Heal th Financia	al Systems	PUTNAM COUNTY HO	SPI TAL	In Li	eu of Form CMS-2552-10
	required by Law (42 USC 1395 since the beginning of the co	3.			m FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX C SUMMARY	OST REPORT CERTIFICATION	Provider CCN: 1513	Peri od: From 01/01/2014 To 12/31/2014	
PART I - COST	REPORT STATUS				·
Provi der use only	1. [ X ] Electronically filed 2. [ ] Manually submitted co 3. [ 0 ] If this is an amended 4. [ F ] Medicare Utilization.	ost report d report enter the number of	f times the provide for low.	Date: 5/29/2 er resubmitted this	
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened		this Provider CCN		

PART II - CERTIFICATION

(5) Amended

MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PUTNAM COUNTY HOSPITAL (151333) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)			
	Officer or	Admi ni strator	of Provider(s)
Title			
Date			

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	56, 820	-811, 524	0	5, 704	1. 00
2.00	Subprovi der - I PF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	67, 030	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	123, 850	-811, 524	0	5, 704	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151333 Peri od: Worksheet S-2 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 7:22 pm 3.00 4. 00 Hospital and Hospital Health Care Complex Address: Street: 1542 SOUTH BLOOMINGTON ST 1.00 PO Box: 1.00 Ci ty: GREENCASTLE State: IN 2.00 Zip Code: 46135-County: PUTNAM 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fied T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal PUTNAM COUNTY HOSPITAL 151333 99915 12/31/2005 Ν 0 3.00 Subprovider - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 PUTNAM COUNTY HOSPITAL 15Z333 99915 12/31/2005 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 Hospi tal -Based Hospi ce 14.00 14.00 15.00 Hospital-Based Health Clinic - RHC 15 00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospital -Based (CORF) I 17. 10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information 22 00 Does this facility qualify and is it currently receiving payments for disproportionate N 22 00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν N 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2. or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

	Medicai d pai d days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	unpai d	HMO days	Medi cai d days	
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is an IPPS hospital, enter t in-state Medicaid paid days in column 1, in-s Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in 4, Medicaid HMO paid and eligible but unpaid column 5, and other Medicaid days in column 6  25.00 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-o Medicaid eligible unpaid days in column 4, Me HMO paid and eligible but unpaid days in colu	col umn days in . e 0 f-state di cai d	0	0	0	0	0	25. 00

care or general surgery. (see instructions)

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151333 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 7:22 pm Unwei ghted Program Name Program Code Unweighted IME Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 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)

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151333 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/28/2015 7:22 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + colNonprovi der Hospi tal 4)) Si te 1.00 2 00 3. 00 4.00 5 00 67.00 Enter in column 1, the program 0. 00 0.00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Ν Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF Ν 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151333 Peri od: Worksheet S-2 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/28/2015 7:22 pm 1. 00 2.00 128.00||f this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|f this is a Medicare certified lung transplant center, enter the certification date in 129.00 column 1 and termination date, if applicable, in column 2. 130.00 of this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 olf this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (0PO), enter the 0PO number in column 1 134 00 and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Ν 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)

1.00

2.00 3 00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141. 00 Name: Contractor's Name: Contractor's Number: 141.00 142. 00 Street: 143. 00 Ci ty: PO Box: 142. 00 State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 145.00 If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no. N 145.00 1. 00 2.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146. 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147. 00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 148. 00 Ν 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for Ν 149.00 no. Part A Title V 1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal N N 155.00 Ν Ν N 156.00 Subprovi der - IPF Ν Ν Ν 156.00 157.00 Subprovi der - IRF Ν 157. 00 Ν N Ν 158. 00 SUBPROVI DER 158 00 159. 00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY N Ν Ν Ν 160. 00 161.00 CMHC 161.00 Ν Ν Ν 161. 10 CORF N Ν Ν 161. 10 1.00 Multicampus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. FTE/Campus CBSA Name County State | Zip Code 0 1.00 2 00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00 166.00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167 00 167.00|s this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no. Υ 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168.00 reasonable cost incurred for the HIT assets (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions)

Health Financial Systems	PUTNAM COUNTY HOSPITAL  COMPLEX IDENTIFICATION DATA Provider CCN: 151333			In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Peri od:	Worksheet S-2	)		
			From 01/01/2014 To 12/31/2014	Part     Date/Time Pre	nared.	
			10 12/01/2011	5/28/2015 7: 2	22 pm	
	Endi ng					
			1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 01/01/2014 period respectively (mm/dd/yyyy)					170. 00	
				1.00		
171.00 ffline 167 is "Y", does this provide Medicare cost plans reported on Wkst. (see instructions)	N	171. 00				

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE:	PUTNAM COUNTY HOS STI ONNAI RE			eri od:	worksheet S-2	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	
					Y/N	5/28/2015 7:2 Date	22 pm
					1. 00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all NO re	sponses. Enter	all dates in	the	
00	Provider Organization and Operation Has the provider changed ownership immediatel reporting period? If yes, enter the date of				N		1.0
	reperting periods in year enter the date or	the change in corumn	2. (666	Y/N	Date	V/I	
00	Has the provider terminated participation in			1. 00 N	2. 00	3. 00	2.00
00	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.  Is the provider involved in business transact	tions, including man	agement	N			3. 00
	contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or 1 relationships? (see instructions)	d to the provider or , or members of the	its board				
				Y/N 1.00	Type 2. 00	Date 3.00	
	Financial Data and Reports			1.00	2.00	3.00	
00	Column 1: Were the financial statements prepared Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Co enter date availabl	mpiled,	Y	A	08/30/2014	4.00
00	column 3. (see instructions) If no, see instructions are the cost report total expenses and total those on the filed financial statements? If y	revenues different		N			5. 00
	those on the fired financial statements: If y	yes, subilit reconcit	ration.		Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
00	Approved Educational Activities  Column 1: Are costs claimed for nursing school the legal operator of the program?	ool? Column 2: If y	es, is th	ne provider is	N		6. 0
00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prog	grams approved and/o		I during the	N N		7. 00 8. 00
00	cost reporting period? If yes, see instructional Are costs claimed for Intern-Resident program yes, see instructions.		rrent cos	st report? If	N		9. 00
0. 00	yes, see instructions. Was an Intern-Resident program been initiated period? If yes, see instructions.	d or renewed in the	current c	cost reporting	N		10.00
1. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		in an App	proved	N		11. 00
						Y/N 1. 00	
2 00	Bad Debts Is the provider seeking reimbursement for bad	d dehts? If ves see	instruct	ions		Υ	12. 00
3. 00	If line 12 is yes, did the provider's bad deberiod? If yes, submit copy.	ot collection policy	change d	luring this cos	. 0	N N	13. 00
4. 00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments w	aived? If	yes, see inst	ructi ons.	N	14.00
5. 00	Did total beds available change from the price	or cost reporting pe	riod? If			N	15. 00
		Description		Par Y/N	t A Date	Part B Y/N	
		0		1. 00	2. 00	3. 00	
5. 00	PS&R Data Was the cost report prepared using the PS&R			l N		l N	16. 00
). 00	Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see			IV		IV	16.00
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records			Y	04/07/2015	Y	17. 00
	for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns						
3. 00	2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not			N		N	18. 00
9. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments			N		N	19. 00
	made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe			N		N	20.00

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151333 Peri od: Worksheet S-2 From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/28/2015 7:22 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν N 21 00 provider's records? If yes, see . i nstructi ons. 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Υ 24.00 If yes, see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Υ 29.00 treated as a funded depreciation account? If yes, see instructions

30.00

31.00

32.00

33.00

34.00

Ν

Ν

N

Ν

Υ

Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see

Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see

Have changes or new agreements occurred in patient care services furnished through contractual

34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians?

arrangements with suppliers of services? If yes, see instructions.

If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If

35. 00	If line 34 is yes, were there new agreements or amended exi		ovi der-based	N	35. 00		
	physicians during the cost reporting period? If yes, see in	structions.					
			Y/N	Date			
			1. 00	2. 00			
	Home Office Costs						
36.00	Were home office costs claimed on the cost report?		N		36.00		
37.00	If line 36 is yes, has a home office cost statement been pr	N		37. 00			
	If yes, see instructions.						
38. 00	If line 36 is yes , was the fiscal year end of the home off	N		38. 00			
	the provider? If yes, enter in column 2 the fiscal year end of the home office.						
39. 00	If line 36 is yes, did the provider render services to othe	N		39. 00			
	see instructions.						
40.00	If line 36 is yes, did the provider render services to the	N		40. 00			
	instructions.						
		1. 00	2.	00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	TI NA	SEVERS		41. 00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report	BLUE & CO., LLC			42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost	317-713-7946	TSEVERS@BLUEAN	DCO. COM	43. 00		
	report preparer in columns 1 and 2, respectively.						

instructions.

instructions.
Purchased Services

no, see instructions. Provider-Based Physicians

If yes, see instructions.

