Heal th Financi		PUTNAM COUI				u of Form CMS-25	552-10
	s required by law (42 USC 1395g since the beginning of the cos					OMB NO. 0938-0 EXPIRES 09-30-	
HOSPITAL AND AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX CO T SUMMARY	ST REPORT CERTIFICAT	TION Pro	vider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet S Parts I-III Date/Time Prep. 5/31/2023 8:41	
PART I - COST	REPORT STATUS						
Provi der use only	 [X] Electronically prepare [Manually prepared cost [0] If this is an amended [F] Medicare Utilization. 	report report enter the num	mber of t	imes the provider re	Date: 5/31/20		41 am
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit	5. Date Received: 7. Contractor No.	rt for th	10. N 11. C is Provider CCN 12. [or Code: Jumn 1 is 4: En Nes reopened = 0	
MI SREPRESENTA ADMI NI STRATI V PROVI DED OR P	TIFICATION BY A CHIEF FINANCIAL TION OR FALSIFICATION OF ANY IN E ACTION, FINE AND/OR IMPRISONM ROCURED THROUGH THE PAYMENT DIR E ACTION, FINES AND/OR IMPRISON	FORMATION CONTAINED ENT UNDER FEDERAL LA ECTLY OR INDIRECTLY	IN THIS AW. FURT	COST REPORT MAY BE P HERMORE, IF SERVICES	IDENTIFIED IN TH	IIS REPORT WERE	
CERTI	FICATION BY CHIEF FINANCIAL OFF	I CER OR ADMINISTRATO	OR OF PRO	VIDER(S)			
l HEF elect State begir are t appli regar	EBY CERTIFY that I have read th ronically filed or manually sub ment of Revenue and Expenses pr ning 01/01/2022 and ending 12/3 rue, correct, complete and prep cable instructions, except as n ding the provision of health ca ded in compliance with such law	e above certificatio mitted cost report a epared by PUTNAM COU 1/2022 and to the be ared from the books oted. I further cert re services, and tha	on statem and submi JNTY HOSF est of my and reco tify that	ent and that I have tted cost report and ITAL (15-1333) for knowledge and belie rds of the provider I am familiar with	the Balance Shee the cost reporti f, this report ar in accordance with the laws and regu	et and ng period nd statement th ulations	
SI GNATU	RE OF CHIEF FINANCIAL OFFICER OF	R ADMINISTRATOR C	CHECKBOX		ELECTRONI C		
	1		2		ATURE STATEMENT		
1	Donnis Monthor	ford	Y	I have read and agrestatement. I certify	that I intend my	/ el ectroni c	1

	Dennis	vveatherrord	signature on this certification be the legally binding equivalent of my original signature.	
2	Signatory Printed Name	Dennis Weatherford		2
3	Signatory Title	CEO		3
4	Date	05/31/2023 08:41:29 AM		4

			Title	XVIII			
		Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	631, 425	943, 952	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	51, 117	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-11, 349		0	10.00
10.01	RURAL HEALTH CLINIC II	0		-1, 141		0	10.01
10. 02	RURAL HEALTH CLINIC III	0		7, 936		0	10.02
200.00	TOTAL	0	682, 542	939, 398	0	0	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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

SPITA	L AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DATA	Provi d	er CCN		Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/31/20	me Pre	epare
	1.00	2.00		3.00		4	4.00	57 517 20	20 0. 4	
	lospital and Hospital Health Care Co									
	Street: 1542 SOUTH BLOOMINGTON ST Sity: GREENCASTLE	PO Box: State: IN	Zin Cod	0. 1412	F Count					1
00 00	City: GREENCASTLE	Component Name	Zip Cod CCN	CBSA		ty: PUTNAM Date	Payme	ent Syst	em (P	2
			Number	Numbe		Certi fi ed		, 0, or		
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	<u>lospital and Hospital-Based Componer</u> lospital	PUTNAM COUNTY HOSPITAL	151333	2690	0 1	12/31/2005	N	0	0	3
	Subprovider - IPF	FUTNAM COUNTY HUSFITAL	101000	2090		12/31/2005		0		4
	Subprovider - IRF									5
	Subprovider - (Other)									6
	Swing Beds - SNF	PUTNAM COUNTY HOSPITAL	15Z333	2690	D	12/31/2005	N	0	N	7
	Wing Beds – NF Hospital-Based SNF									8
	lospi tal -Based NF									10
	lospi tal -Based OLTC									11
	lospi tal -Based HHA									12
	Separately Certified ASC									13
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC	PPI M	158515	2690		02/23/2015	N	0	N	14
	lospital - Based Health Clinic - RHC	FMC	158513	2690		02/25/2015		0	N	15
1	1									
	Hospital-Based Health Clinic - RHC	NPFH	158514	2690	0	03/17/2015	N	0	N	15
	ll Hospital-Based Health Clinic - FQHC									16
	lospi tal -Based (CMHC) I									17
	Renal Dialysis									18
00 0)ther									19
						From: 1.00				-
00 0	Cost Reporting Period (mm/dd/yyyy)					01/01/2		12/31/		20
DO 1	ype of Control (see instructions)					9				21
				-	1 00	2.00		2.0	0	-
ī	npatient PPS Information				1.00	2.00		3.0	0	
	Does this facility qualify and is it	currently receiving pay	/ments for		N					22
	lisproportionate share hospital adju			2						
	3412.106? In column 1, enter "Y" fo									
	Facility subject to 42 CFR Section § nospital?) In column 2, enter "Y" fo		enament							
	Did this hospital receive interim UC		tal UCPs,	for	Ν	N				22
	his cost reporting period? Enter in									
	for the portion of the cost reportin 1. Enter in column 2, "Y" for yes or									
	cost reporting period occurring on c									
	nstructions)									
	s this a newly merged hospital that				Ν	N				22
	letermined at cost report settlement , "Y" for yes or "N" for no, for th			umn						
	period prior to October 1. Enter in			no,						
f	for the portion of the cost reportin	g period on or after Oct	tober 1.							.
)id this hospital receive a geograph rural as a result of the OMB standar				Ν	N		N		22
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportin									
	n column 2, "Y" for yes or "N" for	•								
	reporting period occurring on or aft Does this hospital contain at least									
	counted in accordance with 42 CFR 41									
	ves or "N" for no.									
)id this hospital receive a geograph									22
	rural as a result of the revised OMB adopted by CMS in FY 2021? Enter in									
r		g period prior to Octobe								1
r a	or the portion of the cost reportin		ne cost							
r a f i	n column 2, "Y" for yes or "N" for		wati ana)							
r a f i r	n column 2, "Y" for yes or "N" for reporting period occurring on or aft	er October 1. (see instr								
r a f i r C	n column 2, "Y" for yes or "N" for eporting period occurring on or aft boes this hospital contain at least	er October 1. (see instr 100 but not more than 49	99 beds (a							
r a f i r c	n column 2, "Y" for yes or "N" for reporting period occurring on or aft	er October 1. (see instr 100 but not more than 49	99 beds (a							
r a f r c c SOO W	n column 2, "Y" for yes or "N" for eporting period occurring on or aft boes this hospital contain at least counted in accordance with 42 CFR 41 res or "N" for no. /hich method is used to determine Me	er October 1. (see instr 100 but not more than 49 2.105)? Enter in columr dicaid days on lines 24	99 beds (a n 3, "Y" f and/or 25	îor		0				23
r a f r C C S S O V K	n column 2, "Y" for yes or "N" for eporting period occurring on or aft boes this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me below? In column 1, enter 1 if date	er October 1. (see instr 100 but not more than 49 2.105)? Enter in columr dicaid days on lines 24 of admission, 2 if censu	99 beds (a 1 3, "Y" f and/or 25 us days, c	for i or 3		0				23
r a f r C S S S S S S S S S S S S S S S S S S	n column 2, "Y" for yes or "N" for eporting period occurring on or aft boes this hospital contain at least counted in accordance with 42 CFR 41 res or "N" for no. /hich method is used to determine Me	er October 1. (see instr 100 but not more than 49 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if censu of identifying the days	99 beds (a n 3, "Y" f and/or 25 us days, c in this c	for i or 3		0				23

SPLI	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC	CN: 15-1333	Period:	01/2022		heet S-2	-2552- 2
					From 01/ To 12/	31/2022	Date/	Time Pre 2023 8:4	
		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		Other edi cai d days	
00		1.00	2.00	3.00	4.00	5.00	<u> </u>	6.00	2 24
. 00	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. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	0				0	0		24.0
	HMO paid and eligible but unpaid days in column 5.				Urban	Pural S		of Geogr	
						. 00		. 00	
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the beg	jinning of t	the	1			26.
	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 If this is a sole community hospital (SCH), enter the	age) status ~ "2" for r cation in	ural. If ap column 2.	pl i cabl e,		1			27.
	effect in the cost reporting period.								
						nni ng: . 00		di ng: 00	-
. 00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb	ber				36.
. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of period	ls MDH statu	ıs	C			37.
. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37.
. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.
						′/N	-	Y/N	
	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) Is this hospital subject to the HAC program reduction), (İi), or the mileage i)? Enter	(iii)? Ent requiremer in column 2	er in colur nts in 2 "Y" for ye	ume nn es	<u>. 00</u> N	2	N	39. 40.
. 00	"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 y				XVII		40
						1.0			
. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer	nt for disp	roportionat	e share in	accordance	e N	N	N	45
. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wks1	eption for	extraordi na	ary circumst	tances	N	N	N	46
. 00 . 00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment	capital? E	nter "Y for	yes or "N	for no.	N	N	N	47
	Teachi ng Hospi tal s					- 1			
00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter " cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable C "Y" for yes; otherwise, enter "N" for no in column 2.	'Y" for yes ~ 27, 2020, olumn 1 is ams in the CRs) MA dir	or "N" for under 42 C "Y", or if prior year ect GME pay	no in colu CFR 413.78(b this hospit or penultir yment reduct	umn 1. For b)(2), see tal was nate year, tion? Enter	- N			56.
	For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no ir residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFF which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not comple If line 56 is yes, did this facility elect cost reimt	residents n column 1. cost report e Worksheet applicable R 413.77(e on duty, i ete column	in approved If column ing period? E-4. If cc . For cost)(1)(iv) ar f the respo 2, and comp	d GME progra 1 is "Y", c 2 Enter "Y' olumn 2 is ' reporting p nd (v), rega onse to line olete Worksh	ams trained did 'for yes o 'N", beriods ardless of e 56 is "Y' heet E-4.	or			58

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 01/01/2022 o 12/31/2022	Worksheet S-2 Part I Date/Time Pre 5/31/2023 8:4	pared:
					V	XVIII XIX	
9 00	Are costs claimed on line 100 of Worksheet A? If yes	compl	lete Wkst D-2	Pt. I.	1. 00	2.00 3.00	59.00
		<u>, comp</u>		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1.00	2.00	3.00	
	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 C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. CR) NAHI	see If column 1	N			60. 0
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1. 01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 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				0.00		61.0
	instructions) 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)						61.0
	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) Enter the number of unweighted primary care/or						61. (61. (
1.05	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 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. (
1.06	61.04 minus line 61.03). (see instructions) 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. (
		PI	ogram Name		Unweighted IME FTE Count	Direct GME FTE	
			1.00	2.00	3.00	Count 4.00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				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	61.2
						1.00	
	ACA Provisions Affecting the Health Resources and Ser					1.00	
2. 00	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc		d in this cost	reporting peri	od for which	0.00	62. 0
	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	a Teachi gram. (s	<u>see instructio</u> r		your hospital	0.00	62.0
	Teaching Hospitals that Claim Residents in Nonprovide Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co			N	63.0

Ith Financial Systems FPITAL AND HOSPITAL HEALTH CARE COMPL		M COUNTY HOSPITAL	CN: 15-1333 P	eri od:	u of Form CMS- Worksheet S-2	
				rom 01/01/2022 o 12/31/2022	Part I	epared
			Unwei ghted	Unwei ghted	Ratio (col. 1/	/
			FTES	FTEs in	$(\operatorname{col} \cdot 1 + \operatorname{col} \cdot$	
			Nonprovi der Si te	Hospi tal	2))	
			1.00	2.00	3.00	-
Section 5504 of the ACA Base Year	- FTE Residents in N	onprovider Settinas				
period that begins on or after Ju						
00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 2	er of unweighted nor ations occurring in number of unweighted ir hospital. Enter in	n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64.0
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
	0		FTĔs	FTEsin	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
_			Si te			_
00 Enter in column 1, if line 63	1.00	2.00	3.00	4.00	5.00 0.000000	
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)			Unwei ghted	Unweighted	Ratio (col. 1/	
			FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective f	or cost reporti	ng periods	
beginning on or after July 1, 20 00 Enter in column 1 the number of u FTEs attributable to rotations or Enter in column 2 the number of u FTEs that trained in your hospita	nweighted non-priman ccurring in all nonpu nweighted non-priman	rovider settings. ry care resident	0.00	0. 00	0. 000000	66.
(column 1 divided by (column 1 +						
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + col. 4))	
			Si te	nospi tai	-,,,	
	1.00	2.00	3.00	4.00	5.00	1
00 Enter in column 1, the program			0.00			67.
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						

Heal th	Financial Systems PUTNAM COUNTY HOSPITAL		١r	n Lieu	ı of For	m CMS-2	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO		eriod:		Workshe		
			rom 01/01/ o 12/31/		Part I Date/Ti		
					5/31/20	23 8:4	1 am
					1.C	0	
68.00	Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49 For a cost reporting period beginning prior to October 1, 2022, did you of MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Fina (August 10, 2022)?	otain permissi	on from you		N		68.00
			-	1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS			1.00	2.00	5.00	
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it conta Enter "Y" for yes or "N" for no.	ain an IPF subp	provi der?	Ν			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teachin					0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for ye 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents						
	program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for ye						
	Column 3: If column 2 is Y, indicate which program year began during this (see instructions)	cost reporting	g period.				
	Inpatient Rehabilitation Facility PPS						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it consubprovider? Enter "Y" for yes and "N" for no.	ontain an IRF		Ν			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teachin					0	76.00
	recent cost reporting period ending on or before November 15, 2004? Enter no. Column 2: Did this facility train residents in a new teaching program						
	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)					
					1. C	0	
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for u	10.			N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the (cost reporting	period? Er	nter	Ν		81.00
	"Y" for yes and "N" for no. TEFRA Providers						
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter			no.	N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	42 CFR Section	1				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified (1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	under section			Ν		87.00
			Approved	for	Numbe	r of	
			Permane Adjustme		Appro Permai		
			(Y/N)		Adjusti		
88.00	Column 1: Is this hospital approved for a permanent adjustment to the TEFI	A target	1.00		2.0		88.00
88.00	amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete co					0	88.00
	89. (see instructions) Column 2: Enter the number of approved permanent adjustments.						
		Wkst. A Line	Effecti ve	Date	Appro		
		No.			Permai Adjust		
					Amount	Per	
		1.00	2.00		Discha 3. C	<u> </u>	
89.00	Column 1: If line 88, column 1 is Y, enter the Worksheet A line number	0.00			0.0		89.00
	on which the per discharge permanent adjustment approval was based. Column 2: Enter the effective date (i.e., the cost reporting period						
	beginning date) for the permanent adjustment to the TEFRA target amount						
	per discharge. Column 3: Enter the amount of the approved permanent adjustment to the						
	TEFRA target amount per discharge.		V		XI :		
			1.00		XI 2 2. C		
00.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Eu	ator "V" for	N		Y		90.00
90.00	yes or "N" for no in the applicable column.	iter f for	IN IN		T		90.00
	Is this hospital reimbursed for title V and/or XIX through the cost repor full or in part? Enter "Y" for yes or "N" for no in the applicable column.		N		Y		91.00
	Are title XIX NF patients occupying title XVIII SNF beds (dual certificati				Ν		92.00
93.00	instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and	d XIX? Enter	N		N		93.00
	"Y" for yes or "N" for no in the applicable column.						
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.	o in the	N		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		0. 00 N		0. C N		95.00 96.00
	applicable column.						
97.00	If line 96 is "Y", enter the reduction percentage in the applicable colum	า.	0.00		0. C	0	97.00

HOSPITAL AND HOSPITAL	L HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C		eriod: rom 01/01/2022	Worksheet S-2 Part I	2
			Т	o 12/31/2022	Date/Time Pro 5/31/2023 8:4	
				V	XI X	
				1.00	2.00	
stepdown adjus	r XIX follow Medicare (title XVIII) for t tments on Wkst. B, Pt. I, col. 25? Enter itle V, and in column 2 for title XIX.	he interns and res "Y" for yes or "N"	idents post for no in	Y	Y	98.0
	r XIX follow Medicare (title XVIII) for t r "Y" for yes or "N" for no in column 1 f			Y	Y	98.0
98.02 Does title V o bed costs on W	r XIX follow Medicare (title XVIII) for t kst. D-1, Pt. IV, line 89? Enter "Y" for nd in column 2 for title XIX.			Y	Y	98.0
98.03 Does title V o reimbursed 101	% of inpatient services cost? Enter "Y" f nd in column 2 for title XIX.			N	N	98.0
98.04 Does title V o	r XIX follow Medicare (title XVIII) for a vices cost? Enter "Y" for yes or "N" for			N	Ν	98. (
98.05 Does title V o	r XIX follow Medicare (title XVIII) and a , col. 4? Enter "Y" for yes or "N" for no			Y	Y	98. (
98.06 Does title V o Pts. I through column 2 for t	r XIX follow Medicare (title XVIII) when IV? Enter "Y" for yes or "N" for no in c itle XIX.			Y	Y	98.0
Rural Provider	s ital qualify as a CAH?			Y		105.0
106.00 If this facili	ty qualifies as a CAH, has it elected the	all-inclusive met	hod of payment	Ý		106. 0
107.00 Column 1: If I training progr	services? (see instructions) ine 105 is Y, is this facility eligible f ams? Enter "Y" for yes or "N" for no in c	olumn 1. (see ins	structions)	N		107. 0
approved medic Enter "Y" for 108.00 s this a rura	column 1 is Y and line 70 or line 75 is Y al education program in the CAH's exclude yes or "N" for no in column 2. (see inst I hospital qualifying for an exception to	d IPF and/or IRF ructions) the CRNA fee sche	unit(s)?	N		108. (
CFR Section §4	<u>12.113(c). Enter "Y" for yes or "N" for n</u>	o. Physi cal	Occupati onal	Speech	Respi ratory	
		1.00	2.00	3.00	4.00	
	al qualifies as a CAH or a cost provider,	are Y	Y	Y	N	109.0
	es provided by outside supplier? Enter "Y for no for each therapy.			•		
					1.00	_
for yes or "N" 110.00 Did this hospi Demonstration)		" spital Demonstrati ter "Y" for yes or	on project (§4 "N" for no. li	10A F yes,	1.00 N	
for yes or "N" 110.00 Did this hospi Demonstration) complete Works	for no for each therapy. tal participate in the Rural Community Ho for the current cost reporting period? En	" spital Demonstrati ter "Y" for yes or	on project (§4 "N" for no. li	10A F yes, gh 215, as	N	
for yes or "N" 110.00 Did this hospi Demonstration) complete Works applicable. 111.00 If this facili Health Integra "Y" for yes or integration pr	for no for each therapy. tal participate in the Rural Community Hc for the current cost reporting period? En heet E, Part A, lines 200 through 218, an ty qualifies as a CAH, did it participate tion Project (FCHIP) demonstration for th "N" for no in column 1. If the response ong of the FCHIP demo in which this CAH i apply: "A" for Ambulance services; "B" f	" spital Demonstrati ter "Y" for yes or d Worksheet E-2, I in the Frontier C is cost reporting to column 1 is Y, s participating in	on project (§4 "N" for no. 1 i nes 200 throug community period? Enter enter the n column 2.	10A F yes,		110. C
for yes or "N" 110.00 Did this hospi Demonstration) complete Works applicable. 111.00 If this facili Health Integra "Y" for yes or integration pr Enter all that	for no for each therapy. tal participate in the Rural Community Hc for the current cost reporting period? En heet E, Part A, lines 200 through 218, an ty qualifies as a CAH, did it participate tion Project (FCHIP) demonstration for th "N" for no in column 1. If the response ong of the FCHIP demo in which this CAH i apply: "A" for Ambulance services; "B" f	" spital Demonstrati ter "Y" for yes or d Worksheet E-2, I in the Frontier C is cost reporting to column 1 is Y, s participating in	on project (§4 "N" for no. 1 i nes 200 throug communi ty period? Enter enter the n col umn 2. s; and/or "C"	10A f yes, gh 215, as 1.00 N	N 2.00	 110. 0
for yes or "N" 110.00 Did this hospi Demonstration) complete Works applicable. 111.00 If this facili Health Integra "Y" for yes or integration pr Enter all that for tele-healt 112.00 Did this hospi (PARHM) demons period? Enter "Y", enter in demonstration.	for no for each therapy. tal participate in the Rural Community Hc for the current cost reporting period? En heet E, Part A, lines 200 through 218, an ty qualifies as a CAH, did it participate tion Project (FCHIP) demonstration for th "N" for no in column 1. If the response ong of the FCHIP demo in which this CAH i apply: "A" for Ambulance services; "B" f	spital Demonstrati ter "Y" for yes or d Worksheet E-2, I in the Frontier C is cost reporting to column 1 is Y, s participating in or additional beds Health Model st reporting If column 1 is ticipating in the	on project (§4 "N" for no. 1 i nes 200 throug community period? Enter enter the n column 2.	10A F yes, gh 215, as 1.00	N	110. (
for yes or "N" 110.00 Did this hospi Demonstration) complete Works applicable. 111.00 If this facili Health Integra "Y" for yes or integration pr Enter all that for tele-healt 12.00 Did this hospi (PARHM) demons period? Enter "Y", enter in demonstration. participation 13.00 Did this hospi Transformation reporting peri	for no for each therapy. tal participate in the Rural Community Hc for the current cost reporting period? En heet E, Part A, lines 200 through 218, an ty qualifies as a CAH, did it participate tion Project (FCHIP) demonstration for th "N" for no in column 1. If the response ong of the FCHIP demo in which this CAH i apply: "A" for Ambulance services; "B" f h services. tal participate in the Pennsylvania Rural tration for any portion of the current co "Y" for yes or "N" for no in column 1. column 2, the date the hospital began par In column 3, enter the date the hospita in the demonstration, if applicable. tal participate in the Community Heal th A (CHART) model for any portion of the cur od? Enter "Y" for yes or "N" for no.	" spital Demonstrati ter "Y" for yes or d Worksheet E-2, 1 in the Frontier C is cost reporting to column 1 is Y, s participating in or additional beds Health Model st reporting If column 1 is ticipating in the I ceased ccess and Rural	on project (§4' "N" for no. 1 i nes 200 throug communi ty peri od? Enter enter the n col umn 2. s; and/or "C" 1.00	10A f yes, gh 215, as 1.00 N	N 2.00	110.0
for yes or "N" 110.00 Did this hospi Demonstration) complete Works applicable. 111.00 If this facili Health Integra "Y" for yes or integration pr Enter all that for tele-healt 112.00 Did this hospi (PARHM) demons period? Enter "Y", enter in demonstration. participation 113.00 Did this hospi Transformation participation 115.00 Is this an all in column 2. I for short term psychiatric, r	for no for each therapy. tal participate in the Rural Community Ho for the current cost reporting period? En heet E, Part A, lines 200 through 218, an ty qualifies as a CAH, did it participate tion Project (FCHIP) demonstration for th "N" for no in column 1. If the response ong of the FCHIP demo in which this CAH i apply: "A" for Ambulance services; "B" f h services. tal participate in the Pennsylvania Rural tration for any portion of the current co "Y" for yes or "N" for no in column 1. column 2, the date the hospital began par In column 3, enter the date the hospital in the demonstration, if applicable. tal participate in the Community Health A (CHART) model for any portion of the cur od? Enter "Y" for yes or "N" for no. Cost Reporting Information -inclusive rate provider? Enter "Y" for y f column 1 is yes, enter the method used f column 2 is "E", enter in column 3 eith hospital or "98" percent for long term co ehabilitation and long term hospitals pro-	spital Demonstrati ter "Y" for yes or d Worksheet E-2, I in the Frontier C is cost reporting to column 1 is Y, s participating in or additional beds Health Model st reporting If column 1 is ticipating in the I ceased ccess and Rural rent cost es or "N" for no (A, B, or E only) er "93" percent are (includes	on project (§4' "N" for no. 1 i nes 200 throug communi ty peri od? Enter enter the n col umn 2. s; and/or "C" 1.00	10A f yes, gh 215, as 1.00 N	N 2.00 3.00	110. (111. (111. (112. (113. (
for yes or "N" 110.00 Did this hospi Demonstration) complete Works applicable. 111.00 If this facili Heal th Integra "Y" for yes or integration pr Enter all that for tele-heal t 112.00 Did this hospi (PARHM) demons period? Enter "Y", enter in demonstration participation 113.00 Did this hospi Transformation reporting peri Miscel Ianeous 115.00 Is this an all in column 1. I in column 2. I for short term psychiatric, r the definition 116.00 Is this facili	for no for each therapy. tal participate in the Rural Community Hc for the current cost reporting period? En heet E, Part A, lines 200 through 218, an ty qualifies as a CAH, did it participate tion Project (FCHIP) demonstration for th "N" for no in column 1. If the response ong of the FCHIP demo in which this CAH i apply: "A" for Ambulance services; "B" f h services. tal participate in the Pennsylvania Rural tration for any portion of the current co "Y" for yes or "N" for no in column 1. column 2, the date the hospital began par In column 3, enter the date the hospital in the demonstration, if applicable. tal participate in the Community Health A (CHART) model for any portion of the cur od? Enter "Y" for yes or "N" for no. Cost Reporting Information -inclusive rate provider? Enter "Y" for y f column 1 is yes, enter the method used f column 2 is "E", enter in column 3 eith hospital or "98" percent for long term co	" spital Demonstrati ter "Y" for yes or d Worksheet E-2, 1 in the Frontier C is cost reporting to column 1 is Y, s participating in or additional beds Health Model st reporting If column 1 is ticipating in the I ceased ccess and Rural rent cost es or "N" for no (A, B, or E only) er "93" percent are (includes viders) based on	on project (§4' "N" for no. 1 i nes 200 throug communi ty peri od? Enter enter the n col umn 2. s; and/or "C" <u>1.00</u> N	10A f yes, gh 215, as 1.00 N	N 2.00 3.00	110. 0
for yes or "N" 110. 00 Did this hospi Demonstration) complete Works applicable. 111. 00 If this facili Health Integra "Y" for yes or integration pr Enter all that for tele-healt 112. 00 Did this hospi (PARHM) demons period? Enter "Y", enter in demonstration. participation 113. 00 Did this hospi Transformation participation 115. 00 Is this an all in column 1. I in column 2. I for short term psychiatric, r the definition 116. 00 Is this facili "N" for no.	for no for each therapy. tal participate in the Rural Community Hc for the current cost reporting period? En heet E, Part A, lines 200 through 218, an ty qualifies as a CAH, did it participate tion Project (FCHIP) demonstration for th "N" for no in column 1. If the response ong of the FCHIP demo in which this CAH i apply: "A" for Ambulance services; "B" f h services. tal participate in the Pennsylvania Rural tration for any portion of the current co "Y" for yes or "N" for no in column 1. column 2, the date the hospital began par In column 3, enter the date the hospital in the demonstration, if applicable. tal participate in the Community Health A (CHART) model for any portion of the cur od? Enter "Y" for yes or "N" for no. Cost Reporting Information -inclusive rate provider? Enter "Y" for y f column 1 is yes, enter the method used f column 2 is "E", enter in column 3 eith hospital or "98" percent for long term of in CMS Pub. 15-1, chapter 22, §2208.1. ty classified as a referral center? Enter ty legally-required to carry malpractice	" spital Demonstrati ter "Y" for yes or d Worksheet E-2, I in the Frontier C is cost reporting to column 1 is Y, s participating in or additional beds Health Model st reporting If column 1 is ticipating in the I ceased ccess and Rural rent cost es or "N" for no (A, B, or E only) er "93" percent are (includes viders) based on "Y" for yes or	on project (§4' "N" for no. 11 i nes 200 throug communi ty peri od? Enter enter the a col umn 2. s; and/or "C" 1.00 N N N N	10A f yes, gh 215, as 1.00 N	N 2.00 3.00	110. (111. (111. (112. (113. (0 115. (

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA Provider C		Peri od:	Worksheet S	S-2552- S-2
			From 01/01/2022 To 12/31/2022		renare
				5/31/2023 8	<u>8:41 am</u>
		Premi ums	Losses	Insurance	
					_
.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3.00	0118.
. OTELST amounts of marphactice premiums and pard rosses.		234,10			0110.
			1.00	2.00	
. 02 Are malpractice premiums and paid losses reported in			N		118.
Administrative and General? If yes, submit supportir and amounts contained therein.	ig schedule fisting c	UST Centers			
. OO DO NOT USE THIS LINE					119.
.00 Is this a SCH or EACH that qualifies for the Outpatie			N	N	120.
\$3121 and applicable amendments? (see instructions) F "N" for no. Is this a rural hospital with < 100 beds					
Hold Harmless provision in ACA §3121 and applicable a					
Enter in column 2, "Y" for yes or "N" for no.					
.00 Did this facility incur and report costs for high cos	st implantable device	s charged to	Y		121.
patients? Enter "Y" for yes or "N" for no. .00Does the cost report contain healthcare related taxes	s as defined in §1903	(w)(3) of the	N		122.
Act?Enter "Y" for yes or "N" for no in column 1. If o					
the Worksheet A line number where these taxes are inc					
.00 Did the facility and/or its subproviders (if applicat services, e.g., legal, accounting, tax preparation, t					123.
management/consulting services, from an unrelated or					
for yes or "N" for no.	,				
If column 1 is "Y", were the majority of the expenses					
professional services expenses, for services purchase located in a CBSA outside of the main hospital CBSA?					
"N" for no.					
Certified Transplant Center Information					
.00 Does this facility operate a Medicare-certified trans and "N" for no. If yes, enter certification date(s)		"Y" for yes	N		125.
. 00/If this is a Medicare-certified kidney transplant pro		ification date	9		126.
in column 1 and termination date, if applicable, in c			-		
.00 If this is a Medicare-certified heart transplant prog		fication date			127.
in column 1 and termination date, if applicable, in a .00 If this is a Medicare-certified liver transplant prog		fication date			128.
in column 1 and termination date, if applicable, in c					120.
.00 If this is a Medicare-certified lung transplant progr		ication date			129.
in column 1 and termination date, if applicable, in .00 If this is a Medicare-certified pancreas transplant p		rti fi cati an			130.
date in column 1 and termination date, if applicable,		I IIII Call OII			130.
.00 If this is a Medicare-certified intestinal transplant	t program, enter the	certi fi cati on			131.
date in column 1 and termination date, if applicable,		<u>.</u>			100
.00 If this is a Medicare-certified islet transplant prog in column 1 and termination date, if applicable, in o		fication date			132.
. 00 Removed and reserved					133.
.00 If this is a hospital-based organ procurement organiz		he OPO number			134.
in column 1 and termination date, if applicable, in c	column 2.				_
All Providers .00 Are there any related organization or home office cos	sts as defined in CMS	Pub 15-1	N		140.
chapter 10? Enter "Y" for yes or "N" for no in column	n 1. If yes, and home	office costs			
are claimed, enter in column 2 the home office chain	· · ·	tions)			
1.00 If this facility is part of a chain organization, en	2.00 ter on lines 141 thro	uah 143 the n	3.00 ame and address	of the	
home office and enter the home office contractor name				or the	
. 00 Name: Contractor's M	Name:	Contracto	or's Number:		141.
. 00 Street: PO Box: . 00 Ci ty: State:		Zip Code:			142. 143.
					145.
				1.00	
.00 Are provider based physicians' costs included in Work	<sheet a?<="" td=""><td></td><td></td><td>Y</td><td>144.</td></sheet>			Y	144.
			1 00	2.00	_
.00 If costs for renal services are claimed on Wkst. A, I	ine 74, are the cost	s for	1.00	2.00	145.
inpatient services only? Enter "Y" for yes or "N" for					10.
no, does the dialysis facility include Medicare utili					
period? Enter "Y" for yes or "N" for no in column 2. .00 Has the cost allocation methodology changed from the		t report?	N		146.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provider CC	CN: 15-1333		riod: om 01/01/2022 12/31/2022		epared:
							1.00	_
147.00 Was there a change in the statisti	cal basis? Enter "V"	for ve	s or "N" for	no			N 1.00	147.00
148.00Was there a change in the order of							N	148.00
149.00 Was there a change to the simplifi					for no).	N	149.00
	<u> </u>		Part A	Part	В	Title V	Title XIX	
			1.00	2.00		3.00	4.00	
Does this facility contain a prov								
or charges? Enter "Y" for yes or	<u>'N" for no for each co</u>	omponen			<u>B. (Se</u>			-
55.00Hospi tal			N	N		N	N	155.00
56.00 Subprovider - IPF 57.00 Subprovider - IRF			N N	N N		N	N N	156. 00 157. 00
57. 00 Subprovider - TRF 58. 00 SUBPROVIDER			IN	N		N	N	157.0
59. 00 SNF			Ν	N		Ν	N	158.00
160.00 HOME HEALTH AGENCY			N	N N		N	N	160. 00
61. 00 CMHC			i v	N N		N	N	161. 0
								10110
							1.00	
Multicampus								
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one	or more campu	uses in di	fferer	nt CBSAs?	Ν	165. 0
	Name		County	State	Zip (FTE/Campus	_
	0		1.00	2.00	3.0	0 4.00	5.00	
166.00 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)							0.0	00 166. 00
							1.00	-
Health Information Technology (HI	C) incentive in the Am	neri can	Recovery and	d Reinvest	ment	Act	1.00	
167.00 s this provider a meaningful use							Y	167.00
68.00 If this provider is a CAH (line 10)5 is "Y") and is a m∈	ani ngf	ul user (lin€	e 167 is "	Υ"), e	enter the		168.00
reasonable cost incurred for the I	IIT assets (see instru	uctions	5)					
68.01 If this provider is a CAH and is I						hardshi p		168. 0
exception under §413.70(a)(6)(ii)								
169.00 If this provider is a meaningful u		and I	S NOT A CAH (TINE 105	IS N), enter the	0.0	00169. 0
transition factor. (see instruction	ons)					Pogi ppi pg	Endi ng	-
					-	Begi nni ng 1. 00	2.00	-
70.00 Enter in columns 1 and 2 the EHR I	pedinning date and end	h na da	te for the re	porting		1.00	2.00	170. 0
period respectively (mm/dd/yyyy)				,por tring				
					-	1.00	2.00	-
71.00 If line 167 is "Y", does this prov	/ider have any days fo	or indi	viduals enrol	led in		N		0171.0
section 1876 Medicare cost plans "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (reported on Wkst. S-3, umn 1. If column 1 is	Pt. I	, line 2, col	. 6? Ente				

