. 01	09000 CLINIC 09001 RHEUMATOLOGY	0	0		0	90.00 90.01
91.00	09100 EMERGENCY	26, 988	0		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					92.00
99.10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0		0	99.10
	10900 PANCREAS ACQUI SI TI ON	0	0		0	109.00
	11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION	0	0		0	110. 00 111. 00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF					113.00 114.00
118.00		129, 196	0	· ·	0	118.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 JOHNSON/NI CHOLS WI C	0	0		0	192.00 192.01
192.02	19203 RHEUMATOLOGY	0	0		0	192.02
	19300 NONPALD WORKERS 19301 DME	0	0		0 0	193.00 193.01
193.02	19302 LACTATION CONSULTING	o o	0		0	193.02
194.00	19303 DI ABETI C COUNSELI NG 07950 VACANT SPACE	0	0		0	193. 03 194. 00
194.01	07951 BOARD OF HEALTH	0	0		0	194.01

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1
					From 01/01/2019 To 12/31/2019	Date/Time Prepared: 8/28/2020 10:03 am
	Cost Center Description	MEDI CAL	SOCI AL	UTI LI ZATI ON		
		RECORDS & LI BRARY	SERVI CE (PATI ENT	REVI EW (PATI ENT		
		(TIME SPENT)	DAYS)	DAYS)		
		16.00	17.00	17.01		
194.02	07952 PUTNAM/HENRY PRENATAL	0	0		0	194.02
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	882, 875	0	148, 12	24	202.00
000.00	Part I)	(000(00	0.000000	(4 40505		
203.00	Unit cost multiplier (Wkst. B, Part I)	6.833609	0. 000000			203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	126, 057	0	11, 38	36	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 975704	0. 000000	4. 95690	00	205.00
201 00						201 00
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)					

lealth Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES		Y HOSPITAL Provider C	NI 1E 1222		u of Form CMS-2	2002
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	JN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre	pared:
					8/28/2020 10:	03 am
		Title	XVIII	Hospi tal	Cost	
Cost Contor Description	Tatal Coat	Thorsony Limit	Tatal Casta	Costs RCE	Tatal Casta	
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	Di sal l owance	Total Costs	
	B, Part I,	Auj .		DI Sal I Owalice		
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	3, 752, 512		3, 752, 5	12 0	0	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	1, 737, 554		1, 737, 5	54 0	0	31.00
41. 00 04100 SUBPROVIDER - IRF	0			0 0	0	41. OC
42. 00 04200 SUBPROVI DER	0			0 0	0	42.00
43. 00 04300 NURSERY	0			0 0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	3, 963, 725		3, 963, 72		0	50.00
51.00 05100 RECOVERY ROOM	368, 766		368, 70		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	525, 620		525, 62		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 241, 827		2, 241, 82		0	54.00
54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	166, 626		166, 62		0	54.01
54. 02 03480 ONCOLOGY	4, 650, 488		4, 650, 48		0	54.02
57.00 05700 CT SCAN	641, 779		641, 7		0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0 104 040		2 124 0	0 0	0	59.00
50. 00 06000 LABORATORY	3, 124, 042		3, 124, 04		0	60.00
50.01 06001 BLOOD LABORATORY 54.00 06400 I NTRAVENOUS THERAPY	0			0 0	0	60.01
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	732, 407	0	732, 40	0 0	0	64.00 65.00
56. 00 06600 PHYSI CAL THERAPY	858, 691	0	858, 69		0	66.00
57.00 06700 OCCUPATI ONAL THERAPY	116, 601	0	116, 60		0	67.00
58. 00 06800 SPEECH PATHOLOGY	59, 508	0	59, 50		0	68.00
59. 00 06900 ELECTROCARDI OLOGY	228, 533	0	228, 53		0	69.00
59. 01 06901 CARDI AC REHAB	531, 020		531, 02		0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	42, 163		42, 10	-	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 391, 716		1, 391, 7		0	73.00
73. 01 03950 ONCOLOGY	0			0 0	0	73.01
OUTPATIENT SERVICE COST CENTERS						1
38.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	2, 692, 788		2, 692, 78	38 0	0	88.00
38.01 08801 FAMILY MEDICINE OF CLOVERDALE	2, 078, 856		2, 078, 8	56 0	0	88.01
38.02 08802 NORTH PUTNAM FAMILY HEALTHCARE	2, 138, 887		2, 138, 88	37 0	0	88.02
39. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC	11, 024		11, 02	24 0	0	90.00
PO. 01 09001 RHEUMATOLOGY	368, 904		368, 90		0	90.01
91.00 09100 EMERGENCY	4, 241, 934		4, 241, 93		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 378, 344		1, 378, 34	44	0	92.00
OTHER REIMBURSABLE COST CENTERS	-			_		
99. 10 09910 CORF	0			0	0	99.10
SPECIAL PURPOSE COST CENTERS				0	^	109.00
110. 00 110900 PANCREAS ACQUISETTON 110. 00 11000 ENTESTENAL ACQUESETION	0			0		1109.00
111.00 11100 ISLET ACQUISITION	0			0		111. OC
113.00 11300 INTEREST EXPENSE	0					113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
200.00 Subtotal (see instructions)	38, 044, 315	0	38, 044, 3 [.]	15 0		200.00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds	1, 378, 344	0	1, 378, 34			200.00
202.00 Total (see instructions)	36, 665, 971	0				201.00
	50,005,771	0	000,000,9	, i U	0	1202.06

Health Financial Systems		PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF CO	STS TO CHARGES		Provider C		Period:	Worksheet C	
					From 01/01/2019 To 12/31/2019	Part Date/Time Pre	pared.
					10 12/01/2017	8/28/2020 10:	
				XVIII	Hospi tal	Cost	
			Charges				
Cost Center De	escription	Inpatient	Outpati ent	Total (col. 6		TEFRA	
				+ col. 7)	Ratio	Inpati ent	
		6.00	7.00	8.00	9.00	Rati o 10.00	
INPATIENT ROUTINE SE	ERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30. 00 03000 ADULTS & PEDIA		4, 633, 038		4, 633, 03	8		30.00
31.00 03100 I NTENSI VE CARE		1, 724, 323		1, 724, 32			31.00
41.00 04100 SUBPROVI DER -		0)		41.00
42.00 04200 SUBPROVI DER		0		(D		42.00
43.00 04300 NURSERY		0		(D		43.00
ANCILLARY SERVICE CO	OST CENTERS						
50.00 05000 OPERATING ROOM		995, 598	5, 564, 752	6, 560, 350	0. 604194	0.00000	50.00
51.00 05100 RECOVERY ROOM		114, 554	600, 345	714, 89	9 0. 515830	0.00000	51.00
52.00 05200 DELIVERY ROOM		0	0		0. 000000	0.000000	
53.00 05300 ANESTHESI OLOGY		42, 249	464, 032	506, 28		0.000000	1
54.00 05400 RADI OLOGY-DI AG		894, 126	8, 701, 872	9, 595, 99		0. 000000	
54.01 05401 NUCLEAR MEDICI	NE-DI AGNOSTI C	35, 201	1, 411, 202			0.000000	1
54.02 03480 ONCOLOGY		6, 796	8, 085, 736			0.00000	54.02
57.00 05700 CT SCAN		630, 157	19, 637, 472	20, 267, 62		0.000000	57.00
58.00 05800 MAGNETIC RESON		0	0		0. 000000	0.000000	58.00
59.00 05900 CARDI AC CATHET	ERI ZATI ON	0	0		0. 000000	0.000000	59.00
60.00 06000 LABORATORY		1, 530, 879	15, 555, 929			0.000000	60.00
60.01 06001 BLOOD LABORATO		0	0		0. 000000	0.000000	1
64.00 06400 INTRAVENOUS TH		0	0		0. 000000	0.00000	
65.00 06500 RESPI RATORY TH		1, 597, 344	1,066,923			0.000000	
66.00 06600 PHYSI CAL THERA		524, 592	2, 394, 895			0.000000	66.00
67.00 06700 0CCUPATI ONAL T		144, 192	397, 041	541, 23		0.000000	67.00
68.00 06800 SPEECH PATHOLO		66, 590	180, 371	246, 96		0.000000	68.00
69.00 06900 ELECTROCARDI OL	.0GY	39, 634	1, 294, 223			0.000000	69.00
69. 01 06901 CARDI AC REHAB	FO OLIADOED TO DATLENTO	2, 742	685, 988			0.000000	
	ES CHARGED TO PATIENTS	0	0		0.000000	0.000000	
72.00 07200 I MPL. DEV. CHA		25, 847	103, 233			0.000000	
73.00 07300 DRUGS CHARGED 73.01 03950 ONCOLOGY	TU PATTENTS	976, 073	2, 625, 623			0.000000	1
73.01 03950 ONCOLOGY OUTPATIENT SERVICE 0	COST CENTERS	0	0		0.00000	0. 000000	73.01
	ICS AND INTERNAL MED	0	2, 149, 509	2, 149, 50			88.00
88. 01 08801 FAMILY MEDICIN		0	2, 067, 206				88.01
88. 02 08802 NORTH PUTNAM F		0	1, 376, 133				88.02
89.00 08900 FEDERALLY QUAL		0	1, 370, 133		5		89.00
90. 00 09000 CLINIC	in the mercent of the terret	0	4, 622	4, 62	-	0.000000	
90. 01 09001 RHEUMATOLOGY		0	10, 774			0.000000	
91. 00 09100 EMERGENCY		342, 072	19, 485, 706			0. 000000	1
	DS (NON-DISTINCT PART)	0 12, 0, 2	2, 161, 171	2, 161, 17		0.000000	
OTHER REIMBURSABLE (2,101,171	2,101,17	0.007770	0.000000	72.00
99.10 09910 CORF		0	0	(C		99.10
SPECIAL PURPOSE COST	CENTERS			ı			
109.00 10900 PANCREAS ACQUI		0	0	(C		109.00
110.00 11000 INTESTINAL ACO		0	0		D		110.00
111.00 11100 I SLET ACQUI SI T		0	0		D		111.00
113.00 11300 INTEREST EXPEN							113.00
114.00 11400 UTILIZATION RE							114.00
200.00 Subtotal (see		14, 326, 007	96, 024, 758	110, 350, 76	5		200.00
201.00 Less Observati	on Beds						201.00
202.00 Total (see ins	tructions)	14, 326, 007	96, 024, 758	110, 350, 76	5		202.00

	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	PUTNAM COUNTY	Provi der CCN: 15-1333	Peri od:	u of Form CMS- Worksheet C	2002 .
				From 01/01/2019 To 12/31/2019	Part I Date/Time Pr	epared:
					8/28/2020 10	:03 am
			Title XVIII	Hospi tal	Cost	_
	Cost Center Description	PPS Inpatient				
		Ratio				
	INDATIONT DOUTINE SEDVICE COST CENTERS	11.00				_
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS					30.00
	03100 I NTENSI VE CARE UNI T					31.0
	04100 SUBPROVIDER – I RF					41.0
	04200 SUBPROVI DER					41.0
	04300 NURSERY					42.0
	ANCILLARY SERVICE COST CENTERS					43.0
	05000 OPERATING ROOM	0.000000				50.0
	05100 RECOVERY ROOM	0.000000				51.0
	05200 DELIVERY ROOM & LABOR ROOM	0.000000				52.0
	05300 ANESTHESI OLOGY	0.000000				52.0
	05400 RADI OLOGY-DI AGNOSTI C					
		0.000000				54.0
	05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0.000000				54.0
	03480 ONCOLOGY	0.000000				54.0
	05700 CT SCAN	0.000000				57.0
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.0
	05900 CARDI AC CATHETERI ZATI ON	0.000000				59.0
	06000 LABORATORY	0. 000000				60.0
	06001 BLOOD LABORATORY	0.000000				60. C
	06400 I NTRAVENOUS THERAPY	0. 000000				64.0
	06500 RESPI RATORY THERAPY	0.000000				65.0
	06600 PHYSI CAL THERAPY	0. 000000				66.0
	06700 OCCUPATI ONAL THERAPY	0. 000000				67.0
	06800 SPEECH PATHOLOGY	0. 000000				68.0
	06900 ELECTROCARDI OLOGY	0. 000000				69.0
	06901 CARDI AC REHAB	0. 000000				69.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.0
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.0
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.0
	03950 ONCOLOGY	0. 000000				73.0
	OUTPATIENT SERVICE COST CENTERS					
	08800 PUTNAM PEDIATRICS AND INTERNAL MED					88.0
	08801 FAMILY MEDICINE OF CLOVERDALE					88.0
	08802 NORTH PUTNAM FAMILY HEALTHCARE					88.0
	08900 FEDERALLY QUALIFIED HEALTH CENTER					89.0
	09000 CLINIC	0. 000000				90.0
	09001 RHEUMATOLOGY	0. 000000				90.0
	09100 EMERGENCY	0. 000000				91.0
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.0
	OTHER REIMBURSABLE COST CENTERS					
	09910 CORF					99.1
	SPECIAL PURPOSE COST CENTERS					
	10900 PANCREAS ACQUI SI TI ON					109.0
	11000 INTESTINAL ACQUISITION					110.0
111.00	11100 I SLET ACQUI SI TI ON					111.0
13.00	11300 INTEREST EXPENSE					113.0
114.00	11400 UTILIZATION REVIEW-SNF					114.0
200.00	Subtotal (see instructions)					200.0
201.00	Less Observation Beds					201.0
202.00	Total (see instructions)	1				202.0

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-3	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019		
		Ti †I	e XIX	Hospi tal	Cost	
				Costs	0001	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 752, 512		3, 752, 51	2 0	3, 752, 512	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 737, 554		1, 737, 55	4 0	1, 737, 554	31.00
41.00 04100 SUBPROVI DER – I RF	0			0 0	0	41.00
42. 00 04200 SUBPROVI DER	0			0 0	0	42.00
43.00 04300 NURSERY	0			0 0	0	43.00
ANCILLARY SERVICE COST CENTERS			_			
50.00 05000 OPERATI NG ROOM	3, 963, 725		3, 963, 72	5 0	3, 963, 725	50.00
51.00 05100 RECOVERY ROOM	368, 766		368, 76	6 0	368, 766	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	525, 620		525, 62	0 0	525, 620	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 241, 827		2, 241, 82	7 0	2, 241, 827	54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	166, 626		166, 62	6 0	166, 626	54.01
54. 02 03480 ONCOLOGY	4, 650, 488		4, 650, 48	8 0	4, 650, 488	54.02
57.00 05700 CT SCAN	641, 779		641, 77	9 0	641, 779	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	3, 124, 042		3, 124, 04	2 0	3, 124, 042	60.00
60.01 06001 BLOOD LABORATORY	0			0 0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	732, 407	0	732, 40	7 0	732, 407	65.00
66. 00 06600 PHYSI CAL THERAPY	858, 691	0	858, 69		858, 691	66.00
67.00 06700 OCCUPATI ONAL THERAPY	116, 601	0	116, 60		116, 601	67.00
68.00 06800 SPEECH PATHOLOGY	59, 508	0	59, 50		59, 508	
69. 00 06900 ELECTROCARDI OLOGY	228, 533		228, 53		228, 533	
69. 01 06901 CARDI AC REHAB	531, 020		531, 02		531, 020	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	42, 163		42, 16	3 0	42, 163	
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 391, 716		1, 391, 71		1, 391, 716	
73. 01 03950 ONCOLOGY	0			0 0		
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	2, 692, 788		2, 692, 78	8 0	2, 692, 788	88.00
88.01 08801 FAMILY MEDICINE OF CLOVERDALE	2,078,856		2, 078, 85		2, 078, 856	
88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE	2, 138, 887		2, 138, 88		2, 138, 887	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
90. 00 09000 CLINIC	11, 024		11, 02	4 0	11, 024	
90. 01 09001 RHEUMATOLOGY	368, 904		368, 90		368, 904	
91.00 09100 EMERGENCY	4, 241, 934		4, 241, 93		4, 241, 934	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 378, 344		1, 378, 34		1, 378, 344	
OTHER REIMBURSABLE COST CENTERS				· I · · · · · · · · · · · · · · · · · ·		
99. 10 09910 CORF	0			0	0	99.10
SPECIAL PURPOSE COST CENTERS				<u> </u>		
109.00 10900 PANCREAS ACQUISITION	0			0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0			0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0			0		111.00
113. 00 11300 I NTEREST EXPENSE					0	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
200.00 Subtotal (see instructions)	38,044,315	0	38, 044, 31	5 0	38, 044, 315	
201.00 Less Observation Beds	1, 378, 344		1, 378, 34		1, 378, 344	
202.00 Total (see instructions)	36, 665, 971					
		0				