31.00

32.00

33.00

Heal th	Financial Systems	PUTNAM COUNTY	/ HOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMEN	Γ QUESTI ONNAI RE	Provi der CCN: 151333	From 01/01/2014	Worksheet S-2 Part II Date/Time Pre 5/28/2015 7:2	pared:
		Part B Date 4.00				
16. 00	PS&R Data Was the cost report prepared using the Report only? If either column 1 or 3 is					16. 00

		Part B		
		Date		
		4.00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R			16. 00
	Report only? If either column 1 or 3 is yes,			
	enter the paid-through date of the PS&R			
	Report used in columns 2 and 4 .(see			
	instructions)			
17.00	Was the cost report prepared using the PS&R	04/07/2015		17. 00
	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)			
18. 00				18. 00
	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.			
19. 00				19. 00
19.00	made to PS&R Report data for corrections of			19.00
	other PS&R Report information? If yes, see			
	instructions.			
20. 00				20.00
20.00	made to PS&R Report data for Other? Describe			20.00
	the other adjustments:			
21.00	Was the cost report prepared only using the			21. 00
	provider's records? If yes, see			
	instructions.			
			3.00	
	Cost Report Preparer Contact Information			
41. 00	Enter the first name, last name and the title		MANAGER	41. 00
	held by the cost report preparer in columns 1	l, 2, and 3,		
40.00	respecti vel y.			40.00
42. 00	Enter the employer/company name of the cost r	report		42. 00
40.00	preparer.	-6 +1		42.00
43. 00	Enter the telephone number and email address			43. 00
	report preparer in columns 1 and 2, respective	rei y.	I	I

 Heal th Financial
 Systems
 PUTNAM

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

						10 12/31/2014	5/28/2015 7:2	
	·						I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	Compensite	Line Number	110.	or beas	Avai I abl e	Oran nodi S	11 110 1	
		1.00		2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		19				1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						l ol	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						O	6. 00
7. 00	Total Adults and Peds. (exclude observation			19	6, 93	5 37, 032. 00	o	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		6	2, 19	0 12, 168. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43. 00					0	13. 00
14.00	Total (see instructions)			25	9, 12	5 49, 200. 00	0	14. 00
15.00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16. 00
17.00	SUBPROVI DER - I RF	41. 00		0		0	0	17. 00
18.00	SUBPROVI DER	42. 00		0		o	0	18. 00
19.00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21. 00
22.00	HOME HEALTH AGENCY							22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24.00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25.00	CMHC - CMHC							25.00
25. 10	CMHC - CORF	99. 10					0	25. 10
26.00	RURAL HEALTH CLINIC	88. 00					0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			25				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0		0		32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00

Provi der CCN: 151333 | Peri od: | Worksheet S-3 | Part I | To | 12/31/2014 | Date/Time Prepared: | Frank | Frank | Frank | Prepared: | Frank | Frank | Frank | Prepared: | Frank | Frank | Prepared: | Prepar

				'	0 12/31/2014	5/28/2015 7: 2	
		I/P Days	6 / O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	957	32	1, 543			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2 00	for the portion of LDP room available beds)	237	0				2. 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider	237	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	596	0	649			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF	370	0	56			6. 00
7. 00	Total Adults and Peds. (exclude observation	1, 553	32	2, 248			7. 00
7.00	beds) (see instructions)	., 555	02	2,210			/
8.00	INTENSIVE CARE UNIT	351	6	507			8.00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		0	0			13. 00
14. 00	Total (see instructions)	1, 904	38	2, 755	0.00	194. 66	
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVIDER - I PF	_	_	_			16. 00
17. 00	SUBPROVIDER - IRF	0	0	0	0.00		1
18.00	SUBPROVI DER	0	0	0	0.00	0.00	
19.00	SKILLED NURSING FACILITY						19. 00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE						20. 00 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)	o	0	0			24. 10
25. 00	CMHC - CMHC	_		_			25. 00
25. 10	CMHC - CORF	o	O	0	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	o	0	0	0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	194. 66	27. 00
28. 00	Observation Bed Days		0	824			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			0			30. 00
31. 00				0			31. 00
32. 00		0	0	0			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0			l	I	33. 00

Health Financial Systems PUTNAI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

				To	12/31/2014	Date/Time Prep 5/28/2015 7:22	
		Full Time		Di sch	arges	0, 20, 20.0 , . 2.	
		Equi val ents			_		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1.00		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospi tal Adul ts & Peds. (columns 5, 6, 7 and		0	355	8	514	1. 00
	8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			o	o		2. 00
3.00	HMO IPF Subprovider				Ĭ		3. 00
4. 00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation						7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00		055		54.4	13.00
14.00	Total (see instructions)	0. 00	0	355	8	514	
15. 00 16. 00	CAH visits SUBPROVIDER - IPF						15. 00 16. 00
17. 00	SUBPROVIDER - I RF	0. 00	0	o	0	0	17. 00
18. 00	SUBPROVI DER	0. 00	0	-	o O	0	18. 00
19. 00	SKILLED NURSING FACILITY	0.00	· ·		Ĭ	Ĭ	19. 00
20. 00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00 28. 00	Total (sum of lines 14-26) Observation Bed Days	0. 00					27. 00 28. 00
29. 00	Ambul ance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)				ļ	ļ	32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