ISPI TA	Financial Systems PUTNAM COUNT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	epared
				Y/N	5/31/2023 8:4 Date	41 am
				1.00	2.00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE	MENT QUESTION	NAI RE	1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	r all dates in 1	the	
	Provider Organization and Operation					
	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.
	reporting period? If yes, enter the date of the change in c		instructions)			
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare P	program2 lf	1.00 N	2.00	3.00	2.
	yes, enter in column 2 the date of termination and in colum voluntary or "l" for involuntary.	n 3, "V" for	iv.			
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug ler or its of the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports 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	for Compiled,	N			4
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		Ν			5
			4	Y/N 1.00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column the legal operator of the program?	2: If yes, is	s the provider	N		6
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing programs and/or allied health programs approve		wed during the	N N		7.
00	cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Ν		9.
	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	or renewed in		Ν		10
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11
	Bad Debts				1.00	
. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			st reporting	Y N	12 13
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsura instructions.	ince amounts wa	aived? If yes,	see	Ν	14
	Bed Complement Did total beds available change from the prior cost reporti	ng period?lf	yes, see inst	ructions.	N	15
		Pa	rt A	Par	тВ	
		Y/N	Date	Y/N	Date	
	PS&P Data	1.00	2.00	3.00	4.00	-
	PS&R Data Was the cost report prepared using the PS&R Report only?	N		N		16
	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions)					
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/04/2023	Y	04/04/2023	17
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Ν		N		18
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19

	Financial Systems PUTNAM COUNT AL AND HOSPI TAL HEALTH CARE REIMBURSEMENT QUESTI ONNAI RE	Provider CCN: 1		Peri od:	u of Form CMS Worksheet S	
				From 01/01/2022 To 12/31/2022		
		Description	L)/ /N	5/31/2023 8	:41 am
		Descriptio	on	Y/N	<u>Y/N</u>	_
0.00		0		1.00	3.00	
0.00	If line 16 or 17 is yes, were adjustments made to PS&R			N	Ν	20. (
	Report data for Other? Describe the other adjustments:	Y/N	Data	Y/N	Data	-
			Date		Date	_
1 00		1.00	2.00	3.00	4.00	01.0
1.00	Was the cost report prepared only using the provider's	N		N		21.0
	records? If yes, see instructions.					_
				-	1.00	
	CONDUCTED BY COST DELMBUDSED AND TEEDA HOSDITALS ONLY (EVCE			I	1.00	-
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PI CHILDRENS HUSPI	TALS)			-
2 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions		T	N	22.
			modo duni	ng the east	N	
3.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appraisais	made duri	ng the cost	IN	23.
1 00		orting pariod?	Y	24		
4.00	Were new leases and/or amendments to existing leases entere	su into during this	cust rep	or trug periou?	ř	24.
5.00	If yes, see instructions Have there been new capitalized leases entered into during	IF YAS SOO	Y	25.		
5.00	instructions.	i yes, see	T	20.		
6.00	Were assets subject to Sec. 2314 of DEFRA acquired during th	NOS 500	Ν	26.		
0.00	instructions.	yes, see	IN	20.		
7.00	Has the provider's capitalization policy changed during the	a cost reporting po	riod2 If	Ves submit	Ν	27.
7.00	copy.	e cost reporting pe		yes, subili t	IN	27.
	Interest Expense					
8.00	Were new loans, mortgage agreements or letters of credit en	tered into during	the cost	reporting	Y	28.
5.00	period? If yes, see instructions.	ntereu mito uurmy	the cost	reporting	I	20.
9.00	Did the provider have a funded depreciation account and/or	bond funds (Debt S	ervice Re	serve Fund)	Y	29.
7.00	treated as a funded depreciation account? If yes, see instr				I	27.
0. 00	Has existing debt been replaced prior to its scheduled matu		2 If ves	500	Ν	30.
0.00	instructions.	arrey with new debt	: 11 ycs,	300	IN IN	50.
1.00	Has debt been recalled before scheduled maturity without is	ssuance of new debt	? If ves	SPP	Ν	31.
1.00	instructions.		. 11 303,	500		01.
	Purchased Servi ces			I		
2.00	Have changes or new agreements occurred in patient care ser	rvices furnished th	rough con	tractual	N	32.
	arrangements with suppliers of services? If yes, see instru		<u>g</u>			
3.00	If line 32 is yes, were the requirements of Sec. 2135.2 app		competit	ive biddina? If	Ν	33.
	no, see instructions.			5		
	Provi der-Based Physi ci ans					
4.00	Were services furnished at the provider facility under an a	arrangement with pr	ovi der-ba	sed physicians?	Y	34.
	If yes, see instructions.	J				
5.00	If line 34 is yes, were there new agreements or amended exi	sting agreements w	ith the p	rovi der-based	Y	35.
	physicians during the cost reporting period? If yes, see in					
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
6.00	Were home office costs claimed on the cost report?			N		36.
7.00	If line 36 is yes, has a home office cost statement been pr	repared by the home	office?			37.
	If yes, see instructions.					
8.00	If line 36 is yes, was the fiscal year end of the home off	fice different from	that of			38.
	the provider? If yes, enter in column 2 the fiscal year end	d of the home offic	e.			
9.00	If line 36 is yes, did the provider render services to othe	er chain components	? If yes,			39.
	see instructions.					
	If line 36 is yes, did the provider render services to the	home office? If y	es, see			40.
D. 00	instructions.					
D. 00						
00 . 00				2.0	00	
0. 00		1.00				
	Cost Report Preparer Contact Information			_		
	Enter the first name, last name and the title/position	SKANDER		NASSER		41.
	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,			NASSER		41.
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SKANDER		NASSER		
1. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.			NASSER		
1. 00 2. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	SKANDER		NASSER		41.
1. 00 2. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report preparer.	SKANDER		NASSER SKANDERN@BRADLE	EYCPA. COM	

Heal th	Financial Systems PU	TNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTION	INAI RE	Provider (Period: From 01/01/2022	Worksheet S-2 Part II	
							pared: 1 am
			3	. 00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/pos	ition	PARTNER				41.00
	held by the cost report preparer in columns 1, 2,	and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost repor	t					42.00
	preparer.						
43.00	Enter the telephone number and email address of t	he cost					43.00
	report preparer in columns 1 and 2, respectively.						

	Financial Systems	PUTNAM COUNTY		ON. 1E 1000		u of Form CMS-2	
HUSPI I	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider C	UN: 15-1333	Period: From 01/01/2022	Worksheet S-3 Part I	
					To 12/31/2022	Date/Time Prep 5/31/2023 8:4	
			!			I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1 00	PART I - STATISTICAL DATA	20.00	10	(0)	25 22 204 00	0	1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	30.00	19	6, 93	35 33, 384. 00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
4.00	HMO I RF Subprovi der						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		19	6, 93	35 33, 384. 00	0	7.00
	beds) (see instructions)		.,		00,001.00	Ŭ	
8.00	INTENSIVE CARE UNIT	31.00	6	2, 19	3, 768. 00	0	8.00
9.00	CORONARY CARE UNI T						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)		25	9, 12	25 37, 152. 00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER – IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	00.00					25.00
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.01	RURAL HEALTH CLINIC II	88.01				0	26.01
26.02	RURAL HEALTH CLINIC III	88. 02				0	26.02 26.25
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00	25			0	26.25
27.00 28.00	Total (sum of lines 14-26)		25			0	27.00
28.00	Observation Bed Days Ambulance Trips	,				0	28.00
30.00							
30.00	Employee discount days (see instruction) Employee discount days - IRF						30.00 31.00
31.00	Labor & delivery days (see instructions)		0		0		31.00
32.00	Total ancillary labor & delivery room		0				32.00
JZ. UI	outpatient days (see instructions)						JZ. UI
33.00	LTCH non-covered days						33.00
33.00	LTCH site neutral days and discharges						33.00

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/31/2023 8:4	pared:
		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	
	PART I – STATISTICAL DATA				-		-
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	732	52	1, 39	1		1.00
. 00	HMO and other (see instructions)	397	101				2.0
. 00	HMO I PF Subprovider	0	0				3.00
. 00	HMO IRF Subprovider	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	108	18	12	26		5.0
. 00	Hospital Adults & Peds. Swing Bed NF		0		0		6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	840	70	1, 51	7		7.00
. 00	INTENSIVE CARE UNIT	68	0	15	57		8.0
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY						13.0
4.00	Total (see instructions)	908	70	1, 67	0.00	293.05	
5.00	CAH visits	0	0		0		15.0
6.00	SUBPROVIDER - IPF						16.0
7.00	SUBPROVIDER - IRF						17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00 4.00	AMBULATORY SURGI CAL CENTER (D. P.) HOSPI CE						23.0
4.00	HOSPICE HOSPICE (non-distinct part)				0		24.0
5.00	CMHC - CMHC				0		24.
5.00	RURAL HEALTH CLINIC	654	3, 535	10, 35	0.00	15. 40	
5. 01	RURAL HEALTH CLINIC II	1, 295	3, 191	12, 62		17.43	
6. 02	RURAL HEALTH CLINIC III	1,034	2, 504	8, 71		17.31	
6.25	FEDERALLY QUALIFIED HEALTH CENTER	0	2, 304		0 0.00	0.00	
7.00	Total (sum of lines 14-26)	0	0		0.00	343.19	
3.00	Observation Bed Days		0	70		010117	28.0
9.00	Ambul ance Trips	0	-				29.0
0.00	Employee discount days (see instruction)	ő		1	0		30.0
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	0		0		32.0
2.01	Total ancillary labor & delivery room	J. J	J.		0		32.0
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0			1		33.0
3.01	LTCH site neutral days and discharges	0			1		33.0
4.00	3	0	0		0		34.0

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/31/2023 8:4	pare
	Full Time	·	Di so	charges		
Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
PART I - STATISTICAL DATA 00 Hospital Adults & Peds. (columns 5, 6, 7 and		C	23	8 12	610	1 1.
8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		Ū	19		810	2.
00 HMO I PF Subprovider			17	0		3.
00 HMO RF Subprovider 00 Hospital Adults & Peds. Swing Bed SNF				0		4. 5.
 Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) 						6. 7.
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT						8. 9.
. OO BURN INTENSIVE CARE UNIT						10.
. 00 SURGICAL INTENSIVE CARE UNIT						11.
. 00 OTHER SPECIAL CARE (SPECIFY)						12
00 NURSERY	0.00			. 10	(10	13
.00 Total (see instructions) .00 CAH visits	0.00	C	23	8 12	610	14
.00 CAH visits .00 SUBPROVIDER - IPF						15
. 00 SUBPROVIDER - IRF						17
. 00 SUBPROVI DER						18
.00 SKILLED NURSING FACILITY						19
. 00 NURSING FACILITY						20
. 00 OTHER LONG TERM CARE						21
. OO HOME HEALTH AGENCY						22
. 00 AMBULATORY SURGICAL CENTER (D. P.)						23
00 HOSPICE						24
.10 HOSPICE (non-distinct part)						24
. 00 CMHC - CMHC						25
. OO RURAL HEALTH CLINIC	0.00					26
.01 RURAL HEALTH CLINIC II	0.00					26
.02 RURAL HEALTH CLINIC III	0.00					26
. 25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26
.00 Total (sum of lines 14-26)	0.00					27
.00 Observation Bed Days						28
.00 Ambulance Trips						29
.00 Employee discount days (see instruction)						30
.00 Employee discount days - IRF						31
.00 Labor & delivery days (see instructions)						32
.01 Total ancillary labor & delivery room outpatient days (see instructions)						32
.00 LTCH non-covered days				0		33
. 01 LTCH site neutral days and discharges				0		33
.00 Temporary Expansion COVID-19 PHE Acute Care						34

Heal th	Financial Systems	PUTNAM COUNT	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider (CCN: 15-1333	Peri od:	Worksheet S-8	
			Component	CCN: 15-8515	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
					RHC I	Cost	-
							_
	Oligie Address and I dontificantics				1.	00	
1.00	Clinic Address and Identification Street				1542 S. BLOOMI	NCTON STREET	1.00
1.00			C	ity	State	ZIP Code	1.00
				. 00	2.00	3.00	
2.00	City, State, ZIP Code, County		GREENCASTLE			46135	2.00
			•				
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for			0	3.00
				Gra	nt Award 1.00	Date 2.00	
	Source of Federal Funds				1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00	Health Services for the Homeless (Section 340	O(d), PHS Act)					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 ho	ospital-based I	RHC or FQHC? E	nter "Y" for	N	0	10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of						
	hours.)	Sur	nday	Λ	londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)			1			
11.00	CLINIC			07:00	17:00	07:00	11.00
					1.00	0.00	
12.00	Have you received an approval for an exception	n to the produ	uctivity stand	ard?	1.00 Y	2.00	12.00
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	in CMS Pub.	100-04, chapte	r 9, section	N	0	
	number of providers included in this report. numbers below.			ders and			
				Prov	ider name	CCN	
14.00	RHC/FQHC name, CCN				1.00	2.00	14.00
14.00		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)						
				unty			
2.00	City State 71D Cade County			. 00			2.00
2.00	City, State, ZIP Code, County	Tuesday	PUTNAM	nesday	Thur	sday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC	17:00	07:00	17:00	07:00	17:00	11.00

						2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA	HOSPITAL-BASED RHC/FQHC STATISTICAL DATA			Period:	Worksheet S-8	
c		Component	CCN: 15-8515	From 01/01/2022 To 12/31/2022		
				RHC I	Cost	
	Fri	Friday Sa		turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)			_			
11. 00 CLINIC	07: 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 01/01/202 To 12/31/202		epared:
					RHC II	5/31/2023 8:4 Cost	41 am
						COST	
					1	. 00	
1.00	Clinic Address and Identification Street				51 E. MARKET	STDEET	1 1 00
1.00			Ci	ty	State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		CLOVERDALE		1	N 46120	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u	ırban		1.00	3.00
					t Award	Date	
				1	. 00	2.00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00	Health Services for the Homeless (Section 340						6.00
7.00	Appalachian Regional Commission						7.00
8.00 9.00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
7.00				1			7.00
					1.00	2.00	
10.00	Does this facility operate as other than a ho				N	0	10.00
	yes or "N" for no in column 1. If yes, indica 2.(Enter in subscripts of line 11 the type of						
	hours.)		on(3) and the	operating			
			iday		nday	Tuesday	
		<u>from</u> 1.00	to 2.00	from 3.00	4. 00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			07:00	17: 30	07:00	11.00
					1.00		
12.00	Have you received an approval for an exception	on to the produ	uctivity standa	ard?	1.00 Y	2.00	12.00
	Is this a consolidated cost report as defined				N	C	13.00
	30.8? Enter "Y" for yes or "N" for no in colu						
	number of providers included in this report. numbers below.	List the names	s of all provic	lers and			
				Provid	der name	CCN	
					. 00	2.00	
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XI X	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all		2.00	0.00		0.00	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)		Col	l Inty			
				00			
2.00	City, State, ZIP Code, County		PUTNAM				2.00
		Tuesday to	Wedn from	esday to	Thu	irsday to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)		1	1			
11.00	CLINIC	17: 30	07: 00	17: 30	07:00	17:00	11.00

						2552-10
HOSPITAL-BASED RHC/FOHC STATISTICAL DATA	Provider C	CN: 15-1333	Peri od:	Worksheet S-8		
с		Component	CCN: 15-8513	From 01/01/2022 To 12/31/2022		
				RHC II	Cost	
	Fri	riday Sa		turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	17: 30				11.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Li	eu of Form CMS-2	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1333	Peri od:	Worksheet S-8	
			Component	CCN: 15-8514	From 01/01/2022 To 12/31/2022		
					RHC III	Cost	
					1	. 00	-
	Clinic Address and Identification						
1.00	Street				440 E. PAT RAI		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		BAI NBRI DGE	00		V46105	2.00
2.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ente	n "D" for rung	an "II" for u	ush on		1.00	2.00
3.00	HUSPITAL-BASED FUNCS UNLY: Designation - Ente	er k tor rura			it Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds			1		1	
4.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac						4.00 5.00
5.00 6.00	Health Services for the Homeless (Section 340						6.00
7.00	Appal achi an Regi onal Commissi on						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 hory yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of	ate number of o	ther operation	ns in column	N	0	10.00
	hours.)	Sun	day	Mc	onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1)		I	08:00	17:00	07:00	1 11 00
11.00	CLINIC			08:00	17:00	07:00	11.00
					1.00	2.00	
	Have you received an approval for an exception Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu- number of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colum	9, section n 2 the	Y N	0	12.00 13.00
				Provi	der name	CCN	
	L			-	1.00	2.00	
14.00	RHC/FQHC name, CCN	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		2100				15.00
	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			
0.63				00			0.05
2.00	City, State, ZIP Code, County	Tuesday	PUTNAM	esday	Thu	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	07:00	17.00	07:00	17:00	111 00
11.00		17:00	00:00	17:00	07:00	17:00	11.00

						2552-10
HOSPITAL-BASED RHC/FOHC STATISTICAL DATA	Provider C	CN: 15-1333	Period:	Worksheet S-8		
c		Component	CCN: 15-8514	From 01/01/2022 To 12/31/2022		
	_			RHC III	Cost	
	Fri	Friday Sa		turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC	07: 00	17:00				11.00

Heal th	Financial Systems PUTNAM	I COUNTY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1333	Peri od:	Worksheet S-1	0
				From 01/01/2022 To 12/31/2022		
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 co	olumn 3 divided by li	ne 202 columr	ı 8)	0. 407195	1.00
0 00	Medicaid (see instructions for each line)				0 (74 070	0.00
2.00 3.00	Net revenue from Medicaid				3, 671, 979	
3.00 4.00	Did you receive DSH or supplemental payments from Med If line 3 is yes, does line 2 include all DSH and/or		s from Modic	ai d2	Y N	3.00 4.00
4.00 5.00	If line 4 is no, then enter DSH and/or supplemental p			11 U ?	1, 092, 566	
6.00	Medicaid charges	ayments from medical	u		22, 949, 866	
7.00	Medicaid cost (line 1 times line 6)				9, 345, 071	
8.00	Difference between net revenue and costs for Medicaid	l program (line 7 min	us sum of lir	nes 2 and 5 [.] if	4, 580, 526	
0100	< zero then enter zero)				1,000,020	0.00
	Children's Health Insurance Program (CHIP) (see instr	uctions for each line	e)		-	
9.00	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP charges				0	
	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-al	f < zoro thon				
12.00	enter zero)	one chip (inne in im	nus i i ne 9, i		0	12.00
	Other state or local government indigent care program	(see instructions f	or each line)			
	Net revenue from state or local indigent care program				0	13.00
	Charges for patients covered under state or local ind		0	14.00		
15.00	State or local indigent care program cost (line 1 tim	ues line 14)			0	15.00
	Difference between net revenue and costs for state or		program (Lir	ne 15 minus line	-	
101.00	13; if < zero then enter zero)	recar margent care	program (i i		, , , , , , , , , , , , , , , , , , ,	
	Grants, donations and total unreimbursed cost for Med	licaid, CHIP and state	e∕local indig	jent care program	ns (see	1
	instructions for each line)				1	
	Private grants, donations, or endowment income restri				0	
	Government grants, appropriations or transfers for su				0	
19.00	Total unreimbursed cost for Medicaid , CHIP and state 8, 12 and 16)	e and rocar rhurgent	care programs	s (sum of fines	4, 580, 526	19.00
			Uni nsured pati ents	I nsured pati ents	Total (col. 1 + col. 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	0.00	
20. 00	Charity care charges and uninsured discounts for the (see instructions)	entire facility	635, 50	51 0	635, 561	20.00
21.00	Cost of patients approved for charity care and uninsu	ired discounts (see	258, 79	97 0	258, 797	21.00
22.00	instructions) Payments received from patients for amounts previous!	y written off as		0 0	0	22.00
23.00	charity care Cost of charity care (line 21 minus line 22)		258, 79	97 0	258, 797	22 00
23.00			230, 7	0		23.00
		<u> </u>		<u> </u>	1.00	
24.00	Does the amount on line 20 column 2, include charges imposed on patients covered by Medicaid or other indi		ond a length	of stay limit	N	24.00
25.00	If line 24 is yes, enter the charges for patient days stav limit	beyond the indigent	care program	n's length of	0	25.00
26.00	Total bad debt expense for the entire hospital comple	ex (see instructions)			3, 302, 792	26.00
	Medicare reimbursable bad debts for the entire hospit		ructions)		587, 188	
	Medicare allowable bad debts for the entire hospital				903, 367	
	Non-Medicare bad debt expense (see instructions)		/		2, 399, 425	
	Cost of non-Medicare and non-reimbursable Medicare ba	nd debt expense (see	instructions)		1, 293, 213	
	Cost of uncompensated care (line 23 column 3 plus lin		,		1, 552, 010	
31.00	Total unreimbursed and uncompensated care cost (line	19 plus line 30)			6, 132, 536	31.00

	Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	EXPENSES	Provider C		Period:	Worksheet A	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	nared
					10 12/31/2022	5/31/2023 8:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Reclassi fied	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
	-					col. 4)	
		1.00	2.00	3.00	4.00	5.00	
4 00	GENERAL SERVICE COST CENTERS		0 50/ 050	0.50/.05	04.774	0 (04 704	1 4 00
1.00	00100 CAP REL COSTS-BLDG & FIXT	101 171	2, 596, 953			2, 681, 724	1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	191, 174	6, 315, 016			6, 506, 190	
5.00	00500 ADMINISTRATIVE & GENERAL	3, 176, 916	6, 186, 204			9, 278, 349	5.00
7.00	00700 OPERATION OF PLANT	356, 978	1, 284, 378			1, 641, 356	
8.00	00800 LAUNDRY & LINEN SERVICE	31,654	225, 010			256, 664	8.00
9.00	00900 HOUSEKEEPING	426, 531	118, 268			544, 799	
10.00	01000 DI ETARY	496, 569	702, 873				
11.00		105 011	0		840, 416	840, 416	•
13.00	01300 NURSI NG ADMI NI STRATI ON	185, 811	46, 271	232, 08		232, 082	
16.00	01600 MEDICAL RECORDS & LIBRARY	290, 310	168, 727	459, 03	-	459, 037	16.00
17.00	01700 SOCIAL SERVICE	0	0			0	17.00
17.01	01701 UTI LI ZATI ON REVI EW	118, 464	7, 984	126, 44	3 <u> </u> 0	126, 448	17.01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2 207 020	150 040	2 4(0 07	20.70(2 420 274	20.00
30.00		2, 307, 829	152, 243				
31.00	03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	481, 123	416, 105	897, 22	3 -29, 458	867, 770	31.00
F0 00	05000 OPERATING ROOM	710 001	901, 066	1 (10 00)	7 -409, 523	1 210 464	50.00
50.00	05100 RECOVERY ROOM	718, 921				1, 210, 464	
51.00	05300 ANESTHESI OLOGY	113, 477	29, 540			143, 017	51.00
53.00		869, 541	40, 330			909, 871	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	1, 279, 752	385, 772			1, 665, 524	
54.01	03480 ONCOLOGY	0	195, 631	195, 63		195, 631	•
54.02 57.00		396, 606	5,087,522			5, 484, 128	1
	05700 CT SCAN 06000 LABORATORY	213, 913	371, 929			585, 842	1
60.00 65.00	06500 RESPIRATORY THERAPY	922, 887	1, 801, 547			2, 724, 434 583, 600	1
	06600 PHYSI CAL THERAPY	506, 139 0	77, 461	583, 60 525, 25	-		•
66.00 67.00	06700 OCCUPATIONAL THERAPY	0	525, 254 113, 729			525, 254 113, 729	
68.00	06800 SPEECH PATHOLOGY	0	36, 708			36, 708	•
69.00	06900 ELECTROCARDI OLOGY	86,056	53, 708			139, 826	•
69.00	06901 CARDI AC REHAB	267, 463	10,003			277, 466	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	207,405	10, 003			277,400	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		469, 781	469, 781	•
73.00	07300 DRUGS CHARGED TO PATIENTS	351, 758	1, 040, 875				•
75.00	OUTPATIENT SERVICE COST CENTERS	331,730	1,040,073	1, 372, 03	5 0	1, 372, 033	/ 3.00
88.00	08800 RURAL HEALTH CLINIC	1, 431, 753	268, 822	1, 700, 57	5 -91, 229	1, 609, 346	88.00
88.01	08801 RURAL HEALTH CLINIC II	1, 429, 904	257,606				•
88.02	08802 RURAL HEALTH CLINIC III	1, 365, 980	279,000			1, 704, 779	•
90.00	09000 CLINIC	1, 303, 700	277,073	1, 043, 03	0 0	0	90.00
90.00 90.01	09001 RHEUMATOLOGY	428, 783	29, 281	458, 06	-	458, 064	90.00
91.00	09100 EMERGENCY	3, 334, 763	1, 577, 846			4, 912, 605	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 334, 703	1, 377, 040	4, 712,00	· ·	4, 712, 003	92.00
72.00	SPECIAL PURPOSE COST CENTERS			I			72.00
118.00		21, 781, 055	31, 303, 797	53, 084, 85	2 0	53, 084, 852	118 00
110.00	NONREI MBURSABLE COST CENTERS	21,701,000	31, 303, 777	33, 004, 03		33, 004, 032	1110.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CI ANS PRI VATE OFFI CES	4, 588, 712	1,004,038		-	5, 592, 750	
	19201 JOHNSON/NI CHOLS WI C	266, 077	93, 214			359, 291	
	19300 NONPAI D WORKERS	200,077	93, 214 0				193.00
	07950 VACANT SPACE	0	0				194.00
	07951 BOARD OF HEALTH	0	0				194.00
200.00		26, 635, 844	32, 401, 049				
200.00		20,000,044	02, 101, 047	1 07,000,07	0	0,000,070	

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN:	15-1333	Peri od:	Worksheet A	
				From 01/01/2022 To 12/31/2022	Date/Time Pr	conarod.
				10 12/31/2022	5/31/2023 8:	
Cost Center Description	Adjustments	Net Expenses				
		For Allocation				
	6.00	7.00				_
GENERAL SERVICE COST CENTERS						_
1.00 00100 CAP REL COSTS-BLDG & FIXT	-601, 894	2,079,830				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-2, 846	6, 503, 344				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	-2, 924, 525	6, 353, 824				5.00
7.00 00700 OPERATION OF PLANT	-9, 327	1, 632, 029				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	256, 664				8.00
9. 00 00900 HOUSEKEEPI NG	0	544, 799				9.00
10. 00 01000 DI ETARY	0	359, 026				10.00
	-87, 987	752, 429				11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	-1, 251	230, 831				13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	-131	458, 906				16.00
17. 00 01700 SOCIAL SERVICE	0	0				17.00
17. 01 01701 UTI LI ZATI ON REVI EW	0	126, 448				17.01
30. 00 03000 ADULTS & PEDIATRICS	1 251 702	1 077 574				20.00
	-1, 351, 702	1,077,574				30.00
31.00 03100 I NTENSI VE CARE UNI T	0	867, 770				31.00
ANCI LLARY SERVI CE COST CENTERS	-790	1 200 (74				50.00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	- 790	1, 209, 674				50.00
53. 00 05300 ANESTHESI OLOGY	Ŭ	143, 017				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-717, 596 0	192, 275				53.00
54. 01 05400 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	1, 665, 524 195, 631				54.00
54. 02 03480 0NC0L0GY	-2, 814	5, 481, 314				54.01
57. 00 05700 CT SCAN	-2, 014	585, 842				57.00
60. 00 06000 LABORATORY	0	2, 724, 434				60.00
65. 00 06500 RESPIRATORY THERAPY	0	583, 600				65.00
66. 00 06600 PHYSI CAL THERAPY	0	525, 254				66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	113, 729				67.00
68. 00 06800 SPEECH PATHOLOGY	0	36, 708				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	139, 826				69.00
69. 01 06901 CARDI AC REHAB	-569	276, 897				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	-307	270,077				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	469, 781				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	-26, 441	1, 366, 192				73.00
OUTPATIENT SERVICE COST CENTERS	-20, 441	1, 300, 172				/ 3. 00
88. 00 08800 RURAL HEALTH CLINIC	-131	1, 609, 215				88.00
88. 01 08801 RURAL HEALTH CLINIC II	0	1, 719, 013				88.01
88. 02 08802 RURAL HEALTH CLINIC III	-3, 200	1, 701, 579				88.02
90. 00 09000 CLINIC	0,200	0				90.00
90. 01 09001 RHEUMATOLOGY	-274, 956	183, 108				90.01
91. 00 09100 EMERGENCY	-2, 755, 599	2, 157, 006				91.00
92. 00 09200 OBSERVATION BEDS (NON-DI STINCT PART	21,000,077	2/10//000				92.00
SPECIAL PURPOSE COST CENTERS						72.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-8, 761, 759	44, 323, 093				118.00
NONREI MBURSABLE COST CENTERS	0,,01,,01,	11/020/070				
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0				190.00
192. 00 19200 PHYSI CLANS PRI VATE OFFICES	0	5, 592, 750				192.00
192. 01 19201 JOHNSON/NI CHOLS WI C	0	359, 291				192.01
193. 00 19300 NONPALD WORKERS	0	0				193.00
194. 00 07950 VACANT SPACE	0	o				194.00
194. 01 07951 BOARD OF HEALTH	0	o				194.01
200.00 TOTAL (SUM OF LINES 118 through 199)	-8, 761, 759	50, 275, 134				200.00
						1=- 5. 65

Heal th	Financial Systems		PUTNAM COUNTY	HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provider (CCN: 15-1333	Peri od:	Worksheet A-	6
						From 01/01/2022 To 12/31/2022	Date/Time Pr 5/31/2023 8:	
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - Cafeteria Reclass							
1.00	CAFETERI A		34 <u>7, 9</u> 32	<u>492, 4</u> 84				1.00
	TOTALS		347, 932	492, 484				
	B - Insurance Reclass							
1.00	CAP REL COSTS-BLDG & FIXT	1.00		84, 771				1.00
2.00								2.00
			0	84, 771				
	C - Implant Reclass							
1.00	IMPL. DEV. CHARGED TO	72.00	0	469, 781				1.00
	PATI ENTS							
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
4.00	L	0.00	0	0				4.00
	TOTALS		0	469, 781				
	D - BHC Dept. 985 Reclass							
1.00	RURAL HEALTH CLINIC II	88. 01	19, 559	1, 636				1.00
2.00	RURAL HEALTH CLINIC III	88.02	2 <u>2, 9</u> 38	<u> </u>				2.00
			42, 497	3, 555				
	E - BHC Dept. 980 Reclass	-						
1.00	RURAL HEALTH CLINIC II	88. 01	5, 457	631				1.00
2.00	RURAL HEALTH CLINIC III	88. 02	1 <u>8, 4</u> 59	<u>2, 1</u> 35				2.00
	TOTALS		23, 916	2, 766				
	F - BHC Dept. 982 Reclass							
1.00	RURAL HEALTH CLINIC II	88. 01	4, 075	145				1.00
2.00	RURAL HEALTH CLINIC III	88.02	1 <u>3, 7</u> 84	491				2.00
	TOTALS		17, 859	636				
500.00	Grand Total: Increases		432, 204	1, 053, 993				500.00