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1333	Peri od:	Worksheet C	
					From 01/01/2019 To 12/31/2019		nared
					10 12/01/2017	8/28/2020 10:	03 am
				e XIX	Hospi tal	Cost	
			Charges			TEEDA	
	Cost Center Description	Inpati ent	Outpati ent		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						
30.00	03000 ADULTS & PEDI ATRI CS	4, 633, 038		4, 633, 03	38		30.00
31.00	03100 INTENSIVE CARE UNIT	1, 724, 323		1, 724, 32	23		31.00
41.00	04100 SUBPROVI DER – I RF	0			0		41.00
	04200 SUBPROVI DER	0			0		42.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0			0		43.00
50.00	05000 OPERATING ROOM	995, 598	5, 564, 752	6, 560, 35	0. 604194	0. 000000	50.00
51.00	05100 RECOVERY ROOM	114, 554	600, 345			0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	000,010	, , , , , , , , , , , , , , , , , , , ,	0 0.000000		•
53.00	05300 ANESTHESI OLOGY	42, 249	464, 032	506, 28		0. 000000	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	894, 126	8, 701, 872	9, 595, 99	0. 233621	0. 000000	54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	35, 201	1, 411, 202			0.000000	
54.02	03480 ONCOLOGY	6, 796	8,085,736			0. 000000	
57.00	05700 CT SCAN	630, 157	19, 637, 472	20, 267, 62		0.000000	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0.000000	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	15 555 020	17 004 00	0 0.00000	0.000000	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	1, 530, 879 0	15, 555, 929	17, 086, 80	0. 182834 0. 000000	0.000000	
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0.000000	0.000000	
65.00	06500 RESPIRATORY THERAPY	1, 597, 344	1,066,923	2, 664, 26		0.000000	
66.00	06600 PHYSI CAL THERAPY	524, 592	2, 394, 895			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	144, 192	397, 041	541, 23	0. 215436	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	66, 590	180, 371	246, 96	0. 240961	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	39, 634	1, 294, 223			0. 000000	
69.01	06901 CARDI AC REHAB	2, 742	685, 988	688, 73		0.000000	•
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	102,000	100.00	0 0.00000	0.000000	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	25, 847 976, 073	103, 233			0.000000	
	03950 ONCOLOGY	970,073	2, 625, 623 0		0 0. 000000		•
75.01	OUTPATIENT SERVICE COST CENTERS	0	0	I	0 0.00000	0.000000	1 / 5. 01
88.00	08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	2, 149, 509	2, 149, 50	1. 252746	0.000000	88.00
88.01	08801 FAMILY MEDICINE OF CLOVERDALE	0	2,067,206				88.01
88. 02	08802 NORTH PUTNAM FAMILY HEALTHCARE	0	1, 376, 133	1, 376, 13	1. 554273	0. 000000	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000		
90.00	09000 CLI NI C	0	4, 622	4,62		0.000000	
90.01	09001 RHEUMATOLOGY	0	10, 774				•
91.00	09100 EMERGENCY	342, 072	19, 485, 706				
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 161, 171	2, 161, 17	0. 637776	0. 000000	92.00
99.10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	o	0		0		99.10
77. TU	SPECIAL PURPOSE COST CENTERS	0	0		0		99.10
109.00	10900 PANCREAS ACQUISITION	0	0		0		109.00
	11000 INTESTINAL ACQUISITION	0	0		0		110.00
	11100 I SLET ACQUI SI TI ON	0	0		0		111.00
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
200.00		14, 326, 007	96, 024, 758	110, 350, 76	5		200.00
201.00		14 004 007	04 004 750		F		201. 00 202. 00
202.00	Total (see instructions)	14, 326, 007	96, 024, 758	110, 350, 76		I	202.00

	Financial Systems	PUTNAM COUNTY			u of Form CMS-	-2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1333	Period: From 01/01/2019	Worksheet C Part I	
				To 12/31/2019	Date/Time Pr 8/28/2020 10	epared: ·03 am
			Title XIX	Hospi tal	Cost	- 00 am
	Cost Center Description	PPS Inpatient	·			
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
41.00	04100 SUBPROVI DER – I RF					41.00
42.00	04200 SUBPROVI DER					42.00
43.00	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000				54.01
54.02	03480 ONCOLOGY	0. 000000				54.02
57.00	05700 CT SCAN	0. 000000				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60.00	06000 LABORATORY	0. 000000				60.00
60.00	06001 BLOOD LABORATORY	0. 000000				60.0
64.00	06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65.00	06500 RESPIRATORY THERAPY					
		0. 000000				65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000				68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69.00
69.01	06901 CARDI AC REHAB	0. 000000				69.0
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
73.01	03950 ONCOLOGY	0. 000000				73.0
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800 PUTNAM PEDIATRICS AND INTERNAL MED	0. 000000				88.00
88. 01	08801 FAMILY MEDICINE OF CLOVERDALE	0. 000000				88.0
	08802 NORTH PUTNAM FAMILY HEALTHCARE	0. 000000				88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
90.00	09000 CLINIC	0. 000000				90.00
90.01	09001 RHEUMATOLOGY	0. 000000				90.0
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS					
99.10	09910 CORF					99.10
	SPECIAL PURPOSE COST CENTERS					
109.00	10900 PANCREAS ACQUI SI TI ON					109.00
	11000 INTESTINAL ACQUISITION					110.00
	11100 I SLET ACQUI SI TI ON					111.00
	11300 I NTEREST EXPENSE					113.00
	11400 UTI LI ZATI ON REVI EW-SNF					114.00
200.00						200.00
200.00						200.00
						201.00
202.00	Total (see instructions)	1				J202.

Health Financial Systems	PUTNAM COUNT				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C	CN: 15-1333	Period: From 01/01/2019	Worksheet D Part II	
				To 12/31/2019		pared [.]
				10 12/01/2017	8/28/2020 10:	03 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	-		1			
50.00 05000 OPERATING ROOM	322, 481					50.00
51.00 05100 RECOVERY ROOM	71, 423	714, 899			5,000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000	0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	5, 552	506, 281	0. 01096	6 22, 617	248	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	115, 118	9, 595, 998	0. 01199	415, 140	4, 980	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	5, 519	1, 446, 403	0. 0038	6 19, 012	73	54.01
54. 02 03480 ONCOLOGY	184, 463	8, 092, 532	0. 02279	756	17	54.02
57.00 05700 CT SCAN	45, 233	20, 267, 629	0.00223	324, 146	723	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.0000	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000	0 0	0	59.00
60. 00 06000 LABORATORY	105, 808	17, 086, 808	0.00619	765, 608	4, 741	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	0			0	64.00
65. 00 06500 RESPIRATORY THERAPY	28,677	2,664,267			8, 413	65.00
66. 00 06600 PHYSI CAL THERAPY	57, 910					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	979					67.00
68. 00 06800 SPEECH PATHOLOGY	500	246, 961	0.00202			68.00
69. 00 06900 ELECTROCARDI OLOGY	5, 259					69.00
69. 01 06901 CARDI AC REHAB	53, 234	688, 730			151	69.01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	00,201	000,700			0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	354	0			-	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	39, 474	3, 601, 696				73.00
73. 01 03950 ONCOLOGY	0	3,001,090				73.00
OUTPATIENT SERVICE COST CENTERS	0	0	0.00000	0	0	/ 3. 01
88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	165, 638	2, 149, 509	0. 07705	59 O	0	88.00
88. 01 08801 FAMILY MEDICINE OF CLOVERDALE	90, 465				0	88.01
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE	184, 555				0	88.02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	104, 555	1, 370, 133			0	89.00
90. 00 09000 CLINIC	4, 861	4, 622			0	90.00
90. 01 09001 RHEUMATOLOGY	18, 355				0	90.00
91. 00 09100 EMERGENCY	253, 125					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	136, 402				0	91.00
200.00 Total (lines 50 through 199)	1, 895, 385			3, 590, 862	-	
200. 00 Trotal (Triles 50 through 199)	1, 070, 385	103, 993, 404	I	3, 390, 802	50, 779	∠00.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PAS			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 10:	epared: 03 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	-		0 0		
51.00 05100 RECOVERY ROOM	0	0		0 0	-	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 0	0	54.01
54. 02 03480 ONCOLOGY	0	0)	0 0	0	54.02
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0	l o		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	l o		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	l o		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	•
68.00 06800 SPEECH PATHOLOGY	0			0 0	0	•
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	•
69. 01 06901 CARDI AC REHAB	0	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	-	
73. 01 03950 ONCOLOGY	0	-		0 0	-	
OUTPATIENT SERVICE COST CENTERS			1	0	<u> </u>	70.01
88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	0		0 0	0	88.00
88. 01 08801 FAMILY MEDICINE OF CLOVERDALE	0	-		0 0		
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE					0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
90. 00 09000 CLINIC					0	
90. 01 09001 RHEUMATOLOGY					0	
91. 00 09100 EMERGENCY				0 0	0	•
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00 Total (lines 50 through 199)	0	о		0 0	-	200.00
	1 0	0	1	ч U	0	200.00

	Financial Systems	PUTNAM COUNT				u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-1333	Period: From 01/01/2019	Worksheet D Part IV	
THROUG	GH COSTS				To 12/31/2019		nared
					10 12/31/2017	8/28/2020 10:	03 am
			Title	XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of	F C, Part I,	(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)		(see	
						instructions)	
	1	4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS			1			
50.00	05000 OPERATING ROOM	0			0 6, 560, 350		
	05100 RECOVERY ROOM	0	0		0 714, 899		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 506, 281	0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 9, 595, 998	0.000000	
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 1, 446, 403	0.000000	54.01
54.02	03480 ONCOLOGY	0	0		0 8, 092, 532	0.000000	54.02
57.00	05700 CT SCAN	0	0		0 20, 267, 629	0.00000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0.00000	59.00
60.00	06000 LABORATORY	0	0		0 17, 086, 808	0.00000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0.00000	60.01
64.00	06400 INTRAVENOUS THERAPY	0	0		0 0	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 2, 664, 267	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0)	0 2, 919, 487	0.00000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 541, 233	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 246, 961	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 1, 333, 857	0.000000	69.00
69.01	06901 CARDI AC REHAB	0	0		0 688, 730	0.000000	69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 129, 080	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 601, 696	0.000000	73.00
73.01	03950 ONCOLOGY	0	0		0 0	0. 000000	73.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	0		0 2, 149, 509	0. 000000	88.00
88.01	08801 FAMILY MEDICINE OF CLOVERDALE	0	0		0 2,067,206	0.000000	88.01
88. 02	08802 NORTH PUTNAM FAMILY HEALTHCARE	0	0		0 1, 376, 133	0. 000000	88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0. 000000	89.00
90.00	09000 CLINIC	0	0		0 4,622	0.000000	90.00
90.01	09001 RHEUMATOLOGY	0	0		0 10, 774	0.000000	
91.00	09100 EMERGENCY	0	0		0 19, 827, 778		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 161, 171	0.000000	
200.00		0	0		0 103, 993, 404		200.00

lealth Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	PUTNAM COUNTY	HOSPITAL Provider C	CNI- 15 1222	In Lie Period:	u of Form CMS-: Worksheet D	2552-
FROUGH COSTS	RVICE UTHER PASS	Provider C	UN. 10-1333	From 01/01/2019 To 12/31/2019	Part IV	
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	1		I			
50.00 05000 OPERATING ROOM	0. 000000	481, 959		0 0	0	
1.00 05100 RECOVERY ROOM	0. 000000	50, 043		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
33. 00 05300 ANESTHESI OLOGY	0. 000000	22, 617		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	415, 140		0 0	0	54.C
4. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	19, 012		0 0	0	54.0
4. 02 03480 ONCOLOGY	0. 000000	756		0 0	0	54.0
7.00 05700 CT SCAN	0. 000000	324, 146		0 0	0	57.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.0
0. 00 06000 LABORATORY	0. 000000	765, 608		0 0	0	60.0
0.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.0
4.00 06400 INTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.
5. 00 06500 RESPI RATORY THERAPY	0, 000000	781, 576		0 0	0	65.
6. 00 06600 PHYSI CAL THERAPY	0. 000000	218,099		0 0	0	66.
7.00 06700 OCCUPATI ONAL THERAPY	0. 000000	54,038		0 0	0	67.
8.00 06800 SPEECH PATHOLOGY	0. 000000	36, 706		0 0	0	
9. 00 06900 ELECTROCARDI OLOGY	0. 000000	28, 750		0 0	0	
9. 01 06901 CARDI AC REHAB	0, 000000	1, 954		0 0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000	21, 350		0 0	0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	354, 533		0 0	0	
3. 01 03950 ONCOLOGY	0. 000000	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.000000	0	I	<u> </u>	0	, 0.
8. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	0. 000000	0		0 0	0	88.
B. 01 08801 FAMILY MEDICINE OF CLOVERDALE	0. 000000	0		0 0	0	88.
B. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE	0. 000000	0		0 0	0	
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	
0. 00 09000 CLINIC	0. 000000	0		0 0	0	
0. 01 09000 CETNIC 0. 01 09001 RHEUMATOLOGY	0. 000000	0			0	
1. 00 09100 EMERGENCY	0. 000000	14, 575		0 0	0	
	0. 000000	14, 3/3		0 0	0	1
	0.000000	2 500 0/2				
00.00 Total (lines 50 through 199)		3, 590, 862	I	0 0	0	200.