HUSPI		I TAL		u of Form CMS-2				
	TAL UNCOMPENSATED AND INDIGENT CARE DATA	rovider CCN: 151333	Period: From 01/01/2014 To 12/31/2014	Worksheet S-10 Date/Time Pre				
			10 12/31/2014	5/28/2015 7: 2:				
				1. 00				
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	ed by line 202 colu	mn 8)	0. 365097	1. C			
	Medicaid (see instructions for each line)							
2. 00	Net revenue from Medicaid			1, 429, 450				
3. 00	Did you receive DSH or supplemental payments from Medicaid?		0	Y	3.0			
. 00	If line 3 is "yes", does line 2 include all DSH or supplemental pa		ı d'?	N 214 405	4.0			
. 00	If line 4 is "no", then enter DSH or supplemental payments from Me Medicaid charges	edi cai d		-314, 485 6, 203, 051				
. 00								
3. 00								
. 00	< zero then enter zero) State Children's Health Insurance Program (SCHIP) (see instruction		The 2 and 5, 11	1, 149, 750	8. (			
. 00	Net revenue from stand-alone SCHIP	is for each fine)		0	9. (			
0. 00				0				
1. 00	Stand-alone SCHIP cost (line 1 times line 10)			0				
2. 00	Difference between net revenue and costs for stand-alone SCHIP (Li	ine 11 minus line 9	: if < zero then	Ö				
	enter zero)							
	Other state or local government indigent care program (see instruc							
3. 00	Net revenue from state or local indigent care program (Not include		,		13.			
4. 00	Charges for patients covered under state or local indigent care pr 10)	rogram (Not include	d in lines 6 or	0	14.			
5. 00	State or local indigent care program cost (line 1 times line 14)			0				
6. 00	Difference between net revenue and costs for state or local indigental; if < zero then enter zero)	ent care program (I	ine 15 minus line	0	16.			
	Uncompensated care (see instructions for each line)							
7. 00	Private grants, donations, or endowment income restricted to fundi				17.			
8.00				0				
9. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local i 8, 12 and 16)	indigent care progr	ams (sum of lines	1, 149, 750	19.			
		Uni nsured		Total (col. 1				
		pati ents		+ col . 2)				
		1.00						
0.00	Total initial obligation of nationts approved for abority core (at		2.00	3. 00	20			
0. 00	Total initial obligation of patients approved for charity care (at	t full 1, 417,			20.			
	Total initial obligation of patients approved for charity care (at charges excluding non-reimbursable cost centers) for the entire factors of initial obligation of patients approved for charity care (at the cost of initial obligation of patients).	t full 1,417, acility	849 0	3. 00				
	charges excluding non-reimbursable cost centers) for the entire fa	t full 1,417, acility	849 0	3. 00 1, 417, 849				
1. 00 2. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care times line 20) Partial payment by patients approved for charity care	t full 1,417, acility (line 1 517,	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 1, 417, 849 517, 652 0	21. 22.			
1. 00 2. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care times line 20) Partial payment by patients approved for charity care	t full 1,417, acility	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 1, 417, 849 517, 652	21. 22.			
1. 00 2. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care times line 20) Partial payment by patients approved for charity care	t full 1,417, acility (line 1 517,	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 1, 417, 849 517, 652 0	21. 22.			
1. 00 2. 00 3. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient day	t full 1,417, acility (line 1 517, 517, ays beyond a length	849 0 652 0 0 0 652 0	3. 00 1, 417, 849 517, 652 0 517, 652	21. ( 22. ( 23. (			
2. 00 3. 00 4. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient daimposed on patients covered by Medicaid or other indigent care pro	t full 1,417, acility (line 1 517, 517, ays beyond a length ogram?	0652 0 0 0652 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 1, 417, 849 517, 652 0 517, 652	21. (22. (23. (24. (24. (24. (24. (24. (24. (24. (24			
1. 00 2. 00 3. 00 4. 00 5. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient daimposed on patients covered by Medicaid or other indigent care proof of the control	t full 1,417, acility (line 1 517, 517, ays beyond a length ogram? care program's len	0652 0 0 0652 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 1, 417, 849 517, 652 0 517, 652 1. 00	21.			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient day imposed on patients covered by Medicaid or other indigent care proof line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instru	t full 1,417, acility (line 1 517, 517, ays beyond a length ogram? care program's lenuctions)	0652 0 0 0652 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 1, 417, 849 517, 652 0 517, 652 1. 00	21. 1 22. 23. 1 24. 1 25. 26. 1			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient daimposed on patients covered by Medicaid or other indigent care profile line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instruction medicare bad debts for the entire hospital complex (see instruction)	t full 1,417, acility (line 1 517, 517, 517, ays beyond a length ogram? care program's lenuctions) ons)	0652 0 0 0652 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	3. 00 1, 417, 849 517, 652 0 517, 652 1. 00 0 4, 341, 224 233, 460	21. ( 22. ( 23. ( 24. ( 25. ( 26. ( 27. (			
21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care (Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient dainposed on patients covered by Medicaid or other indigent care profile line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instruction Non-Medicare and non-reimbursable Medicare bad debt expense (line	t full acility (line 1 517,  ays beyond a length ogram? care program's lenuctions) ons) 26 minus line 27)	849 0 652 0 0 0 652 0 of stay limit	3. 00 1, 417, 849 517, 652 0 517, 652 1. 00 0 4, 341, 224 233, 460 4, 107, 764	21. ( 22. ( 23. ( 24. ( 25. ( 26. ( 27. ( 28. (			
20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 29. 00 29. 00	charges excluding non-reimbursable cost centers) for the entire facost of initial obligation of patients approved for charity care (times line 20) Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)  Does the amount in line 20 column 2 include charges for patient day imposed on patients covered by Medicaid or other indigent care prought line 24 is "yes," charges for patient days beyond an indigent Total bad debt expense for the entire hospital complex (see instruction Non-Medicare and non-reimbursable Medicare bad debt expense (line Cost of non-Medicare and non-reimbursable Medicare bad debt expense	t full acility (line 1 517,  ays beyond a length ogram? care program's lenuctions) ons) 26 minus line 27)	849 0 652 0 0 0 652 0 of stay limit	3. 00 1, 417, 849 517, 652 0 517, 652 1. 00 0 4, 341, 224 233, 460	21. ( 22. ( 23. ( 24. ( 25. ( 26. ( 27. ( 28. ( 29. (			

Health Financial Systems		PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2		
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der	CCN: 151333	Peri od:	Worksheet A	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
						5/28/2015 7: 2	
	Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Reclassi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		2, 835, 176			3, 204, 434	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	19, 437	3, 250, 510			3, 281, 135	
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 712, 054	3, 896, 032			5, 482, 925	5.00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	224, 339 22, 507	1, 007, 853 77, 716			1, 298, 344 100, 223	
9. 00	00900 HOUSEKEEPI NG	277, 196	88, 412			365, 608	
10.00	01000 DI ETARY	311, 388	289, 492			174, 253	
11. 00	01100 CAFETERI A	0	0		0 426, 627	426, 627	11. 00
13. 00	01300 NURSING ADMINISTRATION	102, 045	280, 498			382, 543	
16.00	01600 MEDI CAL RECORDS & LI BRARY	354, 803	114, 881	469, 68		469, 684	1
17. 00 17. 01	01700   SOCIAL SERVICE   01701   UTILIZATION REVIEW	74, 374	121			121 86, 460	
17.01	INPATIENT ROUTINE SERVICE COST CENTERS	14, 314	12, 086	00, 40	0  0	00, 400	17.01
30. 00	03000 ADULTS & PEDI ATRI CS	1, 000, 139	44, 967	1, 045, 10	6 3, 422	1, 048, 528	30.00
31.00	03100 INTENSIVE CARE UNIT	720, 734	33, 544			756, 738	1
41. 00	04100 SUBPROVI DER - I RF	0	0		0 0	0	
42. 00	04200 SUBPROVI DER	0	0		0 0	0	
43. 00	04300 NURSERY	0	0		0 0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	408, 528	645, 575	1, 054, 10	3 -101, 469	952, 634	50.00
51. 00	05100 RECOVERY ROOM	79, 015	8, 638			87, 653	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0,,00	ol ol	0	1
53.00	05300 ANESTHESI OLOGY	562, 294	88, 560	650, 85	4 0	650, 854	
54.00	05400 RADI OLOGY-DI AGNOSTI C	596, 010	242, 574	838, 58	4 6, 253	844, 837	54. 00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	139, 702			139, 702	
57. 00	05700 CT SCAN	140, 066	144, 870	284, 93	6 0	284, 936	
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	0	0			0	
60.00	06000 LABORATORY	515, 698	1, 273, 908	1, 789, 60	6 0	1, 789, 606	
60. 01	06001 BLOOD LABORATORY	0	0	.,,	o o	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	o	0		o o	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	332, 921	119, 155			458, 354	
66. 00	06600   PHYSI CAL THERAPY   06700   OCCUPATI ONAL THERAPY	0	453, 324			454, 039	
67. 00 68. 00	06800 SPEECH PATHOLOGY		112, 864 3, 665			112, 864 3, 665	
69. 00	06900 ELECTROCARDI OLOGY	50, 342	84, 393			134, 735	
69. 01	06901 CARDI AC REHAB	72, 345	2, 277	74, 62		74, 622	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 465	77, 632	82, 09		0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	127 010	1 2/1 000	1 207 00	0 158, 695	158, 695	
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07301 ONCOLOGY	126, 010 234, 718	1, 261, 888 1, 953, 194			3, 092, 632 488, 106	
73.01	OUTPATIENT SERVICE COST CENTERS	234, 710	1, 755, 174	2, 107, 71	2 -1,077,000	400, 100	73.01
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89. 00
90. 00	09000 CLI NI C	2, 435	0	2, 43		2, 435	
91.00	09100 EMERGENCY	1, 144, 475	2, 035, 874	3, 180, 34	9 815	3, 181, 164	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
99. 10	09910 CORF	0	0		0 0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0		0 0		109. 00
	11000 INTESTINAL ACQUISITION  11100 ISLET ACQUISITION	0	0		0 0		110.00
	11100  TSLET ACQUISITION   11300  INTEREST EXPENSE	٩	0				111. 00 113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	0	0				114. 00
118.00		9, 088, 338	20, 579, 381	29, 667, 71	9 321, 437		
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS	3, 487, 966	1, 099, 033	4, 586, 99	9 -321, 437	4, 265, 562	
	19301 DME	0	0				193. 00 193. 01
	19302 LACTATION CONSULTING	0	0		o n		193. 01
	19303 DI ABETI C COUNSELI NG		0		ol ol		193. 03
	07950 VACANT SPACE	0	0		o  o		194. 00
	07951 BOARD OF HEALTH	0			0 0		194. 01
194. 02 200. 00	07952 PUTNAM/HENRY PRENATAL TOTAL (SUM OF LINES 118-199)	12, 576, 304	4, 121 21, 682, 535				194. 02
∠UU. UU		12, 370, 304	∠1, UOZ, D3D	J4, Z58, 83	기	J4, ZUB, BJ9	1200.00