Heal th	Financial Systems		PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLASS	SIFICATIONS			Provider (CCN: 15-1333	Peri od:	Worksheet A-6	
						From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 8:4	pared: 1 am
		Decreases						
	Cost Center	Line #	Salary		Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	A - Cafeteria Reclass							
1.00	DI ETARY		347, 932	49 <u>2, 4</u> 84		Q		1.00
	TOTALS		347, 932	492, 484				
	B - Insurance Reclass							
1.00	ADMI NI STRATI VE & GENERAL	5.00		84, 771		2		1.00
2.00						2		2.00
			0	84, 771				
	C - Implant Reclass							
1.00	ADULTS & PEDIATRICS	30.00	0	30, 796		0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	29, 458		0		2.00
3.00	OPERATING ROOM	50.00	0	409, 523		0		3.00
4.00	EMERGENCY	91.00	0	4		0		4.00
	TOTALS			469, 781				
	D - BHC Dept. 985 Reclass							
1.00	RURAL HEALTH CLINIC	88.00	42, 497	3, 555				1.00
2.00								2.00
			42, 497	3, 555		7		
	E - BHC Dept. 980 Reclass	·						
1.00	RURAL HEALTH CLINIC	88.00	23, 916	2, 766		0		1.00
2.00		0.00	0	0		0		2.00
	TOTALS		23, 916	2,766		1		
	F - BHC Dept. 982 Reclass	I		· · ·		1		
1.00	RURAL HEALTH CLINIC	88.00	17, 859	636		0		1.00
2.00		0.00	0	0		0		2.00
	TOTALS		17, 859	636		1		
500.00	Grand Total: Decreases		432, 204	1,053,993		1		500.00

	Financial Systems	PUTNAM COUNT			In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2022 To 12/31/2022		pared:
				Acqui si ti on			
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL AS	SSET BALANCES					
1.00	Land	260, 501	0		0 0	0	
2.00	Land Improvements	404, 895	0		0 0	12, 999	2.00
3.00	Buildings and Fixtures	35, 718, 433	44, 051		0 44, 051	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	25, 347, 938	1, 515, 306		0 1, 515, 306	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	61, 731, 767	1, 559, 357		0 1, 559, 357	12, 999	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	61, 731, 767	1, 559, 357		0 1, 559, 357	12, 999	10.00
		Endi ng Bal ance	Fully				
			Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL AS	SSET BALANCES					
1.00	Land	260, 501	0				1.00
2.00	Land Improvements	391, 896	0				2.00
3.00	Buildings and Fixtures	35, 762, 484	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	26, 863, 244	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	63, 278, 125	0				8.00
9.00	Reconciling Items	0	0				9.00
10 00	Total (line 8 minus line 9)	63, 278, 125	0				10.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2022 To 12/31/2022		pared:
			SU	IMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 812, 307	537, 166	217, 57	6 0	29, 904	1.00
3.00	Total (sum of lines 1-2)	1, 812, 307	537, 166	217, 57	6 0	29, 904	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	IN 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	2, 596, 953				1.00
3.00	Total (sum of lines 1-2)	0	2, 596, 953				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 CO		Period: From 01/01/2022 Fo 12/31/2022		
	COMI	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	Ratio (see instructions)	Insurance	
	1.00	2.00	2)	4,00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	5.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT	61, 718, 768	0	61, 718, 76	3 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	61, 718, 768					3.00
		TION OF OTHER O			F CAPITAL	
Cost Center Description	Taxes	Other Capi tal -Rel ate	Total (sum of cols. 5	Depreciation	Lease	
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS					
1.00 CAP REL COSTS-BLDG & FIXT	0	-		1, 812, 307		1.00
3.00 Total (sum of lines 1-2)	0	Ŭ	(1, 812, 307	-1	3.00
			JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 CAP REL COSTS-BLDG & FIXT	152, 849	84, 771	29, 90	4 0	2, 079, 830	1.00
3.00 Total (sum of lines 1-2)	152, 849					3.00

	Financial Systems		PUTNAM COUNTY			u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1333	Peri od:	Worksheet A-8	
					From 01/01/2022 To 12/31/2022		pared:
				Expense Classification of	n Worksheet A	5/31/2023 8:4	i am
			-	To/From Which the Amount i			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-64, 7270	CAP REL COSTS-BLDG & FIXT	1.00	11	1.00
2.00	Investment income - CAP REL		0,	*** Cost Center Deleted ***	* 2.00	0	2.00
	COSTS-MVBLE EQUIP (chapter 2)		Ū		2100	Ū	2.00
. 00	Investment income - other		0		0.00	0	3.00
00	(chapter 2)	В			F 00	0	4, 00
4.00	Trade, quantity, and time discounts (chapter 8)	В	-44	ADMINISTRATIVE & GENERAL	5.00	0	4.00
5.00	Refunds and rebates of	В	-12, 154	ADMINISTRATIVE & GENERAL	5.00	0	5.00
	expenses (chapter 8)						
5.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay		0		0.00	0	7.00
	stations excluded) (chapter		Ŭ		0100	Ū	
	21)						
8.00	Television and radio service (chapter 21)	A	-9, 3270	DPERATION OF PLANT	7.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9,00
	Provi der-based physi ci an	A-8-2	-4, 735, 739		0100	0	
	adjustment						
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00		A-8-1	0			0	12.00
. 2. 00	transactions (chapter 10)		Ű			Ū	12.00
	Laundry and linen service		0		0.00		
	Cafeteria-employees and guests	В	-56, 3510	CAFETERI A	11.00		111.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical	В	-131	MEDICAL RECORDS & LIBRARY	16.00	0	16.00
	grour	5	101		.0.00	Ű	

16.00	Sale of medical and surgical supplies to other than	В	-131 MEDI CAL RECORDS & LI BRARY	16.00	0	16. 00
17.00	patients Sale of drugs to other than		о	0.00	0	17.00
18.00			o	0.00	0	18.00
19.00	abstracts Nursing and allied health education (tuition, fees,		0	0.00	0	19.00
20.00	books, etc.) Vending machines		0	0.00	0	20.00
	Income from imposition of interest, finance or penalty charges (chapter 21)		0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0	0.00	О	22.00
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	ORESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OPHYSI CAL THERAPY	66.00		24.00
25.00	limitation (chapter 14) Utilization review - physicians' compensation		O*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		OCAP REL COSTS-BLDG & FIXT	1.00	О	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0 *** Cost Center Deleted ***	2.00	0	27.00
	Non-physician Anesthetist		0 *** Cost Center Deleted ***	19.00		28.00
	Physicians' assistant			0.00	0	
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	OOCCUPATI ONAL THERAPY	67.00		30.00
30. 99	Hospice (non-distinct) (see instructions)		OADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	OSPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0	0.00	0	32.00
33.00	CBO Mi sc. Revenue	В	-28, 282 ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Heal th	Financial Systems	eal th Financial Systems PUTNAM COUNTY HOSPITAL In Lieu					2552-10
ADJUS	MENTS TO EXPENSES				Period: From 01/01/2022 To 12/31/2022	Worksheet A-8 Date/Time Pre 5/31/2023 8:4	
				Expense Classification of			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33. 01	Cardiac Rehab Other Misc. Income	В	-57	CARDI AC REHAB	69.01	0	33. 01
33. 02	Pharmacy Rebates & Misc.	В	-11, 969	DRUGS CHARGED TO PATIENTS	73.00	0	33. 02
	Income						
33.03	Admin Other Misc. Income	В		ADMI NI STRATI VE & GENERAL	5.00		00.00
33.04	Nursing Admin Other Misc.	В	-1, 251	NURSING ADMINISTRATION	13.00	0	33.04
	Income	_				_	
33.05	340B Program Offset	A		DRUGS CHARGED TO PATIENTS	73.00		
33.06	Advertising	A		ADMI NI STRATI VE & GENERAL	5.00		33.06
33.07	Advertising	A		OPERATING ROOM	50.00		33.07
33.08	Advertising	A		ONCOLOGY	54.02		33.08
33.09	Advertising	A		CARDI AC REHAB	69.01	0	33.09
33.10	Advertising	A		RURAL HEALTH CLINIC	88.00		33.10
33. 11	Advertising	A		RURAL HEALTH CLINIC III	88.02		33. 11
33. 12	Advertising	А		RHEUMATOLOGY	90.01	0	33.12
33.13	Intercompany Rent	A		CAP REL COSTS-BLDG & FIXT	1.00		
33.14	Community Relations FICA	A		EMPLOYEE BENEFITS DEPARTMEN			33.14
33.15	Community Relations	A		ADMI NI STRATI VE & GENERAL	5.00		33.15
33.16	Lobbyi ng	A		ADMI NI STRATI VE & GENERAL	5.00		33.16
33.17	Physician Recruitment	A		ADULTS & PEDIATRICS	30.00		33.17
33. 18	HAF Expense	A		ADMI NI STRATI VE & GENERAL	5.00		33. 18
33.19	Non-Allowable CRNA	A		ANESTHESI OLOGY	53.00		33.19
33. 20	NON-ALLOWABLE INTEREST EXPENSE	A		CAFETERI A	11.00	0	33.20
50.00	TOTAL (sum of lines 1 thru 49)		-8, 761, 759				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) bescription - an chapter references in this column pertain to cms Pdb. 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	TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period: From 01/01/2022 To 12/31/2022		epared:
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component		Physician/Prov ider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	1, 337, 702		(0 0	0	1.00
2.00	53.00	ANESTHESI OLOGY	460, 541	368, 660	91, 881	0	0	2.00
3.00	90. 01	RHEUMATOLOGY	273, 778	273, 778	(0 0	0	3.00
4.00	91.00	EMERGENCY	3, 089, 819	2, 755, 599	334, 220	0 0	0	4.00
5.00	0.00		0	0	(0 0	0	5.00
6.00	0.00		0	0	(0	0	6.00
7.00	0.00		0	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	10.00
200.00			5, 161, 840	4, 735, 739	426, 101		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE			of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0	, o	(1.00
2.00		ANESTHESI OLOGY	0	0	(2.00
3.00		RHEUMATOLOGY	0	0	(-	3.00
4.00		EMERGENCY	0	0	(0	4.00
5.00	0.00		0	0	(-	5.00
6.00	0.00		0	0	(0	6.00
7.00	0.00		0	0	(0	7.00
8.00	0.00		0	0	(0	8.00
9.00	0.00		0	0	(0	9.00
10.00	0.00		0	0	(-	-	10.00
200.00		Coot Coutour (Dhumi ai an	U Drasvi da ra	0	RCE	,	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	Di sal l owance	Adj ustment		
		rdentrirei	Share of col.		DI Sal I Owalice			
	1.00	2.00	14 15. 00	16.00	17.00	18,00		
1.00		ADULTS & PEDIATRICS	10.00	0	17.00			1.00
2.00		ANESTHESI OLOGY	0	0	(2.00
3.00		RHEUMATOLOGY	0	0	(3.00
4.00		EMERGENCY	0	0	(4.00
5.00	0.00		0	0	(5.00
6.00	0.00		0	0	(-		6.00
7.00	0.00		0	0	(7.00
8.00	0.00		0	0	(8.00
9.00	0.00		0	0	(-		9.00
10.00	0.00		0	0	(-		10.00
200.00	51.00		0			-		200.00
		1					· ·	

	IABLE COST DETERMINATION FOR THERAPY SERVICES F DE SUPPLIERS	FURNI SHED BY	Provider CC	N: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8 Parts I-VI Date/Time Pre 5/31/2023 8:4	pared:		
					Physical Therapy				
						1.00			
	PART I - GENERAL INFORMATION					1.00			
1.00	Total number of weeks worked (excluding aides) (see instruc	tions)			52	1.00		
2.00 3.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	or or thoranis	t was on provid	dor sito (s	o instructions)	780 299	•		
4.00 4.00	Number of unduplicated days in which therapy					194			
	nor therapist was on provider site (see instr	uctions)							
5.00	Number of unduplicated offsite visits - super				h the second	0	5.00		
6.00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther					0	6.00		
	instructions)	aprot nao not	procent during		,,, (000				
7.00	Standard travel expense rate					9.57			
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stant	s Ai des	0.00 Trai nees	8.00		
		1.00	2.00	3.00	4.00	5. 00			
9.00	Total hours worked	0.00	4, 146. 02	1, 672		0.00			
10.00 11.00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 46. 37	92. 74 46. 37		56 0.00 78	0.00	10.00		
11.00	one-half of column 2, line 10; column 3,	40. 37	40.37	54	78		11.00		
	one-half of column 3, line 10)								
12.00	Number of travel hours (provider site)	0	0		0		12.00		
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.0 ⁴ 13.00		
13.01	Number of miles driven (offsite)	Ő	Ö		0		13.0		
						4.00			
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00			
14.00	Supervisors (column 1, line 9 times column 1,	line 10)				0	14.00		
15.00	Therapists (column 2, line 9 times column 2,					384, 502			
16.00	Assistants (column 3, line 9 times column 3,		natary therapy	on Linco 1	1 1/ for all	116, 368			
17.00	Subtotal allowance amount (sum of lines 14 an others)	a 15 for respi	ratory therapy	or times to	1-16 FOF ALL	500, 870	17.00		
18.00	Aides (column 4, line 9 times column 4, line	10)				0	18.00		
19.00						0	•		
20. 00									
	occupational therapy, line 9, is greater than								
	the amount from line 20. Otherwise complete								
21.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,			n of columns	s 1 and 2, line 9	0.00	21.00		
22.00	Weighted allowance excluding aides and traine					0	22.00		
23.00	Total salary equivalency (see instructions)					500, 870	23.00		
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMPL	JTATION - PE	ROVIDER SITE		-		
24.00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					13, 865	24.00		
25.00	Assistants (line 4 times column 3, line 11)					6, 747			
26.00	Subtotal (line 24 for respiratory therapy or					20, 612			
27.00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or si	um of lines	3 and 4 for all	4, 718	27.00		
28.00	Total standard travel allowance and standard	travel expense	at the provide	er site (su	n of lines 26 and	25, 330	28.00		
	27)	-	-						
29.00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum c		d 2 line 12)			0	29.00		
30.00	Assistants (column 3, line 10 times column 3,		u z, inic iz)			0	30.00		
31.00	Subtotal (line 29 for respiratory therapy or					0	31.00		
32.00	Optional travel expense (line 8 times columns	1 and 2, line	13 for respira	atory thera	by or sum of	0	32.00		
33.00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel	expense (line	28)			25, 330	33.00		
34.00	Optional travel allowance and standard travel			d 31)		0			
35.00	Optional travel allowance and optional travel			,		0	35.00		
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND IRAVEL	EXPENSE COMPU	IAIION - SEI	RVICES OUTSIDE PRO	IVIDER SITE	-		
36.00	<u>Standard Travel Expense</u> Therapists (line 5 times column 2, line 11)					0	36.00		
37.00	Assistants (line 6 times column 3, line 11)					0	37.00		
38.00	Subtotal (sum of lines 36 and 37)	of Lines F an	d 6)			0	•		
39.00	Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel		u 0)			0	37.00		
40. 00	Therapists (sum of columns 1 and 2, line 12.0		2, line 10)			0	40.00		
41.00	Assistants (column 3, line 12.01 times column	3, line 10)				0	41.00		
42.00 43.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	of columns 1	3 lino 13 01)			0			
4J. UU	Total Travel Allowance and Travel Expense - 0		,	e of the fol	lowing three line		43. UU		
	or 46, as appropriate.		•						
	Standard travel allowance and standard travel	expense (sum	of lines 38 and	d 39 - see i	nstructions)	0	44.00		
14.00 15.00				4 4 2	netructione)	<u>^</u>	45.0		

ealth Financial Systems EASONABLE COST DETERMINATION FOR THERAPY SERVICES	PUTNAM COUNTY HOSPI TAL FURNI SHED BY Provider CCN: 15-1333 F		In Lie Period:	worksheet A-8-3			
JTSI DE SUPPLI ERS				From 01/01/2022 To 12/31/2022	2 Parts I-VI		
· · · · · · · · · · · · · · · · · · ·				Physical Therapy		1	
					1.00		
6.00 Optional travel allowance and optional travel		fines 42 an Assistants		structions) Trai nees	0 Total	46.0	
	Therapists 1.00	2.00	Ai des 3.00	4.00	5.00		
PART V - OVERTIME COMPUTATION							
7.00 Overtime hours worked during reporting period (if column 5, line 47, is zero or	0.00	0.00	O. C	0 0.00	0.00	47.0	
equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)							
8.00 Overtime rate (see instructions)	0.00	0.00	0.0	0 0.00		48. (
9.00 Total overtime (including base and overtime	0.00	0.00	0.0	0 0.00		49. (
allowance) (multiply line 47 times line 48)						-	
CALCULATION OF LIMIT 0.00 Percentage of overtime hours by category	0.00	0.00	0.0	0 0.00	0.00	50. (
(divide the hours in each column on line 47 by the total overtime worked - column 5,	0.00	0.00	0.0	0.00	0.00	00.1	
line 47) 1.00 Allocation of provider's standard work year	0.00	0.00	0.0	0 0.00	0.00	51. (
for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.0	0.00	0.00	51.	
DETERMINATION OF OVERTIME ALLOWANCE	00.74	(0. F/	0.0			1 5 2	
2.00 Adjusted hourly salary equivalency amount (see instructions)	92.74	69.56	0.0	0 0.00		52.	
3.00 Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.	
 4. 00 Maximum overtime cost (enter the lesser of line 49 or line 53) 5. 00 Portion of overtime already included in 	0	0		0 0 0 0		54. 55.	
hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55.	
6.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0		0 0	0	56.	
the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)							
	<u> </u>				1.00		
Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST /	ADJUSTMENT					
7.00 Salary equivalency amount (from line 23)	(£	24 25))			500, 870 25, 330		
58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46)							
0.00 Overtime allowance (from column 5, line 56)	500 (110	11, 10, 01 10	/		0		
1.00 Equipment cost (see instructions)					0		
2.00 Supplies (see instructions)					0		
3.00 Total allowance (sum of lines 57-62) 4.00 Total cost of outside supplier services (from your records)						63. 64.	
00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)						64. 65.	
LINE 33 CALCULATION	sum of Lipos 24	and 2E for a	11 others		20, 612	100	
100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						100.	
100. 02 Line 33 = Tine 2 = sum of Lines 26 and 27 Line 34 CALCULATION					25, 330		
	101.00 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others						
01.00 Line 27 = line 7 times line 3 for respiratory		101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others 101.02 Line 34 = sum of lines 27 and 31					
D1.00 Line 27 = line 7 times line 3 for respiratory D1.01 Line 31 = line 29 for respiratory therapy or D1.02 Line 34 = sum of lines 27 and 31		and 30 for a			4, 718		
01.00 Line 27 = line 7 times line 3 for respiratory 01.01 Line 31 = line 29 for respiratory therapy or 01.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION 02.00 Line 31 = line 29 for respiratory therapy or	sum of lines 29 sum of lines 29	and 30 for a	II others		0	102.	
D1.00 Line 27 = line 7 times line 3 for respiratory D1.01 Line 31 = line 29 for respiratory therapy or D1.02 Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29 sum of lines 29	and 30 for a	II others	mns 1-3, line	0]	

REASON	Financial Systems HABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	PUTNAM COUNTY FURNI SHED BY	/ HOSPITAL Provider CCN: 15-1333	Period: From 01/01/2022	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre	-3
				To 12/31/2022 Occupational Therapy	5/31/2023 8:4 Cost	
					1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides	s) (see instruct	tions)		51	1.00
2.00	Line 1 multiplied by 15 hours per week	, .			765	2.00
3.00 4.00	Number of unduplicated days in which supervis Number of unduplicated days in which therapy				250 0	
	nor therapist was on provider site (see inst	ructions)				
5.00 6.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the instructions)	apy assistants	(include only visits made	e by therapy	0	5.00 6.00
7.00	Standard travel expense rate				9.57	
8.00	Optional travel expense rate per mile	Supervi sors	Therapists Assistan		0.00 Trai nees	8.00
9.00	Total hours worked	1.00 0.00	<u>2.00</u> <u>3.00</u> <u>1.529.96</u>	4.00 0.00 0.00	5.00 0.00	9,00
10.00	AHSEA (see instructions)	0.00	87.92	0.00	0.00	10.00
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	43. 96	43.96	0. 00		11.00
12.00	one-half of column 3, line 10) 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. 01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0	0 0		13.00 13.01
	· · · · ·	· ·			1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					
14.00 15.00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,				0 134, 514	
16.00	0 Assistants (column 3, line 9 times column 3, line10)					16.00
17.00	0 Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)					17.00
18.00	0 Aides (column 4, line 9 times column 4, line 10)					18.00
19.00 20.00						19.00 20.00
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23 the amount from line 20. Otherwise complete lines 21-23.					
21.00	Weighted average rate excluding aides and tra for respiratory therapy or columns 1 thru 3,			ns 1 and 2, line 9	0.00	21.00
22.00	Weighted allowance excluding aides and trained	0	22.00 23.00			
23.00	10 Total salary equivalency (see instructions) 134,5 PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE 134,5					
	Standard Travel Allowance					
24.00 25.00	Assistants (line 3 times column 2, line 11)	10, 990 0				
26.00	Subtotal (line 24 for respiratory therapy or	10, 990	26.00			
27.00	Standard travel expense (line 7 times line 3 others)	2, 393	27.00			
28.00	Total standard travel allowance and standard 27)	13, 383	28.00			
29.00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		12 line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3,	0				
31.00 32.00	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns	0	31.00 32.00			
	columns 1-3, line 13 for all others)		. 5			
33.00 34.00	Standard travel allowance and standard travel	13, 383 0				
35.00	00 Optional travel allowance and optional travel expense (sum of lines 31 and 32)					
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	ANCE AND TRAVEL	EXPENSE COMPUTATION - SE	RVICES OUTSIDE PRO	OVIDER SITE	
36.00	Therapists (line 5 times column 2, line 11)				0	
37.00 38.00						
39.00	Standard travel expense (line 7 times the sur		d 6)		0	
40.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0		2, line 10)		0	40.00
41.00	Assistants (column 3, line 12.01 times column		-/		0	41.00
42.00 43.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sur	n of columns 1-:	3. line 13.01)		0	
	Total Travel Allowance and Travel Expense - (llowing three line		1
44.00	or 46, as appropriate. Standard travel allowance and standard travel	expense (sum o	of lines 38 and 39 - see	instructions)	0	44.00
	' 023 8:41 am Y:\25350 - Putnam County Hospital\					

UTSI D	ABLE COST DETERMINATION FOR THERAPY SERVICES I E SUPPLIERS	-URNI SHED BY	Provider C	CN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet A-8 Parts I-VI Date/Time Prep 5/31/2023 8:4	pared:
					Occupati onal Therapy	Cost	
						1.00	
5.00	Optional travel allowance and standard travel					0	45.00
6.00	Optional travel allowance and optional travel		of lines 42 an			0	46.00
		Therapists 1.00	Assistants 2.00	Ai des 3.00	Trai nees 4. 00	<u>Total</u> 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	0.00	1.00	0.00	
7.00	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. 00	0.00	47.0
8.00	Overtime rate (see instructions)	0.00	0.00				48.00
9.00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0.00	0.00	0.0	0. 00		49.00
	CALCULATION OF LIMIT	1		1			-
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	0.00	0.0	0.00	0.00	50.00
1. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0. (0.00	0.00	51.00
2.00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	87.92	0.00	0.0	0.00		52.00
2.00	(see instructions)	07.72	0.00	0.0	0.00		52.0
3.00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.0
4.00 5.00	Maximum overtime cost (enter the lesser of line 49 or line 53) Portion of overtime already included in	0	0		0 0		54.00 55.00
5.00	hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		33.0
6. 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	56.0
		I					
						1.00	
7.00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	ND EXCESS COST	ADJUSTMENT			134, 514	57.0
 3. 00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 3. 00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 3. 00 Overtime allowance (from column 5, line 56) 1. 00 Equipment cost (see instructions) 2. 00 Supplies (see instructions) 					13, 383 0 0 0 0	58.0 59.0 60.0 61.0	
3.00	00 Total allowance (sum of lines 57-62)						63.0
1.00 5.00	00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)						64.C 65.C
00 00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	ll others		10, 990	100 C
00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27					2, 393 13, 383	100. 0	
	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory				others	2, 393	
	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	III others		0 2, 393	101. 0 101. 0
	LINE 35 CALCULATION						
01.02	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 0 102. 0

	ABLE COST DETERMINATION FOR THERAPY SERVICES	FURNI SHED BY	Provider CC	N: 15-1333	Period: From 01/01/2022 To 12/31/2022		pared:
					Speech Pathology	Cost	
						1.00	
	PART I - GENERAL INFORMATION	> / · · ·					
1.00 2.00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			51	1.00
3.00	Number of unduplicated days in which supervis	sor or therapis	t was on provid	der site (se	e instructions)	127	3.00
4.00	Number of unduplicated days in which therapy	assistant was				0	4.00
- 00	nor therapist was on provider site (see instr		anists (see in	structions)		0	5.00
5.00 5.00	Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera				by therapy	0	6.00
	assistant and on which supervisor and/or the					_	
7 00	instructions)					0.57	
7.00 3.00	Standard travel expense rate Optional travel expense rate per mile					9.57 0.00	
		Supervi sors	Therapi sts	Assi stants		Trai nees	
9.00	Total hours worked	<u> </u>	2.00	3.00	4.00 00 0.00	5.00	9.00
10.00	AHSEA (see instructions)	0.00	84.50		00 0.00		
11.00	Standard travel allowance (columns 1 and 2,	42. 25	42.25	0.	00		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	о		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12. 0 [.]
13.00	Number of miles driven (provider site)	0	0		0		13.0
13.01	Number of miles driven (offsite)	0	0		0		13.0
						1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	Lipo 10)				0	14.0
15.00	Therapists (column 2, line 9 times column 2,					54, 785	
16.00	Assistants (column 3, line 9 times column 3,					0	16.0
17.00	Subtotal allowance amount (sum of lines 14 ar	nd 15 for respi	ratory therapy	or lines 14	1-16 for all	54, 785	17.0
18.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.0
19.00	Trainees (column 5, line 9 times column 5, li	ne 10)				0	19.0
20. 00	Total allowance amount (sum of lines 17-19 for					54, 785	20.0
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than						
	the amount from line 20. Otherwise complete	lines 21-23.					
21.00	Weighted average rate excluding aides and tra			n of columns	s 1 and 2, line 9	84.50	21.0
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine					64, 643	22.0
23.00	Total salary equivalency (see instructions)					64, 643	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVE	L EXPENSE COMPL	JTATION - PF	ROVIDER SITE		
24 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					5 366	24.0
25.00	Assistants (line 4 times column 3, line 11)					0	
26.00	Subtotal (line 24 for respiratory therapy or					5, 366	26.00
27.00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or su	um of lines	3 and 4 for all	1, 215	27.0
28.00	Total standard travel allowance and standard	travel expense	at the provide	er site (sur	n of lines 26 and	6, 581	28.0
	27)			·			
29.00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum o		d 2 line 12)			0	29.0
30.00	Assistants (column 3, line 10 times column 3,					0	30.0
31.00	Subtotal (line 29 for respiratory therapy or					0	31.0
32.00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respira	atory therap	by or sum of	0	32.0
33.00	Standard travel allowance and standard travel	expense (line	28)			6, 581	33.0
34.00	Optional travel allowance and standard travel			d 31)		0	34.0
35.00	Optional travel allowance and optional travel	expense (sum	of lines 31 and	d 32)		0	35.0
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	INCE AND TRAVEL	EXPENSE COMPU	IAIIUN - SEF	RVICES OUTSIDE PRO	DVIDER SITE	+
36.00	Therapists (line 5 times column 2, line 11)					0	36.0
37.00	Assistants (line 6 times column 3, line 11)					0	
38.00 39.00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	of lines 5 on	d 6)			0	
	Optional Travel Allowance and Optional Travel					0	37.0
40. 00	Therapists (sum of columns 1 and 2, line 12.0)1 times column	2, line 10)			0	
41.00	Assistants (column 3, line 12.01 times column	n 3, line 10)				0	41.0
42.00 43.00	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the sum	n of columns 1-	3. line 13 01)			0	•
. 5. 00	Total Travel Allowance and Travel Expense - C			e of the fol	lowing three line		1 .0.0
	or 46, as appropriate.		•		-		
44.00	Standard travel allowance and standard travel Optional travel allowance and standard travel						44. 0 45. 0
5.00							

ealth Financial Systems EASONABLE COST DETERMINATION FOR THERAPY SERVICES	PUTNAM COUNTY	Provider C	CN· 15_1333	Peri od:	u of Form CMS-2 Worksheet A-8	
UTSI DE SUPPLI ERS			on. 10 1000	From 01/01/2022 To 12/31/2022	Parts I-VI	pared
				Speech Pathology		
					1.00	
6.00 Optional travel allowance and optional travel	expense (sum o Therapists	Assistants	Aides	Trai nees	0 Total	46. C
	1.00	2.00	3.00	4.00	5. 00	
PART V - OVERTIME COMPUTATION			-			
7.00 Overtime hours worked during reporting	0.00	0.00	0.0	0. 00	0.00	47.0
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)						
8.00 Overtime rate (see instructions)	0. 00	0.00				48.
9.00 Total overtime (including base and overtime	0.00	0.00	0. (0. 00		49.0
allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
0.00 Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.0
(divide the hours in each column on line 47						
by the total overtime worked - column 5,						
line 47) 1.00 Allocation of provider's standard work year	0. 00	0.00	0.0	0.00	0.00	51. (
for one full-time employee times the	0.00	0.00	0.0	0.00	0.00	51.
percentages on line 50) (see instructions)						
DETERMINATION OF OVERTIME ALLOWANCE	Г		1	- 1		
2.00 Adjusted hourly salary equivalency amount	84. 50	0.00	0. (0. 00		52.
(see instructions) 3.00 Overtime cost limitation (line 51 times line	0	C		0 0		53.
52)						
4.00 Maximum overtime cost (enter the lesser of	0	C		0 0		54.
line 49 or line 53)						
5.00 Portion of overtime already included in hourly computation at the AHSEA (multiply	0	C		0 0		55.
line 47 times line 52)						
6.00 Overtime allowance (line 54 minus line 55 -	0	C		0 0	0	56.
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 A	ND EXCESS COST				1.00	
7.00 Salary equivalency amount (from line 23)					64, 643	57.
8.00 Travel allowance and expense - provider site					6, 581	58.
9.00 Travel allowance and expense - Offsite service	ces (from lines	44, 45, or 46)		0	
0.00 Overtime allowance (from column 5, line 56) 1.00 Equipment cost (see instructions)					0	
2.00 Supplies (see instructions)					0	
3.00 Total allowance (sum of lines 57-62)					71, 224	
4.00 Total cost of outside supplier services (from	m your records)				36, 708	64.
5.00 Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			0	65.
LINE 33 CALCULATION 00.00 Line 26 = line 24 for respiratory therapy or	sum of Linos 24	and 25 for a	ll othors		5, 366	100
00.01 Line 27 = line 7 times line 3 for respiratory				others	1, 215	
00.02 Line 33 = line 28 = sum of lines 26 and 27					6, 581	
LINE 34 CALCULATION						
01.00 Line 27 = line 7 times line 3 for respiratory				others	1, 215	101.
01.01 Line 31 = line 29 for respiratory therapy or 01.02 Line 34 = sum of lines 27 and 31	Sull OF TITles 29		III Others		1, 215	
LINE 35 CALCULATION					1,213	1.01.
02.00 Line 31 = line 29 for respiratory therapy or						102.
02.01 Line 32 = line 8 times columns 1 and 2, line	13 for respirat	ory therapy c	or sum of colu	umns 1-3, line	0	102.
13 for all others 02.02 Line 35 = sum of lines 31 and 32						102.
					0	1102.