APPORTI ONME	ENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provider C	CN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 8/28/2020 10:	
			Title	e XVIII	Hospi tal	Cost	05 uiii
				Charges	nospi tui	Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	best benter bescription	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Servi ces (see	Servi ces	Servi ces Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	O OPERATING ROOM	0. 604194	0	1, 724, 87	5 0	0	50.00
51.00 0510	O RECOVERY ROOM	0. 515830	0	142, 40	0 8	0	51.00
	O DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	
	O ANESTHESI OLOGY	1. 038198		110, 09		0	•
	0 RADI OLOGY-DI AGNOSTI C	0. 233621				0	
	1 NUCLEAR MEDICINE-DIAGNOSTIC	0. 115200				0	
	O ONCOLOGY	0. 574664				0	•
	O CT SCAN	0. 031665				0	57.00
	O MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0 0	0	
	O CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	
	0 LABORATORY	0. 182834			-	0	•
	1 BLOOD LABORATORY	0. 000000			0 0	0	
	OINTRAVENOUS THERAPY	0. 000000			0 0	0	
	0 RESPIRATORY THERAPY	0. 274900		317, 63	57 0	0	
	O PHYSI CAL THERAPY	0. 294124			-	0	
	O OCCUPATIONAL THERAPY	0. 215436				0	•
	O SPEECH PATHOLOGY	0. 240961			-	0	68.00
	0 ELECTROCARDI OLOGY	0. 171332				0	
	1 CARDI AC REHAB	0. 771013				0	
	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			0 0	0	•
	OIMPL. DEV. CHARGED TO PATIENT	0. 326642		53, 95	8 0	0	•
	O DRUGS CHARGED TO PATIENTS	0. 386406				0	•
73.01 0395	ONCOLOGY	0. 000000	0		0 0	0	73.01
	ATIENT SERVICE COST CENTERS						1
	O PUTNAM PEDIATRICS AND INTERNAL MED	0.00000				0	88.00
88.01 0880	1 FAMILY MEDICINE OF CLOVERDALE	0. 000000				0	88.01
88. 02 0880	2 NORTH PUTNAM FAMILY HEALTHCARE	0. 000000				0	88.02
	O FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
		2. 385115	0	73	8 0	0	90.00
90.01 0900	1 RHEUMATOLOGY	34. 240208	0		0 0	0	90.01
	0 EMERGENCY	0. 213939		3, 935, 00	8 542	0	•
	O OBSERVATION BEDS (NON-DISTINCT PART)	0. 637776				0	
200.00	Subtotal (see instructions)	1	0			0	200.00
201.00	Less PBP Clinic Lab. Services-Program	1			0 0		201.00
	Only Charges						
	Net Charges (line 200 - line 201)	1		26, 698, 61			202.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu	u of Form CMS	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO	CN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pr 8/28/2020 10	
			Title	XVIII	Hospi tal	Cost	
		Cos	sts			L	
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) 6.00	Cost Reimbursed Services Not Subject To				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 042, 159	0				50.00
	05100 RECOVERY ROOM	73, 458	0				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESI OLOGY	114, 297	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	561, 882	0				54.00
	05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	58, 062	0				54.01
	03480 ONCOLOGY	2, 339, 060	686				54.02
	05700 CT SCAN	172, 973	0				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	06000 LABORATORY	965, 914	0				60.00
	06001 BLOOD LABORATORY	0	0				60.01
	06400 I NTRAVENOUS THERAPY	0	0				64.00
	06500 RESPI RATORY THERAPY	87, 318	0				65.00
	06600 PHYSI CAL THERAPY	205, 608	0				66.00
	06700 OCCUPATI ONAL THERAPY	30, 284	0				67.00
	06800 SPEECH PATHOLOGY	6, 778	0				68.00
	06900 ELECTROCARDI OLOGY	56, 278	0				69.00
	06901 CARDI AC REHAB	173, 854	0				69.01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	17, 625	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	174, 550	0				73.00
73.01	03950 ONCOLOGY	0	0				73.01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	0				88.00
88.01	08801 FAMILY MEDICINE OF CLOVERDALE	0	0				88.01
88.02	08802 NORTH PUTNAM FAMILY HEALTHCARE	0	0	1			88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90.00	09000 CLINIC	1, 760	0				90.00
	09001 RHEUMATOLOGY	0	0				90.01
91.00	09100 EMERGENCY	841, 852	116				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	520, 072	0				92.00
200.00		7, 443, 784	802				200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	7, 443, 784	802				202.00

Heal th Financial		PUTNAM COUNT				u of Form CMS-	2552-10
APPORTI ONMENT OF	MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1333	Period:	Worksheet D	
			Component		From 01/01/2019 To 12/31/2019		pared: 03 am
			Title	XVIII S	Swing Beds - SNF		
				Charges		Costs	
Cost	Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see		Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	SERVICE COST CENTERS				_		
	ATING ROOM	0. 604194	0		0 0	0	50.00
51.00 05100 RECO		0. 515830	0		0 0	0	51.00
	VERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 05300 ANES	THESI OLOGY	1. 038198	0		0 0	0	53.00
	OLOGY-DI AGNOSTI C	0. 233621	0		0 0	0	54.00
54.01 05401 NUCL	EAR MEDICINE-DIAGNOSTIC	0. 115200	0		0 0	0	54.01
54.02 03480 ONCO	LOGY	0. 574664	0		0 0	0	54.02
57.00 05700 CT S	SCAN	0. 031665	0		0 0	0	57.00
58.00 05800 MAGN	ETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59.00 05900 CARD	I AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00 06000 LAB0	RATORY	0. 182834	0		0 0	0	60.00
60.01 06001 BL00	D LABORATORY	0. 000000	0		0 0	0	60.01
64.00 06400 I NTR	AVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65.00 06500 RESP	I RATORY THERAPY	0. 274900	0		0 0	0	65.00
	I CAL THERAPY	0. 294124	0		0 0	0	66.00
	IPATI ONAL THERAPY	0. 215436	0		0 0	0	67.00
68.00 06800 SPEE	CH PATHOLOGY	0. 240961	0		0 0	0	68.00
69.00 06900 ELEC	TROCARDI OLOGY	0. 171332	0		0 0	0	69.00
69.01 06901 CARD	I AC REHAB	0. 771013	0		0 0	0	69.01
71.00 07100 MEDI	CAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 I MPL	DEV. CHARGED TO PATIENT	0. 326642	0		0 0	0	72.00
73.00 07300 DRUG	S CHARGED TO PATIENTS	0. 386406	0		0 0	0	73.00
73.01 03950 ONCO		0. 000000	0		0 0	0	73.01
	SERVICE COST CENTERS						
	IAM PEDIATRICS AND INTERNAL MED	0. 000000				0	88.00
	LY MEDICINE OF CLOVERDALE	0. 000000				0	88.01
	H PUTNAM FAMILY HEALTHCARE	0. 000000				0	88.02
89.00 08900 FEDE	RALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90.00 09000 CLIN	II C	2. 385115	0		0 0	0	90.00
90.01 09001 RHEU		34. 240208	0		0 0	0	90.01
91.00 09100 EMER		0. 213939	0		0 0	0	91.00
92.00 09200 0BSE	RVATION BEDS (NON-DISTINCT PART)	0. 637776	0		0 0	0	92.00
	otal (see instructions)		0		0 0	0	200.00
	PBP Clinic Lab. Services-Program				0 0		201.00
	Charges						
202.00 Net	Charges (line 200 - line 201)		0	1	0 0	0	202.00

Health Financial Systems	PUTNAM COUNTY	(HOSPI TAL		In Lieu	of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES ANI	D VACCINE COST	Provider C	CN: 15-1333	Peri od:	Worksheet D	
				From 01/01/2019	Part V	
		Component (CCN: 15-Z333	To 12/31/2019	Date/Time Pre 8/28/2020 10:	
		Titla	XVIII	Swing Beds - SNF	Cost	US alli
	Cos		XVIII	Jowning beds oni	0031	
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0				54.01
54.02 03480 ONCOLOGY	0	0				54.02
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60.01
64.00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
69. 01 06901 CARDI AC REHAB	0	0				69.01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0 0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATI ENT 73.00 07300 DRUGS CHARGED TO PATI ENTS	0	0				
	0	0				73.00 73.01
73. 01 03950 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	U	0				- 73.01
88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	0				88.00
88. 01 08801 FAMILY MEDICINE OF CLOVERDALE	0	0				88.00
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE	0	0				88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 RHEUMATOLOGY	0	0				90.00
91. 00 09100 EMERGENCY		0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	0				201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00
						•

	Financial Systems PUTNAM COUNTY ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	J of Form CMS-2 Worksheet D-1 Date/Time Pre 8/28/2020 10:0	pared:
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(a avaluding nawbarn)	I	3, 621	1.00
2.00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			3, 217	
3.00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	
1.00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	hard days)		1, 909	4.0
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	335	
00	reporting period	an dava) after December	21 of the east		
5.00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.0
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	69	7.0
3. 00	reporting period Total swing-bed NF type inpatient days (including private roo	am dave) after Decomber	21 of the cost	0	8.0
5. 00	reporting period (if calendar year, enter 0 on this line)	Jii days) arter becember	ST OF THE COST	0	0.0
9.00	Total inpatient days including private room days applicable t	to the Program (excludin	g swing-bed and	1, 078	9.0
0.00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private	room davs)	309	10.0
0.00	through December 31 of the cost reporting period (see instruc	ctions)	5	007	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, e	5 (51	room days) after	0	11.0
2.00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.0
	through December 31 of the cost reporting period				
3.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendary)			0	13.0
4.00	Medically necessary private room days applicable to the Progr			0	14.0
	Total nursery days (title V or XIX only)			0	
6.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT		I	0	16.0
7.00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31	of the cost		17.0
8.00	reporting period Medicare rate for swing-bed SNF services applicable to servic	res after December 31 of	the cost		18.0
10.00	reporting period		the cost		10.0
9.00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 o	f the cost	137.42	19.0
20.00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of	the cost	0.00	20.0
1 00	reporting period	>		2 752 512	01 0
21.00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ting period (line	3, 752, 512 0	
	5 x line 17)				
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	r 31 of the cost reporti	ng period (line 6	0	23.0
24.00	Swing-bed cost applicable to NF type services through December	er 31 of the cost report	ing period (line	9, 482	24.0
	7 x line 19)				
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reportin	g period (line 8	0	25.0
26.00	Total swing-bed cost (see instructions)			362, 498	26.0
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 390, 014	27.0
28.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	ed and observation bed c	harges)	0	28.0
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)	1.1.7.20)		0	
31.00 32.00	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ TThe 28)		0. 000000 0. 00	
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	110 31)		0. 00 0	
	General inpatient routine service cost net of swing-bed cost	and private room cost d	ifferential (line	-	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				ł
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			1, 053. 78	38.0
		•	1		
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	e 38)		1, 135, 975 0	

Health Financial Systems	PUTNAM COUNTY				u of Form CMS-	
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2019	Worksheet D-1	
				Fo 12/31/2019		
		Title	XVIII	Hospi tal	Cost	05 am
Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
	Cost	Days	÷ col. 2)		col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0 0	0	42.00
43. 00 I NTENSI VE CARE UNI T	1, 737, 554	388	4, 478. 23	3 196	877, 733	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT 46.00 SURGICAL INTENSIVE CARE UNIT						45.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (W	kst. D-3, col. 3	, line 200)			1, 043, 353	48.00
49.00 Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		3, 057, 061	49.00
PASS THROUGH COST ADJUSTMENTS 50.00 Pass through costs applicable to Program ing	patient routine	services (fro	m Wkst D sum	of Parts L and	0	50.00
					, s	00.00
51.00 Pass through costs applicable to Program inp	patient ancillar	y services (f	rom Wkst. D, s	um of Parts II	0	51.00
and IV) 52.00 Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00 Total Program inpatient operating cost exclu	5 1	lated, non-ph	ysician anesth	etist, and	0	53.00
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00 Program discharges					0	
55.00 Target amount per discharge 56.00 Target amount (line 54 x line 55)					0.00	1
56.00 Target amount (line 54 x line 55) 57.00 Difference between adjusted inpatient operation	ting cost and ta	irget amount (line 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)	0	0		r -	0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost re market basket	eporting period	endi ng 1996,	updated and co	mpounded by the	0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	60.00
61.00 If line 53/54 is less than the lower of line					0	61.00
which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% or	the target		
62.00 Relief payment (see instructions)					0	
63.00 Allowable Inpatient cost plus incentive payr PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see instru	ictions)			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	325, 618	64.00
instructions) (title XVIII only)	-					1 (5 . 00
65.00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	sts after Decemb	er si or the	cost reporting	period (see	0	65.00
66.00 Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	325, 618	66.00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routir	ne costs through	December 31	of the cost re	porting period	0	67.00
(line 12 x line 19)	ie costs through			por tring por rod		
68.00 Title V or XIX swing-bed NF inpatient routir (line 13 x line 20)	ne costs after D	ecember 31 of	the cost repo	rting period	0	68.00
69.00 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						1 70 00
70.00 Skilled nursing facility/other nursing facil 71.00 Adjusted general inpatient routine service of						70.00
72.00 Program routine service cost (line 9 x line	71)					72.00
73.00 Medically necessary private room cost applic 74.00 Total Program general inpatient routine serv		•	,			73.00
75.00 Capital -related cost allocated to inpatient			•	art II, column		75.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00 Program capital-related costs (line 9 x line						77.00
78.00 Inpatient routine service cost (line 74 minu	us line 77)		-1 - 2			78.00
79.00 Aggregate charges to beneficiaries for exces 80.00 Total Program routine service costs for comp				us line 79)		79.00
81.00 Inpatient routine service cost per diem limi	tati on					81.00
82.00 Inpatient routine service cost limitation (I		· .				82.00
83.00 Reasonable inpatient routine service costs (84.00 Program inpatient ancillary services (see in		13)				83.00 84.00
85.00 Utilization review - physician compensation	(see instructio					85.00
86.00 Total Program inpatient operating costs (sur PART IV - COMPUTATION OF OBSERVATION BED PAS		rough 85)				86.00
87.00 Total observation bed days (see instructions					1, 308	87.00
88.00 Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 053. 78 1, 378, 344	88.00
89.00 Observation bed cost (line 87 x line 88) (se	INSTRUCTIONS)					1 90 00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		pared: 03 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	371, 354	3, 752, 512	0. 09896	1, 378, 344	136, 402	90.00
91.00 Nursing School cost	0	3, 752, 512	0.00000	0 1, 378, 344	0	91.00
92.00 Allied health cost	0	3, 752, 512	0.00000	0 1, 378, 344	0	92.00
93.00 All other Medical Education	0	3, 752, 512	0.00000	1, 378, 344	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1333	Period: From 01/01/2019	Worksheet D-1	
			To 12/31/2019	Date/Time Prep 8/28/2020 10:0	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	•			1.00	
	PART I – ALL PROVIDER COMPONENTS				
	Inpatient days (including private room days and swing-bed da			3, 621	1.
00 00	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d		rivate room davs	3, 217 0	2
	do not complete this line.	5, 5, 5,	rivate room aays,		
00 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private r		or 21 of the east	1, 909 335	45
00	reporting period	oom days) thi ough becenic	er si or the cost	330	
00	Total swing-bed SNF type inpatient days (including private r	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	69	7
	reporting period	3.		0,	<i>'</i>
00	Total swing-bed NF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	8
00	Total inpatient days including private room days applicable	to the Program (excludin	g swing-bed and	49	9
	newborn days) (see instructions)				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private	room days) after	0	11
00	December 31 of the cost reporting period (if calendar year, Swing-bed NF type inpatient days applicable to titles V or X		te room days)	0	12
. 00	through December 31 of the cost reporting period	in only (mendaring priva	te room days)	0	'2
	Swing-bed NF type inpatient days applicable to titles V or X			0	13
	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
. 00	Total nursery days (title V or XIX only)	· -··· (-···· -····g -····g -···		0	15
	Nursery days (title V or XIX only)			0	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servi	ces through December 31	of the cost		17
	reporting period				
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to servic reporting period	es through December 31 c	f the cost	137.42	19
. 00	Medicaid rate for swing-bed NF services applicable to servic	es after December 31 of	the cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instructio	nc)		3, 752, 512	21
	Swing-bed cost applicable to SNF type services through Decem		ting period (line	3, 752, 512	22
	5 x line 17)				
	Swing-bed cost applicable to SNF type services after Decembe x line 18)	er 31 of the cost reporti	ng period (line 6	0	23
	Swing-bed cost applicable to NF type services through Decemb 7 x line 19)	er 31 of the cost report	ing period (line	9, 482	24
	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	о	25
00	x line 20) Tatal guing had goot (and instructions)			362, 498	24
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 390, 014	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-b Private room charges (excluding swing-bed charges)	ed and observation bed c	harges)	0	28
	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
	Average per diem private room charge differential (line 32 m	inus line 33)(see instru	ctions)	0.00	
	Average per diem private room cost differential (line 34 x l			0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost		ifferential (line	0 3, 390, 014	36 37
	27 minus line 36)	,			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			
	Adjusted general inpatient routine service cost per diem (se			1, 053. 78	38
. 00					
. 00	Program general inpatient routine service cost (line 9 x lin Medically necessary private room cost applicable to the Prog	ie 38)		51, 635 0	39 40