Provi der CCN: 151333

Period: Worksheet ...
From 01/01/2014
To 12/31/2014 Date/Time Prepared: 5/28/2015 7:22 pm

			5/28/2015 7: 2	2 pm
Cost Center Description	Adjustments 1	Net Expenses		
	(See A-8) Fo	or Allocation		
	6.00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	-412, 888	2, 791, 546		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-3, 145	3, 277, 990		4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL	-2, 329, 689	3, 153, 236		5. 00
7. 00   00700   OPERATION OF PLANT	-3, 802			7. 00
	1	1, 294, 542		1
8. 00   00800 LAUNDRY & LINEN SERVICE	0	100, 223		8. 00
9. 00   00900   HOUSEKEEPI NG	0	365, 608		9. 00
10. 00  01000 DI ETARY	-2, 374	171, 879		10. 00
11. 00  01100  CAFETERI A	-61, 860	364, 767		11.00
13.00 01300 NURSING ADMINISTRATION	ol	382, 543		13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-5, 957	463, 727		16. 00
17. 00 01700 SOCI AL SERVI CE	0	121		17. 00
				17. 00
	J U	86, 460		17.01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS	0	1, 048, 528		30. 00
31.00  03100   I NTENSI VE CARE UNIT	0	756, 738		31. 00
41. 00  04100  SUBPROVI DER - I RF	0	0		41.00
42. 00   04200   SUBPROVI DER	0	0		42.00
43. 00   04300 NURSERY	o	0		43.00
ANCILLARY SERVICE COST CENTERS		•		1
50. 00 05000 OPERATI NG ROOM	0	952, 634		50.00
51. 00   05100   RECOVERY ROOM		87, 653		51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM		07,055		52.00
	1	-		
53. 00   05300   ANESTHESI OLOGY	-471, 638	179, 216		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	-2, 667	842, 170		54. 00
54. 01   05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	139, 702		54. 01
57. 00  05700 CT SCAN	0	284, 936		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	ol		59. 00
60. 00   06000   LABORATORY	0	1, 789, 606		60.00
60. 01   06001   BLOOD LABORATORY	o	0		60. 01
64. 00 06400 I NTRAVENOUS THERAPY		0		64. 00
		٩		
65. 00 06500 RESPIRATORY THERAPY	1	458, 354		65. 00
66. 00   06600   PHYSI CAL THERAPY	-23, 194	430, 845		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	112, 864		67. 00
68. 00  06800 SPEECH PATHOLOGY	0	3, 665		68. 00
69. 00  06900  ELECTROCARDI OLOGY	0	134, 735		69. 00
69. 01   06901   CARDI AC   REHAB	0	74, 622		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	158, 695		72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	-40, 880	3, 051, 752		73. 00
73. 01 07301 ONCOLOGY	-239, 904	248, 202		73. 01
OUTPATIENT SERVICE COST CENTERS	-237, 704	240, 202		73.01
				00.00
88. 00   08800   RURAL HEALTH CLINIC	0	0		88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0			89. 00
90. 00  09000  CLI NI C	-100	2, 335		90. 00
91. 00   09100   EMERGENCY	-1, 526, 672	1, 654, 492		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				1
99. 10 09910 CORF	0	0		99. 10
SPECIAL PURPOSE COST CENTERS	-1	-		
109. 00 10900 PANCREAS ACQUISITION	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		0		110. 00
	1	-1		
111. 00 11100   SLET ACQUISITION	0	0		111.00
113. 00 11300 I NTEREST EXPENSE	0	O		113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		114. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-5, 124, 770	24, 864, 386		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	4, 265, 562		192. 00
193. 00 19300 NONPALD WORKERS	0	0		193. 00
193. 01 19301 DME				193. 00
		O		
193. 02 19302 LACTATI ON CONSULTI NG	0	O		193. 02
193. 03 19303 DI ABETI C COUNSELI NG		0		193. 03
194.00 07950 VACANT SPACE	0	0		194. 00
194. 01 07951 BOARD OF HEALTH	0	0		194. 01
194.02 07952 PUTNAM/HENRY PRENATAL	0	4, 121		194. 02
200.00 TOTAL (SUM OF LINES 118-199)	-5, 124, 770	29, 134, 069		200. 00

Health Financial Systems RECLASSIFICATIONS PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10

RECLASS	DIFICATIONS		Provi der	CCN:	151333	From 01/01/2014 To 12/31/2014	Date/Time Pro	
						12, 01, 2011	5/28/2015 7:	
		Increases						

					To 12/31/201	4   Date/Time Prepared: 5/28/2015 7:22 pm
		Increases			L	372872015 7.22 piii
	Cost Center	Li ne #	Salary	Other		
	2.00	3. 00	4. 00	5. 00		
	A - CAFE RECLASS	3.00	4.00	5.00		
1.00	CAFETERI A	11.00	221, 087	205, 540		1. 00
1.00	TOTALS		221, 087	205, 540		1. 55
	B - EMPLOYEE PROMOTIONS		221,007	200, 010		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	O	11, 188		1. 00
1.00	TOTALS		— — <del>ў</del>	1 <u>1, 188</u>		1. 55
	C - INSURANCE RECLASS		<u> </u>	11, 100		
1.00	NEW CAP REL COSTS-BLDG &	1, 00	0	115, 917		1. 00
	FIXT		٩	, ,,		
	TOTALS	+		115, 917		
	D - DRUG RECLASS	1	-			
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1, 699, 991		1. 00
	TOTALS			1, 699, 991		
	E - PPO DEPRECIATION	1		.,,		
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	13, 061		1. 00
	FLXT			,		
	TOTALS			13, 061		
	G - CLINIC RECLASS	•				
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	240, 280		1. 00
	FLXT					
2.00	ADMINISTRATIVE & GENERAL	5. 00	o	1, 944		2. 00
3.00	OPERATION OF PLANT	7. 00	0	66, 152		3. 00
	TOTALS			308, 376		
	H - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	158, 695		1. 00
	PATI ENT					
	TOTALS		0	158, 695		
	I - MED SUPPLY RECLASS					
1.00	ADULTS & PEDIATRICS	30.00	0	3, 422		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	2, 460		2. 00
3.00	OPERATING ROOM	50.00	0	57, 226		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	6, 253		4. 00
5.00	RESPI RATORY THERAPY	65. 00	0	6, 278		5. 00
6.00	PHYSI CAL THERAPY	66. 00	0	715		6. 00
7.00	DRUGS CHARGED TO PATIENTS	73. 00	0	4, 743		7. 00
8.00	ONCOLOGY	73. 01	0	185		8. 00
9.00	EMERGENCY	<u>91.</u> 00	0			9. 00
	TOTALS		0	82, 097		
500.00	Grand Total: Increases		221, 087	2, 594, 865		500.00

Health Financial Systems RECLASSIFICATIONS PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 151333

| Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

						12/31/2014	5/28/2015 7: 22 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - CAFE RECLASS						
1.00	DI ETARY	1000	221, 087	205, 540	0		1.00
	TOTALS		221, 087	205, 540			
	B - EMPLOYEE PROMOTIONS						
1.00	ADMI NI STRATI VE & GENERAL	500	0	1 <u>1, 1</u> 88			1.00
	TOTALS		0	11, 188			
	C - INSURANCE RECLASS						
1.00	ADMI NI STRATI VE & GENERAL	500	0	11 <u>5, 9</u> 17			1.00
	TOTALS		0	115, 917			
	D - DRUG RECLASS						
1.00	ONCOLOGY	73. 01	0	1, 699, 991	0		1. 00
	TOTALS		0	1, 699, 991			
	E - PPO DEPRECIATION						
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	13, 061	9		1. 00
	TOTALS		0	13, 061			
	G - CLINIC RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	308, 376	9		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
	TOTALS		0	308, 376			
	H - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	158, 695	0		1. 00
	TOTALS			158, 695			
	I - MED SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	82, 097	0		1. 00
	PATI ENTS						
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	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	o	0	0		8. 00
9.00		0.00	o	0	0		9. 00
	TOTALS			82, 097			
500.00	Grand Total: Decreases		221, 087	2, 594, 865			500.00