Health F	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	LOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2022	Worksheet B Part I	
					To 12/31/2022		
			CAPI TAL			373172023 0.4	
	Cost Center Description	Net Expenses	RELATED COSTS BLDG & FIXT	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost		BENEFITS	Subtotui	& GENERAL	
		Allocation (from Wkst A		DEPARTMENT			
		col. 7)					
		0	1.00	4.00	4A	5.00	
	GENERAL SERVICE COST CENTERS	2,079,830	2, 079, 830				1.00
4.00 0	DO400 EMPLOYEE BENEFITS DEPARTMENT	6, 503, 344	2, 827	6, 506, 171			4.00
	DO5OO ADMINISTRATIVE & GENERAL DO7OO OPERATION OF PLANT	6, 353, 824		781, 617			5.00 7.00
	DOBOO LAUNDRY & LINEN SERVICE	1, 632, 029 256, 664		87, 827 7, 788		325, 268 47, 842	8.00
9.00 0	DO900 HOUSEKEEPI NG	544, 799	5, 210	104, 939	654, 948	113, 143	9.00
	D1000 DI ETARY D1100 CAFETERI A	359, 026 752, 429		36, 569 85, 602		79, 157	10.00 11.00
	D1300 NURSI NG ADMI NI STRATI ON	230, 831	12, 287	45, 715			13.00
16.00 C	D1600 MEDICAL RECORDS & LIBRARY	458, 906	73, 019	71, 425		104, 229	16.00
	D1700 SOCIAL SERVICE D1701 UTILIZATION REVIEW	0 126, 448	0 6, 153	0 29, 146	-	0 27, 942	17.00 17.01
	NPATIENT ROUTINE SERVICE COST CENTERS	120, 440	0, 155	27, 140	5 101, 747	27, 742	17.01
	03000 ADULTS & PEDI ATRI CS	1, 077, 574		567, 795			30.00
	D3100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	867,770	52, 492	118, 371	1, 038, 633	179, 425	31.00
50. 00 C	D5000 OPERATING ROOM	1, 209, 674	151, 157	176, 876	5 1, 537, 707	265, 640	50.00
	D5100 RECOVERY ROOM	143,017		27, 919			
	D5300 ANESTHESI OLOGY D5400 RADI OLOGY-DI AGNOSTI C	192, 275 1, 665, 524		213, 933 314, 857		70, 173	53.00 54.00
54.01 C	05401 NUCLEAR MEDICINE-DIAGNOSTIC	195, 631	2, 587	C	198, 218	34, 242	54.01
	D3480 ONCOLOGY D5700 CT SCAN	5, 481, 314		97, 577		979, 262	54.02
	D6000 LABORATORY	585, 842 2, 724, 434	24, 389 46, 376	52, 629 227, 058		114, 510 517, 885	57.00 60.00
	06500 RESPI RATORY THERAPY	583, 600	12, 934	124, 525	5 721, 059	124, 564	65.00
	D6600 PHYSI CAL THERAPY D6700 OCCUPATI ONAL THERAPY	525, 254		(66.00 67.00
	D6800 SPEECH PATHOLOGY	113, 729 36, 708		(19, 647 6, 341	68.00
69. 00 C	D6900 ELECTROCARDI OLOGY	139, 826	1, 848	21, 172	162, 846	28, 132	69.00
	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	276, 897	55, 873 0	65, 804		68, 854 0	69. 01 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	469, 781	0	(, v	81, 155	
	D7300 DRUGS CHARGED TO PATIENTS	1, 366, 192	16, 555	86, 543	1, 469, 290	253, 821	73.00
	DUTPATIENT SERVICE COST CENTERS	1, 609, 215	100, 438	331, 521	2, 041, 174	352, 615	88.00
	D8801 RURAL HEALTH CLINIC II	1, 719, 013		358, 957		379, 718	
	08802 RURAL HEALTH CLINIC III	1, 701, 579		349, 648		375, 098	
	09000 CLINIC 09001 RHEUMATOLOGY	0 183, 108	-,	0 105, 493			
	D9100 EMERGENCY	2, 157, 006		820, 452		532, 891	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	44, 323, 093	1, 794, 627	5, 311, 758	42, 843, 477	6, 121, 907	118.00
N	NONREI MBURSABLE COST CENTERS					· · ·	
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0		1 120 050			190.00
	19200 PHYSICIANS PRIVATE OFFICES 19201 JOHNSON/NICHOLS WIC	5, 592, 750 359, 291	263, 586 0	1, 128, 950 65, 463		1, 206, 700 73, 377	
193.001	19300 NONPALD WORKERS	0	0	(0 0	0	193. 00
	07950 VACANT SPACE 07951 BOARD OF HEALTH	0	12 004	(194. 00 194. 01
200.00	Cross Foot Adjustments		12, 804	C	0 12, 804 0	2, 212	200.00
201.00	Negative Cost Centers		0		0		201.00
202.00	TOTAL (sum lines 118 through 201)	50, 275, 134	2, 079, 830	6, 506, 171	I 50, 275, 134	7, 405, 718	202.00

CDST ALLOCATION - CEMERAL SERVICE COSTS Provider CCK: 15-1333 Ford all ZDST Worksheet B Ford 11 Cost Center Description Description <th>Health Fir</th> <th>nancial Systems</th> <th>PUTNAM COUNT</th> <th>Y HOSPI TAL</th> <th></th> <th>In Lie</th> <th>u of Form CMS-</th> <th>2552-10</th>	Health Fir	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
Cost Center Description OPERATION 07 PLANT CLUMDRY 8 B 000 IDUSCRCEPING DIETARY CAFELERIA 0 SINDIAL SERVICE 00000 CONSTRUCTOR PREL COST-ENG 0F FIT 00000 CONSTRUCTOR PREL COST-ENG 0F FIT 000000 TO 00000 TO 000000 TO 00000 TO 00000 TO 00000 TO 00000 TO 00000 TO 00000 TO 00000 TO 000000 TO 00000 TO 00000 TO 000000 TO 000000 TO 00000 TO 000000 TO 00000000	COST ALLO	CATION - GENERAL SERVICE COSTS		Provider C		From 01/01/2022	Part I Date/Time Pre	
ENERAL SERVICE COST CENTERS 7.00 8.00 9.00 10.00 11.00 1.00 00100 CAP REL COSTS CENTERS 1.00 4.00 4.00 4.00 5.00 7.00 1.00 1.00 1.00 5.00 5.00 7.00 1.00 7.00 1.00 <t< td=""><td></td><td>Cost Center Description</td><td></td><td></td><td>HOUSEKEEPING</td><td>DI ETARY</td><td></td><td></td></t<>		Cost Center Description			HOUSEKEEPING	DI ETARY		
1.00 00100 (CAP REL COSTS-BLOG & FLYT 1.00 5.00 00500 ADM IN STRATI VE & GENERAL 5.00 7.00 00700 (CAP REL COSTS-BLOG & FLYT 2.208,142 8.00 00600 (LANNEY & LINEN SERVICE 16.779 9.00 00700 (NAUSEKEF) NO.MUSEKEF JUNES 7.000 9.00 00000 (LANNEY & LINEN SERVICE 16.779 10.00 010000 (DETART) W B LINEN SERVICE 16.00 10.00 010000 (DETART) 0.973 10.00 010000 (DETART) 0.9630 10.00 1.075,171 10.00 10.00 010000 (DETART) 0.9630 10.00 010000 (DETART) 0.9630 10.00 010000 (DETART) 7.0517 10.00 010000 (DETART) 7.0517 10.00 03000 ADULTS & FEDARTNEY 8.265 0 3.096 10.00 03000 (DETART) 7.0517 51.3152 523.528 137.773 30.00 10.00 03000 (PERAT) 7.0517 7.33.255,552 3.443 0 14.664 54.00					9.00	10.00	11.00	
4.00 00400 LML02VEE EXEMPTIS DEPARTMENT 4.00 7.00 00700 OPERATION 0F PLANT 2.208,142 5.00 7.00 00700 OPERATION 0F PLANT 2.208,142 7.00 9.00 00900 HUDSEKEFPI NG 7.000 1,917 777.008 6.00 9.00 D0900 DILEARY 84,119 1,415 0.00 7.00 0.00	GEN	IERAL SERVICE COST CENTERS						
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88.02 08802 RURAL HEALTH CLINICIII 161,338 0 0 0 88.02 90.00 09000 CLINIC 4,021 0 0 0 90.00 90.01 09001 RHEUMATOLOGY 11,691 0 5,228 0 29,425 90.01 91.00 09200 DESERVATI ON BEDS (NON-DI STINCT PART 144,112 83,168 64,444 0 157,127 91.00 92.00 O9200 DESERVATI ON BEDS (NON-DI STINCT PART 18.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,825,002 325,530 661,176 660,519 1,045,910 92.00 NONREL MBURSABLE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,825,002 325,530 661,176 660,519 1,045,910 192.00 192.00 19200 PHYSI CLANS PRI VATE OFFICES 354,099 16,033 102,846 0 0 192.00 192.01 JOHNSON/NI CHOLS WIC 0 0 0 0 192.01 193.00	88.00 088	300 RURAL HEALTH CLINIC	134, 928	7, 646	60, 33	7 0	0	88.00
90.00 09000 CLINIC 4,021 0 0 0 0 90.00 90.00 90.01 91.00 92.00 92.00 92.01 SUBTOTALS (SUM OF LINES 1 through 117) 1,825,002 325,530 661,176 660,519 1,045,910 18.00 190.00 IPO00 GIFT FLOWER COFFEE SHOP & CANTEEN 11,840 0 5,294	88.01 088	BOT RURAL HEALTH CLINIC II	161, 338	0		0 0	0	88.01
90.01 09001 RHEUMATOLOGY 11, 691 0 5, 228 0 29, 425 90.01 91.00 09100 EMERGENCY 1144, 112 83, 168 64, 444 0 157, 127 91.00 92.00 92.00 DBSERVATI ON BEDS (NON-DI STINCT PART 83, 168 64, 444 0 157, 127 91.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 1, 825, 002 325, 530 661, 176 660, 519 1, 045, 910 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GFT FLOWER COFFEE SHOP & CANTEEN 11, 840 0 5, 294 0 0 192.00 192.00 19200 PHYSI CI ANS PRI VATE OFFICES 354, 099 16, 033 102, 846 0 0 192.00 192.01 JOHNSON/NI CHOLS WIC 0 0 0 0 193.00 193.00 193.00 194.00 07950 VACANT SPACE 0 0 0 0	88.02 088	302 RURAL HEALTH CLINIC III	161, 338	0		0 0	0	88. 02
91.00 09100 EMERGENCY 144, 112 83, 168 64, 444 0 157, 127 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART SPECIAL PURPOSE COST CENTERS 92.00 <td>90.00 090</td> <td>DOO CLINIC</td> <td>4, 021</td> <td>0</td> <td></td> <td>0 0</td> <td>0</td> <td>90.00</td>	90.00 090	DOO CLINIC	4, 021	0		0 0	0	90.00
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,825,002 325,530 661,176 660,519 1,045,910 118.00 NONRE IMBURSABLE COST CENTERS 190.00 19000 GFT FLOWER COFFEE SHOP & CANTEEN 11,840 0 5,294 0 0 190.00 192.00 19200 PHYSI CI ANS PRI VATE OFFICES 354,099 16,033 102,846 0 0 192.00 192.01 19201 JOHNSON/NI CHOLS WIC 0 0 0 0 192.01 193.00 19300 NORKERS 0 0 0 0 193.00 194.00 0 0 0 194.00 194.00 07951 BOARD OF HEALTH 17,201 0 7,692 0 0 194.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 201.00 201.00	90.01 090	001 RHEUMATOLOGY	11, 691	0	5, 22	8 0	29, 425	90.01
SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,825,002 325,530 661,176 660,519 1,045,910 118.00 NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 0 0 0 190.00 0 190.00 GIFT FLOWER COFFEE SHOP & CANTEEN 11,840 0 5,294 0 0 190.00 192.00 19200 PHYSI CI ANS PRI VATE OFFICES 354,099 16,033 102,846 0 0 192.00 192.01 19201 JOHNSON/NI CHOLS WIC 0 0 0 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 194.00 0 194.00 0 0 0 0 194.01 0 17,201 0 7,692 0 0 194.01 200.00 Cross Foot Adj ustments 0 0 0 0 0 0 200.00 201.00 Negati ve Cos			144, 112	83, 168	64, 44	4 0	157, 127	91.00
SUBTOTALS SUBTOTALS SUB of LINES 1 through 117) 1,825,002 325,530 661,176 660,519 1,045,910 118.00 NONREI MBURSABLE COST CENTERS 11,840 0 5,294 0 0 190.00 192.00 19200 PHYSI CLANS RIVATE OFFICES 354,099 16,033 102,846 0 0 192.00 192.01 19201 JOHNSON/NI CHOLS WIC 0 0 0 0 29,264 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 193.00 193.00 194.01 0 0 0 194.01 0 17,201 0 0 0 194.01 0 194.01 0 194.01 0 194.01 0 194.01 0 0 0 0 194.01 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 201.00 201.00 201.00 0								92.00
NORREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 11,840 0 5,294 0 0 190.00 192.00 19200 PHYSI CLANS PRI VATE OFFICES 354,099 16,033 102,846 0 0 192.00 192.01 19201 JOHNSON/NI CHOLS WIC 0 0 0 29,264 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 0 194.00 0 0 194.00 0 0 194.00 194.01 0 7, 692 0 0 194.01 200.00 Cross Foot Adjustments 17, 201 0 7, 692 0 194.01 201.00 Negative Cost Centers 0 0 0 20.00 20.00			i			-		
190.00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 11,840 0 5,294 0 0 190.00 192.00 19200 PHYSI CLANS PRI VATE OFFICES 354,099 16,033 102,846 0 0 192.00 192.01 JOHNSON/NI CHOLS WIC 0 0 0 0 29,264 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 17,201 0 7,692 0 0 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 0 0 0 201.00			1, 825, 002	325, 530	661, 17	6 660, 519	1, 045, 910	118.00
192.00 19200 PHYSI CLANS PRI VATE OFFICES 354,099 16,033 102,846 0 0 192.00 192.01 19201 JOHNSON/NI CHOLS WIC 0 0 0 29,264 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 VACANT SPACE 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 17,201 0 7,692 0 194.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 200.00 201.00 0 0 0 0 201.00			i.	l .	1	1		
192.01 19201 JOHNSON/NI CHOLS WI C 0 0 0 29, 264 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 0 193.00 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 17, 201 0 7, 692 0 194.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00								
193.00 19300 NONPAI D WORKERS 0 0 0 193.00 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 17,201 0 7,692 0 194.01 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 201.00			354,099	16, 033	102, 84	6 0		
194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 17,201 0 7,692 0 194.01 200.00 Cross Foot Adjustments 17,201 0 7,692 0 194.01 201.00 Negative Cost Centers 0 0 0 0 0 201.00			0	0		0 0		
194. 01 07951 BOARD OF HEALTH 17, 201 0 7, 692 0 194. 01 200. 00 Cross Foot Adjustments 17, 201 0 7, 692 0 194. 01 201. 00 Negative Cost Centers 0 0 0 0 0 201. 00			0	0		0		
200.00 Cross Foot Adjustments 200.00			0	0				
201.00 Negative Cost Centers 0 0 0 0 0 201.00			17, 201	0	/, 69	∠ 0	0	
			_				~	
202.00 101AL (Sum Lines 118 through 201) 2,208,142 341,563 777,008 660,519 1,075,174 202.00		5						
	202.00	TOTAL (Sum TIMES THE UNLOUGH 201)	Ζ, 208, 142	341, 563	I ///, 00	000, 519	1, 0/5, 1/4	1202. UU

	Financial Systems	PUTNAM COUNTY				u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2022	Worksheet B Part I	
					To 12/31/2022	Date/Time Pre	
	Cost Conton Decosintion	NUDCLNC	MEDLOAL			5/31/2023 8:4	1 am
	Cost Center Description	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS &	SOCIAL SERVICI	E UTI LI ZATI ON REVI EW	Subtotal	
		ADMINI STRATI ON	LIBRARY		NEVI EW		
		13.00	16.00	17.00	17.01	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPING						9,00
10.00	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION	372, 266					13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	895, 596				16.00
	01700 SOCIAL SERVICE	0	0		C		17.00
17.01	01701 UTI LI ZATI ON REVIEW	0	0	(212, 408		17.01
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	450.444		1		0 757 (00	
	03000 ADULTS & PEDIATRICS	152, 111	325, 219		0 190, 865	3, 757, 639	
31.00	03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS	46, 675	0	(21, 543	1, 554, 971	31.00
50.00	OSOOO OPERATING ROOM	0	277, 238		0 0	2, 562, 575	50.00
	05100 RECOVERY ROOM	0	277,230			2, 562, 575 355, 841	
	05300 ANESTHESI OLOGY	0	0		0	497.333	
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	2, 668, 058	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 0	237, 489	1
54.02	03480 ONCOLOGY	0	0		o c	6, 872, 965	
57.00	05700 CT SCAN	0	0		o c	846, 092	57.00
60.00	06000 LABORATORY	0	0		0 0	3, 729, 219	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	916, 335	
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	723, 556	
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	133, 376	
	06800 SPEECH PATHOLOGY	0	0		0 0	43, 049	
	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	0			202, 609	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			598, 321 0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			550, 936	
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	1, 785, 819	
/0/00	OUTPATIENT SERVICE COST CENTERS			· · · · · · · · · · · · · · · · · · ·	<u> </u>	1,700,017	10100
88.00	08800 RURAL HEALTH CLINIC	0	0	(0 0	2, 596, 700	88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0	(0 C	2, 739, 123	88. 01
88.02	08802 RURAL HEALTH CLINIC III	0	0	(0 0	2, 707, 760	88. 02
90.00	09000 CLINIC	0	0	(0 0	7, 531	
90.01	09001 RHEUMATOLOGY	0	0	(0 0	395, 006	
91.00	09100 EMERGENCY	173, 480	293, 139		0 0	4, 533, 094	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	372, 266	895, 596		212, 408	41, 015, 397	1110 00
110.00	NONREI MBURSABLE COST CENTERS	372,200	075, 570	1	212,400	41,015,377	110.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	(0 0	27.469	190.00
	19200 PHYSI CLANS PRI VATE OFFI CES	0	0		0 0	8, 664, 964	
192.01	19201 JOHNSON/NI CHOLS WI C	0	0		0 0	527, 395	
	19300 NONPALD WORKERS	0	0		0 0		193.00
	07950 VACANT SPACE	0	0		o c		194.00
194 01	07951 BOARD OF HEALTH	0	0		o c		194.01
200.00							200.00
	Negative Cost Centers	0 372, 266	0 895, 596	(0 0 0 212, 408		201.00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL	In Lieu of Form CMS-	-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1333	Period: Worksheet B	
			From 01/01/2022 Part I To 12/31/2022 Date/Time Pro	anarod
			5/31/2023 8:4	
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown Adjustments			
	25.00	26.00		
GENERAL SERVICE COST CENTERS				
1.00 00100 CAP REL COSTS-BLDG & FIXT				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL				5.00
7.00 00700 OPERATION OF PLANT				7.00
8.00 00800 LAUNDRY & LINEN SERVICE				8.00
9.00 00900 HOUSEKEEPI NG				9.00
10. 00 01000 DI ETARY		-		10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSI NG ADMI NI STRATI ON				11.00 13.00
16. 00 01600 MEDICAL RECORDS & LIBRARY				16.00
17. 00 01700 SOCIAL SERVICE				17.00
17. 01 01701 UTI LI ZATI ON REVI EW				17.00
INPATIENT ROUTINE SERVICE COST CENTERS				17.01
30. 00 03000 ADULTS & PEDI ATRI CS	0	3, 757, 639		30.00
31.00 03100 INTENSIVE CARE UNIT	0	1, 554, 971		31.00
ANCILLARY SERVICE COST CENTERS		· · · ·		
50. 00 05000 OPERATI NG ROOM	0	2, 562, 575		50.00
51.00 05100 RECOVERY ROOM	0	355, 841		51.00
53.00 05300 ANESTHESI OLOGY	0	497, 333		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 668, 058		54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	237, 489		54.01
54. 02 03480 ONCOLOGY	0	6, 872, 965		54.02
57. 00 05700 CT SCAN	0	846, 092		57.00
	0	3, 729, 219		60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	916, 335 723, 556		65.00 66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	133, 376		67.00
68. 00 06800 SPEECH PATHOLOGY	0	43, 049		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	202, 609		69.00
69. 01 06901 CARDI AC REHAB	0	598, 321		69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	550, 936		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1, 785, 819		73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	2, 596, 700		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	2, 739, 123		88.01
88. 02 08802 RURAL HEALTH CLINIC III	0	2, 707, 760		88.02
90. 00 09000 CLINIC	0	7, 531		90.00
90. 01 09001 RHEUMATOLOGY	0	395,006		90.01
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4, 533, 094		91.00 92.00
SPECIAL PURPOSE COST CENTERS	<u> </u>			92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 0	41, 015, 397		118.00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	27, 469		190.00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	0	8, 664, 964		192.00
192.01 19201 JOHNSON/NI CHOLS WIC	0	527, 395		192. 01
193. 00 19300 NONPALD WORKERS	0	o		193.00
194.0007950 VACANT SPACE	0	0		194.00
194. 01 07951 BOARD OF HEALTH	0	39, 909		194.01
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	50, 275, 134		202.00

Health Fi	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCATIO	DN OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/31/2023 8:4	pared: 1 am
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPI TAL RELATED COSTS BLDG & FI XT	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	ADMI NI STRATI VE & GENERAL	
		0	1.00	2A	4.00	5.00	
	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT						1.00
	400 EMPLOYEE BENEFITS DEPARTMENT	0	2, 827	2, 82	7 2, 827		4.00
	500 ADMINISTRATIVE & GENERAL	0	270, 277	270, 27		270, 617	5.00
	700 OPERATION OF PLANT	0	163, 018			11, 887	7.00
	800 LAUNDRY & LINEN SERVICE	0	12, 490	12, 49	0 3	1, 748	8.00
	900 HOUSEKEEPI NG	0	5, 210	5, 21		4, 135	
	000 DI ETARY	0	62, 617	62, 61		2, 893	
		0	29,636			5, 478	
	300 NURSI NG ADMI NI STRATI ON 600 MEDI CAL RECORDS & LI BRARY	0	12, 287	12, 28		1, 823 3, 809	
	700 SOCIAL SERVICE	0	73, 019	73, 01	9 31 0 0	3,809	17.00
	701 UTI LI ZATI ON REVI EW	0	6, 153	6, 15	-	1, 021	17.00
	PATIENT ROUTINE SERVICE COST CENTERS		0,100	0,10	0 10	1, 021	17.01
	000 ADULTS & PEDIATRICS	0	113, 649	113, 64	9 247	11, 105	30.00
	100 I NTENSI VE CARE UNI T	0	52, 492	52, 49	2 51	6, 557	31.00
	CILLARY SERVICE COST CENTERS	i					
	000 OPERATING ROOM	0	151, 157	151, 15		9, 708	50.00
	100 RECOVERY ROOM	0	42, 404	42, 40		1, 347	51.00
	300 ANESTHESI OLOGY 400 RADI OLOGY-DI AGNOSTI C	0	E4 002	E4 00	0 93 2 137	2,564	53.00 54.00
	400 NUCLEAR MEDICINE-DIAGNOSTIC	0	56, 002 2, 587	56, 00 2, 58		12, 856 1, 251	54.00
	480 ONCOLOGY	0	89, 741	89, 74		35, 786	
	700 CT SCAN	0	24, 389	24, 38		4, 185	
	000 LABORATORY	0	46, 376	46, 37		18, 926	60.00
65.00 06	500 RESPI RATORY THERAPY	0	12, 934	12, 93	4 54	4, 552	65.00
	600 PHYSI CAL THERAPY	0	31, 484	31, 48		3, 515	
	700 OCCUPATIONAL THERAPY	0	0		0 0	718	67.00
	800 SPEECH PATHOLOGY	0	0		0 0	232	68.00
	900 ELECTROCARDI OLOGY	0	1,848			1, 028	
	901 CARDIAC REHAB 100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	55, 873 0	55, 87	3 29 0 0	2, 516 0	69.01 71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	2, 966	72.00
	300 DRUGS CHARGED TO PATIENTS	0	16, 555	16, 55	-	9, 276	73.00
	TPATIENT SERVICE COST CENTERS	-				.,	
88.00 08	800 RURAL HEALTH CLINIC	0	100, 438	100, 43	8 144	12, 886	88.00
	801 RURAL HEALTH CLINIC II	0	120, 097	120, 09		13, 876	
	802 RURAL HEALTH CLINIC III	0	120, 097	120, 09		13, 708	
	000 CLINIC	0	2, 993	2, 99		19	
	001 RHEUMATOLOGY	0	8, 702				90.01
	100 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART	0	107, 275		5 357 0	19, 474	91.00
	ECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 794, 627	1, 794, 62	7 2, 310	223, 722	118.00
	NREI MBURSABLE COST CENTERS						
190.0019	000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	8, 813		3 0		190. 00
	200 PHYSICIANS PRIVATE OFFICES	0	263, 586	263, 58		44, 077	
	201 JOHNSON/NI CHOLS WI C	0	0		0 28		192.01
	300 NONPALD WORKERS	0	0		0		193.00
	950 VACANT SPACE 951 BOARD OF HEALTH	0	0 12, 804	12, 80			194. 00 194. 01
200.00	Cross Foot Adjustments	0	12,804	12,80	4 U	81	200.00
200.00	Negative Cost Centers		0		o n	Ω	200.00
202.00	TOTAL (sum lines 118 through 201)	0	2, 079, 830	2, 079, 83	0 2, 827	270, 617	
1							

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lieu	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		eriod: rom 01/01/2022	Worksheet B Part II Date/Time Pre 5/31/2023 8:4	pared:
Cost Center Description	OPERATION OF PLANT L	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS	-1					
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMI NI STRATI VE & GENERAL	174.040					5.00
7.00 00700 OPERATION OF PLANT	174, 943	15 570				7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	1, 329	15, 570				8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY	555	87	10, 033	72, 741		9.00 10.00
11. 00 01100 CAFETERIA	6, 664 3, 154	65 0	486 230	72, 741	38, 535	
13. 00 01300 NURSING ADMINISTRATION	1, 308	0	95	0	36, 555	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	7,772	0	566	0	1, 651	
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	1
17. 01 01701 UTI LI ZATI ON REVI EW	655	0	48	0	386	
INPATIENT ROUTINE SERVICE COST CENTERS	000		10			17.01
30. 00 03000 ADULTS & PEDI ATRI CS	12,096	3, 387	882	65, 364	4, 938	30.00
31.00 03100 INTENSIVE CARE UNIT	5, 587	2, 616	407	7, 377	1, 515	31.00
ANCI LLARY SERVICE COST CENTERS	-					1
50.00 05000 OPERATING ROOM	16, 088	2, 210	1, 196	0	4, 940	50.00
51.00 05100 RECOVERY ROOM	4, 513	239	329	0	644	51.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	751	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	5, 960	1, 165	434	0	5, 213	
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	275	0	20	0	0	54.01
54. 02 03480 ONCOLOGY	9, 551	501	696	0	1, 420	
57. 00 05700 CT SCAN	2, 596	0	189	0	764	57.00
	4, 936	0	360	0	4, 419	
65. 00 06500 RESPIRATORY THERAPY	1,377	0	100	0	1, 633	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	3, 351	430	244 0	0	0	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	197	0	14	0	288	
69. 01 06901 CARDI AC REHAB	5, 947	0	433	0	798	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	433	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 762	0	128	0	1, 094	
OUTPATIENT SERVICE COST CENTERS	.,	-		-1	.,	
88.00 08800 RURAL HEALTH CLINIC	10, 690	349	779	0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	12, 782	0	0	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	12, 782	0	0	0	0	88. 02
90. 00 09000 CLINIC	319	0	0	0	0	90.00
90. 01 09001 RHEUMATOLOGY	926	0	68	0	1, 055	90.01
91. 00 09100 EMERGENCY	11, 417	3, 790	832	0	5, 631	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART						92.00
SPECIAL PURPOSE COST CENTERS	1					
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	144, 589	14, 839	8, 536	72, 741	37, 486	118.00
NONREI MBURSABLE COST CENTERS	0.20	0	(0	ol	0	190.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS PRIVATE OFFICES	938 28, 053	0 731	68 1, 330			190.00
192. 01 19200 PHYSICIANS PRIVATE OFFICES	20,000	/31	1, 330	0		192.00
193. 00 19300 NONPALD WORKERS		0	0	0		192.01
193. 00 19300 NONPATD WORKERS 194. 00 07950 VACANT SPACE		0		0		193.00
194. 01 07951 BOARD OF HEALTH	1, 363	0	99	0		194.00
200.00 Cross Foot Adjustments	1, 505	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	0	200.00
201.00 Negative Cost Centers	0	0	n	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	174, 943	15, 570	10, 033	72, 741		202.00
				· · · · · ·		

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lieu	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2022	Worksheet B Part II	
				To 12/31/2022	Date/Time Pre	
Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVIC	UTILIZATION	5/31/2023 8:4 Subtotal	
	ADMI NI STRATI ON	RECORDS &		REVI EW		
	12.00	LIBRARY	17.00	17.01	24.00	
GENERAL SERVICE COST CENTERS	13.00	16.00	17.00	17.01	24.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						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						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11.00
13.00 01300 NURSING ADMINISTRATION	15, 879					13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	86, 848	1			16.00
17. 00 01700 SOCIAL SERVICE	0	C	1			17.00
17. 01 01701 UTI LI ZATI ON REVI EW	0	C	(8, 276		17.01
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS	6, 488	31, 538		7,437	257, 131	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 991	51, 550 C		839	79, 432	
ANCI LLARY SERVICE COST CENTERS	.,	-				
50. 00 05000 OPERATI NG ROOM	0	26, 884		0 0	212, 260	50.00
51.00 05100 RECOVERY ROOM	0	C	1	0 0	49, 488	1
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	3, 408	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0				81, 767 4, 133	
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54. 02 03480 ONCOLOGY	0				137, 737	
57. 00 05700 CT SCAN	o	C		o o	32, 146	
60. 00 06000 LABORATORY	0	C		0 0	75, 116	1
65. 00 06500 RESPI RATORY THERAPY	0	C) (0 0	20, 650	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	39, 024	
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	718	
68. 00 06800 SPEECH PATHOLOGY	0	C		0	232	1
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0				3, 384 65, 596	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				05, 590	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 0	2, 966	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	28, 853	
OUTPATIENT SERVICE COST CENTERS	I		1	1 1		
88.00 08800 RURAL HEALTH CLINIC	0	C	1	0 0	125, 286	1
88. 01 08801 RURAL HEALTH CLINIC II	0	C			146, 911	
88. 02 08802 RURAL HEALTH CLINIC III 90. 00 09000 CLINIC	0				146, 739 3, 331	
90. 01 09001 RHEUMATOLOGY	0	0			12, 674	
91. 00 09100 EMERGENCY	7,400	28, 426		0 0	184, 602	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
SPECIAL PURPOSE COST CENTERS			1	1		
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	15, 879	86, 848		8, 276	1, 713, 584	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN	0	C		0 0	0.975	190.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS PRIVATE OFFICES	0	C			338, 266	
192. 01 19201 JOHNSON/NI CHOLS WI C	0	C		0		192.01
193.00 19300 NONPALD WORKERS	0	C) (0 0		193.00
194.0007950 VACANT SPACE	0	C		0 0		194.00
194. 01 07951 BOARD OF HEALTH	0	C		0 0		194.01
200.00 Cross Foot Adjustments	~	~				200. 00 201. 00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 15, 879	86, 848		0 0 0 8,276	0 2, 079, 830	
	15, 079	00, 040	1 ,	0,270	2,017,030	1-02.00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lieu of	f Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	N: 15-1333		rksheet B rt II
				To 12/31/2022 Da	te/Time Prepared:
Cost Center Description	Intern &	Total		5/	31/2023 8:41 am
	Residents Cost				
	& Post				
	Stepdown				
	Adjustments 25.00	26.00			
GENERAL SERVICE COST CENTERS	20100	20100			
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.00
9. 00 00900 HOUSEKEEPING					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
17. 01 01701 UTI LI ZATI ON REVI EW					17.01
INPATIENT ROUTINE SERVICE COST CENTERS	0	257, 131			30.00
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	0	79, 432			31.00
ANCI LLARY SERVICE COST CENTERS	0	77,432			31.00
50. 00 05000 OPERATI NG ROOM	0	212, 260			50.00
51.00 05100 RECOVERY ROOM	0	49, 488			51.00
53.00 05300 ANESTHESI OLOGY	0	3, 408			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	81, 767			54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	4, 133			54.01
54. 02 03480 ONCOLOGY	0	137, 737			54.02
57. 00 05700 CT SCAN 60. 00 06000 LABORATORY	0	32, 146			57.00 60.00
65. 00 06500 RESPI RATORY THERAPY	0	75, 116 20, 650			65.00
66. 00 06600 PHYSI CAL THERAPY	0	39, 024			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	718			67.00
68.00 06800 SPEECH PATHOLOGY	0	232			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 384			69.00
69. 01 06901 CARDI AC REHAB	0	65, 596			69.01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	2,966			72.00 73.00
OUTPATIENT SERVICE COST CENTERS	U	28, 853			/3.00
88. 00 08800 RURAL HEALTH CLINIC	0	125, 286			88.00
88.01 08801 RURAL HEALTH CLINIC II	0	146, 911			88.01
88.02 08802 RURAL HEALTH CLINIC III	0	146, 739			88.02
90. 00 09000 CLINIC	0	3, 331			90.00
90. 01 09001 RHEUMATOLOGY	0	12, 674			90.01
91.00 09100 EMERGENCY	0	184, 602			91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART SPECIAL PURPOSE COST CENTERS	0				92.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 713, 584			118.00
NONREI MBURSABLE COST CENTERS	0	1, 713, 304			110.00
190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	9, 875			190.00
192.00 19200 PHYSI CLANS PRI VATE OFFI CES	0	338, 266			192.00
192.01 19201 JOHNSON/NI CHOLS WI C	0	3, 758			192.01
193.00 19300 NONPALD WORKERS	0	0			193.00
194. 00 07950 VACANT SPACE	0	0			194.00
194.01 07951 BOARD OF HEALTH 200.00 Cross Foot Adjustments	0	14, 347 0			194. 01 200. 00
201.00 Negative Cost Centers	0	0			200.00
202.00 TOTAL (sum lines 118 through 201)	0	2, 079, 830			202.00
	1				1