	Financial Systems ATION OF INPATIENT OPERATING COST	PUTNAM COUNTY		CN: 15-1333	Period:	u of Form CMS- Worksheet D-1	
20111 01				10 1000	From 01/01/2019		
					To 12/31/2019	Date/Time Pre 8/28/2020 10:	
	Cost Costos Decesisti es	Tatal		e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpati ent	Average Per Diem (col.		Program Cost (col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	0	C	0.0	0 0	0	42.0
3.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 737, 554	388	4, 478. 2	23 0	0	43.0
4.00	CORONARY CARE UNIT	1,757,554	500	, +/0.2	-5 0	0	44.0
5.00	BURN INTENSIVE CARE UNIT						45.0
6.00	SURGICAL INTENSIVE CARE UNIT						46.0
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.C
	cost center bescription					1.00	
8.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	line 200)			61, 634	48.0
9.00	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		113, 269	49.0
0 00	PASS THROUGH COST ADJUSTMENTS	ationt routing	convigor (fro		m of Dorte L ond	0	50 0
0.00	Pass through costs applicable to Program inp	atrent routine :	services (iio	III WKSL. D, SU	m of Parts F and	l U	50. C
51.00	Pass through costs applicable to Program inp	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	O	51.0
	and IV)						
2.00	Total Program excludable cost (sum of lines		lated non	voloion one-t	botict and	0	
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		ateu, non-pn	ysician anest	netist, anu		03.0
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program discharges					0	
	Target amount per discharge					0.00	
6.00 7.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raet amount (line 56 minus	line 53)	0	
8.00	Bonus payment (see instructions)	The cost and ta	get anount (TTHE 50 milling	The 55)	0	
9.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and c	ompounded by the		
	market basket						
0.00	Lesser of lines 53/54 or 55 from prior year					0.00	
51.00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					C	61.0
	amount (line 56), otherwise enter zero (see						
	Relief payment (see instructions)					0	
53.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0) 63. C
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of th	e cost report	ing period (See	0	64.0
	instructions)(title XVIII only)	-				-	
55.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.0
56.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line)	64 nlus lina	65)(title XV/	II only) For	C	66.0
50.00	CAH (see instructions)		by prus rine	05)(11116 XVI	TT Only). TO	0	00.0
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	C	67. C
(0.00	(line 12 x line 19)						
58.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs atter D	ecember 31 or	the cost rep	orting period	C	68.0
59.00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 68)		0	69.0
	PART III - SKILLED NURSING FACILITY, OTHER N						
'0.00 '1.00	Skilled nursing facility/other nursing facil)		70.0
2.00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /0 ÷ iine	2)			71.0
3.00	Medically necessary private room cost applic	· ·	(line 14 x l	ine 35)			73.0
4.00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)			74.0
5.00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75.0
6.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
7.00	Program capital -related costs (line 9 x line						77.0
8.00	Inpatient routine service cost (line 74 minu						78.0
9.00	Aggregate charges to beneficiaries for exces				70)		79.0
0.00 1.00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ust ilmitatio	n (iine /8 mi	nus i ne 79)		80. 81.
2.00	Inpatient routine service cost per drem fining Inpatient routine service cost limitation (I)				82.0
3.00	Reasonable inpatient routine service costs (83.0
4.00	Program inpatient ancillary services (see in						84.0
5.00	Utilization review - physician compensation						85.0
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS		ougn 85)				86.0
37.00	Total observation bed days (see instructions					1, 308	8 87.0
88.00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 053. 78	88.0
	Observation bed cost (line 87 x line 88) (se					1, 378, 344	

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		pared: 03 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	371, 354	3, 752, 512	0. 09896	1 1, 378, 344	136, 402	90.00
91.00 Nursing School cost	0	3, 752, 512	0.00000	0 1, 378, 344	0	91.00
92.00 Allied health cost	0	3, 752, 512	0.00000	0 1, 378, 344	0	92.00
93.00 All other Medical Education	0	3, 752, 512	0.00000	0 1, 378, 344	0	93.00

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider (CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	epar
		e XVIII	Hospi tal	8/28/2020 10: Cost	03
Cost Center Description	11 11 1	Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
		l i o ondi goo	Charges	(col. 1 x	
			ondi geo	col. 2)	
		1.00	2.00	3.00	\vdash
INPATIENT ROUTINE SERVICE COST CENTERS					\square
00 03000 ADULTS & PEDI ATRI CS			1, 797, 891		13
00 03100 INTENSIVE CARE UNIT			811, 764		3
00 04100 SUBPROVIDER - IRF			0		4
00 04200 SUBPROVI DER			0		4
00 04300 NURSERY					4
ANCILLARY SERVICE COST CENTERS		•			1
00 05000 OPERATING ROOM		0.60419	94 481, 959	291, 197	5
00 05100 RECOVERY ROOM		0. 51583	30 50, 043	25, 814	5
00 05200 DELIVERY ROOM & LABOR ROOM		0.00000	0 00	0	5
00 05300 ANESTHESI OLOGY		1.03819	22, 617	23, 481	5
00 05400 RADI OLOGY-DI AGNOSTI C		0. 23362	415, 140	96, 985	5
01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 11520	19, 012	2, 190	5
02 03480 ONCOLOGY		0. 57466	54 756	434	5
00 05700 CT SCAN		0. 03166	324, 146	10, 264	5
00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.00000	0 00	0	5
00 05900 CARDI AC CATHETERI ZATI ON		0.00000	0 00	0	5
00 06000 LABORATORY		0. 18283	765, 608	139, 979	6
01 06001 BLOOD LABORATORY		0.00000	0 00	0	
00 06400 INTRAVENOUS THERAPY		0.00000	0 00	0	6
00 06500 RESPI RATORY THERAPY		0. 27490	781, 576	214, 855	6
00 06600 PHYSI CAL THERAPY		0. 29412	24 218, 099	64, 148	6
00 06700 OCCUPATI ONAL THERAPY		0. 21543	36 54, 038	11, 642	6
00 06800 SPEECH PATHOLOGY		0. 24096	51 36, 706	8, 845	6
00 06900 ELECTROCARDI OLOGY		0. 17133	32 28, 750	4, 926	6
01 06901 CARDI AC REHAB		0. 7710	13 1, 954	1, 507	6
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	0 00	0	7
00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 32664	42 21, 350	6, 974	7
00 07300 DRUGS CHARGED TO PATIENTS		0. 38640	354, 533	136, 994	7
01 03950 ONCOLOGY		0.0000	0 00	0	7
OUTPATIENT SERVICE COST CENTERS					
00 08800 PUTNAM PEDIATRICS AND INTERNAL MED		0.0000		0	8
01 08801 FAMILY MEDICINE OF CLOVERDALE		0.0000		0	
02 08802 NORTH PUTNAM FAMILY HEALTHCARE		0.0000	00	0	8
00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	8
00 09000 CLINIC		2. 3851	15 0	0	9
01 09001 RHEUMATOLOGY		34.24020		0	9
00 09100 EMERGENCY		0. 21393	39 14, 575	3, 118	9
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 63777		0	9
D.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 590, 862	1, 043, 353	20
1.00 Less PBP Clinic Laboratory Services-Program only charges	6 (line 61)		0		20
2.00 Net charges (line 200 minus line 201)	,		3, 590, 862		20

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1333	Peri od:	Worksheet D-3	3
	in ovider e	011. 10 1000	From 01/01/2019		,
	Component	CCN: 15-Z333	To 12/31/2019	8/28/2020 10:	
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
0. 00 03000 ADULTS & PEDIATRICS			0		1 30.0
I. 00 03100 I NTENSI VE CARE UNI T			0		31.0
I. 00 04100 SUBPROVI DER – I RF			0		41.0
2. 00 04200 SUBPROVI DER			0		42.0
3. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS					
D. 00 05000 OPERATING ROOM		0. 60419		20, 187	
I. 00 05100 RECOVERY ROOM		0. 51583		0	
2. 00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	
3. 00 05300 ANESTHESI OLOGY		1.03819		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23362		3, 541	
4. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 11520		0	
4. 02 03480 ONCOLOGY		0. 57466		0	
7. 00 05700 CT SCAN		0.03166		387	
3. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 9. 00 05900 CARDIAC CATHETERIZATION		0.00000		0	
0. 00 06000 LABORATORY		0. 00000		0 9, 563	
D. 01 06000 LABORATORY		0. 18283		9, 503	
4. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	
5. 00 06500 RESPIRATORY THERAPY		0. 27490		-	
5. 00 06600 PHYSI CAL THERAPY		0. 29412			
7. 00 06700 OCCUPATI ONAL THERAPY		0. 21543			
3. 00 06800 SPEECH PATHOLOGY		0. 24096			
9. 00 06900 ELECTROCARDI OLOGY		0. 17133			
9. 01 06901 CARDI AC REHAB		0. 7710		0	
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	0 00	0	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 32664	12 0	0	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 38640	21, 144	8, 170	73.0
3. 01 03950 ONCOLOGY		0.0000	0 00	0	73.0
OUTPATIENT SERVICE COST CENTERS					
3. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED		0.0000		0	
3.01 08801 FAMILY MEDICINE OF CLOVERDALE		0.0000		0	
3. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE		0.0000		0	
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
0. 00 09000 CLINIC		2. 3851		0	
0. 01 09001 RHEUMATOLOGY		34. 24020		0	
I. 00 09100 EMERGENCY		0. 21393			
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 00.00 Total (sum of lines 50 through 94 and 96 through 98)		0. 6377		0 109, 179	
00.00 Total (sum of lines 50 through 94 and 96 through 98) 01.00 Less PBP Clinic Laboratory Services-Program only charc			383, 004 0	109, 179	200. (

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1333	Period: From 01/01/2019 To 12/31/2019		epar
	Ti tl	e XIX	Hospi tal	Cost	00
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x	
		1.00	2.00	col. 2) 3.00	+
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
. 00 03000 ADULTS & PEDI ATRI CS			56, 586		1 30
. 00 03100 I NTENSI VE CARE UNI T			32, 941		31
. 00 04100 SUBPROVI DER – I RF			0		41
. 00 04200 SUBPROVI DER			0		42
. 00 04300 NURSERY			0		43
ANCILLARY SERVICE COST CENTERS					
. OO 05000 OPERATING ROOM		0.60419	39, 763	24, 025	5
. 00 05100 RECOVERY ROOM		0. 51583	30 0	0	5
. OO 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	
. 00 05300 ANESTHESI OLOGY		1. 03819		1, 320	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23362		2, 199	
. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 11520		77	
02 03480 ONCOLOGY		0. 57466			
.00 05700 CT SCAN		0. 03166			
00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.00000		0	
00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	
		0. 18283			
01 06001 BLOOD LABORATORY		0.00000		0	
. 00 06400 I NTRAVENOUS THERAPY . 00 06500 RESPI RATORY THERAPY		0.00000		0	-
. 00 06600 PHYSICAL THERAPY		0. 27490		3, 667 1, 742	
. 00 06700 OCCUPATIONAL THERAPY		0. 29412			
. 00 06800 SPEECH PATHOLOGY		0. 21543		72	
. 00 06900 ELECTROCARDI OLOGY		0. 17133		1, 385	
01 06901 CARDI AC REHAB		0. 77101		0	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000		0	
. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 32664		0	
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 38640		10, 262	
. 01 03950 ONCOLOGY		0.00000			
OUTPATIENT SERVICE COST CENTERS				`	1
. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED		1. 25274	16 0	0	8
. 01 08801 FAMILY MEDICINE OF CLOVERDALE		1.00563	36 0	0	8
02 08802 NORTH PUTNAM FAMILY HEALTHCARE		1. 55427	73 0	0	88
00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
. 00 09000 CLINIC		2. 38511		0	
. 01 09001 RHEUMATOLOGY		34. 24020		0	
. 00 09100 EMERGENCY		0. 21393			
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 63777		0	1
0.00 Total (sum of lines 50 through 94 and 96 through 98)			203, 331	61, 634	
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		20
2.00 Net charges (line 200 minus line 201)			203, 331		20

	Financial Systems PUTNAM COUNTY TION OF REIMBURSEMENT SETTLEMENT	HOSPI TAL Provi der CCN: 15-1333	In Lie Period: From 01/01/2019 To 12/31/2019		
				8/28/2020 10:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			7, 444, 586	1.00
	Medical and other services reimbursed under OPPS (see instruc	ctions)		0	1
	OPPS payments			0	
	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
	Line 2 times line 5			0	
	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	1
	Organ acquisitions			0	10.00
	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			7, 444, 586	11.00
	Reasonable charges				
	Ancillary service charges			0	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	line 69)		0	
	Customary charges			0	14.00
	Aggregate amount actually collected from patients liable for			0	
	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13		on a chargebasis	0	16.00
	Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0.000000	17.00
	Total customary charges (see instructions)			0	
	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds l	ne 11) (see	0	19.00
	Excess of reasonable cost over customary charges (complete or	nly if line 11 exceeds l	ne 18) (see	0	20.00
	instructions)			7 540 000	01.00
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			7, 519, 032 0	1
	Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructior	ns)		49, 545	25.00
	Deductibles and Coinsurance amounts relating to amount on lir		ructions)	4, 312, 292	
	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 2	2 and 23] (see	3, 157, 195	27.00
	instructions) Direct graduate medical education payments (from Wkst. E-4, I	line 50)		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			3, 157, 195	
	Primary payer payments Subtotal (line 30 minus line 31)			5, 599 3, 151, 596	
A	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
1	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			860, 503 559, 327	
	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		763, 078	36.00
	Subtotal (see instructions)			3, 710, 923	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
1	Pioneer ACO demonstration payment adjustment (see instruction	ns)		-	39.50
	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instru	ctions)	0	
	Subtotal (see instructions)			3, 710, 923	1
	Sequestration adjustment (see instructions)			74, 218	
	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40.02
	Interim payments			4, 200, 480	1
	Interim payments-PARHM				41.01
	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42.00
	Balance due provider/program (see instructions)			-563, 775	•
	Balance due provider/program-PARHM (see instructions)				43.01
	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	44.00
-	TO BE COMPLETED BY CONTRACTOR			l	1
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	91.00 92.00
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2019		
				To 12/31/2019	Date/Time Prep 8/28/2020 10:0	pared 03 am
		Title	XVIII	Hospi tal	Cost	
		Inpati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		3, 029, 80	0	4, 200, 480 0	1.0 2.0
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3.0
. 01	ADJUSTMENTS TO PROVIDER	05/14/2019	74, 10	00	0	3.0
. 02				0	0	3.0
. 03				0	0	3.0
. 04 . 05				0	0	3. 3.
. 05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		74, 10	-	0	3.
,,	3. 50-3. 98)		, , , , ,		Ű	0.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E–3, line and column as appropriate)		3, 103, 90	02	4, 200, 480	4.
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5
02				0	0	5.
03				0	0	5.
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51 52				0	0	5
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM		418, 59		563, 775 3, 636, 705	6
00	Total Medicare program liability (see instructions)		2, 685, 31	2 Contractor	3,636,705 NPR Date	7.
				Number	(Mo/Day/Yr)	

VALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2019		
		Component (CN: 15-Z333	To 12/31/2019	P Date/Time Pre 8/28/2020 10:	
		Title	XVIII	Swing Beds - SN		
		Inpatien	t Part A	Pa	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		464, 9	98	0	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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					
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	3.
04				0	0	3.
05				0	0	3.
	Provider to Program				-	4
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	-
52				0	0	-
53 54				0	0	-
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	-
77	3, 50-3, 98)			0	0]].
00	Total interim payments (sum of lines 1, 2, and 3.99)		464, 9	98	0	4.
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				-	
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					1
01	TENTATI VE TO PROVI DER			0	0	5
02				0	0	
03				0	0	
	Provider to Program					
50	TENTATIVE TO PROGRAM			0	0	5
51				0	0	
52				0	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
00	the cost report. (1)					
01	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM		52, 5	-	0	
00	Total Medicare program liability (see instructions)		412, 4	33	0	7
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		C		1.00	2.00	1