					Fr To	com 01/01/2014 0 12/31/2014		
				Acquisition:	S			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1. 00	2. 00	3. 00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	F BALANCES		.1		_	_	
1.00	Land	0	(		0	0	0	1. 00
2.00	Land Improvements	456, 842	92!		0	925	0	2. 00
3.00	Buildings and Fixtures	28, 479, 064	467, 815	5	0	467, 815	0	3. 00
4.00	Building Improvements	0	(		0	0	0	4. 00
5.00	Fi xed Equipment	0	(		0	0	0	5. 00
6.00	Movable Equipment	18, 310, 675	1, 759, 949	9	0	1, 759, 949	0	6. 00
7.00	HIT designated Assets	0	(		0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	47, 246, 581	2, 228, 689	9	0	2, 228, 689	0	8. 00
9.00	Reconciling Items	119, 208	651, 879	9	0	651, 879	0	9. 00
10.00	Total (line 8 minus line 9)	47, 127, 373	1, 576, 810		0	1, 576, 810	0	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6. 00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	0	(					1. 00
2.00	Land Improvements	457, 767	(	)				2. 00
3.00	Buildings and Fixtures	28, 946, 879	(	)				3. 00
4.00	Building Improvements	0	(					4. 00
5.00	Fixed Equipment	0	(					5. 00
6.00	Movable Equipment	20, 070, 624	(					6. 00
7.00	HIT designated Assets	0	(					7. 00
8.00	Subtotal (sum of lines 1-7)	49, 475, 270	(					8. 00
9.00	Reconciling Items	771, 087	(					9. 00
10.00	Total (line 8 minus line 9)	48, 704, 183	(					10. 00

Heal th	Financial Systems	PUTNAM COUNT	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151333	Peri od: From 01/01/2014 To 12/31/2014		pared:	
			SL	IMMARY OF CAP	PI TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10.00	11.00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	2, 835, 176	0		0 0	0	1. 00	
3.00	Total (sum of lines 1-2)	2, 835, 176	0		0 0	0	3. 00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	2, 835, 176				1. 00	
3.00	Total (sum of lines 1-2)	0	2, 835, 176				3. 00	

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014		pared:
	COM	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	instructions)	Insurance	
	1. 00	2. 00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 NEW CAP REL COSTS-BLDG & FLXT	28, 946, 880	0	28, 946, 880	1. 000000	0	1.00
3.00 Total (sum of lines 1-2)	28, 946, 880	0	28, 946, 880	1. 000000	0	3. 00
	ALLOCA:	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL				
Cost Center Description	Taxes	Other Capi tal-Relate		Depreciation	Lease	
	6, 00	d Costs 7.00	through 7) 8.00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		7.00	8.00	9.00	10.00	
1.00 NEW CAP REL COSTS-BLDG & FLXT	INTERS 0	0	1	2, 763, 461	0	1. 00
3.00 Total (sum of lines 1-2)	0	-		2, 763, 461		3. 00
3.00   Total (Suiii of Titles 1-2)	U		I JMMARY OF CAPI		U	3.00
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
	11 00	12.00	12.00	instructions)	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	11. 00	12.00	13. 00	14. 00	15. 00	
		115 017			2 701 544	1 00
	-87, 832			0 0		
3.00  Total (sum of lines 1-2)	-87, 832	115, 917	1	0	2, 791, 546	3. 00

				To	12/31/2014		
				Expense Classification on		5/28/2015 7: 22	2 piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4. 00 1. 00	5. 00 0	1. 00
	REL COSTS-BLDG & FLXT (chapter			FIXT			
2. 00	2)  Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
	(chapter 2)		O				
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0. 00	0	5. 00
6.00	expenses (chapter 8) Rental of provider space by		0		0. 00	O	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
7.00	stations excluded) (chapter		O		0.00	Ŭ	7.00
8. 00	[21] Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21)		0		0. 00	0	9. 00
10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-2, 235, 974		0.00	0	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
	(chapter 23)				0.00		
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests		0		0. 00 0. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee	1	0		0.00	0	15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than				2.23		
17. 00	patients Sale of drugs to other than		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and		0		0. 00	0	18. 00
	abstracts		-				
19. 00	Nursing school (tuition, fees, books, etc.)		U		0. 00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
21.00	interest, finance or penalty		J		0.00		200
22. 00	charges (chapter 21)   Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	-23, 194	PHYSI CAL THERAPY	66. 00		24. 00
	limitation (chapter 14)		_				
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
26. 00	(chapter 21) Depreciation - NEW CAP REL		0	NEW CAP REL COSTS-BLDG &	1. 00	0	26. 00
	COSTS-BLDG & FLXT			FIXT			
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	*** Cost Center Deleted ***	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00	-	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of limitation (chapter 14)						
32. 00	CAH HIT Adjustment for		0		0. 00	О	32. 00
33. 00	Depreciation and Interest DISCOUNTS	В	-3, 270	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
			• •			1	

					0 12/31/2014	Date/Time Pre 5/28/2015 7:2	pared: 2 pm
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
					•		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1. 00	2. 00	3.00	4. 00	5. 00	
33. 01	VENDOR REBATE/REFUND	В	-26, 555	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	PHARMACY REBATES	В	-40, 880	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 02
33. 03	SI LVER RECOVERY	В		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 03
33. 04	DIABETIC COUNSELING OTHER	В	-100	CLI NI C	90.00	0	33. 04
	INCOME						
33. 05	MEDICAL RECORDS FEES	В	-5, 957	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 05
33. 06	VENDING MACHINES	В	-2, 374	DI ETARY	10.00	0	33. 06
33. 07	CAFETERIA SALES	В	-61, 860	CAFETERI A	11. 00	0	33. 07
33. 08	OTHER MISC INCOME	В	-20, 142	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
33. 09	NONALLOWABLE INTEREST EXPENSE	Α	-85, 945	NEW CAP REL COSTS-BLDG &	1.00	11	33. 09
				FLXT			
33. 10	INVESTMENT INCOME	В	-1, 887	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 10
				FLXT			
33. 11	LOBBYING OFFSEST	A	-679	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	ADVERTISING OFFSET	A	-18, 001	ADMINISTRATIVE & GENERAL	5. 00	0	33. 12
33. 13	COMMUNITY RELATIONS OFFSET	A	-163, 175	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13
33. 14	COMMUNITY RELATIONS OFFSET	A	-2, 968	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 14
33. 15	TELEPHONE WAGES	A	-735	ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
33. 16	TELEPHONE BENEFITS	A	-177	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 16
33. 17	TELEPHONE OTHER	A	-807	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
33. 18	TELEVISION OFFSET	A	-3, 802	OPERATION OF PLANT	7. 00	0	33. 18
33. 19	PHYSICIAN RECRUITMENT	A	-11, 906	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20	HAF EXPENSE	A	-2, 083, 489	ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 21	MISC REVENUE-CBO	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 21
33. 22	ADVERTISING OFFSET	A	-2, 240	ONCOLOGY	73. 01	0	33. 22
33. 23	EHR DEPRECIATION	A	-325, 056	NEW CAP REL COSTS-BLDG &	1.00	9	33. 23
				FIXT			
33. 24	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 24
	(3)						
33. 25	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 25
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-5, 124, 770				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

						10 12/31/2012	5/28/2015 7:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		EMERGENCY	1, 774, 854					
2.00		LABORATORY	60, 000		60, 000	l .		
3.00		ONCOLOGY	237, 664			"	_	
4.00		ANESTHESI OLOGY	598, 398	471, 638	126, 760	0	0	
5.00	0. 00		0	(	0	0	0	5. 00
6.00	0. 00		0	(	0	0	0	0.00
7. 00	0. 00		0	(	0	0	0	7. 00
8. 00	0. 00		0	(	0	0	0	0.00
9. 00	0. 00		0	(	0	0	0	9. 00
10. 00	0. 00		0	(	0	0	0	10. 00
200.00			2, 670, 916		· · · · · · · · · · · · · · · · · · ·		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identi fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	4 00				Educati on	12	11.00	
4 00	1.00	2.00	8. 00	9. 00	12. 00	13.00	14.00	4.00
1.00		EMERGENCY	0	1	-	1	_	
2.00		LABORATORY	0			0	_	
3.00		ONCOLOGY ANESTHESI OLOGY	0				0	
4. 00 5. 00		ANESTHESI ULUGY	0			0	_	1
	0. 00 0. 00		0				0	
6.00	0.00		0				0	0.00
7.00	0.00		0			0	_	
8.00	0.00		0			0	0	0.00
9. 00 10. 00	0.00		0				0	
200.00	0.00		0					200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		rueittiriei	Share of col.	LIIIII	Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		EMERGENCY	0					1. 00
2.00		LABORATORY	l o			0		2. 00
3.00		ONCOLOGY	0		0	237, 664		3. 00
4.00		ANESTHESI OLOGY	0		0	471, 638		4. 00
5. 00	0.00		0		0	0		5. 00
6. 00	0. 00		l 0		ol o			6. 00
7. 00	0. 00		0		o o	l		7. 00
8. 00	0. 00		0		o o	l		8. 00
9. 00	0. 00		Ö		0	l		9. 00
10. 00	0. 00		Ö		0	l		10.00
200.00			0		0			200.00
	. '			•	•	•		•