	Financial Systems	PUTNAM COUNT		01 45 405-		eu of Form CMS-2	
COST AL	LLOCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2022	Worksheet B-1	
					o 12/31/2022		
		CAPI TAL				5/31/2023 8:4	
		RELATED COSTS					
	Cost Center Description	BLDG & FIXT	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	
		(SQUARE FEET)	BENEFITS		& GENERAL	PLANT	
			DEPARTMENT		(ACCUM. COST)	(SQUARE FEET)	
			(GROSS				
		1.00	SALARIES)	5A	E 00	7.00	
	GENERAL SERVICE COST CENTERS	1.00	4.00	JA	5.00	7.00	-
	00100 CAP REL COSTS-BLDG & FIXT	112, 566					1.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	153	26, 444, 670				4.00
	00500 ADMINI STRATI VE & GENERAL	14, 628	3, 176, 916		42, 869, 416	1	5.00
	00700 OPERATION OF PLANT	8, 823	356, 978				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	676	31, 654	C	276, 942	676	8.00
	00900 HOUSEKEEPI NG	282	426, 531	C	654, 948	282	9.00
	01000 DI ETARY	3, 389	148, 637	1	458, 212		•
	01100 CAFETERI A	1,604	347, 932		867, 667	1,604	•
	01300 NURSI NG ADMI NI STRATI ON	665	185, 811		288, 833		•
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 952 0	290, 310				•
	01700 SUCTAL SERVICE 01701 UTILIZATION REVIEW	333	118, 464		-	0 333	17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	555	110, 404		101,747		17.01
+	03000 ADULTS & PEDI ATRI CS	6, 151	2, 307, 829	C	1, 759, 018	6, 151	30.00
	03100 I NTENSI VE CARE UNI T	2,841	481, 123				31.00
	ANCI LLARY SERVICE COST CENTERS	2,011	1017120		1,000,000	2/0/1	
	05000 OPERATING ROOM	8, 181	718, 921	C	1, 537, 707	8, 181	50.00
51.00	05100 RECOVERY ROOM	2, 295	113, 477	C	213, 340	2, 295	51.00
53.00	05300 ANESTHESI OLOGY	0	869, 541	C	406, 208	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	3, 031	1, 279, 752	C	2, 036, 383	3, 031	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	140	0	-			•
	03480 ONCOLOGY	4, 857	396, 606				•
	05700 CT SCAN	1, 320	213, 913		662, 860		•
		2,510	922, 887		2, 997, 868		•
		700	506, 139				•
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 704	0				•
	06800 SPEECH PATHOLOGY	0					67.00 68.00
	06900 ELECTROCARDI OLOGY	100	86, 056				1
	06901 CARDI AC REHAB	3, 024	267, 463			3, 024	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0,021	207, 100	c c		0,021	1
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ő	C	-	0	1
	07300 DRUGS CHARGED TO PATIENTS	896	351, 758				1
	OUTPATIENT SERVICE COST CENTERS						1
88.00	08800 RURAL HEALTH CLINIC	5, 436	1, 347, 481	C	2, 041, 174	5, 436	88.00
	08801 RURAL HEALTH CLINIC II	6, 500	1, 458, 995			6, 500	
	08802 RURAL HEALTH CLINIC III	6, 500	1, 421, 161				
	09000 CLI NI C	162	C	-	=,		
	09001 RHEUMATOLOGY	471	428, 783				•
	09100 EMERGENCY	5, 806	3, 334, 763	C	3, 084, 733	5, 806	
+	09200 OBSERVATION BEDS (NON-DISTINCT PART					<u> </u>	92.00
118.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	97, 130	21, 589, 881	-7, 405, 718	35, 437, 759	72 524	110 00
+	NONREIMBURSABLE COST CENTERS	77,130	21, 307, 001	-7,405,710	55,457,759	13, 520	118.00
	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	477	0	C	8, 813	477	190.00
	19200 PHYSICIANS PRIVATE OFFICES	14, 266	4, 588, 712				192.00
	19201 JOHNSON/NI CHOLS WI C	0	266, 077				192.01
	19300 NONPAI D WORKERS	0	0	C	0		193.00
	07950 VACANT SPACE	0	C	C	0		194.00
194.01	07951 BOARD OF HEALTH	693	C	c	12, 804	693	194.01
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	2, 079, 830	6, 506, 171		7, 405, 718	2, 208, 142	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	18. 476538	0. 246030		0. 172751	24.821182	
204.00	Cost to be allocated (per Wkst. B,		2, 827		270, 617	174, 943	204.00
205 00	Part II)		0 000107		0.00/010	1 0// /01	205 00
205.00	Unit cost multiplier (Wkst. B, Part		0. 000107		0. 006313	1. 966491	205.00
206.00	NAHE adjustment amount to be allocated					1	206.00
200.00	(per Wkst. B-2)					1	
207.00	NAHE unit cost multiplier (Wkst. D,					1	207.00
	Parts III and IV)					1	
		·					

Health Fi	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	OCATION - STATISTICAL BASIS		Provider C		eri od:	Worksheet B-1	
				To	rom 01/01/2022 0 12/31/2022	Date/Time Pre	
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	5/31/2023 8:4 NURSI NG	1 am
	cost center bescription	LINEN SERVICE		(TOTAL PATIENT		ADMI NI STRATI ON	
		(POUNDS OF		DAYS)			
		LAUNDRY)				(DI RECT NURSI NG HOURS)	
		8.00	9.00	10.00	11.00	13.00	
	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT	1					1.00
	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00	500 ADMINI STRATI VE & GENERAL						5.00
	700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE	178, 564					7.00 8.00
	900 HOUSEKEEPI NG	1,002	70, 004				9.00
	000 DI ETARY	740					10.00
	100 CAFETERI A 300 NURSI NG ADMI NI STRATI ON	0	1, 604 665		314, 317 2, 821	98, 571	11.00 13.00
	600 MEDI CAL RECORDS & LI BRARY	0	3, 952		13, 465	0, 371	16.00
	700 SOCIAL SERVICE	0	0	-	0	0	17.00
	701 UTI LI ZATI ON REVIEW PATI ENT ROUTI NE SERVI CE COST CENTERS	0	333	0	3, 145	0	17.01
	000 ADULTS & PEDIATRICS	38, 845	6, 151	1, 391	40, 277	40, 277	30.00
	100 INTENSIVE CARE UNIT	29, 996	2, 841	157	12, 359	12, 359	31.00
	CILLARY SERVICE COST CENTERS	25, 348	8, 343	0	40, 296	0	50.00
	100 RECOVERY ROOM	2,746		-	5, 249	0	51.00
	300 ANESTHESI OLOGY	0	0	-	6, 125	0	53.00
	400 RADI OLOGY-DI AGNOSTI C 401 NUCLEAR MEDI CI NE-DI AGNOSTI C	13, 358	3, 031	0	42, 524 0	0	54.00 54.01
	400 ONCOLOGY	5,740	4, 857		11, 584	0	54.01
57.00 05	700 CT SCAN	0	1, 320	0	6, 229	0	57.00
	000 LABORATORY 500 RESPI RATORY THERAPY	0	2, 510 700		36,047	0	60.00 65.00
1	600 PHYSI CAL THERAPY	4, 931	1, 704		13, 321 0	0	66.00
67.00 06	700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	800 SPEECH PATHOLOGY	0	0		0	0	68.00
	900 ELECTROCARDI OLOGY 901 CARDI AC REHAB		100 3, 024		2, 350 6, 510	0	69.00 69.01
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	300 DRUGS CHARGED TO PATI ENTS TPATI ENT SERVI CE COST CENTERS	0	896	0	8, 923	0	73.00
88.00 08	800 RURAL HEALTH CLINIC	3, 997	5, 436		0	0	88.00
	801 RURAL HEALTH CLINIC II 802 RURAL HEALTH CLINIC III	0	0	0	0	0	88.01
	000 CLINIC	0	0	0	0	0	88.02 90.00
90.01 09	001 RHEUMATOLOGY	0	471	0	8, 602	0	90.01
	100 EMERGENCY	43, 479	5, 806	0	45, 935	45, 935	
	200 OBSERVATION BEDS (NON-DISTINCT PART ECIAL PURPOSE COST CENTERS						92.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	170, 182	59, 568	1, 548	305, 762	98, 571	118.00
	NREIMBURSABLE COST CENTERS 000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	477	0	0	0	190.00
	200 PHYSI CI ANS PRI VATE OFFICES	8, 382			0		190.00
192.01 19	201 JOHNSON/NI CHOLS WI C	0	0		8, 555	0	192. 01
	300 NONPAI D WORKERS 950 VACANT SPACE	0	0		0		193.00
	950 VACANT SPACE 951 BOARD OF HEALTH		693		0		194.00 194.01
200.00	Cross Foot Adjustments	-			-	-	200. 00
201.00	Negative Cost Centers	241 5/2	777 000	((0.510	1 075 174	272.244	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	341, 563	777, 008	660, 519	1, 075, 174	372, 266	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 912832	11. 099480	426. 691860	3. 420668	3. 776628	203.00
204.00	Cost to be allocated (per Wkst. B,	15, 570	10, 033	72, 741	38, 535	15, 879	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 087196	0. 143320	46. 990310	0. 122599	0. 161092	205 00
	11)				3. 1220//	3. 1010/2	
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
I		I.	I	I I	I	I	I

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of	Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC			rksheet B-1
				From 01/01/2022 To 12/31/2022 Dat	te/Time Prepared:
Cast Canton Decerintian	MEDLCAL	SOCI AL SERVI CE		5/3	31/2023 8:41 am
Cost Center Description	MEDICAL RECORDS &	SUCIAL SERVICE	UTI LI ZATI ON REVI EW		
	LI BRARY	(PATI ENT DA	(TOTAL PATIEN	Т	
	(TIME SPENT)	YS)	DAYS)		
	16.00	17.00	17.01		
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT	1				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9.00
11. 00 01100 CAFETERI A					11.00
13.00 01300 NURSING ADMINISTRATION					13.00
16.00 01600 MEDI CAL RECORDS & LI BRARY	84, 146				16.00
17.00 01700 SOCIAL SERVICE	0	0	4 54		17.00
17. 01 01701 UTI LI ZATI ON REVI EW I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	1, 54	8	17.01
30. 00 03000 ADULTS & PEDIATRICS	30, 556	0	1, 39	1	30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		15		31.00
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	26, 048			0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	51.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	53.00 54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0	54.00
54. 02 03480 ONCOLOGY	0	0		0	54.02
57. 00 05700 CT SCAN	0	0		0	57.00
60. 00 06000 LABORATORY	0	0		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0	69.01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	72.00
OUTPATIENT SERVICE COST CENTERS	0	0		0	/ 3. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0	0		0	88.02
90. 00 09000 CLINIC	0	0		0	90.00
90. 01 09001 RHEUMATOLOGY 91. 00 09100 EMERGENCY	27, 542	0		0	90. 01 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	27, 342	0		0	92.00
SPECIAL PURPOSE COST CENTERS	1			1	
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	84, 146	0	1, 54	8	118.00
NONREI MBURSABLE COST CENTERS	-			0	
190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS PRI VATE OFFI CES	0	0		0	190. 00 192. 00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 192. 01 19201 JOHNSON/NI CHOLS WI C		0		0	192.00
193. 00 19300 NONPAI D WORKERS	0	0		Ő	193.00
194.0007950 VACANT SPACE	0	0		0	194.00
194.01 07951 BOARD OF HEALTH	0	0		0	194.01
200.00 Cross Foot Adjustments					200.00
201.00Negative Cost Centers202.00Cost to be allocated (per Wkst. B,	895, 596	0	212, 40	8	201.00 202.00
Part I)	070, 070	0	212, 40	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	10. 643358	0. 000000	137. 21447	о	203.00
204.00 Cost to be allocated (per Wkst. B,	86, 848	0	8, 27	6	204.00
Part II)		0 0000	F 0.//		
205.00 Unit cost multiplier (Wkst. B, Part	1. 032111	0. 000000	5.34625	3	205.00
206.00 NAHE adjustment amount to be allocated					206.00
(per Wkst. B-2)					
207.00 NAHE unit cost multiplier (Wkst. D,					207.00
Parts III and IV)	l		l		I

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	5/31/2023 8:4	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.757.400		0.757.4			
30. 00 03000 ADULTS & PEDI ATRI CS	3, 757, 639		3, 757, 6		0	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 554, 971		1, 554, 9	71 0	0	31.00
ANCI LLARY SERVI CE COST CENTERS		1			-	
50.00 05000 OPERATI NG ROOM	2, 562, 575		2, 562, 5		0	50.00
51.00 05100 RECOVERY ROOM	355, 841		355, 8		0	51.00
53. 00 05300 ANESTHESI OLOGY	497, 333		497, 3		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 668, 058		2, 668, 0		0	54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	237, 489		237, 4		0	54.01
54. 02 03480 ONCOLOGY	6, 872, 965		6, 872, 9		0	54.02
57.00 05700 CT SCAN	846, 092		846, 0		0	57.00
60. 00 06000 LABORATORY	3, 729, 219		3, 729, 2	19 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	916, 335				0	65.00
66. 00 06600 PHYSI CAL THERAPY	723, 556		723, 5		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	133, 376	0	133, 3	76 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	43, 049	0	43, 0	49 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	202, 609		202, 6	09 0	0	69.00
69. 01 06901 CARDI AC REHAB	598, 321		598, 3	21 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	550, 936		550, 9	36 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 785, 819		1, 785, 8	19 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	2, 596, 700		2, 596, 7	00 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	2, 739, 123		2, 739, 1	23 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	2,707,760		2, 707, 7	60 0	0	88.02
90. 00 09000 CLINIC	7,531		7,5	31 0	0	90.00
90. 01 09001 RHEUMATOLOGY	395,006		395, 0	06 0	0	90.01
91.00 09100 EMERGENCY	4, 533, 094		4, 533, 0	94 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 196, 842		1, 196, 8		0	
200.00 Subtotal (see instructions)	42, 212, 239				0	200.00
201.00 Less Observation Beds	1, 196, 842		1, 196, 8			201.00
202.00 Total (see instructions)	41, 015, 397					202.00
		-			-	

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/31/2023 8:4	epared:
	_		e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 611, 202		2, 611, 20)2		30.00
31.00 03100 INTENSIVE CARE UNIT	627, 573		627, 57	'3		31.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	316, 968	3, 855, 321	4, 172, 28	0. 614189	0.00000	
51.00 05100 RECOVERY ROOM	51, 364	509, 599	560, 96	0. 634340	0.00000	51.00
53.00 05300 ANESTHESI OLOGY	19, 593	445, 322	464, 91	5 1.069729	0.00000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	730, 225	8, 361, 198	9, 091, 42	0. 293470	0.00000	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	20, 712	1, 334, 092	1, 354, 80	0. 175294	0.00000	54.01
54. 02 03480 ONCOLOGY	8, 216	10, 948, 545	10, 956, 76	0. 627281	0.00000	54.02
57.00 05700 CT SCAN	501, 571	13, 875, 294	14, 376, 86	0. 058851	0.00000	57.00
60. 00 06000 LABORATORY	1, 452, 578	15, 478, 212	16, 930, 79	0. 220263	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 191, 475	838, 181	2, 029, 65	0. 451473	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	370, 746	2, 246, 545	2, 617, 29	0. 276452	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	171, 208	382, 408	553, 61	6 0. 240918	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	26, 789	139, 905	166, 69	0. 258252	0.00000	68.00
69.00 06900 ELECTROCARDI OLOGY	25, 546	813, 640	839, 18	0. 241435	0.00000	69.00
69. 01 06901 CARDI AC REHAB	0	1, 071, 179	1, 071, 17	0. 558563	0.00000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0.000000	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	208, 354	331, 597	539, 95	1. 020344	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 019, 698	2, 145, 612	3, 165, 31	0 0. 564185	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						1
88.00 08800 RURAL HEALTH CLINIC	0	2, 231, 878	2, 231, 87	/8		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	2, 406, 213	2, 406, 21	3		88.01
88.02 08802 RURAL HEALTH CLINIC III	0	2, 138, 876	2, 138, 87	6		88.02
90. 00 09000 CLINIC	0	6, 517	6, 5	7 1. 155593	0.00000	90.00
90. 01 09001 RHEUMATOLOGY	0	319, 969	319, 96	1. 234513	0.00000	90.01
91.00 09100 EMERGENCY	274, 805	19, 748, 806	20, 023, 6	1 0. 226387	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	62, 010	1, 407, 239	1, 469, 24	0. 814594	0.00000	92.00
200.00 Subtotal (see instructions)	9, 690, 633	91, 036, 148	100, 726, 78	31		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	9, 690, 633	91, 036, 148	100, 726, 78	31		202.00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL	In Lie	u of Form CMS-255	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepa 5/31/2023 8:41	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS				3	30. 00
31. 00 03100 I NTENSI VE CARE UNI T				3	31.00
ANCILLARY SERVICE COST CENTERS	· · · · ·				
50. 00 05000 OPERATI NG ROOM	0. 000000			5	50.00
51.00 05100 RECOVERY ROOM	0. 000000			5	51.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			5	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			5	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000			5	54.01
54. 02 03480 ONCOLOGY	0. 000000			5	54.02
57.00 05700 CT SCAN	0. 000000			5	57.00
60. 00 06000 LABORATORY	0. 000000			6	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			6	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			6	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 000000			6	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			6	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			6	69.00
69. 01 06901 CARDI AC REHAB	0. 000000			6	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			7	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			7	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			7	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC				8	88.00
88.01 08801 RURAL HEALTH CLINIC II				8	88. 01
88.02 08802 RURAL HEALTH CLINIC III				8	88. 02
90. 00 09000 CLINIC	0. 000000				90.00
90. 01 09001 RHEUMATOLOGY	0. 000000				90. 01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000				92.00
200.00 Subtotal (see instructions)					00.00
201.00 Less Observation Beds					01.00
202.00 Total (see instructions)				20	02.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	5/31/2023 8:4	
		Titl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26) 1.00	Therapy Limit Adj. 2.00	Total Costs	RCE Di sal I owance	Total Costs	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS	3, 757, 639		3, 757, 6	39 0	3, 757, 639	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 554, 971		1, 554, 9		1, 554, 971	31.00
ANCI LLARY SERVICE COST CENTERS	1,004,771	I	1,004,7		1, 334, 771	51.00
50. 00 05000 OPERATING ROOM	2, 562, 575		2, 562, 5	75 0	2, 562, 575	50.00
51.00 05100 RECOVERY ROOM	355, 841		355, 8		355, 841	
53. 00 05300 ANESTHESI OLOGY	497, 333		497, 3		497, 333	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 668, 058		2, 668, 0		2, 668, 058	1
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	237, 489		237, 4		237, 489	
54. 02 03480 0NC0L0GY	6, 872, 965		6, 872, 9		6, 872, 965	
57. 00 05700 CT SCAN	846, 092		846, 0		846, 092	
60. 00 06000 LABORATORY	3, 729, 219		3, 729, 2		3, 729, 219	
65. 00 06500 RESPI RATORY THERAPY	916, 335				916, 335	
66. 00 06600 PHYSI CAL THERAPY	723, 556		723, 5		723, 556	66.00
67.00 06700 OCCUPATI ONAL THERAPY	133, 376	C	133, 3	76 0	133, 376	67.00
68.00 06800 SPEECH PATHOLOGY	43,049	C C	43, 0	19 0	43, 049	68.00
69.00 06900 ELECTROCARDI OLOGY	202, 609		202, 6	0 0	202, 609	69.00
69. 01 06901 CARDI AC REHAB	598, 321		598, 3	21 0	598, 321	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	550, 936		550, 9	36 0	550, 936	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 785, 819		1, 785, 8	19 0	1, 785, 819	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	2, 596, 700		2, 596, 7		2, 596, 700	
88.01 08801 RURAL HEALTH CLINIC II	2, 739, 123		2, 739, 1		2, 739, 123	
88.02 08802 RURAL HEALTH CLINIC III	2, 707, 760		2, 707, 7		2, 707, 760	
90. 00 09000 CLI NI C	7, 531		7, 5		7, 531	
90. 01 09001 RHEUMATOLOGY	395, 006		395, 0		395, 006	1
91. 00 09100 EMERGENCY	4, 533, 094		4, 533, 0		4, 533, 094	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 196, 842		1, 196, 8		1, 196, 842	
200.00 Subtotal (see instructions)	42, 212, 239				42, 212, 239	
201.00 Less Observation Beds	1, 196, 842		1, 196, 8		1, 196, 842	
202.00 Total (see instructions)	41, 015, 397	[C	41, 015, 3	97 0	41, 015, 397	202.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/31/2023 8:4	pared: 1 am
		Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	2, 611, 202		2, 611, 20)2		30.00
31.00 03100 INTENSIVE CARE UNIT	627, 573		627, 5	73		31.00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	316, 968	3, 855, 321	4, 172, 28	0. 614189	0.000000	50.00
51.00 05100 RECOVERY ROOM	51, 364	509, 599	560, 90	0. 634340	0. 000000	51.00
53. 00 05300 ANESTHESI OLOGY	19, 593	445, 322	464, 9	1. 069729	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	730, 225	8, 361, 198	9, 091, 42	0. 293470	0. 000000	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	20, 712	1, 334, 092	1, 354, 80	0. 175294	0. 000000	54.01
54. 02 03480 ONCOLOGY	8, 216	10, 948, 545	10, 956, 70	0. 627281	0. 000000	54.02
57.00 05700 CT SCAN	501, 571	13, 875, 294	14, 376, 80	0. 058851	0. 000000	57.00
60. 00 06000 LABORATORY	1, 452, 578	15, 478, 212	16, 930, 79	0. 220263	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 191, 475	838, 181	2, 029, 65	0. 451473	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	370, 746	2, 246, 545	2, 617, 29	0. 276452	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	171, 208	382, 408	553, 6	0. 240918	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	26, 789	139, 905	166, 69	0. 258252	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	25, 546	813, 640	839, 18	0. 241435	0. 000000	69.00
69. 01 06901 CARDI AC REHAB	0	1, 071, 179	1, 071, 1	0. 558563	0. 000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0.000000	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	208, 354	331, 597	539, 9	1. 020344	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 019, 698	2, 145, 612	3, 165, 3 ⁻	0. 564185	0. 000000	73.00
OUTPATIENT SERVICE COST CENTERS	· · ·					
88.00 08800 RURAL HEALTH CLINIC	0	2, 231, 878	2, 231, 8	1. 163460	0.00000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	2, 406, 213	2, 406, 2	1. 138354	0. 000000	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	2, 138, 876	2, 138, 8	1. 265973	0. 000000	88. 02
90. 00 09000 CLINIC	0	6, 517	6, 5	1. 155593	0. 000000	90.00
90. 01 09001 RHEUMATOLOGY	0	319, 969	319, 90	59 1. 234513	0. 000000	90.01
91.00 09100 EMERGENCY	274, 805	19, 748, 806	20, 023, 6 ⁻	0. 226387	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	62,010	1, 407, 239	1, 469, 24	0. 814594	0. 000000	92.00
200.00 Subtotal (see instructions)	9, 690, 633	91, 036, 148				200.00
201.00 Less Observation Beds		· ·				201.00
202.00 Total (see instructions)	9, 690, 633	91, 036, 148	100, 726, 78	31		202.00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL	In Lie	」 of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Prepared: 5/31/2023 8:41 am
		Title XIX	Hospi tal	Cost
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
ANCI LLARY SERVI CE COST CENTERS	· · ·			
50.00 05000 OPERATI NG ROOM	0. 000000			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
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
60. 00 06000 LABORATORY	0. 000000			60.00
65. 00 06500 RESPI RATORY 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			69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0. 000000			88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000			88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000			88. 02
90. 00 09000 CLINIC	0. 000000			90.00
90. 01 09001 RHEUMATOLOGY	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022	5/31/2023 8:4	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	212, 260	4, 172, 289	0. 05087	4 167, 077	8, 500	50.00
51.00 05100 RECOVERY ROOM	49, 488	560, 963	0. 08822	20 25, 188	2, 222	51.00
53.00 05300 ANESTHESI OLOGY	3, 408	464, 915	0.00733	30 11, 150	82	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	81, 767	9, 091, 423	0.00899	373, 749	3, 361	54.00
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	4, 133	1, 354, 804	0.00305	51 18, 106	55	54.01
54. 02 03480 ONCOLOGY	137, 737	10, 956, 761	0.01257	968	12	54.02
57.00 05700 CT SCAN	32, 146	14, 376, 865	0.00223	192, 606	431	57.00
60. 00 06000 LABORATORY	75, 116	16, 930, 790	0.00443	725, 150	3, 217	60.00
65. 00 06500 RESPI RATORY THERAPY	20, 650	2, 029, 656	0. 01017	563, 448	5, 733	65.00
66. 00 06600 PHYSI CAL THERAPY	39, 024	2, 617, 291	0. 0149	0 168, 029	2, 505	66.00
67.00 06700 OCCUPATI ONAL THERAPY	718	553, 616	0.00129	77, 700	101	67.00
68.00 06800 SPEECH PATHOLOGY	232	166, 694	0.00139	14,655	20	68.00
69.00 06900 ELECTROCARDI OLOGY	3, 384	839, 186	0.00403	13, 345	54	69.00
69. 01 06901 CARDI AC REHAB	65, 596	1, 071, 179	0.06123	37 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	2,966	539, 951	0.00549	78, 366	430	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	28, 853	3, 165, 310	0.00911	5 516,088	4, 704	73.00
OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·				· · · ·	
88.00 08800 RURAL HEALTH CLINIC	125, 286	2, 231, 878	0.05613	35 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	146, 911	2, 406, 213	0.06105	5 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	146, 739				0	88. 02
90. 00 09000 CLINIC	3, 331				0	90,00
90. 01 09001 RHEUMATOLOGY	12,674				0	90.01
91. 00 09100 EMERGENCY	184, 602				158	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	81, 899		1			92.00
200.00 Total (lines 50 through 199)	1, 458, 920			2, 964, 941		

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In I	_ieu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 01/01/20 To 12/31/20		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Heal	th Allied Health	
	Anesthetist	Program	Program	Post-Stepdo		
	Cost	Post-Stepdown		Adj ustment	S	
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	i		r			
50.00 05000 OPERATI NG ROOM	0	0		0	0 0	
51.00 05100 RECOVERY ROOM	0	0		0	0 0	
53. 00 05300 ANESTHESI OLOGY	0	0		0	0 0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0 0	
54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0	0 0	
54. 02 03480 ONCOLOGY	0	0		0	0 0	54.02
57.00 05700 CT SCAN	0	0		0	0 0	57.00
60. 00 06000 LABORATORY	0	0		0	0 0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0 0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0 0	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	0	0		0	0 0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0	0 0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	0 0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0 0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0 0	73.00
OUTPATIENT SERVICE COST CENTERS			_			
88.00 08800 RURAL HEALTH CLINIC	0	0		0	0 0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0	0 0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0	0		0	0 0	88.02
90. 00 09000 CLINIC	0	0		0	0 0	90.00
90. 01 09001 RHEUMATOLOGY	0	0		0	0 0	90.01
91.00 09100 EMERGENCY	0	0		0	0 0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	0		0	0 0	200.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2022 To 12/31/2022		nared
					5/31/2023 8:4	1 am
	-		XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
	4.00	5.00	6.00	7.00	instructions) 8.00	
ANCI LLARY SERVI CE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
50. 00 05000 OPERATING ROOM	0	0		0 4, 172, 289	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	-		0 560, 963		51.00
53. 00 05300 ANESTHESI OLOGY	0			0 464, 915		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 9, 091, 423		
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 1, 354, 804		
54. 02 03480 ONCOLOGY	0	0		0 10, 956, 761		
57. 00 05700 CT SCAN	0	0		0 14, 376, 865		
60. 00 06000 LABORATORY	0	0		0 16, 930, 790		
65. 00 06500 RESPIRATORY THERAPY	0	0		0 2, 029, 656		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 617, 291		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 553, 616		
68.00 06800 SPEECH PATHOLOGY	0	0		0 166, 694		68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 839, 186	0.000000	69.00
69. 01 06901 CARDI AC REHAB	0	0)	0 1, 071, 179	0. 000000	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0 0	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0 539, 951	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 3, 165, 310	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS	T	1			1	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 2, 231, 878		
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 2, 406, 213		
88.02 08802 RURAL HEALTH CLINIC III	0	0		0 2, 138, 876		
90. 00 09000 CLI NI C	0	0		0 6, 517		
90. 01 09001 RHEUMATOLOGY	0	0		0 319, 969		
91.00 09100 EMERGENCY	0	0		0 20, 023, 611		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	1	0 1, 469, 249		
200.00 Total (lines 50 through 199)	0	0	1	0 97, 488, 006	I	200. 00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-1333	Period: From 01/01/2022	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2022	Date/Time Pre	
					5/31/2023 8:4	1 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col. 10)	12.00	x col. 12)	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0. 000000	167, 077		0 0	0	50,00
51. 00 05100 RECOVERY ROOM	0. 000000			-	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	25, 188		0 0	-	51.00
		11, 150		0 0	0	53.00
	0.000000	373, 749		0 0	0	54.00 54.01
54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0.000000	18, 106		0 0	0	
54. 02 03480 ONCOLOGY	0.000000	968		0 0	0	54.02
57.00 05700 CT SCAN	0.000000	192, 606		0 0	0	57.00
	0.000000	725, 150		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0.000000	563, 448		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	168, 029		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0.000000	77, 700		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	14, 655		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	13, 345		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0.00000	0		0 0	0	69.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0.000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	78, 366		0 0	0	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 000000	516, 088		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	0.00000					
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000	0		0 0	0	88.01
88. 02 08802 RURAL HEALTH CLINIC III	0.000000	0		0 0	0	88.02
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 09001 RHEUMATOLOGY	0.000000	0		0 0	0	90.01
91.00 09100 EMERGENCY	0.000000	17, 096		0 0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 000000	2, 220		0 0	0	92.00
200.00 Total (lines 50 through 199)		2, 964, 941	I	0 0	0	200. 00