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu								
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1333 Period: Wo From 01/01/2019 Pai To 12/31/2019 Da 8/2								
	Title XVIII Hospital							
				_				
			1.00	_				
TO BE COMPLETED BY CONTRACTOR FOR NONS				-				
HEALTH INFORMATION TECHNOLOGY DATA COL				1.00				
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14								
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12								
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8–12								
4.00 Total inpatient days from S-3, Pt. I of 5.00 Total hospital charges from Wkst C, Pt				4.00 5.00				
6.00 Total hospital charity care charges fr				6.00				
	for the purchase of certified HIT technolog	av Wkat S 2 Dt I		7.00				
line 168	of the purchase of certified his technolog	YY WKST. 3-2, PT. T		7.00				
8.00 Calculation of the HIT incentive payme	(see instructions)			8.00				
9.00 Sequestration adjustment amount (see i				9.00				
	after sequestration (see instructions)			10.00				
INPATIENT HOSPITAL SERVICES UNDER THE								
30.00 Initial/interim HIT payment adjustment	ee instructions)			30.00				
31.00 Other Adjustment (specify)				31.00				
32.00 Balance due provider (line 8 (or line	minus line 30 and line 31) (see instruct	i ons)		32.00				

ALCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Pro	vider CCN: 15-1333	Peri od:	Worksheet E-2	
	Corr	ponent CCN: 15-Z333	From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 10:	
		Title XVIII	Swing Beds - SNF		
			Part A 1.00	<u>Part B</u> 2.00	
C	OMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	npatient routine services - swing bed-SNF (see instructions)		328, 874	0	1.0
. 00 I	npatient routine services - swing bed-NF (see instructions)				2.0
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,			0	3.0
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-b	ed pass-through, see	9		
	nstructions) Wursing and allied health payment-PARHM (see instructions)				3.0
	Per diem cost for interns and residents not in approved teaching	nrogram (see		0.00	4.0
	nstructions)	program (See		0.00	
	Program days		309	0	5.0
. 00 I	nterns and residents not in approved teaching program (see instr	uctions)		0	6.0
1	Jtilization review - physician compensation - SNF optional method	l onl y	0		7.0
1	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		439, 145	0	8.0
	Primary payer payments (see instructions)		420 145	0	9.0
	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applicabl	o to physician	439, 145	0	10. 0
	professional services)	e to physician	0	0	
	Subtotal (line 10 minus line 11)		439, 145	0	12.0
	Coinsurance billed to program patients (from provider records) (e	exclude coinsurance	18, 244	0	13.0
	for physician professional services)				
	30% of Part B costs (line 12 x 80%)			0	14.0
	Subtotal (see instructions)		420, 901	0	15.0
	<pre>DTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)</pre>		0	0	16.0 16.5
	Rural community hospital demonstration project (§410A Demonstrati	on) navment	0		16.5
	adjustment (see instructions)	on) payment	Ŭ		10.
	Demonstration payment adjustment amount before sequestration		0	0	16.9
7.00 A	Allowable bad debts (see instructions)		0	0	17.(
	djusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruct	ions)	0	0	
1	Total (see instructions)		420, 901	0	19.0
1	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration)		8, 418 0	0	
	Sequestration adjustment-PARHM pass-throughs		0	0	19.0
	nterim payments		464, 998	0	20.0
	nterim payments-PARHM				20.0
1.00 1	Fentative settlement (for contractor use only)		0	0	21.0
	Tentative settlement-PARHM (for contractor use only)				21.0
1	Balance due provider/program (line 19 minus lines 19.01, 20, and	21)	-52, 515	0	
	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	with CMS Dub 15.2	0	0	22. C
	chapter 1, §115.2	with CMS Pub. 13-2,	0	0	23.0
	ural Community Hospital Demonstration Project (§410A Demonstrati	on) Adiustment			
00. 00 I	s this the first year of the current 5-year demonstration period				200.0
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement	<u> </u>			
	Medicare swing-bed SNF inpatient routine service costs (from Wkst 66 (title XVIII hospital))	. D-I, PT. II, IINE			201.0
	Medicare swing-bed SNF inpatient ancillary service costs (from Wk	st D_3 col 3 liu	he		202.0
	200 (title XVIII swing-bed SNF))	31. 0 3, 601. 3, 111			202.0
1	Fotal (sum of lines 201 and 202)				203.0
	Medicare swing-bed SNF discharges (see instructions)				204.0
	omputation of Demonstration Target Amount Limitation (N/A in fir	st year of the curre	ent 5-year demons	tration	
	eriod)				
1	Medicare swing-bed SNF target amount Medicare swing-bed SNF inpatient routine cost cap (line 205 times	lino 204)			205. (206. (
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				200.0
	Program reimbursement under the §410A Demonstration (see instruct				207.0
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, c		1		208.0
a	and 3)				
	djustment to Medicare swing-bed SNF PPS payments (see instructio	ns)			209.0
	Reserved for future use				210. 0
	omparision of PPS versus Cost Reimbursement				
	Total adjustment to Medicare swing-bed SNF PPS payment (line 209 nstructions)	prus rine 210) (see			215.0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019		pare
		Title XVIII	Hospi tal	Cost	<u></u>
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COS	T REI MBURSEMENT		
. 00	Inpatient services			3, 057, 061	1.
. 00	Nursing and Allied Health Managed Care payment (see instru	ctions)		0	2.
00	Organ acqui si ti on			0	-
. 00	Subtotal (sum of lines 1 through 3)			3, 057, 061	4.
00	Primary payer payments	`		1, 125	
. 00	Total cost (line 4 less line 5). For CAH (see instructions COMPUTATION OF LESSER OF COST OR CHARGES			3, 086, 507	0.
	Reasonable charges				-
. 00	Routi ne servi ce charges			0	7.
. 00	Ancillary service charges			0	
. 00	Organ acquisition charges, net of revenue			0	-
0.00	Total reasonable charges				10.
	Customary charges				
. 00	Aggregate amount actually collected from patients liable f	or payment for services or	a charge basis	0	11.
2.00	Amounts that would have been realized from patients liable				12.
	had such payment been made in accordance with 42 CFR 413.1	3(e)	0		
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
. 00	Total customary charges (see instructions)			0	14
. 00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds l	ine 6) (see	0	15
	instructions)				
. 00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds li	ne 14) (see	0	16
	instructions)				
7.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet	F (1) F (0)		0	18
00 . 00	Cost of covered services (sum of lines 6, 17 and 18)	E-4, ITHE 49)		3, 086, 507	
00	Deductibles (exclude professional component)			3, 088, 507	
. 00	Excess reasonable cost (from line 16)			355, 252	
. 00	Subtotal (line 19 minus line 20 and 21)			2, 733, 255	
3.00	Coi nsurance			6, 479	
. 00	Subtotal (line 22 minus line 23)			2, 726, 776	
. 00	Allowable bad debts (exclude bad debts for professional se	rvices) (see instructions)		20, 520	
. 00	Adjusted reimbursable bad debts (see instructions)			13, 338	
. 00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		10, 114	
. 00	Subtotal (sum of lines 24 and 25, or line 26)	,		2, 740, 114	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruct	ions)		0	
. 99	Demonstration payment adjustment amount before sequestration			0	29
. 00	Subtotal (see instructions)			2, 740, 114	30
. 01	Sequestration adjustment (see instructions)			54, 802	30
. 02	Demonstration payment adjustment amount after sequestratio	n		0	30
. 03	Sequestration adjustment-PARHM				30
. 00	Interim payments			3, 103, 902	
. 01					31
. 00	Tentative settlement (for contractor use only)			0	
. 01	Tentative settlement-PARHM (for contractor use only)				32
. 00	Balance due provider/program (line 30 minus lines 30.01, 3			-418, 590	
. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26 Protested amounts (nonallowable cost report items) in acco				33
1.00				0	34

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2019 To 12/31/2019		epare
		Title XIX	Hospi tal	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	PVICES FOR TITLES V OR		2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES		ATA SERVICES		1
00	Inpati ent hospital/SNF/NF services		113, 269		1 1.
00	Medical and other services		,	0	
00	Organ acquisition (certified transplant centers only)		0		3.
00	Subtotal (sum of lines 1, 2 and 3)		113, 269	0	4.
00	Inpatient primary payer payments		0		5.
00	Outpatient primary payer payments			0	6.
00	Subtotal (line 4 less sum of lines 5 and 6)		113, 269	0	7.
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
00	Routine service charges		89, 527		8.
00	Ancillary service charges		203, 331	0	
. 00 . 00	Organ acquisition charges, net of revenue		0		10.
00	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		-	0	
. 00	CUSTOMARY CHARGES		292, 858	0	1 12.
00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13
. 00	basi s	i services on a charge	0	Ŭ	'0.
00	Amounts that would have been realized from patients liable fo	r payment for services	on 0	0	14
	a charge basis had such payment been made in accordance with				
00	Ratio of line 13 to line 14 (not to exceed 1.000000)	,	0. 000000	0.000000	15
00	Total customary charges (see instructions)		292, 858	0	16
00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	179, 589	0	17
	line 4) (see instructions)				
00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds li	ne 0	0	18.
~ ~	16) (see instructions)				
. 00	Interns and Residents (see instructions)		0	0	
00	Cost of physicians' services in a teaching hospital (see inst		112 2/0	0	
00	Cost of covered services (enter the lesser of line 4 or line PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		113, 269	0	21
00	Other than outlier payments	compreted for PPS prov		0	22
. 00	Outlier payments		0	0	
	Program capital payments		0	0	24
00	Capital exception payments (see instructions)		0		25
00	Routine and Ancillary service other pass through costs		0	0	26
00	Subtotal (sum of lines 22 through 26)		0	0	27
00	Customary charges (title V or XIX PPS covered services only)		0	0	28
00	Titles V or XIX (sum of lines 21 and 27)		113, 269	0	29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
00	Excess of reasonable cost (from line 18)		0	0	30
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	113, 269	0	
00	Deducti bl es		0	0	
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review	4 22)	112 0/0	_	35
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	u <i>33)</i>	113, 269	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		112 240	0	
00	Subtotal (line 36 ± line 37) Direct graduate medical education navments (from West E_4)		113, 269	0	38
00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		113, 269	0	
00	Interim payments		159, 037	0	
. 00	Balance due provider/program (line 40 minus line 41)		-45, 768		
. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	-43,700	0	
00	chapter 1, §115.2	noo wi tii owo i ub io-z,	0	0	1 3

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2019 o 12/31/2019	Worksheet G Date/Time Pre 8/28/2020 10:	
		General Fund	Speci fi c Purpose Fund	Endowment Fund	4.00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	-2, 188, 860	0	0	0	1.00
00	Temporary investments	0	0	0	0	•
00	Notes receivable	0	0	0	0	3.00
00	Accounts recei vabl e Other recei vabl e	20, 924, 197 4, 455, 370	0	0	0	4.00
00	Allowances for uncollectible notes and accounts receivable		0	0	0	6.00
00	Inventory	841, 396	-	0	0	
00	Prepai d'expenses	491, 234	0	0	0	8.00
00	Other current assets	0	0	0	0	
	Due from other funds	0	0	0	0	10.0
	Total current assets (sum of lines 1-10)	15, 076, 380	0	0	0	11.0
	FI XED ASSETS Land	195, 501	0	0	0	12.0
	Land improvements	356, 155	0	0	0	13.0
	Accumulated depreciation	-266, 634	0	0	0	•
5.00	Bui I di ngs	34, 682, 383	0	0	0	15.0
	Accumulated depreciation	-23, 458, 023	0	0	0	16.0
	Leasehold improvements	0	0	0	0	17.0
	Accumulated depreciation	0	0	0	0	18.0 19.0
	Fixed equipment Accumulated depreciation		0	0	0	20.0
	Automobiles and trucks	0	0	0	0	20.0
	Accumulated depreciation	0	0	0	0	22.0
3.00	Major movable equipment	24, 590, 930	0	0	0	23.0
	Accumulated depreciation	-20, 626, 578		0	0	24.0
	Minor equipment depreciable	0	0	0	0	25.0
	Accumulated depreciation	0	0	0	0	26.0
	HIT designated Assets Accumulated depreciation	0	0	0	0	27.0 28.0
	Mi nor equi pment-nondepreci abl e		0	0	0	29.0
	Total fixed assets (sum of lines 12-29)	15, 473, 734	-	0	0	
	OTHER ASSETS					
	Investments	6, 462, 339	0	0	0	31.0
	Deposits on leases	0	0	0	0	32.0
	Due from owners/officers	0 244, 752	0	0	0	33.0
	Other assets Total other assets (sum of lines 31-34)	6, 707, 091	0	0	0	34. C
	Total assets (sum of lines 11, 30, and 35)	37, 257, 205	0	0	0	
	CURRENT LI ABI LI TI ES	0772077200				1 001 0
7.00	Accounts payable	5, 854, 869	0	0	0	37.0
	Salaries, wages, and fees payable	148, 858		0	0	
	Payroll taxes payable	226, 831	0	0	0	
	Notes and Loans payable (short term)	1, 604, 283	0	0	0	
	Deferred income Accelerated payments		0	0	0	41.0
	Due to other funds	0	0	0	0	
	Other current liabilities	567, 758	0	0	0	
5.00	Total current liabilities (sum of lines 37 thru 44)	8, 402, 599	0	0	0	45.C
	LONG TERM LIABILITIES					
	Mortgage payable	0	0	0	0	
	Notes payable	12, 932, 470		0	0	
	Unsecured Loans Other Long term liabilities	0	0	0	0	48.0 49.0
	Total long term liabilities (sum of lines 46 thru 49)	12, 932, 470	-	0	0	
	Total liabilities (sum of lines 45 and 50)	21, 335, 069		0	0	51.0
	CAPITAL ACCOUNTS					1
2.00	General fund balance	15, 922, 136				52.0
	Specific purpose fund		0			53. C
	Donor created - endowment fund balance - restricted			0		54.0
	Donor created - endowment fund balance - unrestricted			0		55.0
	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56.0 57.0
	Plant fund balance - reserve for plant improvement,				0	57.0
	replacement, and expansion				0	30.0
9.00	Total fund balances (sum of lines 52 thru 58)	15, 922, 136	0	0	0	59.0
. 00						

Heal th	Financial Systems	PUTNAM COUNTY	HOSPI TAL			In Lie	u of Form CM	S-2	552-10
STATEM	IENT OF CHANGES IN FUND BALANCES		Provider CO	CN: 15-1333		eriod: com 01/01/2019 o 12/31/2019	Worksheet C Date/Time F 8/28/2020 1	Prep	
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fund		
		1.00	2.00	3.00	_	4.00	5.00	_	
1.00	Fund balances at beginning of period		20, 358, 938			0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-4, 436, 802						2.00
3.00 4.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	15, 922, 136		0	0		0	3.00 4.00
5.00	Additions (crediti adjustillents) (specify)	0			0			0	5.00
6.00		0			0			0	6.00
7.00		0			0			0	7.00
8.00		0			0			0	8.00
9.00		0			0			0	9.00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		0 15, 922, 136			0			10. 00 11. 00
12.00	Deductions (debit adjustments) (specify)	0	15, 722, 150		0	0		о	12.00
13.00		0			0			Ő	13.00
14.00		0			0			0	14.00
15.00		0			0			0	15.00
16.00		0			0			0	16.00
17.00 18.00	Total deductions (sum of lines 12-17)	0	0		0	0		0	17.00 18.00
18.00	Fund balance at end of period per balance		15, 922, 136			0			19.00
17100	sheet (line 11 minus line 18)		10,722,100			Ũ			
		Endowment	PI ant	Fund					
		Fund							
		6.00	7.00	8.00					
1.00	Fund balances at beginning of period	0			0				1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)	0			~				2.00
3.00 4.00	Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0				3.00 4.00
5.00	Additions (crediti adjustillents) (specify)		0						4.00 5.00
6.00			0						6.00
7.00			0						7.00
8.00			0						8.00
9.00			0		~				9.00
10.00 11.00	Total additions (sum of line 4–9) Subtotal (line 3 plus line 10)	0			0 0				10. 00 11. 00
12.00	Deductions (debit adjustments) (specify)	0	0		0				12.00
13.00			0						13.00
14.00			0						14.00
15.00			0						15.00
16.00			0						16.00
17.00 18.00	Total deductions (sum of lines 12-17)	o	0		0				17.00 18.00
18.00	Fund balance at end of period per balance	0			0				18.00
17.00	sheet (line 11 minus line 18)				0				17.00
		. I	, i						