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	PUTNAM COUNTY FURNI SHED BY		CCN: 151333	In Lie Period: From 01/01/2014	worksheet A-8 Parts I-VI	
001310	2 3011 21 213				To 12/31/2014		
					Physical Therapy	Cost	
						1.00	
1. 00	PART I - GENERAL INFORMATION  Total number of weeks worked (excluding aides	s) (see instruct	tions)			52	1.00
2. 00 3. 00 4. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy nor therapist was on provider site (see insti	assistant was o				780 282 267	3. 00
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)	rvisors or thera apy assistants (	(include only	visits made b		0	
7. 00 8. 00	Standard travel expense rate Optional travel expense rate per mile					3. 45 0. 00	
0.00	expense rute per mire	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	0.00
9. 00	Total hours worked	1. 00	2. 00 2, 651. 00	3. 00 2, 579. 0	4. 00	5. 00	9. 00
	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	0. 00 38. 26	76. 52 38. 26	57. 3 28. 7	0.00	0.00	10. 00 11. 00
12. 01	one-half of column 3, line 10) Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site)	0 0	0		0 0 0		12. 00 12. 01 13. 00
	Number of miles driven (offsite)	0	0		0		13. 01
						1.00	
14 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				0	14. 00
15.00	Therapists (column 2, line 9 times column 2,	line 10)				202, 855	15. 00
17. 00	Assistants (column 3, line 9 times column 3, line10) Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all others)  148,009 350,864						
18. 00 19. 00	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	
20. 00	Total allowance amount (sum of lines 17-19 for lf the sum of columns 1 and 2 for respiratory	or respiratory t				350, 864	20. 00
	occupational therapy, line 9, is greater than	n line 2, make r					
21. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra	<u>lines 21-23.</u> ainees (line 17	divided by su	m of columns	1 and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and traine					0	22.00
	Total salary equivalency (see instructions)					350, 864	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVEL	EXPENSE COMPL	UTATION - PRO	VIDER SITE		1
24. 00	Therapists (line 3 times column 2, line 11)					10, 789	1
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others)		7, 663 18, 452	1
27. 00	Standard travel expense (line 7 times line 3				and 4 for all	1, 894	27. 00
28. 00	others) Total standard travel allowance and standard	travel expense	at the provide	er site (sum	of lines 26 and	20, 346	28. 00
	27) Optional Travel Allowance and Optional Travel	Expense					1
29. 00	Therapists (column 2, line 10 times the sum of Assistants (column 2, line 10 times solumn 2)		d 2, line 12 )			0	
30. 00 31. 00	Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or		and 30 for a	II others)		0	1
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 therapy	or sum of	0	32. 00
33. 00	Standard travel allowance and standard travel	expense (line	28)			20, 346	33. 00
34. 00 35. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel			,		0 0	1
55.00	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				ICES OUTSIDE PRO		33.00
36. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36. 00
37. 00	Assistants (line 6 times column 3, line 11)					0	1
38. 00 39. 00	Subtotal (sum of lines 36 and 37)	m of lines 5 and	1 6)			0	1
J 7. UU	Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel	Expense					37.00
40. 00 41. 00	Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column		2, line 10)			0	1
	production (document of fillion 12. of times column	. 5, 11110 10)					1 11.00

0 44.00

0 45.00

0 42.00

0 43.00

42.00

43.00

Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)

or 46, as appropriate.
44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)

45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45,

Subtotal (sum of lines 40 and 41)

	Financial Systems	PUTNAM COUNTY				eu of Form CMS-2	
	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151333	Peri od: From 01/01/2014 To 12/31/2014		pared:
					Physical Therapy		
						1. 00	
46. 00	Optional travel allowance and optional travel						46. 00
		Therapists	Assi stants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0. (	0.00	0.00	47. 00
48.00	Overtime rate (see instructions)	0. 00	0. 00	0.0	0.00		48. 00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0.00	0.0	0.00		49. 00
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0. (	0.00	0.00	50.00
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0. 0	0.00	0.00	51.00
52. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	76. 52	57. 39	0. (	0.00		52.00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53. 00
54. 00	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54. 00
55. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55. 00
56. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56. 00
	respiratory therapy and columns 1 through 3 for all others.)						
		ND EVOEGO COOT	AD WOTHER			1. 00	
57 00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	ND EXCESS COST	ADJUSTMENT			350, 864	57.00
	Travel allowance and expense - provider site	(from lines 33,	34, or 35))			20, 346	
	Travel allowance and expense - Offsite service	es (from lines	44, 45, or 46	)		0	1
60.00	Overtime allowance (from column 5, line 56) Equipment cost (see instructions)					0 0	
	Supplies (see instructions)						
	Total allowance (sum of lines 57-62)					371, 210	
64.00	Total cost of outside supplier services (from	your records)				394, 404	
65. 00	Excess over limitation (line 64 minus line 63	- if negative,	enter zero)			23, 194	65.00
100 00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		18 452	100. 00
	Line 27 = line 7 times line 3 for respiratory				others		100. 01
100. 02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	· ·				20, 346	100. 02
	Line 27 = line 7 times line 3 for respiratory				others		101.00
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29	and 30 for a	II others			101. 01 101. 02
	Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	II others		0	102.00
	Line 32 = line 8 times columns 1 and 2, line 13 for all others				ımns 1-3, line		102. 01