Health Financial Systems	PUTNAM COUNT			In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/31/2023 8:4	
		Title	xVIII	Hospi tal	Cost	
			Charges	noopr tui	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	. ,	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 614189		, , , , , ,		0	50.00
51.00 05100 RECOVERY ROOM	0. 634340		83, 01		0	51.00
53. 00 05300 ANESTHESI OLOGY	1.069729		69, 63		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 293470		1, 689, 19		0	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 175294	0	457, 32		0	54.01
54. 02 03480 ONCOLOGY	0. 627281	0	5, 236, 41		0	54.02
57. 00 05700 CT SCAN	0. 058851	0	3, 359, 89		0	57.00
	0. 220263		4, 330, 30		0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 451473		163, 62		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 276452		603, 28		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0. 240918 0. 258252		88, 42		0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 258252		20, 99		0	69.00
69. 01 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0. 241435		207, 42 302, 85		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1. 020344		114, 22		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 564185		498, 73		-	73.00
OUTPATIENT SERVICE COST CENTERS	0. 304103	0	470,73	5 10	0	75.00
88. 00 08800 RURAL HEALTH CLINIC						88.00
88. 01 08801 RURAL HEALTH CLINIC II						88.01
88. 02 08802 RURAL HEALTH CLINIC III						88.02
90. 00 09000 CLINIC	1. 155593	0	1, 01	7 0	0	90.00
90. 01 09001 RHEUMATOLOGY	1. 234513		.,	0 0	0	90.01
91. 00 09100 EMERGENCY	0. 226387	0	3, 518, 65	6 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.814594	0	385, 45		0	92.00
200.00 Subtotal (see instructions)		0	22, 035, 43		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	22, 035, 43	9 188	0	202.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-1333	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pr 5/31/2023 8:	epared: 41 am
		Title	e XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	555, 829					50.00
51.00 05100 RECOVERY ROOM	52, 662	0				51.00
53. 00 05300 ANESTHESI OLOGY	74, 495	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	495, 727	0				54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	80, 166	0				54.01
54. 02 03480 ONCOLOGY	3, 284, 705	109				54.02
57.00 05700 CT SCAN	197, 733	0				57.00
60. 00 06000 LABORATORY	953, 805	0				60.00
65. 00 06500 RESPI RATORY THERAPY	73, 870	0)			65.00
66. 00 06600 PHYSI CAL THERAPY	166, 778	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	21, 302	0				67.00
68.00 06800 SPEECH PATHOLOGY	5, 421	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	50, 079	0				69.00
69. 01 06901 CARDI AC REHAB	169, 162	0				69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	116, 547	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	281, 379	6				73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
88.02 08802 RURAL HEALTH CLINIC III						88. 02
90. 00 09000 CLINIC	1, 175	0				90.00
90. 01 09001 RHEUMATOLOGY	0	0				90.01
91.00 09100 EMERGENCY	796, 578	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	313, 986	0				92.00
200.00 Subtotal (see instructions)	7, 691, 399	115				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	7, 691, 399	115				202.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1333	Period: From 01/01/2022	Worksheet D-1	
			To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
	Inpatient days (including private room days and swing-bed da Inpatient days (including private room days, excluding swing			2, 226 2, 100	
	Private room days (excluding swing-bed and observation bed o		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	bed days)		1, 391	4
	Total swing-bed SNF type inpatient days (including private n		er 31 of the cost	126	
00	reporting period Total swing-bed SNF type inpatient days (including private n	room days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			-	
00	Total swing-bed NF type inpatient days (including private reporting period	oom days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	to the Program (oveluding	swing bod and	732	9
	newborn days) (see instructions)	0 1 0			
00	Swing-bed SNF type inpatient days applicable to title XVIII through December 31 of the cost reporting period (see instru		room days)	108	10
00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	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)		a room days)	0	12
	through December 31 of the cost reporting period	<u> </u>	3 .	0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or X after December 31 of the cost reporting period (if calendar			0	13
00	Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			0	
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ices through December 31 o	of the cost		17
. 00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ices after December 31 of	the cost		18
00	Medicaid rate for swing-bed NF services applicable to servic reporting period	ces through December 31 of	f the cost	250.44	19
00	Medicaid rate for swing-bed NF services applicable to service reporting period	ces after December 31 of 1	the cost	0.00	20
	Total general inpatient routine service cost (see instruction			3, 757, 639	
00	Swing-bed cost applicable to SNF type services through Decer 5 x line 17)	mber 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	er 31 of the cost reportin	ng period (line 6	0	23
00	Swing-bed cost applicable to NF type services through Decemb	ber 31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	r 21 of the cost reporting	ported (line 9	0	25
	x line 20)			0	25
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	t (ling 21 minus ling 26)		212, 697 3, 544, 942	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			3, 344, 742	2'
	General inpatient routine service charges (excluding swing-b	bed and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	7 ÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4))		0.00	
	Average per diem private room charge differential (line 32 m		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)	-	66 H H K K H	0	
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	ι and private room cost di	TTERENTIAL (LINE	3, 544, 942	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AL			1 600 07	20
	Adjusted general inpatient routine service cost per diem (se Program general inpatient routine service cost (line 9 x lin			1, 688. 07 1, 235, 667	
	Medically necessary private room cost applicable to the Prod			1, 235, 007	
	,, p				

COMPUTA	Financial Systems TION OF INPATIENT OPERATING COST	PUTNAM COUNT	Provi der C		Period: From 01/01/2022	Worksheet D-1	
					o 12/31/2022		
	Cost Center Description	Total	Ti tl e Total	XVIII Average Per	Hospital Program Days	Cost Program Cost	
			Inpatient Days	Diem (col. 1 ÷		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
2.00	NURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units						42.0
	NTENSI VE CARE UNI T	1, 554, 971	157	9, 904. 27	68	673, 490	43.0
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. C
	SURGICAL INTENSIVE CARE UNIT						45.0
7.00 0	DTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.0
	·					1.00	
	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisitio			III line 10	column 1)	1, 118, 413 0	
9.00 1	Total Program inpatient costs (sum of lines 4					3, 027, 570	
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	Wkst D sum	of Parts L and	0	50.0
1	11)						
	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry services (fr	om Wkst. D, su	m of Parts II	0	51.0
	Total Program excludable cost (sum of lines !					0	
	Fotal Program inpatient operating cost exclud medical education costs (line 49 minus line 5	5 1	erated, non-pny	sician anestne	tist, and	0	53.0
	ARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.0
	Fogram discharges Farget amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor ι Γarget amount (line 54 x sum of lines 55, 55.					0.00	
1	Difference between adjusted inpatient operati			ine 56 minus l	ine 53)	0	
	Bonus payment (see instructions)					0	
	Frended costs (lesser of line 53 ÷ line 54, or updated and compounded by the market basket)	or line 55 from	the cost repo	rting period e	ndi ng 1996,	0.00	59.
	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 fro	m prior year c	ost report, up	dated by the	0.00	60.
1.00 (5	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x	ser of 50% of t	he amount by w	hich operating	costs (İine	0	61.
	enter zero. (see instructions) Relief payment (see instructions)		-			0	62.1
3.00 4	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of the	cost reportir	g period (See	182, 312	64.
1	nstructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	ost reporting	neriod (See	0	65.
i	nstructions)(title XVIII only)						
	Fotal Medicare swing-bed SNF inpatient routin CAH, see instructions	ne costs (line	64 plus line 6	5)(title XVIII	only); for	182, 312	66.
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 o	f the cost rep	orting period	0	67.
8.00 1	(line 13 x line 20)	e costs after D	ecember 31 of	the cost repor	ting period	0	68.
9.00 1	Total title V or XIX swing-bed NF inpatient i					0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70.
	Adjusted general inpatient routine service co	5		• •			71.
	Program routine service cost (line 9 x line 3 Medically necessary private room cost applica		(lipo 14 v li	po 25)			72.
	Total Program general inpatient routine servi			THE 35)			74.
	Capital-related cost allocated to inpatient i	routine service	e costs (from Ŵ	orksheet B, Pa	rt II, column		75.
1	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.
7.00 F	Program capital-related costs (line 9 x line	76)					77.
	Inpatient routine service cost (line 74 minus	,	rouldor record				78.
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	• •		· .	is line 79)		79. 80.
1. 00 I	npatient routine service cost per diem limit	tati on			~		81.
	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (s		· .				82. 83.
	Program inpatient ancillary services (see ins		13)				83.
5.00 L	Jtilization review - physician compensation	(see instructio					85.
	Total Program inpatient operating costs (sum		rough 85)				86.
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					709	87.
8.00 A	Adjusted general inpatient routine cost per o	diem (line 27 ÷				1, 688. 07	88.
1.00 10	Observation bed cost (line 87 x line 88) (see			0221231\HFS\25		1, 196, 842	89.

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:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x 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	257, 131	3, 757, 639	0. 06842	9 1, 196, 842	81, 899	90.00
91.00 Nursing Program cost	0	3, 757, 639	0.00000	0 1, 196, 842	0	91.00
92.00 Allied health cost	0	3, 757, 639	0.00000	0 1, 196, 842	0	92.00
93.00 All other Medical Education	0	3, 757, 639	0. 00000	0 1, 196, 842	0	93.00

INI 00 In 00 In 00 In 00 Pr 00 To 00 Sw 00 Sw 00 Sw 00 Sw 00 Sw 00 Me 00 Sw 00 Ne 00 Ne 00 Ne 00 Ne 00 Sw 00 Sw 00 Sw 00 Sw <th>Cost Center Description RT I - ALL PROVIDER COMPONENTS PATIENT DAYS patient days (including private room days, rivate room days (excluding swing-bed and o o not complete this line. emi-private room days (excluding swing-bed and o o not complete this line. emi-private room days (excluding swing-bed otal swing-bed SNF type inpatient days (incl eporting period otal swing-bed SNF type inpatient days (incl eporting period otal swing-bed NF type inpatient days (incl eporting period otal swing-bed NF type inpatient days (incl eporting period otal swing-bed NF type inpatient days (incl eporting period (if calendar year, enter 0 otal inpatient days including private room ewborn days) (see instructions) wing-bed SNF type inpatient days applicable erough December 31 of the cost reporting period ot frough December 31 of the cost reporting period ot frough December 31 of the cost reporting period ot al nursery days (title V or XIX only) ING BED ADJUSTMENT exporting period</th> <th>excluding swing-be- bservation bed days and observation bed luding private room on this line) uding private room of uding private room of uding private room of on this line) days applicable to to title XVIII only riod (see instruction to title XVIII only calendar year, enti- to titles V or XIX of (if calendar yea able to the Program</th> <th>ed and newborn days; s). If you have only i days) i days) through Decen days) after December days) after December the Program (excluding y (including private ons) y (including private er 0 on this line) only (including private only (including private only (including private only (including private only (including private) only (including private) only (including private)</th> <th>Hospital Hospital Private room days, mber 31 of the cost er 31 of the cost ber 31 of the cost ing swing-bed and e room days) e room days) after vate room days) vate room days)</th> <th>Date/Time Prep 5/31/2023 8: 41 Cost 1.00 2,226 2,100 0 1,391 126 0 0 0 0 0 0 0 0 0 0 0 0 0</th>	Cost Center Description RT I - ALL PROVIDER COMPONENTS PATIENT DAYS patient days (including private room days, rivate room days (excluding swing-bed and o o not complete this line. emi-private room days (excluding swing-bed and o o not complete this line. emi-private room days (excluding swing-bed otal swing-bed SNF type inpatient days (incl eporting period otal swing-bed SNF type inpatient days (incl eporting period otal swing-bed NF type inpatient days (incl eporting period otal swing-bed NF type inpatient days (incl eporting period otal swing-bed NF type inpatient days (incl eporting period (if calendar year, enter 0 otal inpatient days including private room ewborn days) (see instructions) wing-bed SNF type inpatient days applicable erough December 31 of the cost reporting period ot frough December 31 of the cost reporting period ot frough December 31 of the cost reporting period ot al nursery days (title V or XIX only) ING BED ADJUSTMENT exporting period	excluding swing-be- bservation bed days and observation bed luding private room on this line) uding private room of uding private room of uding private room of on this line) days applicable to to title XVIII only riod (see instruction to title XVIII only calendar year, enti- to titles V or XIX of (if calendar yea able to the Program	ed and newborn days; s). If you have only i days) i days) through Decen days) after December days) after December the Program (excluding y (including private ons) y (including private er 0 on this line) only (including private only (including private only (including private only (including private only (including private) only (including private) only (including private)	Hospital Hospital Private room days, mber 31 of the cost er 31 of the cost ber 31 of the cost ing swing-bed and e room days) e room days) after vate room days) vate room days)	Date/Time Prep 5/31/2023 8: 41 Cost 1.00 2,226 2,100 0 1,391 126 0 0 0 0 0 0 0 0 0 0 0 0 0
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D0 To D0 To D0 To D0 To D0 To D0 To D0 To D0 To D0 To D0 To D0 To 00 Sw 00 Sw 00 Me 00 Me 00 Me 00 Sw 00 <	otal swing-bed SNF type inpatient days (inc sporting period (if calendar year, enter 0 btal swing-bed NF type inpatient days (incl sporting period that swing-bed NF type inpatient days (incl eporting period (if calendar year, enter 0 btal inpatient days including private room ewborn days) (see instructions) wing-bed SNF type inpatient days applicable prough December 31 of the cost reporting period (if wing-bed SNF type inpatient days applicable prough December 31 of the cost reporting period (if wing-bed SNF type inpatient days applicable prough December 31 of the cost reporting period (if wing-bed NF type inpatient days applicable prough December 31 of the cost reporting period ing-bed NF type inpatient days applicable for December 31 of the cost reporting period ing-bed NF type inpatient days applicable for December 31 of the cost reporting period ing-bed NF type inpatient days applicable for December 31 of the cost reporting period ing-bed VF type inpatient days applicable for December 31 of the cost reporting period dial nursery days (title V or XIX only) <u>ING BED ADJUSTMENT</u>	on this line) uding private room on this line) days applicable to to title XVIII only riod (see instructi to title XVIII only calendar year, enti to titles V or XIX riod to titles V or XIX od (if calendar yea able to the Program	days) through December days) after December the Program (excludi y (including private ons) y (including private only (including private only (including private only (including private only (including private	ber 31 of the cost ing swing-bed and e room days) e room days) after vate room days) vate room days)	0 0 52 0 0 0 0 0 0 0
D0 To D0 re D0 re D0 To D0 To D0 To D0 To D0 To D0 Sw 00 Sw 00 Sw 00 Me 00 Me 00 Me 00 Me 00 Sw	A porting period NF type inpatient days (incleporting period tal swing-bed NF type inpatient days (incleporting period (if calendar year, enter 0 tal inpatient days including private room swborn days) (see instructions) wing-bed SNF type inpatient days applicable prough December 31 of the cost reporting period (if wing-bed NF type inpatient days applicable becember 31 of the cost reporting period (if wing-bed NF type inpatient days applicable prough December 31 of the cost reporting period (if wing-bed NF type inpatient days applicable becember 31 of the cost reporting period (if wing-bed NF type inpatient days applicable becember 31 of the cost reporting period (if use-bed NF type inpatient days applicable cost applicable of the cost reporting period (if use-bed NF type inpatient days applicable to tal nursery days (title V or XIX only) ursery days (title V or XIX only) ING BED ADJUSTMENT	uding private room on this line) days applicable to to title XVIII only riod (see instruction calendar year, enty to titles V or XIX riod to titles V or XIX od (if calendar yea able to the Program	days) after December the Program (excludi y (including privata ons) y (including privata er 0 on this line) only (including priv only (including priv ar, enter 0 on this l	r 31 of the cost ing swing-bed and e room days) e room days) after vate room days) vate room days)	0 52 0 0 0 0 0 0 0
DO To DO To DO Ne DO Sw DO Me DO Me DO Me DO Me DO Me DO Sw	otal swing-bed NF type inpatient days (incleporting period (if calendar year, enter 0 otal inpatient days including private room ewborn days) (see instructions) ving-bed SNF type inpatient days applicable brough December 31 of the cost reporting period (if exember 31 of the cost reporting period (if wing-bed NF type inpatient days applicable brough December 31 of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost reporting period) applicable of the cost reporting period (if the cost cost cost) applicable of the cost reporting period (if the cost) of the cost cost) applicable of the cost cost (if the cost) applicable of the cost cost) applicable of the cost cost (if the cost) applicable of the cost (if the cost) applicable of the cost (if the cost) applicable of the cost) applicable of the cost (if the cost) applicable of the cost) applicable of the cost (if the cost) applicable of the cost) applicable of the cost (if the cost) applicable of the cost) applicable of the cost (if the cost) applicable of the cost) applicable of the cost) applicable of the cost (if the cost) applicable of the cost	on this line) days applicable to to title XVIII only riod (see instruction to title XVIII only calendar year, enti to titles V or XIX riod to titles V or XIX od (if calendar yea able to the Program	the Program (excluding y (including private ons) y (including private er 0 on this line) only (including priv only (including priv or, enter 0 on this l	ing swing-bed and e room days) e room days) after vate room days) vate room days) line)	52 0 0 0 0 0 0 0
DO To 00 Ne 00 Sw 00 Me 00 Me 00 Me 00 Me 00 Sw 00 Me 00 Sw	otal inpatient days including private room ewborn days) (see instructions) wing-bed SNF type inpatient days applicable brough December 31 of the cost reporting pe wing-bed SNF type inpatient days applicable ecember 31 of the cost reporting period (if wing-bed NF type inpatient days applicable brough December 31 of the cost reporting pe wing-bed NF type inpatient days applicable free December 31 of the cost reporting period dically necessary private room days applic tal nursery days (title V or XIX only) <u>UNG BED ADJUSTMENT</u>	days applicable to to title XVIII only riod (see instruction to title XVIII only calendar year, entr to titles V or XIX riod to titles V or XIX od (if calendar yea able to the Program	y (including private ons) y (including private er 0 on this line) only (including priv only (including priv only (including priv	e room days) e room days) after vate room days) vate room days) line)	
.00 Sw th .00 Sw De .00 Sw th .00 Sw af .00 Sw af .00 Sw af .00 Sw af .00 Me .00 SW .00 Me .00 Me .00 Sw .00 S	wing-bed SNF type inpatient days applicable prough December 31 of the cost reporting pe wing-bed SNF type inpatient days applicable accember 31 of the cost reporting period (if wing-bed NF type inpatient days applicable prough December 31 of the cost reporting pe wing-bed NF type inpatient days applicable ter December 31 of the cost reporting period cally necessary private room days applic betal nursery days (title V or XIX only) <u>ING BED ADJUSTMENT</u> edicare rate for swing-bed SNF services app	riod (see instruction to title XVIII only calendar year, entr to titles V or XIX riod to titles V or XIX od (if calendar yea able to the Program	ons) y (including private er 0 on this line) only (including priv only (including priv ar, enter 0 on this l	e room days) after vate room days) vate room days) line)	0 0 0 0 0
00 Sw 00 Sw 00 Sw 00 Sw 00 Me 00 Me 00 Me 00 Me 00 Me 00 Me 00 Sw	wing-bed SNF type inpatient days applicable eccember 31 of the cost reporting period (if wing-bed NF type inpatient days applicable nrough December 31 of the cost reporting pe wing-bed NF type inpatient days applicable fter December 31 of the cost reporting peri edically necessary private room days applic total nursery days (title V or XIX only) ursery days (title V or XIX only) <u>TING BED ADJUSTMENT</u> edicare rate for swing-bed SNF services app	to title XVIII only calendar year, entr to titles V or XIX riod to titles V or XIX od (if calendar yea able to the Program	y (including private er 0 on this line) only (including priv only (including priv only (including priv ar, enter 0 on this l	vate room days) vate room days) line)	0 0 0 0
00 Sw th 00 Sw af 00 Me 00 Nu 00 Me 00 Me 00 Me 00 Me 00 Me 00 Me 00 Sw	wing-bed NF type inpatient days applicable brough December 31 of the cost reporting pe wing-bed NF type inpatient days applicable fter December 31 of the cost reporting peri edically necessary private room days applic total nursery days (title V or XIX only) ursery days (title V or XIX only) ING BED ADJUSTMENT edicare rate for swing-bed SNF services app	to titles V or XIX riod to titles V or XIX od (if calendar yea able to the Program	only (including priv only (including priv ar, enter 0 on this	vate room days) line)	0 0 0
.00 Sw af .00 Me .00 To .00 Nu .00 Nu .00 Me .00 Sw	ving-bed NF type inpatient days applicable Fter December 31 of the cost reporting peri adically necessary private room days applic btal nursery days (title V or XIX only) ursery days (title V or XIX only) ING BED ADJUSTMENT edicare rate for swing-bed SNF services app	to titles V or XIX od (if calendar yea able to the Program	nr, enter 0 on this I	line)	0
00 Me 00 To 00 Nu 00 Me 00 Me 00 Me 00 Me 00 Sw	edically necessary private room days applic otal nursery days (title V or XIX only) ursery days (title V or XIX only) 'ING BED ADJUSTMENT edicare rate for swing-bed SNF services app	ablè to the Program			0
Nu SW 00 Me 00 Me 00 Me 00 Me 00 Me 00 S 00 S 00 Sw	ursery days (title V or XIX only) TING BED ADJUSTMENT edicare rate for swing-bed SNF services app	licable to services			-
.00 Me re .00 Me re .00 Me re .00 Me re .00 Me re .00 Sw 5 .00 Sw 7 .00 Sw 7 .00 Sw 7 .00 Sw 7 .00 Sw 7	edicare rate for swing-bed SNF services app	licable to services			0
. 00 Me re. . 00 Me re. . 00 Me re. . 00 To . 00 Sw 5 . 00 Sw 7 . 00 Sw 7 . 00 Sw 7 . 00 Sw	0		s through December 3	1 of the cost	
.00 Me .00 Me .00 Me .00 To .00 Sw	edicare rate for swing-bed SNF services app	licable to services	0		
00 re 00 Me re 00 To 00 Sw 5 00 Sw 7 00 Sw 7 00 Sw x 00 To	eporting period edicaid rate for swing-bed NF services appl	icable to services	through December 31	of the cost	250.44
. 00 To . 00 Sw 5 . 00 Sw . 00 Sw 7 . 00 Sw 7 . 00 Sw X . 00 To	eporting period		-		0.00
. 00 Sw 5 . 00 Sw X . 00 Sw 7 . 00 Sw X . 00 To	eporting period tal general inpatient routine service cost				3, 757, 639
. 00 Sw x . 00 Sw 7 . 00 Sw x . 00 To	ving-bed cost applicable to SNF type servic x line 17)			orting period (line	0
. 00 Sw 7 . 00 Sw x . 00 To	ving-bed cost applicable to SNF type servic line 18)	es after December 3	1 of the cost repor	ting period (line 6	0
. 00 Sw x . 00 To	ving-bed cost applicable to NF type service x line 19)	s through December	31 of the cost repo	rting period (line	0
00 To	ving-bed cost applicable to NF type service	s after December 31	of the cost report	ing period (line 8	0
00 160	line 20) otal swing-bed cost (see instructions)				212, 697
PR	eneral inpatient routine service cost net o IVATE ROOM DIFFERENTIAL ADJUSTMENT				3, 544, 942
	eneral inpatient routine service charges (e rivate room charges (excluding swing-bed ch		and observation bed	charges)	0
	emi-private room charges (excluding swing-bed ch				0
	eneral inpatient routine service cost/charg	0,	line 28)		0.000000
	verage private room per diem charge (line 2				0.00
	verage semi-private room per diem charge (l	,			0.00
	/erage per diem private room charge differe			ructions)	0.00
	• • • •	ial (line 34 x line	9 31)		0.00
	verage per diem private room cost different				0 3, 544, 942
27	rivate room cost differential adjustment (l	ine 3 x line 35)	nd private room cost	differential (line	0,077,/421
	rivate room cost differential adjustment (l eneral inpatient routine service cost net o 7 minus line 36)	ine 3 x line 35)	nd private room cost	differential (line	
	rivate room cost differential adjustment (l eneral inpatient routine service cost net o	ine 3 x line 35) f swing-bed cost an	•	differential (line	
	rivate room cost differential adjustment (I eneral inpatient routine service cost net o 7 minus line 36) RT II - HOSPITAL AND SUBPROVIDERS ONLY	ine 3 x line 35) f swing-bed cost and THROUGH COST ADJUS	TMENTS	differential (line	1, 688. 07
.00 Me	rivate room cost differential adjustment (I eneral inpatient routine service cost net o 7 minus line 36) RT II - HOSPITAL AND SUBPROVIDERS ONLY OGRAM INPATIENT OPERATING COST BEFORE PASS	ine 3 x line 35) f swing-bed cost and THROUGH COST ADJUST ost per diem (see i	TMENTS nstructi ons)	differential (line	

COMPUTA	Financial Systems TION OF INPATIENT OPERATING COST	PUTNAM COUNT	Provider C		Peri od:	worksheet D-1	
					From 01/01/2022 To 12/31/2022		
	Cost Center Description	Total	Ti tl Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4.00	4) 5.00	
	NURSERY (title V & XIX only) ntensive Care Type Inpatient Hospital Units						42.00
	INTENSIVE CARE UNIT	1, 554, 971	157	9, 904. 2	7 0	0	43.00
							44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00
47.00 0	OTHER SPECIAL CARE (SPECIFY)			1			47.00
	Cost Center Description					1.00	
	Program inpatient ancillary service cost (Wks Program inpatient cellular therapy acquisitio			III lino 10	column 1)	81, 754 0	
	Total Program inpatient costs (sum of lines 4					169, 534	
	PASS THROUGH COST ADJUSTMENTS	ationt routing	aamulaaa (fram	What D aum	of Dorto I and		
	Pass through costs applicable to Program inpa)	atient routine	services (Trom	WKST. D, SUM	or Parts I and	0	50.00
	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	0	51.00
52.00 1	Fotal Program excludable cost (sum of lines !					0	
	Fotal Program inpatient operating cost exclue medical education costs (line 49 minus line !		lated, non-phy	sician anesth	etist, and	0	53.00
Т	ARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program discharges Farget amount per discharge					0.00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor u					0.00	
	Farget amount (line 54 x sum of lines 55, 55.		raat amount (1	ino E4 minuc	line E2)	0	
1	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and ta	rget amount (i	The so minus	TThe 53)		
59.00 1	Frended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost repo	rting period	endi ng 1996,	0.00	
	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior vear c	ost report. u	pdated by the	0.00	60.00
61.00 0	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less	e 53 ÷ line 54	is less than t	he lowest of	lines 55 plus	0	61.00
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % of	the target am	ount (line 56), otherwise		
62.00 F	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)			0	63.00
	Medicare swing-bed SNF inpatient routine cos nstructions)(title XVIII only)	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64.00
65.00 N	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65.00
	nstructions)(title XVIII only) Fotal Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only); for	0	66.00
	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	f the cost re	porting period	0	67.00
((line 12 x line 19)	0					
(Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 01	the cost repo	rting period	0	
	Fotal title V or XIX swing-bed NF inpatient n PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
	Skilled nursing facility/other nursing facili		•				70.00
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.0
	Program routine service cost (line 9 x line Medically necessary private room cost applica		(line 14 v li	no 35)			72.00
	Total Program general inpatient routine servi	0	•				74.0
	Capital-related cost allocated to inpatient (routine service	costs (from W	orksheet B, P	art II, column		75.0
	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.0
77.00 F	Program capital-related costs (line 9 x line						77.0
	Inpatient routine service cost (line 74 minus			- >			78.0
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	• •		· · · ·	us line 79)		79.0
	Inpatient routine service cost per diem limi				,		81.0
	Inpatient routine service cost limitation (li						82.0
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		S)				83. 0 84. 0
	Jtilization review - physician compensation		ns)				85.00
86.00 1	Total Program inpatient operating costs (sum	of lines 83 th					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS					709	07.0
	Fotal observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			1, 688. 07	
	Observation bed cost (line 87 x line 88) (see	•				1, 196, 842	

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:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x 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	257, 131	3, 757, 639	0. 06842	9 1, 196, 842	81, 899	90.00
91.00 Nursing Program cost	0	3, 757, 639	0.00000	0 1, 196, 842	0	91.00
92.00 Allied health cost	0	3, 757, 639	0.00000	0 1, 196, 842	0	92.00
93.00 All other Medical Education	0	3, 757, 639	0. 00000	0 1, 196, 842	0	93.00

Heal th Financial Systems PUTNAM COUNTY				eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1333	Period: From 01/01/2022	Worksheet D-3	5
			To 12/31/2022		epared:
			10 12/01/2022	5/31/2023 8:4	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			1, 302, 460	1	30.00
31. 00 03100 INTENSI VE CARE UNI T			287, 185		30.00
ANCI LLARY SERVICE COST CENTERS			207, 103		31.00
50. 00 05000 OPERATI NG ROOM		0.6141	89 167, 077	102, 617	50.00
51. 00 05100 RECOVERY ROOM		0.6343			
53. 00 05300 ANESTHESI OLOGY		1. 0697			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2934			
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 1752			
54. 02 03480 ONCOLOGY		0. 6272			
57. 00 05700 CT SCAN		0. 0588			
60. 00 06000 LABORATORY		0. 2202			
65. 00 06500 RESPI RATORY THERAPY		0. 4514			
66. 00 06600 PHYSI CAL THERAPY		0. 2764	52 168, 029		
67.00 06700 OCCUPATI ONAL THERAPY		0.2409	18 77, 700	18, 719	67.00
68.00 06800 SPEECH PATHOLOGY		0. 2582	52 14, 655	3, 785	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 2414	35 13, 345	3, 222	69.00
69. 01 06901 CARDI AC REHAB		0. 5585	63 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0000	0 00	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1.0203	44 78, 366	79, 960	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 5641	85 516, 088	291, 169	73.00
OUTPATIENT SERVICE COST CENTERS				1	
88.00 08800 RURAL HEALTH CLINIC		0.0000		0	
88.01 08801 RURAL HEALTH CLINIC II		0.0000		0	
88.02 08802 RURAL HEALTH CLINIC III		0.0000		0	
90. 00 09000 CLINIC		1. 1555		-	
90. 01 09001 RHEUMATOLOGY		1. 2345		0	
91. 00 09100 EMERGENCY		0. 2263			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.8145			92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			2, 964, 941		
201.00 Less PBP Clinic Laboratory Services-Program only charg	jes (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)		1	2, 964, 941		202.00

Health Financial Systems PL	JTNAM COUNTY HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	Worksheet D-3	
	6		From 01/01/2022		
	Component	CCN: 15-Z333	To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
	Title	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
		-	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					00.00
30. 00 03000 ADULTS & PEDIATRICS					30.00 31.00
31. 00 03100 I NTENSI VE CARE UNI T ANCI LLARY SERVI CE COST CENTERS					31.00
50. 00 05000 OPERATI NG ROOM		0. 61418	9 916	563	50.00
51. 00 05100 RECOVERY ROOM		0. 63434			
53. 00 05300 ANESTHESI OLOGY		1. 06972		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 29347		-	
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 17529			
54. 02 03480 0NC0L0GY		0. 62728			•
57. 00 05700 CT SCAN		0. 05885		111	
60. 00 06000 LABORATORY		0. 22026			•
65. 00 06500 RESPI RATORY THERAPY		0. 45147	3 55, 439	25, 029	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 27645	2 52, 919	14, 630	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 24091	8 27, 986	6, 742	67.00
68.00 06800 SPEECH PATHOLOGY		0. 25825	2 401	104	
69. 00 06900 ELECTROCARDI OLOGY		0. 24143		0	
69. 01 06901 CARDI AC REHAB		0. 55856		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.00000		0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		1. 02034		0	
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 56418	5 23, 475	13, 244	73.00
OUTPATIENT SERVICE COST CENTERS		0.0000			
88.00 08800 RURAL HEALTH CLINIC		0.00000		0	
88.01 08801 RURAL HEALTH CLINIC II		0.00000		0	
88. 02 08802 RURAL HEALTH CLINIC III 90. 00 09000 CLINIC		0.00000		0	
90. 00 109000 CET NTC 90. 01 109001 RHEUMATOLOGY		1. 15559		0	
90. 01 09001 RHE0MATOLOGT 91. 00 09100 EMERGENCY		0. 22638		-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 22030		0	
200.00 Total (sum of lines 50 through 94 and 96 th	rough 98)	0.01435	190, 418	-	200.00
201.00 Less PBP Clinic Laboratory Services-Program			0	000	201.00
202.00 Net charges (line 200 minus line 201)			190, 418		202.00
		i.		1	

Health Financial Systems PUTNAM COUNT			In Lie	u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1333	Peri od:	Worksheet D-3	
			From 01/01/2022 To 12/31/2022		narod
			10 12/31/2022	5/31/2023 8:4	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
	-	1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS			89, 775	[30.00
31. 00 03100 INTENSI VE CARE UNI T			89,775		30.00
ANCI LLARY SERVICE COST CENTERS			0		31.00
50. 00 05000 OPERATING ROOM		0. 6141	8, 523	5, 235	50.00
51. 00 05100 RECOVERY ROOM		0.6343			
53. 00 05300 ANESTHESI OLOGY		1. 0697			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2934			
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 1752			1
54. 02 03480 ONCOLOGY		0. 6272		0	
57.00 05700 CT SCAN		0. 0588	51 26, 397	1, 553	57.00
60. 00 06000 LABORATORY		0. 2202	63 43, 735	9, 633	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 4514	73 32, 723	14, 774	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 2764	52 3, 442	952	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 2409		327	
68. 00 06800 SPEECH PATHOLOGY		0. 2582		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 2414			
69. 01 06901 CARDI AC REHAB		0. 5585		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0.0000		0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		1. 0203			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 5641	35 29, 355	16, 562	73.00
OUTPATIENT SERVICE COST CENTERS		1 1 1 1 1 1			
88.00 08800 RURAL HEALTH CLINIC		1. 1634			
88. 01 08801 RURAL HEALTH CLINIC II		1.1383		-	
88. 02 08802 RURAL HEALTH CLINIC III 90. 00 09000 CLINIC		1.2659		0	
90. 00 109000 CLINIC 90. 01 09001 RHEUMATOLOGY		1. 1555 1. 2345			
90. 01 09001 RHE0MAT0L0GY 91. 00 09100 EMERGENCY		0. 2263		-	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART		0. 2203			
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.0145	223, 313		200.00
201.00 Less PBP Clinic Laboratory Services-Program only char	mes (line 61)		223, 313		201.00
202.00 Net charges (line 200 minus line 201)	900 (IIII0 01)		223, 313		202.00
		1	220,010	I	