ATEMEN	NT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	- CCN: 15-1333	Period:	Worksheet G-2	2
				From 01/01/2019 To 12/31/2019		
	Cost Center Description		I npati ent	Outpati ent	Total	
D			1.00	2.00	3.00	
	ART I - PATIENT REVENUES eneral Inpatient Routine Services					-
	lospi tal		4, 633, 0	38	4, 633, 038	1.00
	SUBPROVIDER – IPF		4,033,0	50	4,033,030	2.00
	SUBPROVIDER - IRF			0	0	
	SUBPROVIDER			0	0	
	wing bed - SNF			0	0	
oo s	wing bed - NF			0	0	6.00
00 S	KILLED NURSING FACILITY					7.00
DO N	IURSI NG FACI LI TY					8.00
0 00	THER LONG TERM CARE					9.00
00 T	otal general inpatient care services (sum of lines 1-9)		4, 633, 0	38	4, 633, 038	10.00
	ntensive Care Type Inpatient Hospital Services				1	
	NTENSI VE CARE UNI T		1, 724, 3	23	1, 724, 323	
	CORONARY CARE UNIT					12.00
	BURN INTENSIVE CARE UNIT					13.00
	SURGICAL INTENSIVE CARE UNIT					14.00
	ITHER SPECIAL CARE (SPECIFY)		1 704 0	22	1 704 000	15.00
	otal intensive care type inpatient hospital services (sum of	lines	1, 724, 3	23	1, 724, 323	16.00
	1–15) Total inpatient routine care services (sum of lines 10 and 16		6, 357, 3	61	6, 357, 361	17.00
	Incillary services	9	7, 614, 1			
	Dutpatient services		342, 0			
	UTNAM PEDIATRICS AND INTERNAL MED		542,0	0 1, 948, 784		
	AMILY MEDICINE OF CLOVERDALE			0 2,067,206		
	IORTH PUTNAM FAMILY HEALTHCARE			0 1, 084, 486		
	EDERALLY QUALIFIED HEALTH CENTER			0 ()		
	IOME HEALTH AGENCY			0	, I	22.00
	MBULANCE SERVICES					23.00
	MHC					24.00
10 C	ORF			0 0	0 0	24.10
00 A	MBULATORY SURGICAL CENTER (D. P.)					25.00
00 H	IOSPI CE					26.00
00 P	PHYSICIAN PRIVATE OFFICES		350, 5	25 13, 342, 006	13, 692, 531	27.00
01 J	IOHNSON NI CHOLS / WI C			0 425, 224	425, 224	27.01
	otal patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	14, 664, 1	51 109, 301, 220	123, 965, 371	28.00
	6-3, line 1)					-
	ART II - OPERATING EXPENSES			50.000.000		
	Operating expenses (per Wkst. A, column 3, line 200)			50, 333, 999		29.00
	DD (SPECIFY)			0		30.00
00				0		31.00
00				0		32.00
00				0		33.00
00				0		35.00
	otal additions (sum of lines 30-35)			0		36.00
	DEDUCT (SPECIFY)			0		37.00
00				0		38.00
00				0		39.00
00				0		40.00
00				0		41.00
	otal deductions (sum of lines 37-41)			(42.00
	otal operating expenses (sum of lines 29 and 36 minus line 4	2)(transf	-er	50, 333, 999		43.00
	o Wkst. G-3, line 4)	· •			1	1

Heal th	Financial Systems	PUTNAM COUNTY HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN	: 15-1333	Period:	Worksheet G-3	
					From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
					10 12/31/2017	8/28/2020 10:	
		-				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part					123, 965, 371	1.00
2.00	Less contractual allowances and discounts on	patients' account	S			80, 796, 569	2.00
3.00	Net patient revenues (line 1 minus line 2)					43, 168, 802	3.00
4.00	Less total operating expenses (from Wkst. G-		3)			50, 333, 999	4.00
5.00	Net income from service to patients (line 3	minus line 4)				-7, 165, 197	5.00
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					0	7.00 8.00
8.00							
9.00	Revenue from television and radio service					0	9.00
10.00	Purchase di scounts					0	10.00
11.00	Rebates and refunds of expenses					0	11.00
						0	12.00
	Revenue from Laundry and Linen service					0	13.00
	Revenue from meals sold to employees and gue	sts				0	14.00
	Revenue from rental of living quarters					0	15.00
	Revenue from sale of medical and surgical su		an patients			0	16.00
	Revenue from sale of drugs to other than pat					0	
	Revenue from sale of medical records and abs					0	
	Tuition (fees, sale of textbooks, uniforms,					0	19.00
	Revenue from gifts, flowers, coffee shops, a	nd canteen				0	20.00
	Rental of vending machines					0	21.00
	Rental of hospital space					0	22.00
23.00	Governmental appropriations					0	23.00
	OTHER OPERATING & NON-OPERATING INC					2, 728, 395	
25.00	Total other income (sum of lines 6-24)					2, 728, 395	
26.00						-4, 436, 802	
	OTHER EXPENSES (SPECIFY)					0	27.00
28.00						0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)				-4, 436, 802	29.00

	Financial Systems	PUTNAM COUNT					u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333		eriod:	Worksheet M-1	
			Component	CCN: 15-8515		rom 01/01/2019 5 12/31/2019	Date/Time Pre 8/28/2020 10:	
						RHC I	Cost	_
		Compensati on	Other Costs	Total (col.	1	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
							col. 4)	
		1.00	2.00	3.00		4.00	5.00	
1 00	FACILITY HEALTH CARE STAFF COSTS	500.00/		500.0	0		500.00/	1 00
1.00	Physi ci an	533, 226	0			0		1.00
2.00	Physician Assistant	0	0		0	0	0	2.00
3.00	Nurse Practitioner	289, 911	0		11	0	289, 911	3.00
4.00	Visiting Nurse	175 000	0		0	0	0	4.00
5.00	Other Nurse	175, 293	0			0	175, 293	5.00
6.00	Clinical Psychologist	118, 854	0		54 0	0	118, 854	6.00
7.00	Clinical Social Worker	0	0		~	0	0	7.00
8.00	Laboratory Technician	0	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	1 117 204	0		0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	1, 117, 284	0			-	1, 117, 284	
11.00	Physician Services Under Agreement	0	0		0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	0	
14.00 15.00	Subtotal (sum of lines 11 through 13) Medical Supplies	0	0		0	0	0	14.00 15.00
15.00 16.00	Transportation (Health Care Staff)	0	0		0	0	0	15.00
17.00	Depreciation-Medical Equipment	0	0		0	0	0	17.00
	Professional Liability Insurance	0	0		0	0	0	17.00
19.00	Other Health Care Costs	0	0		0	0	0	18.00
20.00	Allowable GME Costs	0	0		U	0	0	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	0		0	0	0	20.00
21.00	Total Cost of Health Care Services (sum of	1, 117, 284	0		~	0	1, 117, 284	
22.00	lines 10, 14, and 21)	1, 117, 204	0	1, 117, 2	04	0	1, 117, 204	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1				
23.00	Pharmacy	0	0		0	0	0	23.00
24.00	Dental	0	0		0	0	0	24.00
25.00	Optometry	0	0		0	0	0	25.00
25.01	Tel eheal th	0	0		0	0	0	25.01
25.02	Chronic Care Management	0	0		0	0	0	25.02
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs					-		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27)							
	FACILITY OVERHEAD							
29.00	Facility Costs	0	0		0	0	0	29.00
30.00	Administrative Costs	233, 569	414, 585	648, 1	54	-98, 162	549, 992	30.00
31.00	Total Facility Overhead (sum of lines 29 and	233, 569	414, 585	648, 1	54	-98, 162	549, 992	31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	1, 350, 853	414, 585	1, 765, 4	38	-98, 162	1, 667, 276	32.00
	and 31)							

llool th	Financial Customa	PUTNAM COUNT				of Form CMC	2552 10
	Financial Systems	PUTNAW COUNT	Provider C	CN- 15 1222	Peri od:	u of Form CMS- Worksheet M-1	
ANALIS	IS OF HUSPITAL-DASED RHC/FUHC CUSTS		Provider C	CN. 10-1555	From 01/01/2019	worksneet w-	I
			Component	CCN: 15-8515	To 12/31/2019	Date/Time Pre	
						8/28/2020 10:	03 am
					RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		(00	col. 6)	-			
		6.00	7.00				-
1.00	FACILITY HEALTH CARE STAFF COSTS Physi ci an	0	533, 226				1.00
2.00	5	0		1			2.00
2.00	Physician Assistant Nurse Practitioner	0	-	1			2.00
3.00 4.00	Visiting Nurse	0	209, 911				4.00
4.00 5.00	Other Nurse	0	175, 293				5.00
6.00	Clinical Psychologist	0					6.00
7.00	Clinical Social Worker	0	110, 054	1			7.00
7.00 8.00	Laboratory Technician	0					8.00
8.00 9.00	Other Facility Health Care Staff Costs	0					9,00
9.00 10.00	Subtotal (sum of lines 1 through 9)	0	-	1			10.00
11.00	Physician Services Under Agreement	0	.,,==.				11.00
12.00	Physician Supervision Under Agreement	0					12.00
	Other Costs Under Agreement	0					12.00
13.00	Subtotal (sum of lines 11 through 13)	0	-	1			14.00
14.00	Medical Supplies	0					15.00
	Transportation (Health Care Staff)	0		1			16.00
17.00	Depreciation-Medical Equipment	0					17.00
	Professional Liability Insurance	0					18.00
	Other Health Care Costs	0					19.00
	Allowable GME Costs	0					20.00
	Subtotal (sum of lines 15 through 20)	0	C				21.00
	Total Cost of Health Care Services (sum of	0	-				22.00
22.00	lines 10, 14, and 21)	0	1, 117, 204				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES		L				
23.00	Pharmacy	0	C				23.00
24.00	Dental	0					24.00
25.00	Optometry	0					25.00
25.01	Tel eheal th	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	C C)			28.00
	through 27)						
	FACILITY OVERHEAD						1
29.00	Facility Costs	0	0				29.00
30.00	Administrative Costs	-9, 226	540, 766				30.00
31.00	Total Facility Overhead (sum of lines 29 and	-9, 226	540, 766				31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	-9, 226	1, 658, 050				32.00
	and 31)						

1.00 F	S OF HOSPITAL-BASED RHC/FQHC COSTS	Compensati on	Provider Component Component Other Costs	CCN: 15-8513 Total (col.	Fr Tc	RHC II	Worksheet M-1 Date/Time Pre 8/28/2020 10: Cost	
1.00 F			·	Total (col.	To	RHC 11	8/28/2020 10: Cost	
1.00 F			Other Costs		1			
1.00 F			Other Costs		1			
1.00 F							Recl assi fi ed	
1.00 F				+ col. 2)		i ons	Trial Balance	
1.00 F							(col. 3 +	
1.00 F						1.00	col . 4)	
1.00 F		1.00	2.00	3.00		4.00	5.00	
		270.000		270.0	00	0	270.000	1 00
2.00 11	Physician	279, 900	0			0	279,900	1.00
	Physician Assistant	447, 869	0	447,8		Ű	447, 869	2.00
	Nurse Practitioner	0	0		0	0	0	3.00
	/isiting Nurse	100 571	0	100 5	0	0	0	4.00
	Other Nurse	133, 571	0	133, 5		Ű	133, 571	5.00
	Clinical Psychologist	0	0		0	0	0	6.00
	Clinical Social Worker	0	0		~	0	-	7.00
	_aboratory Technician	0	0		0	Ű	0	8.00
	Other Facility Health Care Staff Costs	0	0	0/1 0	0	0	0	9.00
	Subtotal (sum of lines 1 through 9)	861, 340	0	861, 3		0	861, 340	10.00
	Physician Services Under Agreement	0	0		0	0	0	11.00
	Physician Supervision Under Agreement	0	0		~	Ű	0	12.00
	Other Costs Under Agreement	0	0		0	0	0	13.00
	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	0	14.00
	Medical Supplies	0	0		-	0	0	15.00
	Transportation (Health Care Staff) Depreciation-Medical Equipment	0	0		0	0	0	16.00 17.00
	Professional Liability Insurance	0	0		0	0	0	17.00
	Other Health Care Costs	0	0		0	0	0	18.00
	Allowable GME Costs	0	0		0	0	0	20.00
	Subtotal (sum of lines 15 through 20)	0	0		0	0	0	20.00
	Total Cost of Health Care Services (sum of	861, 340	0	861, 3	-	0	861, 340	
	ines 10, 14, and 21)	001, 340	0	001, 3	40	0	001, 340	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
	Pharmacy	0	0		0	0	0	23.00
	Dental	0	0		0	0	0	24.00
	Detometry	0	0		0	0	0	25.00
	Tel eheal th	0	0		0	0	0	25.00
	Chronic Care Management	0	0		0	0	0	25.01
	All other nonreimbursable costs	0	0		0	0	0	26.00
	Vonallowable GME costs	0	0		0	0	0	27.00
	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27)	0	0		0	Ŭ	0	20.00
	ACILITY OVERHEAD							
	Facility Costs	0	0		0	0	0	29.00
	Administrative Costs	257, 900	365, 784			-123, 029	500, 655	30.00
	Total Facility Overhead (sum of lines 29 and	257, 900	365, 784			-123, 029	500, 655	31.00
	30)	20., 700	200,701	520,0	J .	.20, 02,	222,000	500
-	Fotal facility costs (sum of lines 22, 28	1, 119, 240	365, 784	1, 485, 0	24	-123, 029	1, 361, 995	32.00
	and 31)		,	,		.,		

ANALYSI S OF HOSPI TAL-BASED RHC/FOHC COSTS Provi der CCN: Component CCN Adj ustments Adj ustments Net Expenses for Al locati on (col. 5 + col. 6) 6.00 7.00 FACI LI TY HEALTH CARE STAFF COSTS 1.00 Physi ci an 0 279,900 0 447,869		Period: From 01/01/2019 To 12/31/2019 RHC II	Worksheet M-1 Date/Time Pre 8/28/2020 10: Cost	epared:
Adjustments Net Expenses for Allocation (col. 5 + col. 6) 6.00 7.00 FACILITY HEALTH CARE STAFF COSTS 1.00 Physician 0 279,900	N: 15-8513	To 12/31/2019	8/28/2020 10:	
FACILITY HEALTH CARE STAFF COSTS 6.00 7.00 FACILITY HEALTH CARE STAFF COSTS 0 279,900		RHCII		<u>03 am</u>
FACILITY HEALTH CARE STAFF COSTS 6.00 7.00 FACILITY HEALTH CARE STAFF COSTS 0 279,900			COST	
FACILITY HEALTH CARE STAFF COSTS 6.00 7.00 FACILITY HEALTH CARE STAFF COSTS 0 279,900				
All location (col. 5 + col. 6) 6.00 7.00 FACILITY HEALTH CARE STAFF COSTS 0 1.00 Physician 0				
FACILITY HEALTH CARE STAFF COSTS 0 279,900				
FACILITY HEALTH CARE STAFF COSTS 6.00 7.00 1.00 Physician 0 279,900				
FACILITY HEALTH CARE STAFF COSTS 1.00 Physi ci an 0 279, 900				
1. 00 Physi ci an 0 279, 900				
2.00 Physician Assistant 0 447.869				1.00
				2.00
3.00 Nurse Practitioner 0 0				3.00
4.00 Visiting Nurse 0 0				4.00
5.00 Other Nurse 0 133,571				5.00
6.00 Clinical Psychologist 0 0				6.00
7.00 Clinical Social Worker 0 0				7.00
8.00 Laboratory Technician 0 0				8.00
9.00 Other Facility Health Care Staff Costs 0 0				9.00
10.00 Subtotal (sum of lines 1 through 9) 0 861, 340				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
15.00Medical Supplies0016.00Transportation (Health Care Staff)00				15.00
				16.00
17.00Depreciation-Medical Equipment0018.00Professional Liability Insurance00				17.00
19.00 Other Heal th Care Costs 0 0				19.00
20. 00 Allowable GME Costs				20.00
21.00 Subtotal (sum of lines 15 through 20) 0 0				21.00
22. 00 Total Cost of Health Care Services (sum of 0 861, 340				22.00
Li nes 10, 14, and 21)				22.00
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 0				29.00
30. 00 Administrative Costs -835 499, 820				30.00
31.00 Total Facility Overhead (sum of lines 29 and -835 499,820				31.00
30)				
32.00 Total facility costs (sum of lines 22, 28 -835 1, 361, 160				32.00
and 31)				1