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CCN:	F	Period: From 01/01/2014 To 12/31/2014	Worksheet A-8- Parts I-VI Date/Time Prep 5/28/2015 7:22	pare
					Occupati onal Therapy	Cost	<u> </u>
						1. 00	
	PART I - GENERAL INFORMATION						
00 00 00 00	Total number of weeks worked (excluding aide: Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi: Number of unduplicated days in which therapy	sor or therapist w assistant was on	as on provider s			49 735 244 0	1. 2. 3. 4.
00 00	nor therapist was on provider site (see instance) Number of unduplicated offsite visits - super Number of unduplicated offsite visits - therapsistant and on which supervisor and/or the instructions)	rvisors or therapi apy assistants (in	clude only visit	s made by		0	5. 6.
00	Standard travel expense rate					3. 45	7.
00	Optional travel expense rate per mile	Supervi sors T	herapists Ass	si stants	Ai des	0.00 Trai nees	8.
		1.00	2. 00	3.00	4. 00	5. 00	
	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0. 00 0. 00 36. 27	1, 739. 00 72. 54 36. 27	0. 00 0. 00 0. 00	0.00	0. 00 0. 00	9. 10. 11.
2. 01 3. 00	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite)	0 0 0 0	0 0 0	(	0 0 0 0 1		12. 12. 13. 13.
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
1. 00	Supervisors (column 1, line 9 times column 1	•				0	14.
	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					126, 147 0	15 16
	O Aides (column 4, line 9 times column 4, line 10) O Trainees (column 5, line 9 times column 5, line 10)						
0. 00	Total allowance amount (sum of lines 17-19 for lift the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater that the amount from line 20. Otherwise complete	or respiratory the y therapy or colum n line 2, make no	ns 1-3 for physi	cal thera	apy, speech path	126, 147 ology or line 23	19. 20.
	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,	ainees (line 17 di		columns 1	1 and 2, line 9	0.00	21
. 00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (line 2 times	line 21)			0 126, 147	22 23
. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	WANCE AND TRAVEL E	XPENSE COMPUTATI	ON - PROV	/IDER SITE	120, 147	23
. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					8, 850	24
. 00	Assistants (line 4 times column 3, line 11)					0, 650	25
. 00	Subtotal (line 24 for respiratory therapy or				4 6 11	8, 850	26
. 00	Standard travel expense (line 7 times line 3 others)	for respiratory t	nerapy or sum or	Tines 3	and 4 for all	842	27
. 00	Total standard travel allowance and standard 27)	travel expense at	the provider si	te (sum o	of lines 26 and	9, 692	28
. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum of		line 12 )			0	29
. 00	Assistants (column 3, line 10 times column 3		, 11110 12 )			Ö	30
	Subtotal (line 29 for respiratory therapy or				6	0	31
. 00	Optional travel expense (line 8 times column:	s 1 and 2, line 13	for respiratory	therapy	or sum of	0	32
. 00	columns 1-3, line 13 for all others)						
. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel					9, 692	
. 00	columns 1-3, line 13 for all others)	I expense (sum of	lines 27 and 31)			9, 692 0 0	34
. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	expense (sum of expense (sum of	lines 27 and 31) lines 31 and 32)		CES OUTSI DE PRO	0 0	34
. 00 . 00 . 00 . 00 . 00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	expense (sum of expense (sum of	lines 27 and 31) lines 31 and 32)		CES OUTSIDE PRO	0 0 VI DER SI TE	34 35 36
. 00 . 00 . 00 . 00 . 00 . 00 . 00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	expense (sum of expense (sum of	lines 27 and 31) lines 31 and 32)		CES OUTSI DE PRO	O O O O O O O O O O O O O O O O O O O	34 35 36 37
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11)	l expense (sum of l expense (sum of ANCE AND TRAVEL EX	lines 27 and 31) lines 31 and 32) PENSE COMPUTATIO		CES OUTSIDE PRO	0 0 VI DER SI TE	34 35 36 37 38
. 00 2. 00 3. 00 3. 00 5. 00 5. 00 6. 00 7. 00 8. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel	l expense (sum of l expense (sum of ANCE AND TRAVEL EX m of lines 5 and 6 Expense	lines 27 and 31) lines 31 and 32) PENSE COMPUTATIO		CES OUTSIDE PRO	O O O O O O O O O O O O O O O O O O O	34 35 36 37 38 39
. 00 2. 00 3. 00 3. 00 5. 00 5. 00 6. 00 7. 00 9. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	m of lines 5 and 6 Expense O1 times column 2,	lines 27 and 31) lines 31 and 32) PENSE COMPUTATIO		CES OUTSIDE PRO	O O O O O O O O O O O O O O O O O O O	34 35 36 37 38 39 40
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/ Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel	m of lines 5 and 6 Expense O1 times column 2,	lines 27 and 31) lines 31 and 32) PENSE COMPUTATIO		CES OUTSI DE PRO	O O O O O O O O O O O O O O O O O O O	34 35 36 37 38 39
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave Optional travel allowance and standard trave Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column	m of lines 5 and 6 Expense On times column 2, n 3, line 10) m of columns 1-3,	lines 27 and 31) lines 31 and 32) PENSE COMPUTATIO  line 10)  line 13.01)	N - SERVI		0 0 0 0 0 0 0 0 0 0	34 35 36 37 38 39 40 41 42

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151333	Peri od: From 01/01/2014 To 12/31/2014	Worksheet A-8 Parts I-VI Date/Time Pre 5/28/2015 7:2	pared:
					Occupati onal Therapy	Cost	
					1	1.00	
5 00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	nd 42 - see in	nstructions)	1. 00	45. 00
	Optional travel allowance and optional travel				· ·	0	
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2. 00	3.00	4. 00	5. 00	
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	0. (	0.00		48. 0
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						
	Percentage of overtime hours by category	0. 00	0.00	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. (	0.00	0.00	51. 0
	for one full-time employee times the						
	percentages on line 50) (see instructions)  DETERMINATION OF OVERTIME ALLOWANCE						
	Adjusted hourly salary equivalency amount	72. 54	0.00	0. (	0.00		52.0
	(see instructions)						
3. 00	Overtime cost limitation (line 51 times line 52)	0	0	1	0 0		53. 0
4. 00	Maximum overtime cost (enter the lesser of	0	0		0 0		54.0
F 00	line 49 or line 53)						
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply	٩	0	1	0 0		55. 0
	line 47 times line 52)						
6. 00	Overtime allowance (line 54 minus line 55 -	0	0	1	0 0	0	56. 0
	if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
7. 00 8. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 33	34 or 35))			126, 147 9, 692	
9. 00	Travel allowance and expense - Offsite service			)		0	59.0
0. 00	Overtime allowance (from column 5, line 56)					0	
	Equipment cost (see instructions)					0	1
3. 00	Supplies (see instructions) Total allowance (sum of lines 57-62)					135, 839	1
	Total cost of outside supplier services (from	your records)				112, 864	
5. 00	Excess over limitation (line 64 minus line 63	- if negative	, enter zero)			0	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		8, 850	100 0
	Line 27 = line 7 times line 3 for respiratory				others		100. C
00. 02	Line 33 = line 28 = sum of lines 26 and 27					9, 692	
11 00	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory	therapy or com	m of lines 2 a	and 4 for all	others	040	  101. C
	Line 31 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or				OTHEL 2		101.0
	Line 34 = sum of lines 27 and 31						101. 0
20.05	LINE 35 CALCULATION	6	0 100 0				100 -
J2. 00	Line 31 = line 29 for respiratory therapy or				ımns 1-3 line		102. 0 102. 0
12 01							1104. (
2. 01	Line 32 = line 8 times columns 1 and 2, line 13 for all others	15 TOT TESPITA	tory thorapy o	n sum or core	annis i o, i i i		102. (

leal th	Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ABLE COST DETERMINATION FOR THERAPY SERVICES   E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151333	Peri od: From 01/01/2014 To 12/31/2014	Worksheet A-8- Parts I-VI Date/Time Prep 5/28/2015 7:22	pared:
					Speech Pathology		
						1. 00	
	PART I - GENERAL INFORMATION					1.00	
. 00	Total number of weeks worked (excluding aides	s) (see instruct	ions)			9	1.00
2. 00 3. 00 4. 00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy	assistant was o				135 43 0	2. 00 3. 00 4. 00
5. 00 5. 00	nor therapist was on provider site (see instructions)  Number of unduplicated offsite visits - supervisors or therapists (see instructions)  Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see						5. 00 6. 00
	instructions)	aprac was not p	resent durring	the visit(s	(366		
7.00	Standard travel expense rate Optional travel expense rate per mile					3. 45 0. 00	7. 00
3. 00	optional traver expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	8. 00
0.0		1.00	2.00	3.00	4. 00	5. 00	
0.00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	100. 00 69. 73	1		0. 00 0. 00	9. 00 10. 00
	Standard travel allowance (columns 1 and 2,	34. 87	34. 87	1			11. 00
	one-half of column 2, line 10; column 3,						
2. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	0		0		12. 00
2. 01	Number of travel hours (offsite)	0	0	l .	0		12. 0
	Number of miles driven (provider site) Number of miles driven (offsite)	0	0	1	0		13. 00 13. 01
3. 01	Number of mires driven (orisite)	O <sub>I</sub>		1	O		13.0
						1. 00	
4. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				0	14. 00
5. 00	Therapists (column 2, line 9 times column 2,					6, 973	
6. 00	Assistants (column 3, line 9 times column 3,				47.6	0	16.00
7. 00	Subtotal allowance amount (sum of lines 14 ar others)	na 15 Tor respir	atory therapy	or lines 14	-16 for all	6, 973	17. 00
	Aides (column 4, line 9 times column 4, line					0	18. 00
	Trainees (column 5, line 9 times column 5, li				£!! -+b	0	19.00
0. 00	Total allowance amount (sum of lines 17-19 for If the sum of columns 1 and 2 for respiratory					6, 973	20. 00
	occupational therapy, line 9, is greater than	ıline 2, make n					
	the amount from line 20. Otherwise complete Weighted average rate excluding aides and tra		divided by su	ım of columns	1 and 2 line 0	69. 73	21. 00
1.00	for respiratory therapy or columns 1 thru 3,			iii or coruiiiis	1 and 2, Time 9	07. 73	21.00
	Weighted allowance excluding aides and traine	ees (line 2 time	s line 21)			9, 414	
3. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMP	PIITATION - PRO	OVIDER SITE	9, 414	23. 00
	Standard Travel Allowance	THE THE PROPERTY OF	EXTENSE COM	017711017	SVIDER SITE		
4. 00	Therapists (line 3 times column 2, line 11)					1, 499	24. 00
5. 00 6. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for a	ull others)		0 1, 499	25. 00 26. 00
7. 00	Standard travel expense (line 7 times line 3				3 and 4 for all	148	
0 00	others)	traval avnanca	at the provid	lar aita (aum	of Lines 24 and	1 (47	20.00
8. 00	Total standard travel allowance and standard 27)	rraver expense	at the provid	iei site (sum	or rines zo and	1, 647	28. 00
	Optional Travel Allowance and Optional Travel						
9. 00 0. 00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		2, line 12)			0	29. 00 30. 00
1. 00	Subtotal (line 29 for respiratory therapy or	,	and 30 for a	ıll others)		0	31.00
2. 00	Optional travel expense (line 8 times columns				y or sum of	Ō	32. 00
3 00	columns 1-3, line 13 for all others)	evnence (line	287			1 417	32 04
3. 00 4. 00	Standard travel allowance and standard travel Optional travel allowance and standard travel			nd 31)		1, 647 0	33. 00 34. 00
5. 00	Optional travel allowance and optional travel	expense (sum o	flines 31 an	nd 32)		0	35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL	EXPENSE COMPU	TATION - SER	VICES OUTSIDE PRO	OVI DER SITE	
	Standard Travel Expense Therapists (Line 5 times column 2 Line 11)						