CUL	Financial Systems PUTNAM COUNTY H ITION OF REIMBURSEMENT SETTLEMENT	IOSPI TAL Provi der CCN: 15-1333	Peri od:	u of Form CMS-2 Worksheet E	2002-
001			From 01/01/2022	Part B	narod
			To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		7, 691, 514 0	
0	OPPS payments	li ons)		0	
0	Outlier payment (see instructions)			0	
1	Outlier reconciliation amount (see instructions)			0	
	Enter the hospital specific payment to cost ratio (see instruc Line 2 times line 5	ctions)		0.000	
	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
0	Transitional corridor payment (see instructions)			0	-
	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		0	
	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 7, 691, 514	10. 11.
	COMPUTATION OF LESSER OF COST OR CHARGES			7,071,011	
	Reasonabl e charges				
	Ancillary service charges	no (0)			12.
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)	ne 69)		0	
	Customary charges				
	Aggregate amount actually collected from patients liable for p			0	
00	Amounts that would have been realized from patients liable for	1 5	on a chargebasis	0	16.
00	had such payment been made in accordance with 42 CFR §413.13(ε Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0.000000	17
	Total customary charges (see instructions)			0	
00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19.
00	instructions) Excess of reasonable cost over customary charges (complete onl	vifling 11 exceeds li	no 18) (soo	0	20.
00	instructions)	y IT THE IT EXCEEds IT	110 (300	0	20.
	Lesser of cost or charges (see instructions)			7, 768, 429	
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instr Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)		0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance amounts (for CAH, see instructions			73, 760	
	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			3, 424, 782 4, 269, 887	
00	instructions)	Jus the sum of filles 22		4, 209, 007	27.
00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	-
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29) Primary payer payments			4, 269, 887 6, 730	
00	Subtotal (line 30 minus line 31)			4, 263, 157	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 829, 153	33. 34.
	Adjusted reimbursable bad debts (see instructions)			538, 949	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		356, 904	
	Subtotal (see instructions)			4, 802, 106	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	39
	N95 respirator payment adjustment amount (see instructions)			0	
	Demonstration payment adjustment amount before sequestration			0	
	Partial or full credits received from manufacturers for replace	ced devices (see instruc	ctions)	0	
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			4, 802, 106	
	Sequestration adjustment (see instructions)			60, 506	
	Demonstration payment adjustment amount after sequestration			0	40.
	Sequestration adjustment-PARHM or CHART pass-throughs Interim payments			3, 797, 648	40
	Interim payments			5,777,040	41.
00	Tentative settlement (for contractors use only)			0	42.
	Tentative settlement-PARHM or CHART (for contractor use only)			040.050	42.
	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			943, 952	43. 43.
	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2.	chapter 1,	0	
	§115. 2		- 1		
	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	93.
	Total (sum of lines 91 and 93)				94

Health Financial Systems	PUTNAM COUNTY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-133	3 Period: From 01/01/2022	Worksheet E	
		To 12/31/2022	Date/Time Pre	pared:
			5/31/2023 8:4	<u>1 am</u>
	Title XVIII	Hospi tal	Cost	
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			0	200.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet E-1 Part I Date/Time Prep 5/31/2023 8:41	oared: 1 am
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2, 162, 64	2	3, 797, 648	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04				0	0	3.04
3.05				0	0	3.05
2 50	Provider to Program	1			0	2 5
3.50 3.51	ADJUSTMENTS TO PROGRAM			0	0	3.50 3.5
3.51				0	0	3.5 3.52
3.52				0	0	3. 52
3.54				0	0	3. 54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 162, 64	2	3, 797, 648	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	5.02
5.03				0	0	5.03
	Provider to Program	1				
5.50	TENTATI VE TO PROGRAM			0	0	5.50
5.51 5.52				0	0	5.5 [°] 5.52
5.92 5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
0.77	5. 50-5. 98)				0	J. 7
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		631, 42	5	943, 952	6.0
6. 02	SETTLEMENT TO PROGRAM			0	0	6.02
7.00	Total Medicare program liability (see instructions)		2, 794, 06		4, 741, 600	7.0
				Contractor Number	NPR Date	
		C)	1.00	(Mo/Day/Yr) 2.00	

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider C		Period: From 01/01/202		
		Component	CCN: 15-Z333	To 12/31/202	22 Date/Time Pre 5/31/2023 8:4	
		Title	XVIII	Swing Beds - S		
		Inpatien	t Part A	Pa	art B	
		mm/dd/yyyy	Amount	mm/dd/yyyy		
		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		196, 6	52 0	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.
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	
03				0	0	
04				0	0	
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	
52				0	0	
53				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	3
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)		196, 6	52	0	4
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5
	Program to Provider					
)1)2	TENTATI VE TO PROVI DER			0	0	
03				0	0	
	Provider to Program					1
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	
)) 00	5. 50-5. 98) Determined net settlement amount (balance due) based on			0		6
	the cost report. (1) SETTLEMENT TO PROVIDER		E1 1	17	0	
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		51, 1	0	0	
02	Total Medicare program liability (see instructions)		247, 7	0	0	
	,			Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1333 Period: From 01/01/2022 To 12/31/2022 Worksheet E-1 Part II Date/Time Prej 5/31/2023 8:4' Image: Completed by contractor for Nonstandard cost reports Image: Cost reports Image: Cost reports	
Title XVIII Hospital Cost To be completed by contractor for nonstandard cost reports To be completed by contractor for nonstandard cost reports	am
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	1.00
2.00 Medicare days (see instructions)	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	3.00
4.00 Total inpatient days (see instructions)	4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00 Calculation of the HIT incentive payment (see instructions)	8.00
9.00 Sequestration adjustment amount (see instructions)	9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

LCULAT	inancial Systems PUTNAM COUNTY HO TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1333	Peri od:	u of Form CMS-2 Worksheet E-2	
		Component CCN: 15-Z333	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
		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)		184, 135	0	1.
	npatient routine services - swing bed-NF (see instructions)			-	2.
00 A	ncillary services (from Wkst. D-3, col. 3, line 200, for Part	A, and sum of Wkst. D,	67, 327	0	3.
P	art V, cols. 6 and 7, line 202, for Part B) (For CAH and swing	-bed pass-through, see			
	nstructions)				
	lursing and allied health payment-PARHM or CHART (see instructi			0.00	3.
	er diem cost for interns and residents not in approved teachin nstructions)	g program (see		0.00	4.
	Program days		108	0	5.
	nterns and residents not in approved teaching program (see ins	tructions)	100	0	6.
	tilization review - physician compensation - SNF optional meth		0	-	7.
00 S	ubtotal (sum of lines 1 through 3 plus lines 6 and 7)	2	251, 462	0	8.
	rimary payer payments (see instructions)		0	0	9.
	ubtotal (line 8 minus line 9)		251, 462	0	10.
	eductibles billed to program patients (exclude amounts applica	ble to physician	0	0	11.
	rofessional services)		251 442	0	12
	ubtotal (line 10 minus line 11) coinsurance billed to program patients (from provider records)	(aveluda, coi psuranco	251, 462 1, 556	0	12. 13.
	for physician professional services)	(exclude collisulatice	1, 550	0	13.
	0% of Part B costs (line 12 x 80%)			0	14
	ubtotal (see instructions)		249, 906	0	15
. 00 0	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16
. 50 P	ioneer ACO demonstration payment adjustment (see instructions)				16
	ural community hospital demonstration project (§410A Demonstra	tion) payment	0		16
	djustment (see instructions)				
	emonstration payment adjustment amount before sequestration		1 575	0	16
	llowable bad debts (see instructions) djusted reimbursable bad debts (see instructions)		1, 575 1, 024	0	17
	llowable bad debts for dual eligible beneficiaries (see instru	ctions)	1, 024	0	
	otal (see instructions)		250, 930	0	19
	equestration adjustment (see instructions)		3, 161	0	
	emonstration payment adjustment amount after sequestration)		0	0	
. 03 S	equestration adjustment-PARHM or CHART pass-throughs				19
. 25 S	equestration for non-claims based amounts (see instructions)		0	0	19
. 00 1	nterim payments		196, 652	0	20
	nterim payments-PARHM or CHART				20
	entative settlement (for contractor use only)		0	0	
	entative settlement-PARHM or CHART (for contractor use only)	40.05.00.00	54 447		21
	alance due provider/program (line 19 minus lines 19.01, 19.02,	19.25, 20, and 21)	51, 117	0	22
	alance due provider/program-PARHM or CHART (see instructions) protested amounts (nonallowable cost report items) in accordanc	o with CMS Dub 15.2	0	0	22
	hapter 1, §115.2	e with cm3 Fub. 15-2,	0	0	23
	ural Community Hospital Demonstration Project (§410A Demonstra	tion) Adjustment			
	s this the first year of the current 5-year demonstration peri				200
	entury Cures Act? Enter "Y" for yes or "N" for no.				
	ost Reimbursement				
	ledicare swing-bed SNF inpatient routine service costs (from Wk 6 (title XVIII hospital))	ST. D-I, PT. II, IINE			201
	ledicare swing-bed SNF inpatient ancillary service costs (from	Wkst D-3 col 3 lin	0		202
	00 (title XVIII swing-bed SNF))				202
	otal (sum of lines 201 and 202)				203
	ledicare swing-bed SNF discharges (see instructions)				204
	omputation of Demonstration Target Amount Limitation (N/A in f	irst year of the curre	nt 5-year demonst	ration	
	eriod)		-		0.05
	ledicare swing-bed SNF target amount	aa Lina 204)			205
	ledicare swing-bed SNF inpatient routine cost cap (line 205 tim djustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				206
	program reimbursement under the §410A Demonstration (see instru				207
	ledicare swing-bed SNF inpatient service costs (from Wkst. E-2,		1		207
	nd 3)	Soli i, Sui di HHCS	·		
	djustment to Medicare swing-bed SNF PPS payments (see instruct	i ons)			209
0. 00 R	leserved for future use				210
	omparision of PPS versus Cost Reimbursement				
5. 00 T	otal adjustment to Medicare swing-bed SNF PPS payment (line 20	9 plus line 210) (see			215

	EMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2022 To 12/31/2022		epar
		Title XVIII	Hospi tal	Cost	I a
			- Hospi tui	0031	
				1.00	
	ION OF REIMBURSEMENT SETTLEMENT FOR	MEDICARE PART A SERVICES - COST	F REI MBURSEMENT		
00 Inpatient service	S			3, 027, 570	1
00 Nursing and Allie	d Health Managed Care payment (see	instructions)		0	2
00 Organ acquisition	I			0	1 3
1.5	acquisition cost (see instructions)			0	
	lines 1 through 3.01)			3, 027, 570	
00 Primary payer pay				0	-
	4 less line 5). For CAH (see instru	ictions)		3, 057, 846	6
	SSER OF COST OR CHARGES				-
Reasonabl e charge					
00 Routine service o				0	
00 Ancillary service	5			0	
	charges, net of revenue			0	
0.00 Total reasonable Customary charges				0	
	actually collected from patients lis	able for navment for services on	a charge basis	0	11
00 0	d have been realized from patients	1.5	Ű	0	
	been made in accordance with 42 CFR	1 3	si a charge basi s		'2
	to line 12 (not to exceed 1.000000)			0, 000000	13
	charges (see instructions)			0	
	iry charges over reasonable cost (co	mplete only if line 14 exceeds li	ine 6) (see	0	
instructions)	· · · · · · · · · · · · · · · · · · ·			-	
0.00 Excess of reasona	ble cost over customary charges (co	mplete only if line 6 exceeds li	ne 14) (see	0	16
instructions)					
.00 Cost of physiciar	s' services in a teaching hospital	(see instructions)		0	17
	IMBURSEMENT SETTLEMENT				4
	edical education payments (from Wor			0	
1	services (sum of lines 6, 17 and 18)			3, 057, 846	
	ude professional component)			275, 340	
	e cost (from line 16)			0	
-	minus line 20 and 21)			2, 782, 506	
. 00 Coi nsurance					23
.00 Subtotal (line 22 .00 Allowable bad deb		nal carviace) (cae instructions)		2, 782, 506	
	nts (exclude bad debts for profession able bad debts (see instructions)	That services) (see instructions)		72, 639 47, 215	
	its for dual eligible beneficiaries	(soo instructions)		14, 374	
	lines 24 and 25, or line 26)	(see mistractions)		2, 829, 721	
	(SEE INSTRUCTIONS) (SPECIFY)			2,029,721	
	istration payment adjustment (see in:	ustructions)		0	
	erated depreciation.			0	
· · · · · · · · · · · · · · · · · · ·	ment adjustment amount before seque:	estration		0	
. 00 Subtotal (see ins		stration		2, 829, 721	
	ustment (see instructions)			35, 654	
	ment adjustment amount after seques	stration		0	
	ustment-PARHM or CHART	-		Ŭ	30
				2, 162, 642	
.03 Sequestration adj	DADUM on CUADT				31
. 03 Sequestration adj . 00 Interim payments	PARHM OF CHART			0	
.03 Sequestration adj .00 Interim payments .01 Interim payments-	ient (for contractor use only)				32
 0.03 Sequestration adj 00 Interim payments 01 Interim payments 00 Tentative settlem 		use only)			1 02
 .03 Sequestration adj .00 Interim payments .01 Interim payments .00 Tentative settlem .01 Tentative settlem 	ent (for contractor use only)	5.		631, 425	
 .03 Sequestration adj .00 Interim payments .01 Interim payments .00 Tentative settlem .01 Tentative settlem .00 Balance due provi 	nent (for contractor use only) nent-PARHM or CHART (for contractor)	0.01, 30.02, 31, and 32)	03, 31.01, and	631, 425	

CALCU	Financial Systems PUTNAM COUNTY F ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-1333	Peri od:	Worksheet E-3	2552-10
CALCUL			From 01/01/2022 To 12/31/2022	Part VII	pared:
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITLES V OR X	IX SERVICES		-
1.00	Inpatient hospital/SNF/NF services		169, 534		1 1.00
2.00	Medical and other services		107, 334	0	
3.00	Organ acquisition (certified transplant programs only)		0	Ū	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		169, 534	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments		1/0 50/	0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		169, 534	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
8.00	Routi ne servi ce charges		89, 775		8.00
9.00	Ancillary service charges		223, 313	0	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		313, 088	0	12.00
	CUSTOMARY CHARGES				1 4 9 9 9
13.00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for	r navment for services o	n 0	0	14.00
14.00	a charge basis had such payment been made in accordance with			0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		313, 088	0	
17.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	143, 554	0	17.00
10.00	line 4) (see instructions)			0	10.00
18.00	Excess of reasonable cost over customary charges (complete onl 16) (see instructions)	Ty IT II ne 4 exceeds II n	e U	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line		169, 534	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		ders.		
22.00	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00 26.00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		169, 534	0	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	169, 534	0	
32.00	Deducti bl es Coi nsurance		0	0	
33.00			0	0	
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	169, 534	0	1
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	-	0	0	
38.00	Subtotal (line 36 ± line 37)		169, 534	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		169, 534	0	
41.00	Interim payments		169, 534	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
42.00 43.00	Protested amounts (nonallowable cost report items) in accordan	nee with CMS Dub 15 0	0	0	43.00

	SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column	Provider C	F	eriod: rom 01/01/2022 o 12/31/2022	Worksheet G Date/Time Pre 5/31/2023 8:4	
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
C	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	21, 483, 727	C	0	0	1.00
2.00	Temporary investments	0	C	0	0	2.00
	Notes receivable	0	C	0	0	3.00
	Accounts receivable	10, 354, 011		0	0	4.00
	Other receivable Allowances for uncollectible notes and accounts receivable	1, 935, 009 -6, 963, 914		0	0	5.0 6.0
	Inventory	606, 464		0	0	7.0
	Prepai d'expenses	439, 794		0	0	8.0
	Other current assets	0	C	0	0	9.0
	Due from other funds	0	C	0	0	10.0
	Total current assets (sum of lines 1-10)	27, 855, 091	C	0	0	11.0
	Land	260, 501	C	0	0	12.0
	Land improvements	391, 896		0	0	13.0
1	Accumulated depreciation	-336, 445		0	0	14.00
	Bui I di ngs	35, 762, 484		0	0	15.0
	Accumulated depreciation	-26, 010, 825		0	0	16.0
1	Leasehold improvements Accumulated depreciation	0		0	0	17.0 18.0
	Fi xed equipment	0		0	0	19.0
	Accumul ated depreciation	0	C C	0	0	20.0
21.00	Automobiles and trucks	0	C	0	0	21.0
1	Accumulated depreciation	0	C	0	0	22.0
1	Major movable equipment	26, 863, 244		0	0	23.0
	Accumulated depreciation Minor equipment depreciable	-23, 203, 676		0	0	24.0 25.0
	Accumul ated depreciation	0		0	0	26.0
	HIT designated Assets	0	C	0	0	27.0
28.00	Accumulated depreciation	0	C	0	0	28.0
	Minor equipment-nondepreciable	0	C	0	0	29.0
	Total fixed assets (sum of lines 12-29) THER ASSETS	13, 727, 179	C	0	0	30.0
	Investments	8, 246, 133	C	0	0	31.0
	Deposits on Leases	0	C	0	0	32.0
3.00 [Due from owners/officers	0	C	0	0	33.0
	Other assets	244, 895		0	0	34.0
	Total other assets (sum of lines 31-34)	8, 491, 028		0	0	35.0
	Total assets (sum of lines 11, 30, and 35)	50, 073, 298	C	0	0	36.0
	Accounts payable	4, 821, 479	C	0	0	37.00
	Salaries, wages, and fees payable	2, 520, 335			0	38.0
	Payroll taxes payable	267, 344	C	0	0	39.0
	Notes and Loans payable (short term)	0	C	0	0	40.0
1	Deferred income	0	C	0	0	41.0 42.0
	Accelerated payments Due to other funds	0	C C	0	0	
1	Other current liabilities	2, 082, 714	-	0	0	
1	Total current liabilities (sum of lines 37 thru 44)	9, 691, 872		0	0	45.0
	ONG TERM LIABILITIES					
	Mortgage payable	0	C		0	
	Notes payable Jnsecured Loans	4, 018, 963		0	0	47.0 48.0
	Other long term liabilities	0		0	0	40.0
	Total long term liabilities (sum of lines 46 thru 49)	4, 018, 963		0	0	50.0
	Total liabilities (sum of lines 45 and 50)	13, 710, 835	C	0	0	51.0
-	CAPI TAL ACCOUNTS					
	General fund balance	36, 362, 463				52.0
	Specific purpose fund Donor created - endowment fund balance - restricted		C			53.0 54.0
	Donor created - endowment fund balance - unrestricted			0		55.0
	Governing body created - endowment fund balance			0		56.0
57.00 I	Plant fund balance - invested in plant				0	57.0
	Plant fund balance - reserve for plant improvement,				0	58.0
	replacement, and expansion Total fund balances (sum of lines 52 thru 59)	26 262 4/2		_	0	E0 0
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	36, 362, 463 50, 073, 298			0	59.0 60.0
0.00	59)	00,010,270	1	, V	0	1 00.0

Heal th	Financial Systems	PUTNAM COUNTY	HOSPI TAL			In Lie	u of Form CMS-	2552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1333		eriod: com 01/01/2022 o 12/31/2022	Worksheet G-1 Date/Time Pre 5/31/2023 8:4	pared:
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fund	
		1.00	2.00	3.00		4.00	5.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 17.\ 00\\ 18.\ 00\\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\\ 10.\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ 00\ $	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 661, 771 0 0 0 0 0 0 0 0 0 0 0 0	40, 782, 567 -5, 081, 875 35, 700, 692 661, 771 36, 362, 463			0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		36, 362, 463			0		19.00
		Endowment Fund	Pl ant	Fund				
		6.00	7.00	8.00				
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Rounding Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0 0		0 0 0 0			$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$
14.00 15.00 16.00 17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0		0 0			14.00 15.00 16.00 17.00 18.00 19.00

ATEMEN	IT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	N: 15-1333	Peri od: From 01/01/2022 To 12/31/2022	Worksheet G-2 Parts I & II Date/Time Pre 5/31/2023 8:4	<u>e</u> epare
	Cost Center Description		Inpatient	Outpati ent	Total	
			1.00	2.00	3.00	
	ART I - PATIENT REVENUES					
	eneral Inpatient Routine Services			1		
	ospi tal		3, 757, 38	31	3, 757, 381	
	UBPROVIDER - IPF					2.
	UBPROVIDER - IRF					3.
	UBPROVI DER			0	0	4.
	wing bed - SNF wing bed - NF			0	0	
	KILLED NURSING FACILITY			0	0	7.
	URSING FACILITY					8.
	THER LONG TERM CARE					9.
	otal general inpatient care services (sum of lines 1-9)		3, 757, 38	31	3, 757, 381	
	ntensive Care Type Inpatient Hospital Services		3,737,30		3,737,301	1 10.
	NTENSI VE CARE UNI T		1, 849, 90	00	1, 849, 900	11.
	ORONARY CARE UNIT		, = , , ,		, , , , , , , , , , , , , , , , ,	12.
	URN INTENSIVE CARE UNIT					13.
. 00 SI	URGICAL INTENSIVE CARE UNIT					14.
. 00 0	THER SPECIAL CARE (SPECIFY)					15.
. 00 T	otal intensive care type inpatient hospital services (sum of I	i nes	1, 849, 90	00	1, 849, 900	16
1	1-15)					
	otal inpatient routine care services (sum of lines 10 and 16)		5, 607, 28		5, 607, 281	
	ncillary services		6, 185, 40	63, 633, 233		
	utpatient services		348, 8			
	URAL HEALTH CLINIC			0 2, 231, 878		
	URAL HEALTH CLINIC II			0 2, 406, 213		
	URAL HEALTH CLINIC III			0 2, 138, 876		
	EDERALLY QUALIFIED HEALTH CENTER			0 0	0	
	OME HEALTH AGENCY					22
	MBULANCE SERVICES					23
						24
	MBULATORY SURGICAL CENTER (D. P.) OSPICE					25
	THER (SPECIFY)			0 0	o	
	ther Patient Service Revenue - NRCCs			0 6, 194, 098		
	ENTURY VILLA NET REVENUE		8, 574, 96			
	THER (SPECIFY)		0, 374, 70	0 0		
	THER (SPECIFY)			0 0	0	
	otal patient revenues (sum of lines 17-27)(transfer column 3 1	o Wkst	20, 716, 50			
	-3, line 1)				,,,	
	ART II - OPERATING EXPENSES	· ·				
. 00 0	perating expenses (per Wkst. A, column 3, line 200)			59, 036, 893		29
	entury Villa Operating Expenses		8, 180, 80	65		30
. 00				0		31
. 00				0		32
. 00				0		33
. 00				0		34
. 00				0 0 100 0/5		35
	otal additions (sum of lines 30-35)			8, 180, 865		36
	EDUCT (SPECI FY)			0		37
. 00				0		38
. 00				U		39
. 00				0		40
. 00	atal daduatiana (aum af linea 27.41)			0		41
	otal deductions (sum of lines 37-41)	(transfor		47 017 750		42
. 00 T	otal operating expenses (sum of lines 29 and 36 minus line 42) o Wkst. G-3, line 4)	(transfer		67, 217, 758		43

Heal th	Financial Systems	PUTNAM COUNTY H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN: '	15-1333	Peri od:	Worksheet G-3	
					From 01/01/2022 To 12/31/2022	Date/Time Pre	norod.
					10 12/31/2022	5/31/2023 8:4	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part					123, 642, 583	
2.00	Less contractual allowances and discounts on	patients' account	S			73, 423, 224	2.00
3.00	Net patient revenues (line 1 minus line 2)					50, 219, 359	
4.00	Less total operating expenses (from Wkst. G-2		3)			67, 217, 758	
5.00	Net income from service to patients (line 3 m	ninus line 4)				-16, 998, 399	5.00
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					64, 780	
8.00	Revenues from telephone and other miscellaneo	ous communication	servi ces			0	
9.00	Revenue from television and radio service					0	
10.00	Purchase di scounts					4	10.00
11.00	Rebates and refunds of expenses					12, 154	
12.00	5					0	
13.00						0	
	Revenue from meals sold to employees and gues	sts				56, 351	•
15.00	J					0	
16.00	Revenue from sale of medical and surgical sup		an patients			0	
17.00						0	
	Revenue from sale of medical records and abst					131	18.00
	Tuition (fees, sale of textbooks, uniforms, e					0	
20.00	Revenue from gifts, flowers, coffee shops, ar	nd canteen				0	20.00
21.00	Rental of vending machines					0	
22.00	Rental of hospital space					0	22.00
23.00	Governmental appropriations					754, 750	23.00
24.00	Misc Revenue					1, 763, 847	24.00
24.01	340B Program Revenue					811, 045	24.01
24.02	IGT Revenue					7, 412, 826	24.02
24.50	COVI D-19 PHE Fundi ng					1, 040, 636	24.50
25.00	Total other income (sum of lines 6-24)					11, 916, 524	25.00
26.00	Total (line 5 plus line 25)					-5, 081, 875	26.00
27.00	OTHER EXPENSES (SPECIFY)					0	27.00
28.00	Total other expenses (sum of line 27 and subs	scripts)				0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)				-5, 081, 875	29.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333	Peri od:	Worksheet M-1	
			Component	CCN: 15-8515	From 01/01/2022 To 12/31/2022		
					RHC I	Cost	
		Compensati on	Other Costs	Total (col.	1 Reclassi ficati	Recl assi fi ed	
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	307, 601	19, 582	327, 1	33 0	327, 183	1.00
2.00	Physician Assistant	0	C		0 0	0	2.00
3.00	Nurse Practitioner	432, 951	42, 350	475, 3	-46, 052	429, 249	3.00
4.00	Visiting Nurse	0	C		0 0	0	4.00
5.00	Other Nurse	0	C		0 0	0	5.00
6.00	Clinical Psychologist	172, 246	21, 862	194, 1	0 80	194, 108	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	C		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	912, 798	83, 794	996, 5	-46,052	950, 540	10.00
11.00	Physician Services Under Agreement	0	C		0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	C		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)	0	0		0 0	0	
15.00	Medical Supplies	0	144, 143	144, 1	13 0		
16.00	Transportation (Health Care Staff)	0	0		0 0	0	
17.00	Depreciation-Medical Equipment	0	0		0 0	-	
18.00	Professional Liability Insurance	0	0		0 0		18.00
19.00	Other Health Care Costs	0	64		-25	-	
20.00	Allowable GME Costs	0			20		20.00
21.00	Subtotal (sum of lines 15 through 20)	0	144, 207	144, 2	-25	144, 182	
22.00	Total Cost of Health Care Services (sum of	912, 798					
22.00	lines 10, 14, and 21)	,12,1,0	220,001	1, 110, 7	10,077	1,071,722	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23.00	Pharmacy	0	C		0 0	0	23.00
24.00	Dental	0	0		0 0	-	24.00
25.00	Optometry	0	0		0 0	0	1
25.01	Tel eheal th	3, 993	0	3, 9	a 0	3, 993	
25.02	Chronic Care Management	0, 770	0	0, 7	0 0	0,770	
26.00	All other nonreimbursable costs	0				0	26.00
27.00	Nonallowable GME costs	0			0		27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	3, 993	C	3, 9	93 0	3, 993	
20.00	through 27)	5, 775	0	5,7	0	5, 775	20.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	6, 828	6, 8	-709	6, 119	29.00
30.00	5	514, 962	-,		-		
30.00	Administrative Costs Total Facility Overhead (sum of lines 29 and						30.00
31.00	30)	514, 962	40, 822	555, /	-45, 153	510, 631	31.00
32.00	Total facility costs (sum of lines 22, 28	1, 431, 753	268, 823	1, 700, 5	76 -91, 230	1, 609, 346	32.00
32.00	and 31)	1,431,703	200, 023	1,700,5	-71,230	1, 007, 340	32.00
			l	I	1	I	I

	Financial Systems	PUTNAM COUNT				u of Form CMS-	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333	Peri od:	Worksheet M-1	1
			Component	CCN: 15-8515	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
					RHC I	Cost	
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
		(00	6)	-			
		6.00	7.00				-
1.00	FACILITY HEALTH CARE STAFF COSTS Physician	0	327, 183				1.00
2.00	Physician Assistant	0	327, 183	1			2.00
3.00	Nurse Practitioner	0	429, 249				3.00
4.00	Visiting Nurse	0	427, 247	1			4.00
5.00	Other Nurse	0	0				5.00
6.00	Clinical Psychologist	0	194, 108				6.00
7.00	Clinical Social Worker	0	0				7.00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	0	•			9.00
10.00	Subtotal (sum of lines 1 through 9)	0	950, 540				10.00
11.00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	144, 143				15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
18.00	Professional Liability Insurance	0	0				18.00
19.00	Other Health Care Costs	0	39				19.00
20. 00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	144, 182				21.00
22.00	Total Cost of Health Care Services (sum of	0	1, 094, 722				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
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	3, 993				25.01
25.02 26.00	Chronic Care Management All other nonreimbursable costs	0	0	•			25.02
26.00	Nonallowable GME costs	0	0				28.00
27.00	Total Nonreimbursable Costs (sum of lines 23	0	3, 993				27.00
20.00	through 27)	0	3, 773				20.00
	FACILITY OVERHEAD			1			1
29.00	Facility Costs	0	6, 119				29.00
30.00	Admini strati ve Costs	-131	504, 381				30.00
31.00	Total Facility Overhead (sum of lines 29 and	-131	510, 500	1			31.00
	30)		2.2,000				
32.00	Total facility costs (sum of lines 22, 28	-131	1, 609, 215				32.00
	and 31)						

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333	Peri od:	Worksheet M-1	
			Component	CCN: 15-8513	From 01/01/2022 To 12/31/2022		
					RHC II	Cost	
		Compensati on	Other Costs	Total (col.	1 Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS	001.017	05.5/0		7.0	0.17.170	
1.00	Physi ci an	321, 917	25, 562				1
2.00	Physician Assistant	536, 120	59, 061				2.00
3.00	Nurse Practitioner	0	0		0 21, 154		3.00
4.00	Visiting Nurse	0	0			0	4.00
5.00	Other Nurse	0	0			-	5.00
6.00	Clinical Psychologist	0	1 007	ог <i>(</i>	0	0	6.00
7.00	Clinical Social Worker	21, 554 0	4, 087	1		25, 641	7.00 8.00
8.00 9.00	Laboratory Technician	0			0 0	0	
9.00 10.00	Other Facility Health Care Staff Costs	0 879, 591	88, 710		0	-	
10.00	Subtotal (sum of lines 1 through 9) Physician Services Under Agreement	879, 591	88,710	908, 3	01 21, 154	989, 455 0	11.00
12.00	Physician Supervision Under Agreement	0	0			0	12.00
12.00	Other Costs Under Agreement	0	0			0	12.00
13.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
14.00	Medical Supplies	0	102, 618	102, 6	18 0		
16.00	Transportation (Health Care Staff)	0	102, 010	102,0		0	1
17.00	Depreciation-Medical Equipment	0	0			0	
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	341	3	41 6	347	19.00
20.00	Allowable GME Costs	0	541	5	41 0	547	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	102, 959	102, 9	50 6	102, 965	•
21.00	Total Cost of Health Care Services (sum of	879, 591	191, 669				
22.00	lines 10, 14, and 21)	077, 371	171,007	1,071,2	21,100	1,072,420	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	C)	0 0	0	23.00
24.00	Dental	0	C)	0 0	0	24.00
25.00	Optometry	0	C)	0 0	0	25.00
25.01	Tel eheal th	1, 478	C	1,4	78 41	1, 519	25.01
25.02	Chronic Care Management	0	C		0 0		
26.00	All other nonreimbursable costs	0	C)	0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	1, 478	C	1,4	78 41	1, 519	28.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	6, 002			6, 164	29.00
30.00	Administrative Costs	548, 835	59, 933				1
31.00	Total Facility Overhead (sum of lines 29 and	548, 835	65, 935	614, 7	70 10, 304	625, 074	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	1, 429, 904	257, 604	1, 687, 5	08 31, 505	1, 719, 013	32.00
	and 31)			1		I	