	Financial Systems	PUTNAM COUNT			-		u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333		riod: om 01/01/2019	Worksheet M-1	
			Component	CCN: 15-8514	To	12/31/2019	Date/Time Pre 8/28/2020 10:	
						RHC III	Cost	_
		Compensati on	Other Costs	Total (col.	1 R	Recl assi fi cat	Recl assi fi ed	
				+ col. 2)		i ons	Trial Balance	
							(col. 3 +	
					_		col. 4)	
		1.00	2.00	3.00		4.00	5.00	
1 00	FACILITY HEALTH CARE STAFF COSTS	221 000		221.0		0	221 000	1 00
1.00	Physician	321, 900	0			0	321,900	1.00
2.00	Physician Assistant	50, 486	0			0	50, 486	2.00
3.00	Nurse Practitioner	198, 799	0			0	198, 799	3.00
4.00	Visiting Nurse	0	0		0	0	0	4.00
5.00	Other Nurse	82, 130	0	02/1		0	82, 130	5.00
6.00	Clinical Psychologist	0	0		0	0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	653, 315	0	653, 3	15	0	653, 315	10.00
11.00	Physician Services Under Agreement	0	0		0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	o	0		0	o	0	14.00
15.00	Medical Supplies	0	0		0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	0	17.00
	Professional Liability Insurance	0	0		0	0	0	18.00
19.00	Other Heal th Care Costs	0	0		0	0	0	19.00
20.00	Allowable GME Costs	0	0		Ŭ	0	0	20.00
20.00	Subtotal (sum of lines 15 through 20)	0	0		0	0	0	20.00
21.00	Total Cost of Health Care Services (sum of	452 215	0	452.2	15	0	-	
22.00		653, 315	0	653, 3	15	0	653, 315	22.00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0		0	0	0	23.00
24.00	Dental	0	0		0	0	0	24.00
25.00	Optometry	0	0		0	0	0	25.00
25.00	Tel eheal th	0	0		0	0	0	25.00
25.01	Chronic Care Management	0	0		0	0	0	25.01
26.02	All other nonreimbursable costs	0	0		0	0	0	25.02
		0	0		U	0	0	
27.00	Nonallowable GME costs		0		~		0	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27)							
20.00	FACILITY OVERHEAD	~		1	0		^	20.00
29.00	Facility Costs	0	0		0	0	0	29.00
30.00	Administrative Costs	316, 277	356, 454			-77, 765	594, 966	30.00
31.00	Total Facility Overhead (sum of lines 29 and	316, 277	356, 454	672, 7	31	-77, 765	594, 966	31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	969, 592	356, 454	1, 326, 0	46	-77, 765	1, 248, 281	32.00
	and 31)			1				1

ANALYSI S	OF HOSPITAL-BASED RHC/FQHC COSTS						
	OF HOSFITAL-DASED KHC/TQHC COSTS		Provider C	CN: 15-1333	Peri od:	Worksheet M-1	
			Component (CCN: 15-8514	From 01/01/2019 To 12/31/2019	Date/Time Pre 8/28/2020 10:	
					RHC III	Cost	00 ulli
		Adjustments	Net Expenses			0001	
		,	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
	CILITY HEALTH CARE STAFF COSTS						
	ysi ci an	0	321, 900				1.00
	ysician Assistant	0	50, 486				2.00
1	rse Practitioner	0	198, 799				3.00
1	siting Nurse	0	0				4.00
	her Nurse	0	82, 130				5.00
	inical Psychologist	0	0				6.00
	inical Social Worker	0	0				7.00
	boratory Techni ci an	0	0				8.00
	her Facility Health Care Staff Costs	0	0				9.00
	btotal (sum of lines 1 through 9)	0	653, 315				10.00
	ysician Services Under Agreement	0	0				11.00
	ysician Supervision Under Agreement	0	0				12.00
13.00 Otl	her Costs Under Agreement	0	0				13.00
14.00 Sul	btotal (sum of lines 11 through 13)	0	0				14.00
	dical Supplies	0	0				15.00
	ansportation (Health Care Staff)	0	0				16.00
	preciation-Medical Equipment	0	0				17.00
	ofessional Liability Insurance	0	0				18.00
	her Health Care Costs	0	0				19.00
	lowable GME Costs						20.00
	btotal (sum of lines 15 through 20)	0	0				21.00
	tal Cost of Health Care Services (sum of	0	653, 315				22.00
	nes 10, 14, and 21)						-
	STS OTHER THAN RHC/FQHC SERVICES						
	armacy	0	0				23.00
1	ntal	0	0				24.00
	tometry	0	0				25.00
	lehealth	0	0				25.01
	ronic Care Management	0	-				25.02
	l other nonreimbursable costs	0	0				26.00
	nallowable GME costs	0	0				27.00
	tal Nonreimbursable Costs (sum of lines 23	0	0				28.00
	rough 27) CILITY OVERHEAD						-
	cility Costs	0	0				29.00
	ministrative Costs	-8, 714	586, 252				30.00
	tal Facility Overhead (sum of lines 29 and	-8, 714	586, 252				31.00
31.00 10	3	-0, /14	500, 252				31.00
	tal facility costs (sum of lines 22, 28	-8, 714	1, 239, 567				32.00
	5	5,714	1,207,007				52.00
and	d 31)						

Health Financial Systems		COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-1
ALLOCATION OF OVERHEAD TO HOSPITAL-BA	SED RHC/FQHC SERVICES		Provider CO		Period:	Worksheet M-2	
			Component (rom 01/01/2019 o 12/31/2019	Date/Time Pre	nared
			componente		0 12/01/2017	8/28/2020 10:	
					RHC I	Cost	
	Number of	FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
	Personr	nel		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							
. 00 Physi ci an		1.57	5, 013				1.0
.00 Physician Assistant		0.00	0	2/100			2.0
.00 Nurse Practitioner		2.38	3, 376				3.0
.00 Subtotal (sum of lines 1 throug	jh 3)	3.95	8, 389		11, 592	11, 592	4.0
.00 Visiting Nurse		0.00	0			0	5.0
.00 Clinical Psychologist		0. 93	889			889	6.0
.00 Clinical Social Worker		0.00	0			0	7.0
0.01 Medical Nutrition Therapist (FC		0.00	0			0	7.0
02 Diabetes Self Management Traini	ng (FQHC	0.00	0			0	7.0
onl y)							
8.00 Total FTEs and Visits (sum of I	ines 4	4.88	9, 278			12, 481	8.0
through 7)							
2.00 Physician Services Under Agreen	ients		0			0	9.0
						1.00	
DETERMINATION OF ALLOWABLE COST	APPLICABLE TO HOSPITAL	-BASE	RHC/FOHC SEE	RVLCES		1.00	
0.00 Total costs of health care serv	vices (from Wkst. M-1,)	col. 7,	, line 22)			1, 117, 284	10.0
1.00 Total nonreimbursable costs (fr	om Wkst. M-1, col. 7,	line 28	8)			0	11.0
2.00 Cost of all services (excluding	overhead) (sum of line	es 10 a	and 11)			1, 117, 284	12.0
3.00 Ratio of hospital-based RHC/FQF						1.000000	
4.00 Total hospital-based RHC/FQHC o			<i>,</i>	ne 31)		540, 766	14.0
5.00 Parent provider overhead alloca				,		1,034,738	15.0
6.00 Total overhead (sum of lines 14	J (<i>,</i>			1, 575, 504	
7.00 Allowable GME overhead (see ins						0	
8.00 Enter the amount from line 16	/					1, 575, 504	
9.00 Overhead applicable to hospital	-based RHC/FQHC service	es (lin	ne 13 x line ²	18)		1, 575, 504	
0.00 Total allowable cost of besnits						2 (02 700	

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 2,692,788
 20.00

Health Financial Systems	PUTNAM C	OUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-1
ALLOCATION OF OVERHEAD TO HOSPITAL-BAS	SED RHC/FQHC SERVICES		Provider CO		Period: From 01/01/2019	Worksheet M-2	
			Component (To 12/31/2019		
					RHC II	Cost	
	Number of	FTE T	「otal Visits	Producti vi ty	Mi ni mum	Greater of	
	Personne	st		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							
. 00 Physi ci an		D. 87	3, 173				1.0
.00 Physician Assistant		3. 29	6, 379	2, 10	6, 909		2.0
.00 Nurse Practitioner	(0. 00	0		0 0		3.0
.00 Subtotal (sum of lines 1 throug	h 3) 4	4. 16	9, 552		10, 563	10, 563	4.0
.00 Visiting Nurse	(0. 00	0			0	5.0
.00 Clinical Psychologist	(0. 00	0			0	6.0
.00 Clinical Social Worker		0. 00	0			0	7.0
.01 Medical Nutrition Therapist (FC		0. 00	0			0	7.0
. 02 Diabetes Self Management Traini	ng (FQHC (0. 00	0			0	7.0
onl y)							
8.00 Total FTEs and Visits (sum of I	ines 4 4	4. 16	9, 552			10, 563	8.0
through 7)							
0.00 Physician Services Under Agreem	ents		0			0	9.0
						1.00	
DETERMINATION OF ALLOWABLE COST	APPLI CABLE TO HOSPI TAL-	BASED	RHC/FQHC SEF	RVICES		1.00	
0.00 Total costs of health care serv	ices (from Wkst. M-1, co	ol. 7,	line 22)			861, 340	10.0
1.00 Total nonreimbursable costs (fr	om Wkst. M-1, col. 7, li	ne 28	5)			0	11.0
2.00 Cost of all services (excluding	overhead) (sum of lines	s 10 a	nd 11)			861, 340	12.0
3.00 Ratio of hospital-based RHC/FQH	C services (line 10 divi	ded b	v line 12)			1.000000	13.0
4.00 Total hospital-based RHC/FQHC o	verhead - (from Workshee	et. M-	1, col. 7, li	ne 31)		499, 820	14.0
5.00 Parent provider overhead alloca				,		717, 696	
6.00 Total overhead (sum of lines 14			<i>,</i>			1, 217, 516	
7.00 Allowable GME overhead (see ins						0	
8.00 Enter the amount from line 16	<i>,</i>					1, 217, 516	18.0
9.00 Overhead applicable to hospital	-based RHC/FQHC services	s (lin	e 13 x line 1	18)		1, 217, 516	
0.00 Total allowable cost of becnite						2 070 054	

 20.00
 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19)
 2,078,856
 20.00

	Financial Systems	PUTNAM COUNT				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period: From 01/01/2019	Worksheet M-2	
			Component	CCN: 15-8514	To 12/31/2019	Date/Time Pre 8/28/2020 10:	
					RHC III	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						
	Positions	-1	I	1	- F		
	Physi ci an	1.91					1.0
	Physician Assistant	0.58					2.0
	Nurse Practitioner	1.56					3.0
	Subtotal (sum of lines 1 through 3)	4.05			12, 516	12, 516	4.0
	Visiting Nurse	0.00				0	5.0
	Clinical Psychologist	0.00				0	6.0
	Clinical Social Worker	0.00				0	7.0
	Medical Nutrition Therapist (FQHC only)	0.00				0	7.(
. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.0
. 00	Total FTEs and Visits (sum of lines 4	4.05	6, 665			12, 516	8.0
	through 7)						
. 00	Physician Services Under Agreements		0			0	9.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE			RVICES		(50.015	
	Total costs of health care services (from W					653, 315	
	Total nonreimbursable costs (from Wkst. M-1						11. (
	Cost of all services (excluding overhead) (653, 315	
	Ratio of hospital-based RHC/FQHC services (1.000000	
	Total hospital-based RHC/FQHC overhead - (f			ine 31)		586, 252	
	Parent provider overhead allocated to facil	ιτy (see instru	CTIONS)			899, 320	
	Total overhead (sum of lines 14 and 15)					1, 485, 572	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	ouo i ()		10)		1, 485, 572	
	Overhead applicable to hospital-based RHC/F					1, 485, 572	
20.00	Total allowable cost of hospital-based RHC/	FUHC services (sum of lines 1	U and 19)		2, 138, 887	20. (

ERVICES	ETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES otal Allowable Cost of hospital-based RHC/FQHC Services (fro ost of vaccines and their administration (from Wkst. M-4, li	Component CCN: 15-8515 Title XVIII om Wkst. M-2, line 20)	Period: From 01/01/2019 To 12/31/2019 RHC I	Worksheet M-3 Date/Time Pre 8/28/2020 10: Cost	pared
. 00 To . 00 Co . 00 To . 00 To . 00 To . 00 Ph . 00 To	ETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES otal Allowable Cost of hospital-based RHC/FQHC Services (fro ost of vaccines and their administration (from Wkst. M-4, li	Title XVIII om Wkst. M-2, line 20)	To 12/31/2019	8/28/2020 10:	
. 00 To . 00 Co . 00 To . 00 To . 00 Ph . 00 To	otal Allowable Cost of hospital-based RHC/FQHC Services (fro ost of vaccines and their administration (from Wkst. M-4, li	om Wkst. M-2, line 20)	RHC I		<u>03 am</u>
. 00 To . 00 Co . 00 To . 00 To . 00 Ph . 00 To	otal Allowable Cost of hospital-based RHC/FQHC Services (fro ost of vaccines and their administration (from Wkst. M-4, li	om Wkst. M-2, line 20)	RHC I	COST	
. 00 To . 00 Co . 00 To . 00 To . 00 Ph . 00 To	otal Allowable Cost of hospital-based RHC/FQHC Services (fro ost of vaccines and their administration (from Wkst. M-4, li	· · · · · ·			
. 00 To . 00 Co . 00 To . 00 To . 00 Ph . 00 To	otal Allowable Cost of hospital-based RHC/FQHC Services (fro ost of vaccines and their administration (from Wkst. M-4, li	· · · · · ·		1.00	<u> </u>
2. 00 Co 3. 00 To 3. 00 To 3. 00 Ph 3. 00 To	ost of vaccines and their administration (from Wkst. M-4, li	· · · · · ·			
. 00 To . 00 To . 00 Ph . 00 To	•			2, 692, 788] 1.(
. 00 To . 00 Ph . 00 To		ne 15)		160, 350	2.
. 00 Ph . 00 To	otal allowable cost excluding vaccine (line 1 minus line 2)			2, 532, 438	
. 00 To	otal Visits (from Wkst. M-2, column 5, line 8)			12, 481	
1	hysicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
<u>. 00 AC</u>	otal adjusted visits (line 4 plus line 5) diusted cast par visit (line 2 divided by line 6)			12, 481	6. 7.
	djusted cost per visit (line 3 divided by line 6)		Cal cul ati on	202.90	1.
			carcuration		
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1)	Period 2)	
00 0-	or vicit powent limit (from CNS Dub 100 04 chapter 0 500) 6 or your contractor	1.00	2.00	0
	er visit payment limit (from CMS Pub. 100-04, chapter 9, §20 ate for Program covered visits (see instructions)		0. 00 202. 90	84. 70 202. 90	
	ALCULATION OF SETTLEMENT		202.90	202.90	. 7.
	rogram covered visits excluding mental health services (from	contractor records)	0	1, 084	10.
	rogram cost excluding costs for mental health services (line		0	219, 944	
2.00 Pr	rogram covered visits for mental health services (from contr	actor records)	0	0	
3.00 Pr	rogram covered cost from mental health services (line 9 x li	ne 12)	0	0	13.
	imit adjustment for mental health services (see instructions		0	0	14.
1	raduate Medical Education Pass Through Cost (see instruction				15.
	otal Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	219, 944	
	otal program charges (see instructions)(from contractor's re			206, 561	
	otal program preventive charges (see instructions)(from prov otal program preventive costs ((line 16.02/line 16.01) times			0	
	otal Program non-preventive costs ((line 16 minus lines 16.0	-		162, 673	
	Titles V and XIX see instructions.)			102, 070	10.
	otal program cost (see instructions)		0	162, 673	16.
	rimary payer amounts			0	17.
	ess: Beneficiary deductible for RHC only (see instructions)	(from contractor		16, 603	18.
1	ecords)			05 400	
	eneficiary coinsurance for RHC/FQHC services (see instructio ecords)	ons) (from contractor		35, 138	19.
1	et Medicare cost excluding vaccines (see instructions)			162, 673	20.
	rogram cost of vaccines and their administration (from Wkst.	M-4. line 16)		16, 569	
1	otal reimbursable Program cost (line 20 plus line 21)			179, 242	
3.00 AI	llowable bad debts (see instructions)			0	23.
	djusted reimbursable bad debts (see instructions)			0	23.
	llowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	>		0	
	ioneer ACO demonstration payment adjustment (see instruction	15)		0	
	emonstration payment adjustment amount before sequestration et reimbursable amount (see instructions)			0 179, 242	
	equestration adjustment (see instructions)			3, 585	
	emonstration payment adjustment amount after sequestration			3, 303 0	1
	nterim payments			143, 215	
	entative settlement (for contractor use only)			0	
9.00 Ba	alance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		32, 442	29.
	rotested amounts (nonallowable cost report items) in accorda hapter I, §115.2	ance with CMS Pub. 15-II		0	30.