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	-2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333	Peri od:	Worksheet M-	1
			Component	CCN: 15-8513	From 01/01/2022 To 12/31/2022	Date/Time Pro 5/31/2023 8:4	
					RHC II	Cost	
		Adjustments	Net Expenses				
		-	for Allocation				
			(col. 5 + col.				
			6)	-			
		6.00	7.00				
1 00	FACILITY HEALTH CARE STAFF COSTS	0	247 470				1 1 00
1.00 2.00	Physician Physician Assistant	0	347, 479	1			1.00
2.00	Physician Assistant Nurse Practitioner	0	595, 181 21, 154	1			3.00
3.00 4.00	Visiting Nurse	0	21, 154	1			4.00
4.00 5.00	Other Nurse	0	0				5.00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	0	25, 641				7.00
8.00	Laboratory Techni ci an	0	23, 041	1			8.00
9.00	Other Facility Health Care Staff Costs	0	0				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	989, 455				10.00
11.00	Physician Services Under Agreement	0	0, 400	1			11.00
12.00	Physician Supervision Under Agreement	0	0	•			12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	102, 618				15.00
16.00	Transportation (Health Care Staff)	0	0	1			16.00
17.00	Depreciation-Medical Equipment	0	0				17.00
	Professional Liability Insurance	0	0				18.00
	Other Health Care Costs	0	347				19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	102, 965				21.00
22.00	Total Cost of Health Care Services (sum of	0	1, 092, 420				22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
	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	1, 519	1			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	1, 519				28.00
	through 27) FACILITY OVERHEAD			1			-
29.00	Facility Costs	0	6, 164				29.00
30.00	Administrative Costs	0	618, 910	•			30.00
30.00	Total Facility Overhead (sum of lines 29 and	0	625, 074	•			31.00
51.00	30)	0	023,074				31.00
32.00	Total facility costs (sum of lines 22, 28	0	1, 719, 013				32.00
	and 31)	Ŭ	.,,.				
							•

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RHC/FOHC COSTS			CN: 15-1333	Peri od:	Worksheet M-1	
7.0.1210				CCN: 15-8514	From 01/01/2022 To 12/31/2022		
					RHC III	Cost	
		Compensation	Other Costs	Total (col	1 Recl assi fi cati		
		oompensation	00010	+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	445, 070	53, 370	498, 4	40 C	498, 440	1.00
2.00	Physician Assistant	117, 069	15, 935	133, 0	04 C	133, 004	2.00
3.00	Nurse Practitioner	241, 169	23, 246	264, 4	15 24, 856	289, 271	3.00
4.00	Visiting Nurse	0	C		0 0	0	4.00
5.00	Other Nurse	0	C)	0 0	0	5.00
6.00	Clinical Psychologist	0	C)	0 0	0	6.00
7.00	Clinical Social Worker	75, 766	9, 427	85, 1	93 C	85, 193	7.00
8.00	Laboratory Techni ci an	0	C)	0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	C)	0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	879, 074	101, 978	981, 0	52 24, 856	1, 005, 908	10.00
11.00	Physician Services Under Agreement	0	C)	0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	C)	0 0	0	12.00
13.00	Other Costs Under Agreement	0	C)	0 0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	C)	0 0	0	14.00
15.00	Medical Supplies	0	96, 979	96, 9	79 C	96, 979	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
18.00	Professional Liability Insurance	0	0		0 0		18.00
19.00	Other Health Care Costs	0	150	1	50 20	170	
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	97, 129				
22.00	Total Cost of Health Care Services (sum of	879, 074	199, 107	1, 078, 1	81 24, 876	1, 103, 057	22.00
	lines 10, 14, and 21)						
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	0	0	J			
23.00	Pharmacy	-	-		0 0		23.00
24.00	Dental	0			0 0		24.00
25.00	Optometry Tal sheal th	-			0 0	-	25.00
25. 01 25. 02	Telehealth Chronic Care Management	638 0			38 C	638 0 0	25.01 25.02
25.02 26.00	All other nonreimbursable costs	0					25.02
26.00	Nonallowable GME costs	0	U		0		26.00
27.00	Total Nonreimbursable Costs (sum of lines 23	638	C	6	38 0	638	
28.00	through 27)	030	0	0	30 0	030	20.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	4, 963	4.9	63 548	5, 511	29.00
30.00	Administrative Costs	486, 268					
31.00	Total Facility Overhead (sum of lines 29 and	486, 268					31.00
01.00	30)	100, 200	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		5 · · · · · · · · · · · · · · · · · · ·		
32.00	Total facility costs (sum of lines 22, 28	1, 365, 980	279, 073	1, 645, 0	53 59, 726	1, 704, 779	32.00
	and 31)						

1.00 P 2.00 P	S OF HOSPITAL-BASED RHC/FQHC COSTS		Net Expenses	CN: 15-1333 CCN: 15-8514	Period: From 01/01/2022 To 12/31/2022	Worksheet M-1 Date/Time Pre	
1.00 P 2.00 P		5	Net Expenses	CCN: 15-8514		Date/Time Pre	pared
1.00 P 2.00 P		5				5/31/2023 8:4	
1.00 P 2.00 P		5			RHC III	Cost	
1.00 P 2.00 P		5			<u> </u>		
1.00 P 2.00 P			for Allocation				
1.00 P 2.00 P			(col. 5 + col.				
1.00 P 2.00 P			6)				
1.00 P 2.00 P		6.00	7.00				
2.00 P	ACILITY HEALTH CARE STAFF COSTS	-		1			4
	Physi ci an	0	498, 440				1.00
	Physician Assistant	0	133, 004				2.00
	Nurse Practitioner	0	289, 271				3.00
1	/isiting Nurse	0	0				4.00
)ther Nurse	0	0				5.00
	Clinical Psychologist Clinical Social Worker	0	85, 193				6.00 7.00
	_aboratory Techni ci an	0	03, 193				8.00
	Ther Facility Health Care Staff Costs	0	0				9.00
	Subtotal (sum of lines 1 through 9)	0	1, 005, 908				10.00
	Physician Services Under Agreement	0	1,003,900	1			11.00
	Physician Supervision Under Agreement	0	0				12.00
	Other Costs Under Agreement	0	0				13.00
	Subtotal (sum of lines 11 through 13)	0	0				14.00
	Medical Supplies	0	96, 979				15.00
	Fransportation (Health Care Staff)	0	0				16.00
	Depreciation-Medical Equipment	0	0				17.00
	Professional Liability Insurance	0	0				18.00
19.00 0	Other Health Care Costs	0	170				19.00
20.00 A	Allowable GME Costs						20.00
21.00 S	Subtotal (sum of lines 15 through 20)	0	97, 149				21.00
22.00 T	Total Cost of Health Care Services (sum of	0	1, 103, 057				22.00
	ines 10, 14, and 21)						
	OSTS OTHER THAN RHC/FQHC SERVICES						4
	Pharmacy	0	0				23.00
	Dental	0	0				24.00
	Optometry	0	0				25.00
	fel eheal th	0	638				25.01
	Chronic Care Management	0	0				25.02
	All other nonreimbursable costs	0	0				26.00
	Nonallowable GME costs	0	(20				27.00
	Fotal Nonreimbursable Costs (sum of lines 23	0	638				28.00
	through 27) ACILITY OVERHEAD			1			1
	Facility Costs	0	5, 511				29.00
	Administrative Costs	-3, 200					30.00
	Fotal Facility Overhead (sum of lines 29 and	-3, 200	597, 884				31.00
	30)	5,200	577,004				
	Fotal facility costs (sum of lines 22, 28	-3, 200	1, 701, 579				32.00
	and 31)		,				

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-1
ALLOCAT	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C	CN: 15-1333	Peri od:	Worksheet M-2	
			Component	CON. 15 0515	From 01/01/2022		norod.
			component	CCN: 15-8515	To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
					RHC I	Cost	i an
		Number of FTE	Total Visits	Producti vi t	/ Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
+	VISITS AND PRODUCTIVITY						
- H	Positions						
	Physi ci an	0. 92			1 1		1.0
	Physician Assistant	0.00			1 0		2.0
3.00	Nurse Practitioner	2.86		2	1 3		3.0
. 00	Subtotal (sum of lines 1 through 3)	3. 78	8, 946		4	8, 946	4.0
	Visiting Nurse	0.00				0	5.0
. 00	Clinical Psychologist	1.04	1, 403	5		1, 403	6.0
. 00	Clinical Social Worker	0.00	2	2		2	7.0
	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
	Diabetes Self Management Training (FQHC	0.00	0)		0	7.0
	onl y)						
	Total FTEs and Visits (sum of lines 4	4. 82	10, 351			10, 351	8.0
	through 7)						
9.00	Physician Services Under Agreements		0)		0	9.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	0 HOSPI TAL-BASE	D RHC/FOHC SER	2VLCES		1.00	-
- H	Total costs of health care services (from W					1, 094, 722	1 10. 0
	Total nonreimbursable costs (from Wkst. M-1,						11.0
	Cost of all services (excluding overhead) (s		,			1, 098, 715	
	Ratio of hospital-based RHC/FQHC services (I					0, 996366	
	Parent provider overhead allocated to facili			- /		510, 500 987, 485	
	Total overhead (sum of lines 14 and 15)	J	- /			1, 497, 985	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					1, 497, 985	18. C
	Overhead applicable to hospital-based RHC/FC	DHC services (li	ne 13 x line 1	8)		1, 492, 541	
	Tatal allowable past of bearital based DUC/					2 507 242	

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 2,587,263 20.00

<u>Heal th</u>	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-1
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Peri od:	Worksheet M-2	
			Composite		From 01/01/2022		
			Component	CCN: 15-8513	To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
					RHC II	Cost	i am
		Number of FTE	Total Visits	Productivity	/ Minimum Visits		
		Personnel	lotal fronto		(col. 1 x col.		
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY		-	•		•	
	Posi ti ons						1
. 00	Physi ci an	0.86	2, 342		1 1		1.0
. 00	Physician Assistant	3. 35	10, 012		1 3		2.0
. 00	Nurse Practitioner	0.11	110		1 0		3.0
. 00	Subtotal (sum of lines 1 through 3)	4.32	12, 464		4	12, 464	4.0
. 00	Visiting Nurse	0.00	0			0	5.0
. 00	Clinical Psychologist	0.00	1			1	6.0
. 00	Clinical Social Worker	0. 21	161			161	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7.0
. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7.0
	only)						
. 00	Total FTEs and Visits (sum of lines 4	4. 53	12, 626			12, 626	8.0
	through 7)						
. 00	Physician Services Under Agreements		0			0	9.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	0 HOSPITAL-BASE	D RHC/FOHC SER	VLCES		1.00	
0 00	Total costs of health care services (from W			11020		1, 092, 420	1 10 0
	Total nonreimbursable costs (from Wkst. M-1)					1, 519	
2.00	Cost of all services (excluding overhead) (1, 093, 939	
3.00	Ratio of hospital-based RHC/FQHC services (0, 998611	
1.00	Total hospital-based RHC/FQHC overhead - (fi		625, 074	14. C			
5.00	Parent provider overhead allocated to facili			- /		1, 020, 110	
5.00	Total overhead (sum of lines 14 and 15)	5 (- /			1, 645, 184	
7.00	Allowable GME overhead (see instructions)					0	
8.00	Enter the amount from line 16					1, 645, 184	18. C
	Overhead applicable to hospital-based RHC/F	QHC services (li	ne 13 x line 1	8)		1, 642, 899	
	Tatal allowable and af based block					2 725 210	

20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 2,735,319 20.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider CO		Peri od:	Worksheet M-2	
			Component (CCN: 15-8514	From 01/01/2022 To 12/31/2022		narod
			component (JUN. 15-6514	10 12/31/2022	5/31/2023 8:4	
			_		RHC III	Cost	
		Number of FTE	Total Visits		/ Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.		
		1.00	0.00	0.00	3)	4	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	Positions						-
1.00	Physi ci an	1.75	3, 004		1 2		1.00
2.00	Physician Assistant	0, 89			1 1		2.00
3.00	Nurse Practitioner	1.90			1 2		3.00
4.00	Subtotal (sum of lines 1 through 3)	4.54			5	7, 923	4.00
5.00	Visiting Nurse	0.00			0	0	5.00
6.00	Clinical Psychologist	0.00				7	6.00
7.00	Clinical Social Worker	0.89				784	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
	only)						
8.00	Total FTEs and Visits (sum of lines 4	5.43	8, 714			8, 714	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWARLE COST ADDILLOADLE T					1.00	
10.00	DETERMINATION OF ALLOWABLE COST APPLICABLE T Total costs of health care services (from W			VICES		1 102 057	10.00
	Total nonreimbursable costs (from Wkst. M-1,					1, 103, 057	11.00
12.00	Cost of all services (excluding overhead) (s					1, 103, 695	
12.00	Ratio of hospital-based RHC/FQHC services (1					0, 999422	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		597, 884	
15.00	Parent provider overhead allocated to facili					1, 006, 181	
16.00	Total overhead (sum of lines 14 and 15)	.j (300 matrice				1, 604, 065	
17.00	Allowable GME overhead (see instructions)					0	
18.00	Enter the amount from line 16					1, 604, 065	
19.00	Overhead applicable to hospital-based RHC/FG	DHC services (li	ne 13 x line 1	8)		1, 603, 138	
20.00	Total allowable cost of hospital-based RHC/F	-OHC services (s	um of lines 10	and 19)		2, 706, 195	20.00

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/F	-QHC Provider CCN: 15-1333	Peri od:	Worksheet M-3	
ERVI CES	Component CCN: 15-8515	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
	Title XVIII	RHC I	Cost	i ani
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICE	S			
.00 Total Allowable Cost of hospital-based RHC/FQHC Services	(from Wkst. M-2, line 20)		2, 587, 263	1. (
.00 Cost of injections/infusions and their administration (fr			143, 294	2.
.00 Total allowable cost excluding injections/infusions (line	e 1 minus line 2)		2, 443, 969	
.00 Total Visits (from Wkst. M-2, column 5, line 8)			10, 351	
0.00 Physicians visits under agreement (from Wkst. M-2, column	15, line 9)		0	
0.00 Total adjusted visits (line 4 plus line 5)			10, 351	6.
.00 Adjusted cost per visit (line 3 divided by line 6)			236.11	7.
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2022	
			through	
		1.00	12/31/2022)	
00 Dem visit gevenent limit (Gran CNC Dub 100 04 sharter 0	620 (1.00	2.00	
8.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9,	\$20.6 or your contractor)	0.00	265.00	
2.00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	236.11	9.
0.00 Program covered visits excluding mental health services (from contractor records)	0	609	10.
1.00 Program cost excluding costs for mental health services (· · · · · · · · · · · · · · · · · · ·	0	143, 791	
2.00 Program covered visits for mental health services (from c	· · · · · ·	0	45	
3.00 Program covered cost from mental health services (from e		0	10, 625	
4.00 Limit adjustment for mental health services (see instruct		0	10, 625	
5.00 Graduate Medical Education Pass Through Cost (see instruc		-	,	15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns		0	154, 416	
6.01 Total program charges (see instructions)(from contractor)			128, 679	16.
6.02 Total program preventive charges (see instructions) (from	provider's records)		3, 415	16.
6.03 Total program preventive costs ((line 16.02/line 16.01) t	imes line 16)		4, 098	16.
6.04 Total Program non-preventive costs ((line 16 minus lines	16.03 and 18) times .80)		105, 924	16.
(Titles V and XIX see instructions.)				
6.05 Total program cost (see instructions)		0	110, 022	16.
7.00 Primary payer amounts			0	
8.00 Less: Beneficiary deductible for RHC only (see instructi	ons) (from contractor		17, 913	18.
records)			21 270	10
9.00 Beneficiary coinsurance for RHC/FQHC services (see instru records)	ictions) (from contractor		21, 379	19.
0.00 Net Medicare cost excluding vaccines (see instructions)			110, 022	20.
1.00 Program cost of vaccines and their administration (from W	/kst M-4 line 16)		4, 348	
2.00 Total reimbursable Program cost (line 20 plus line 21)			114, 370	
3.00 Allowable bad debts (see instructions)			0	
3.01 Adjusted reimbursable bad debts (see instructions)			0	
4.00 Allowable bad debts for dual eligible beneficiaries (see	instructions)		0	24.
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.
5.50 Pioneer ACO demonstration payment adjustment (see instruc	ti ons)		0	25.
5.99 Demonstration payment adjustment amount before sequestrat	i on		0	
6.00 Net reimbursable amount (see instructions)			114, 370	
6.01 Sequestration adjustment (see instructions)			1, 441	
6.02 Demonstration payment adjustment amount after sequestrati	on		0	
7.00 Interim payments			124, 278	
8.00 Tentative settlement (for contractor use only)			0	
9.00 Balance due component/program (line 26 minus lines 26.01,			-11, 349	
0.00 Protested amounts (nonallowable cost report items) in acc	cordance with CMS Pub. 15-II,		0	30.

ERVI CES					
		Component CCN: 15-8513	From 01/01/2022 To 12/31/2022	Date/Time Prep 5/31/2023 8:4	
		Title XVIII	RHC II	Cost	i ani
				0001	
				1.00	
	RMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
	Allowable Cost of hospital-based RHC/FQHC Services (from	· · · · ·		2, 735, 319	1.
	of injections/infusions and their administration (from WI			90, 870	
4	allowable cost excluding injections/infusions (line 1 mi	inus line 2)		2, 644, 449	
	Visits (from Wkst. M-2, column 5, line 8)			12, 626	
	icians visits under agreement (from Wkst. M-2, column 5, l	line 9)		0	5.
	adjusted visits (line 4 plus line 5)			12, 626	6.
. 00 Adj us	sted cost per visit (line 3 divided by line 6)		Cal cul ati on	209.44	7.
			Carcuration		
			Rate Period	Rate Period 1	
			N/A	(01/01/2022	
				through	
				12/31/2022)	
			1.00	2.00	
	visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	. 6 or your contractor)	0.00	219.47	8.
	for Program covered visits (see instructions) JLATION OF SETTLEMENT		0.00	209.44	9.
	ram covered visits excluding mental health services (from	contractor records)	0	1, 287	1 10.
5	ram cost excluding costs for mental health services (line	· · · · · · · · · · · · · · · · · · ·	0	269, 549	
5	ram covered visits for mental health services (from contra		0	20,701,7	12
	ram covered cost from mental health services (line 9 x lin		0	1, 676	
	t adjustment for mental health services (see instructions)	-	0	1, 676	
	uate Medical Education Pass Through Cost (see instructions				15.
6.00 Total	Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	271, 225	16.
6.01 Total	program charges (see instructions)(from contractor's real	cords)		260, 775	16.
	program preventive charges (see instructions)(from provi			10, 635	
	program preventive costs ((line 16.02/line 16.01) times	-		11, 061	
	Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		170, 662	16.
	es V and XIX see instructions.)		0	101 700	11
	program cost (see instructions)		0	181, 723	16. 17.
	ary payer amounts Beneficiary deductible for RHC only (see instructions)	(from contractor		46, 837	
recor				40, 037	10.
	ficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		40, 661	19.
recor	5	<i>,</i> , ,			
0.00 Net M	Medicare cost excluding vaccines (see instructions)			181, 723	20.
	ram cost of vaccines and their administration (from Wkst.	M-4, line 16)		8, 772	
4	reimbursable Program cost (line 20 plus line 21)			190, 495	
	wable bad debts (see instructions)			0	23.
	sted reimbursable bad debts (see instructions)			0	23.
	wable bad debts for dual eligible beneficiaries (see insti	ructions)		0	24.
	R ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	c)		0	25. 25.
	eer ACO demonstration payment adjustment (see instructions nstration payment adjustment amount before sequestration	<i></i>		0	
	reimbursable amount (see instructions)			190, 495	
	estration adjustment (see instructions)			2, 400	
	nstration payment adjustment amount after sequestration			2, 100	
	rim payments			189, 236	
	ative settlement (for contractor use only)			0	28.
	nce due component/program (line 26 minus lines 26.01, 26.0	02, 27, and 28)		-1, 141	29.
9.00 Balar					

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	HOSPI TAL Provi der CCN: 15-1333	Peri od:	u of Form CMS-2 Worksheet M-3	
RVI CES		From 01/01/2022		
	Component CCN: 15-8514	To 12/31/2022	Date/Time Pre 5/31/2023 8:4	
	Title XVIII	RHC III	Cost	1 ani
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES	m Wkat M 2 Line 20)		2 70/ 105	1 1
00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro 00 Cost of injections/infusions and their administration (from V			2, 706, 195 66, 583	
00 Total allowable cost excluding injections/infusions (line 1 m			2, 639, 612	
00 Total Visits (from Wkst. M-2, column 5, line 8)	in nus Trne 2)		8, 714	
00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0, 711	5.
00 Total adjusted visits (line 4 plus line 5)			8, 714	6.
00 Adjusted cost per visit (line 3 divided by line 6)			302.92	
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2022	
		NZ A	through	
			12/31/2022)	
		1.00	2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	D.6 or your contractor)	0.00	293.29	8.
00 Rate for Program covered visits (see instructions)		0.00	293.29	9.
CALCULATION OF SETTLEMENT				1
0.00 Program covered visits excluding mental health services (from		0	1,000	
1.00 Program cost excluding costs for mental health services (line 2.00 Program covered visits for mental health services (from contr		0	293, 290	
2.00 Program covered visits for mental health services (from contr 3.00 Program covered cost from mental health services (line 9 x li	<i>,</i>	0	34 9, 972	
1.00 Limit adjustment for mental health services (see instructions		0	9,972	
5.00 Graduate Medical Education Pass Through Cost (see instruction		Ŭ	7, 772	15
5.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	303, 262	
b.01 Total program charges (see instructions)(from contractor's re			209, 803	
5.02 Total program preventive charges (see instructions)(from prov	/ider's records)		13, 552	16.
b.03 Total program preventive costs ((line 16.02/line 16.01) times	s line 16)		19, 589	16
5.04 Total Program non-preventive costs ((line 16 minus lines 16.0	03 and 18) times .80)		206, 836	16
(Titles V and XIX see instructions.)				
b. 05 Total program cost (see instructions)		0	226, 425	
7.00 Primary payer amounts			0	17.
B. 00 Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		25, 128	18.
0.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		34, 211	19.
records)			,	
0.00 Net Medicare cost excluding vaccines (see instructions)			226, 425	20
0.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		8, 333	
2.00 Total reimbursable Program cost (line 20 plus line 21)			234, 758	
8.00 Allowable bad debts (see instructions)			0	
8.01 Adjusted reimbursable bad debts (see instructions) 1.00 Allowable bad debts for dual eligible beneficiaries (see inst	tructionel		0	23
H.OO Allowable bad debts for dual eligible beneficiaries (see inst 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tructions)		0	
5.50 Pioneer ACO demonstration payment adjustment (see instruction	(ar		0	
5. 99 Demonstration payment adjustment amount before sequestration	,		0	
5. 00 Net reimbursable amount (see instructions)			234, 758	
5. 01 Sequestration adjustment (see instructions)			2, 958	
b. 02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			223, 864	27
B. 00 Tentative settlement (for contractor use only)			0	
0.00 Balance due component/program (line 26 minus lines 26.01, 26.			7, 936	
).00 Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-II.		0	30.

COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE	COST	Provider CC Component C		Period: From 01/01/2022 To 12/31/2022	Worksheet M-4 Date/Time Prep 5/31/2023 8:4	
		Title	XVIII	RHC I	Cost	
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
1.00 Health care staff cost (from Wkst. M-1,	col. 7, line 10)	950, 540	950, 5	40 950, 540	950, 540	1.00
2.00 Ratio of injection/infusion staff time care staff time	to total health	0. 004723	0.0053	0. 002152	0. 000000	2.00
3.00 Injection/infusion health care staff co 2)	st (line 1 x line	4, 489	5,0	65 2, 046	0	3.00
4.00 Injections/infusions and related medica (from your records)		36, 597			0	4.00
5.00 Direct cost of injections/infusions (li		41, 086				5.00
6.00 Total direct cost of the hospital-based Worksheet M-1, col. 7, line 22)		1, 094, 722				6.00
7.00 Total overhead (from Wkst. M-2, line 19		1, 492, 541	1, 492, 5			7.00
8.00 Ratio of injection/infusion direct cost cost (line 5 divided by line 6)		0. 037531	0. 0159			8. 00
9.00 Overhead cost - injection/infusion (lin		56, 017				9.00
10.00 Total injection/infusion costs and thei costs (sum of lines 5 and 9)		97, 103				10. 0
11.00 Total number of injections/infusions (f		452		10 206	-	11.0
12.00 Cost per injection/infusion (line 10/li		214.83				
13.00 Number of injection/infusion administer beneficiaries	5	4		41 7	0	
3.01 Number of COVID-19 vaccine injections/i administered to MA enrollees				0	0	13.0
14.00 Program cost of injections/infusions an administration costs (line 12 times the and 13.01, as applicable)		859	3, 3	25 164		14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1.00	2.00	
15.00 Total cost of injections/infusions and 2, 2.01, and 2.02, line 10) (transfer t			columns 1,		143, 294	15.00
16.00 Total Program cost of injections/infusi			(sum of		4, 348	16.00

	Financial Systems PUTNAM COUNT ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CO	CN: 15-1333	Peri od:	Worksheet M-4	2552-1
		Component (CCN: 15-8513	From 01/01/2022 To 12/31/2022	Date/Time Pre	
					5/31/2023 8:4	1 am
		PNEUMOCOCCAL	XVIII INFLUENZA	RHC II	Cost MONOCLONAL	
		VACCI NES	VACCI NES	COVI D-19 VACCI NES	ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	989, 455	989, 4	55 989, 455	989, 455	1.0
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 000871	0.0041	0. 000878	0. 000000	2.0
3.00	Injection/infusion health care staff cost (line 1 x line 2)	862	4, 0	64 869	0	3.0
1.00	Injections/infusions and related medical supplies costs (from your records)	11, 074	19, 4	23 0	0	4.0
5.00	Direct cost of injections/infusions (line 3 plus line 4)	11, 936	23, 4			5.0
5.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 092, 420	1, 092, 4	20 1, 092, 420	1, 092, 420	6.0
7.00	Total overhead (from Wkst. M-2, line 19)	1, 642, 899				7.C
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 010926				8.0
9.00	Overhead cost - injection/infusion (line 7 x line 8)	17, 950				9.0
0. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	29, 886			0	10. 0
1.00	Total number of injections/infusions (from your records)	123		80 124		
2.00	Cost per injection/infusion (line 10/line 11)	242.98				12.0
3.00	Number of injection/infusion administered to Program beneficiaries	2		30 10		
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	_	13. C
4.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	486	8, 1	11 175	0	14.0
					COST OF INJECTIONS / INFUSIONS AND	
				1.00	ADMI NI STRATI ON 2. 00	
5.00	Total cost of injections/infusions and their administration		columns 1,	1.00	90, 870	15.0
6.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. Total Program cost of injections/infusions and their admini		(sum of		8, 772	16. (

	Financial Systems PUTNAM COUNT		N. 1E 1000	Period:	u of Form CMS-2 Worksheet M-4	
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST		Provider CCN: 15-1333		From 01/01/2022		
		Component (CCN: 15-8514	To 12/31/2022	Date/Time Pre	
				DUO LLI	5/31/2023 8: 4	1 am
		PNEUMOCOCCAL	XVIII INFLUENZA	RHC III		
		VACCI NES	VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY	
		VACCINES	VACCINES	VACCINES	PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	1,005,908	1, 005, 9	08 1, 005, 908	1, 005, 908	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 000728	0.0028	43 0. 001492	0. 000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	732	2, 8	60 1, 501	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	9, 714	12, 3	32 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	10, 446	15, 1	92 1, 501	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 103, 057	1, 103, 0	57 1, 103, 057	1, 103, 057	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1, 603, 138				7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 009470				8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	15, 182				9.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	25, 628				10.00
11.00	Total number of injections/infusions (from your records)	104		06 213		
12.00	Cost per injection/infusion (line 10/line 11)	246.42	91.			
13.00	Number of injection/infusion administered to Program beneficiaries	0		84 36		
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	0	7,7	11 622	0	14.00
		<u> </u>			COST OF	
					INFUSIONS AND ADMINISTRATION	
				1.00	2.00	
15.00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		66, 583	15.00
16.00		istration costs			8, 333	16.00

th Financial Systems PUTNAM COUNT	Y HOSPI TAL	In Lie	u of Form CMS-2	2552
LYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1333	Peri od:	Worksheet M-5	
VICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8515	From 01/01/2022 To 12/31/2022	Date/Time Prep 5/31/2023 8:41	
		RHC I	Cost	i dii
		Par	t B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
O Total interim payments paid to hospital-based RHC/FQHC			124, 278	1.
O Interim payments payable on individual bills, either submit			0	2.
the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write			
0 List separately each retroactive lump sum adjustment amount	based on subsequent			3.
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				
1			0	3
2			0	3
3			0	3
4			0	3
5			0	3
Provider to Program			0	2
0			0	3
1 2			0	3
3			0	3
4			0	3
, 9 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		Ő	3
D Total interim payments (sum of lines 1, 2, and 3.99) (trans			124, 278	4
27)				
TO BE COMPLETED BY CONTRACTOR				
0 List separately each tentative settlement payment after des	sk review. Also show date o	f		5
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
1			0	5
2			0	5
3 Drawidan ta Drawan			0	5
Provider to Program				
0			0	5
1 2			0	5
2 9 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5
Determined net settlement amount (balance due) based on the			0	6
1 SETTLEMENT TO PROVIDER			0	6
2 SETTLEMENT TO PROGRAM			11, 349	6
0 Total Medicare program liability (see instructions)			112, 929	7
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	
0 Name of Contractor	WISCONSIN PHYSICIAN SERVIC			8.

Health Financial Systems PUTNAM COUNTY	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 01/01/2022		
	Component CCN: 15-8513	To 12/31/2022	Date/Time Prep 5/31/2023 8:4	
		RHC II	Cost	i ani
			T B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
1.00 Total interim payments paid to hospital-based RHC/FQHC			189, 236	1.00
2.00 Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.00
the contractor for services rendered in the cost reporting				
"NONE" or enter a zero				
3.00 List separately each retroactive lump sum adjustment amount	based on subsequent			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			0	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.4			0	3.99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) (trans	fer to Worksheet M-3, line		189, 236	4.00
27) TO BE COMPLETED BY CONTRACTOR				
5.00 List separately each tentative settlement payment after des	k raviaw. Alaa ahaw data a	£		5.00
each payment. If none, write "NONE" or enter a zero. (1)	K review. Also show date o	1		5.00
Program to Provider				
5.01			0	5.01
5.02			0	5.02
5.03			0	5.03
Provider to Program			0	0.00
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			Ĭ	6.00
6.01 SETTLEMENT TO PROVIDER	(-)		0	6.01
6.02 SETTLEMENT TO PROGRAM			1, 141	6. 02
7.00 Total Medicare program liability (see instructions)			188, 095	7.00
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	
8.00 Name of Contractor	WISCONSIN PHYSICIAN SERVIC	ES 08001		8.00

Ith Financial Systems PUTNAM COUNTY	(HOSPI TAL	In Lie	u of Form CMS-2	2552-
ALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1333	Peri od:	Worksheet M-5	
RVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8514	From 01/01/2022 To 12/31/2022	Date/Time Prep 5/31/2023 8:4	
		RHC III	Cost	
		Par	tВ	
		mm/dd/yyyy	Amount	
		1.00	2.00	
DO Total interim payments paid to hospital-based RHC/FQHC			223, 864	1.0
00 Interim payments payable on individual bills, either submitted the contractor for services rendered in the cost reporting payable.			0	2.0
"NONE" or enter a zero				
DO List separately each retroactive lump sum adjustment amount	List separately each retroactive lump sum adjustment amount based on subsequent			
revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)	Also show date of each			
Program to Provider				
)1			0	3.
02			0	
03			0	3.
04			0	3.
05			0	3.
Provider to Program				1
50			0	3.
51			0	3.
52			0	3.
53			0	3.
54			0	3.
99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3.
Total interim payments (sum of lines 1, 2, and 3.99) (transf 27)	fer to Worksheet M-3, line		223, 864	4.
TO BE COMPLETED BY CONTRACTOR				1
DO List separately each tentative settlement payment after desk	<pre>< review. Also show date o</pre>	f		5.
each payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
01			0	5.
02			0	5.
03			0	5.
Provider to Program				
50			0	
51			0	5.
52 DD Subtatal (our of lines 5 01 5 40 minus our of lines 5 50 5 6	20)		0	5.
99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9			0	5.
D0 Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER	cost report. (1)		7 024	6. 6.
D2 SETTLEMENT TO PROVIDER			7, 936 0	6.
DO Total Medicare program liability (see instructions)			231, 800	
		Contractor	NPR Date	/.
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	
00 Name of Contractor	VI SCONSI N PHYSI CI AN SERVI CI		2.00	8.0