	Financial Systems PUTNAM COUNTY F TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CE			From 01/01/2019		
		Component CCN: 15-8513	To 12/31/2019	Date/Time Pre 8/28/2020 10:	
		Title XVIII	RHC II	Cost	05 41
				1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES Total Allowable Cost of hospital-based RHC/FQHC Services (fro	www.st M 2 Lipo 20)		2, 078, 856	1.0
	Cost of vaccines and their administration (from Wkst. M-4, li			2,078,850	
1	Total allowable cost excluding vaccine (line 1 minus line 2)	ne is)		1, 960, 466	
	Total Visits (from Wkst. M-2, column 5, line 8)			10, 563	
1	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
	Total adjusted visits (line 4 plus line 5)			10, 563	6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			185.60	7.
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1) 1.00	Period 2) 2.00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20) 6 or your contractor)	0.00	2.00	8.
	Rate for Program covered visits (see instructions)		185.60		
	CALCULATION OF SETTLEMENT				
0. 00 🛛	Program covered visits excluding mental health services (from	contractor records)	0	1, 657	10.
1.00	Program cost excluding costs for mental health services (line	e 9 x line 10)	0	307, 539	11.
1	Program covered visits for mental health services (from contr		0	0	
	Program covered cost from mental health services (line 9 x li		0	0	
	Limit adjustment for mental health services (see instructions		0	0	
	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	207 520	15. 16.
	Total program charges (see instructions)(from contractor's re		0	307, 539 320, 340	
	Total program preventive charges (see instructions)(from prov			0	16.
	Total program preventive costs ((line 16.02/line 16.01) times			0	16.
6.04	Total Program non-preventive costs ((line 16 minus lines 16.0	03 and 18) times .80)		211, 714	16.
	(Titles V and XIX see instructions.)				
	Total program cost (see instructions)		0	211, 714	
1	Primary payer amounts	(from contractor		0	
	Less: Beneficiary deductible for RHC only (see instructions) records)	(ITOM CONTRACTOR		42, 897	18.
9.00	Beneficiary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		54, 262	19.
1	records) Net Medicare cost excluding vaccines (see instructions)			211, 714	20.
	Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		28, 519	
	Total reimbursable Program cost (line 20 plus line 21)			240, 233	
1	Allowable bad debts (see instructions)			0	23.
3. 01	Adjusted reimbursable bad debts (see instructions)			0	23.
1	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	IS)		0	
	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 240, 233	
	Sequestration adjustment (see instructions)			4,805	
	Demonstration payment adjustment amount after sequestration			4,005	
	Interim payments			163, 769	
	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 26.			71, 659	29.
	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	nce with CMS Pub. 15-II	,	0	30.

	al Systems PUTNAM COUNTY F F REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Period:	u of Form CMS-2 Worksheet M-3	
SERVICES	REIMBURSEMENT SETTLEMENT FOR HUSPITAL-DASED RHC/FURC		From 01/01/2019		
		Component CCN: 15-8514	To 12/31/2019	Date/Time Pre 8/28/2020 10:	
		Title XVIII	RHC III	Cost	<u>.</u>
				1.00	
DETERMI	NATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
	Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst M-2 line 20)		2, 138, 887	1 1.
	f vaccines and their administration (from Wkst. M-4, li			97,065	
	allowable cost excluding vaccine (line 1 minus line 2)			2,041,822	
	/isits (from Wkst. M-2, column 5, line 8)			12, 516	4.
. 00 Physi c	ans visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
	adjusted visits (line 4 plus line 5)			12, 516	
.00 Adjust	ed cost per visit (line 3 divided by line 6)			163.14	7.
			Cal cul ati on	of Limit (1)	
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1) 1.00	Period 2) 2.00	
.00 Per vi	sit payment limit (from CMS Pub. 100-04, chapter 9, §20) 6 or your contractor)	0.00	2.00	8.
	or Program covered visits (see instructions)	, o or your contractor)	163. 14		
	TION OF SETTLEMENT		100.11	100.11	1 1
	n covered visits excluding mental health services (from	contractor records)	0	1, 353	1 10.
	n cost excluding costs for mental health services (line		0	220, 728	11
2.00 Progra	n covered visits for mental health services (from contr	actor records)	0	0	12
· · · ·	n covered cost from mental health services (line 9 x li		0	0	
	adjustment for mental health services (see instructions	·	0	0	
	te Medical Education Pass Through Cost (see instruction	-		000 700	15.
	Program cost (sum of lines 11, 14, and 15, columns 1, 2 program charges (see instructions)(from contractor's re		0	220, 728	
	program preventive charges (see instructions)(from prov	·		216, 066 0	
	program preventive costs ((line 16.02/line 16.01) times			0	16.
	Program non-preventive costs ((line 16 minus lines 16.0	-		161, 154	
	s V and XIX see instructions.)	, ,			
6.05 Total	program cost (see instructions)		0	161, 154	16.
	y payer amounts			0	
	Beneficiary deductible for RHC only (see instructions)	(from contractor		19, 285	18.
record	·	(from contractor		24 520	10
9.00 Benefic records	ciary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		36, 520	19.
	dicare cost excluding vaccines (see instructions)			161, 154	20
	n cost of vaccines and their administration (from Wkst.	M-4, line 16)		27, 257	
2.00 Total	reimbursable Program cost (line 20 plus line 21)			188, 411	22
	ole bad debts (see instructions)			0	
	ed reimbursable bad debts (see instructions)			0	
	ble bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	 ACO demonstration payment adjustment (see instruction tration payment adjustment amount before sequestration 	15)		0	
	mbursable amount (see instructions)			188, 411	
	tration adjustment (see instructions)			3, 768	
	tration payment adjustment amount after sequestration			0,700	
	n payments			181, 862	
	ve settlement (for contractor use only)			0	
	e due component/program (line 26 minus lines 26.01, 26.	· · · · ·		2, 781	
	ted amounts (nonallowable cost report items) in accorda ^ I, §115.2	nce with CMS Pub. 15-II	,	0	30

Heal th	Financial Systems PUTNAM COUNTY H	In Lieu of Form CMS-2552-10			
	COMPUTATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA Provider CCN: 15-1333 Pe			Worksheet M-4	
VACCIN	E COST	Component CCN: 15-8515	From 01/01/2019 To 12/31/2019		
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		1, 117, 284		
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	4, 181		3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	5	33, 424		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		37, 605		
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22			6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 575, 504		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	tal direct cost (line 5	0. 033658	0. 025890	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	53, 028	40, 790	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	90, 633	69, 717	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	180	633	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	503.52	110. 14	12.00
13.00	Number of pneumococcal and influenza vaccine injections admir beneficiaries	istered to Program	13	91	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	6, 546	10, 023	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3			160, 350	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		16, 569	16.00

Health Financial Systems PUT	In Lie	In Lieu of Form CMS-2552-10			
		Period:	Worksheet M-4		
VACCINE COST		Component CCN: 15-8513	From 01/01/2019 To 12/31/2019		
		Title XVIII	RHC II	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00 Health care staff cost (from Wkst. M-1, col. 7, I	,		861, 340		
2.00 Ratio of pneumococcal and influenza vaccine staff					
3.00 Pneumococcal and influenza vaccine health care st	•	,	1, 659		
4.00 Medical supplies cost - pneumococcal and influenz	•	5	21, 487	17, 831	
5.00 Direct cost of pneumococcal and influenza vaccine	· ·		23, 146		5.00
6.00 Total direct cost of the hospital-based RHC/FQHC	(from Worksh	eet M-1, col. 7, line 22	.) 861, 340		
7.00 Total overhead (from Wkst. M-2, line 19)			1, 217, 516		
8.00 Ratio of pneumococcal and influenza vaccine direc divided by line 6)	t cost to to	tal direct cost (line 5	0. 026872	0. 030078	8.00
9.00 Overhead cost - pneumococcal and influenza vaccin	e (line 7 x	line 8)	32, 717	36, 620	9.00
10.00 Total pneumococcal and influenza vaccine cost and lines 5 and 9)	lits (their)	administration (sum of	55, 863	62, 527	10.00
11.00 Total number of pneumococcal and influenza vaccin	e injections	(from your records)	129	628	11.00
12.00 Cost per pneumococcal and influenza vaccine injec	tion (line 1	0/line 11)	433.05	99.57	12.00
13.00 Number of pneumococcal and influenza vaccine injer	ctions admin	istered to Program	27	169	13.00
14.00 Program cost of pneumococcal and influenza vaccin (line 12 x line 13)	e and its (t	heir) administration	11, 692	16, 827	14.00
15.00 Total cost of pneumococcal and influenza vaccine of cols. 1 and 2, line 10) (transfer this amount				118, 390	15.00
16.00 Total Program cost of pneumococcal and influenza administration (sum of cols. 1 and 2, line 14) (t	vacci ne and	its (their)		28, 519	16.00
line 21)					

Heal th	Financial Systems PUTNAM COUNTY H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1333	Period:	Worksheet M-4	
VACCIN	E COST	Component CCN: 15-8514	From 01/01/2019 To 12/31/2019		
		Title XVIII	RHC III	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		653, 315		
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	1, 069		
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	5	12, 371		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		13, 440		
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22			
7.00	Total overhead (from Wkst. M-2, line 19)		1, 485, 572		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	tal direct cost (line 5	0. 020572	0. 024809	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	30, 561	36, 856	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	44, 001	53, 064	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	82	456	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	536.60	116.37	12.00
13.00	Number of pneumococcal and influenza vaccine injections admir beneficiaries	istered to Program	20	142	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	10, 732	16, 525	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3			97, 065	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		27, 257	16.00

Health Financial Systems PUTNAM COUN	TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1333	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2019		
	Component CCN: 15-8515	To 12/31/2019	Date/Time Prep 8/28/2020 10:0	
		RHC I	Cost	US alli
			T B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC		1.00	143, 215	1.00
2.00 Interim payments payable on individual bills, either submi	tted or to be submitted to		0	2.00
the contractor for services rendered in the cost reporting			Ű	2.00
"NONE" or enter a zero	,			
3.00 List separately each retroactive lump sum adjustment amour	nt based on subsequent			3.00
revision of the interim rate for the cost reporting period				
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider		- I		
3.01			0	3.01
3. 02			0	3.02
3.03			0	3.03
3.04			0	3.04
3.05			0	3.05
Provider to Program				
3. 50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3. 53			0	3.53
3. 54			0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3	3. 98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trar	nsfer to Worksheet M-3, line	9	143, 215	4.00
27)				
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after de	esk review. Also show date o	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
5. 01			0	5.01
5. 02			0	5.02
5. 03			0	5.03
Provider to Program				
5. 50			0	5.50
5. 51			0	5.51
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5			0	5.99
6.00 Determined net settlement amount (balance due) based on th	ne cost report. (1)			6.00
6. 01 SETTLEMENT TO PROVIDER			32, 442	6.01
6.02 SETTLEMENT TO PROGRAM			0	6.02
7.00 Total Medicare program liability (see instructions)		-	175, 657	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	0.07
8.00 Name of Contractor		1		8.00

Health Financial Systems PUTNAM COUNT	Y HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1333	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2019		
	Component CCN: 15-8513	To 12/31/2019		
			8/28/2020 10:0	03 am
		RHC I I	Cost	
		mm/dd/yyyy	Amount	
1.00 Tatal interim asymptotic solid to been ital based DUG (FOUG		1.00	2.00	1 00
1.00 Total interim payments paid to hospital-based RHC/FQHC			163, 769	1.00
2.00 Interim payments payable on individual bills, either submit			0	2.00
the contractor for services rendered in the cost reporting	period. It none, write			
"NONE" or enter a zero				
3.00 List separately each retroactive lump sum adjustment amount				3.00
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			0	3.01
3. 02			0	3.02
3. 03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program				
3.50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3.53			0	3.53
3. 54			Ő	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trans		_	163, 769	4.00
27)			100,707	1.00
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after des	sk review. Also show date o	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)		-		
Program to Provider				
5. 01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program			-	
5. 50			0	5.50
5. 51			0	5.51
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.99
6.00 Determined net settlement amount (balance due) based on the			0	6.00
6.01 SETTLEMENT TO PROVIDER			71, 659	6.00
6.02 SETTLEMENT TO PROVIDER			/1, 059	6.01
			-	
7.00 Total Medicare program liability (see instructions)		Contract	235, 428	7.00
		Contractor	NPR Date	
	0	Number	(Mo/Day/Yr)	
0.00 Name of Contractor	0	1.00	2.00	0.00
8.00 Name of Contractor				8.00

Health Financial Systems PUTNAM COUN	TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1333	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/2019		
	Component CCN: 15-8514	To 12/31/2019	Date/Time Prep 8/28/2020 10:0	
		RHC III	Cost	US alli
			T B	
		mm/dd/yyyy	Amount	
		1,00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC		1.00	181, 862	1.00
2.00 Interim payments payable on individual bills, either submi	tted or to be submitted to		0	2.00
the contractor for services rendered in the cost reporting			Ŭ	2.00
"NONE" or enter a zero	5 F			
3.00 List separately each retroactive lump sum adjustment amount	nt based on subsequent			3.00
revision of the interim rate for the cost reporting period				
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
3.01			0	3.01
3. 02			0	3.02
3. 03			0	3.03
3.04			0	3.04
3. 05			0	3.05
Provider to Program				
3.50			0	3.50
3. 51			0	3.51
3. 52			0	3.52
3. 53			0	3.53
3. 54			0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3	3. 98)		0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trai	nsfer to Worksheet M-3, line	9	181, 862	4.00
27)				
TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after de	esk review. Also show date o	of		5.00
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
5. 01			0	5.01
5. 02			0	5.02
5. 03			0	5.03
Provider to Program				
5. 50			0	5.50
5. 51			0	5.51
5. 52			0	5.52
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-			0	5.99
6.00 Determined net settlement amount (balance due) based on th	ne cost report. (1)			6.00
6. 01 SETTLEMENT TO PROVIDER			2, 781	6.01
6.02 SETTLEMENT TO PROGRAM			0	6.02
7.00 Total Medicare program liability (see instructions)		-	184, 643	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	0.02
8.00 Name of Contractor				8.00