REASON	Financial Systems  ABLE COST DETERMINATION FOR THERAPY SERVICES IN SUPPLIERS	PUTNAM COUNTY FURNI SHED BY		CCN: 151333	Peri od: From 01/01/2014 To 12/31/2014 Speech Pathol ogy	Date/Time Pre 5/28/2015 7:2	-3 pared:	
					opecen rather egy	1.00		
46 00	Optional travel allowance and optional travel	expense (sum o	f Lines 42 an	d 43 - see ir	nstructions)		46. 00	
10.00	oper onal craver arrenance and oper onal craver	Therapists	Assi stants	Ai des	Trai nees	Total	10.00	
		1.00	2.00	3. 00	4. 00	5. 00		
	PART V - OVERTIME COMPUTATION					0.00		
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0. (	0.00	0.00	47. 00	
48.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48. 00	
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0. 00	0.00	0. (	0.00		49. 00	
	CALCULATION OF LIMIT				1			
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0. 00	0.00	50.00	
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0. 00	0. 00	0. (	0.00	0.00	51. 00	
52. 00	Adjusted hourly salary equivalency amount	69. 73	0.00	0.0	0.00		52. 00	
53. 00	(see instructions) Overtime cost limitation (line 51 times line	07. 73	0.00	0.0	0.00		53. 00	
	52)							
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00	
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0		55. 00	
56. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56. 00	
	respiratory therapy and columns 1 through 3 for all others.)							
						1. 00		
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST A	ADJUSTMENT					
	Salary equivalency amount (from line 23)					9, 414		
58. 00	Travel allowance and expense - provider site					1, 647	58. 00	
59. 00		es (from lines 4	44, 45, or 46	)		0	59.00	
60.00						0	60.00	
61.00	Equipment cost (see instructions)					0	61.00	
62.00	Supplies (see instructions)					0	62.00	
63.00	Total allowance (sum of lines 57-62)					11, 061	63.00	
64.00	Total cost of outside supplier services (from	your records)				3, 600	64.00	
65. 00	Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			0	65. 00	
	LINE 33 CALCULATION							
	Line 26 = line 24 for respiratory therapy or					l	100. 00	
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	therapy or sum	of lines 3 a	nd 4 for all	others	l e	100. 01 100. 02	
	Line 27 = line 7 times line 3 for respiratory	therany or sum	of lines 2 a	nd 4 for all	others	140	1 101. 00	
101 00					Other S		101.00	
	101.01 Line 31 = line 29 for respiratory therapy or sum of lines 29 and 30 for all others							
101.01								
101.01	Line 34 = sum of lines 27 and 31							
101. 01 101. 02	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	Sum of lines 20	and 30 for a	ll others		0	102 00	
101. 01 101. 02 102. 00	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or				umns 1-3. line		102. 00 102. 01	
101. 01 101. 02 102. 00	Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				umns 1-3, line		102. 00 102. 01	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

				T	o 12/31/2014	Date/Time Pre 5/28/2015 7:2	
			CAPI TAL			5/28/2015 /: 2	Z pili
			RELATED COSTS				
	Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE	
		for Cost	FLXT	BENEFITS DEDARTMENT		& GENERAL	
		Allocation (from Wkst A		DEPARTMENT			
		col. 7)					
		0	1. 00	4. 00	4A	5. 00	
1 00	GENERAL SERVICE COST CENTERS	2 701 547	2 701 547	<u> </u>			1 00
1. 00 4. 00	OO100  NEW CAP REL COSTS-BLDG & FIXT   OO400  EMPLOYEE BENEFITS DEPARTMENT	2, 791, 546 3, 277, 990		3, 277, 990			1. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	3, 153, 236		447, 093	3, 980, 411	3, 980, 411	5. 00
7. 00	00700 OPERATION OF PLANT	1, 294, 542			1, 600, 612		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	100, 223			124, 748	1	
9.00	00900 HOUSEKEEPI NG	365, 608				1	9. 00
10. 00 11. 00	01000   DI ETARY   01100   CAFETERI A	171, 879 364, 767			276, 098 467, 566	1	
13. 00	01300 NURSING ADMINISTRATION	382, 543				1	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	463, 727			671, 684	1	
17. 00	01700 SOCIAL SERVICE	121	0	0	121	19	17. 00
17. 01	01701 UTILIZATION REVIEW	86, 460	4, 965	19, 422	110, 847	17, 541	17. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS  03000 ADULTS & PEDI ATRI CS	1, 048, 528	240 702	261, 180	1, 550, 490	245 254	30.00
31. 00	03100   NTENSIVE CARE UNIT	756, 738		188, 215	1, 023, 320		31.00
41. 00	04100 SUBPROVI DER - I RF	0	0	0	0,020,020	0	ı
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00	04300 NURSERY	0	0	0	0	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS    05000   OPERATI NG ROOM	952, 634	257, 471	106, 685	1 214 700	208, 374	50.00
51. 00	05100 RECOVERY ROOM	87, 653			1, 316, 790 171, 593		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	07,000	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	179, 216	0	146, 840	326, 056	51, 596	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	842, 170		155, 644	1, 084, 401		
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	139, 702		0	143, 564		
57. 00 58. 00	05700  CT SCAN   05800  MAGNETIC RESONANCE IMAGING (MRI)	284, 936	36, 411	36, 577	357, 924	56, 639	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	o o	59. 00
60.00	06000 LABORATORY	1, 789, 606	68, 188	134, 671	1, 992, 465	315, 296	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	450.254	10.040	0 040	C 5 ( 4 12 4	0 271	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	458, 354 430, 845			564, 134 519, 528	1	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	112, 864		Ö	112, 864	1	
68. 00	06800 SPEECH PATHOLOGY	3, 665		0	3, 665	1	
69. 00	06900 ELECTROCARDI OLOGY	134, 735			150, 640		
69. 01	06901   CARDIAC REHAB   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	74, 622	19, 943	18, 892	113, 457	i .	1
71. 00 72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	158, 695	0	J 0	158, 695	0 5 25, 113	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	3, 051, 752		32, 907			
73. 01	07301 ONCOLOGY	248, 202			443, 970	1	
	OUTPATIENT SERVICE COST CENTERS	1					
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90.00	09000 CLINIC	2, 335	4, 469	636	7, 440	1, 177	90.00
91. 00	09100 EMERGENCY	1, 654, 492					
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0	,	92.00
00.40	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
109 00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	-	· -	0	1	110. 00
111.00	11100   SLET ACQUISITION	0	0	0	0		111. 00
	11300   NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	04.044.004	0 047 407	0.047.400	00 070 450	0.0/0.707	114.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)   NONREI MBURSABLE COST CENTERS	24, 864, 386	2, 217, 187	2, 367, 122	23, 379, 159	3, 069, 737	]118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	13, 158	0	13, 158	2, 082	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	4, 265, 562				1	
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	19301 DME	0	0	0	0		193. 01
	19302  LACTATION CONSULTING   19303  DIABETIC COUNSELING			0	0		193. 02 193. 03
	07950 VACANT SPACE	0	42, 673	0	42, 673		194. 00
	07951 BOARD OF HEALTH	0	23, 088		23, 088	1	194. 01
	07952 PUTNAM/HENRY PRENATAL	4, 121	0	0	4, 121	i e	194. 02
200.00		1		_	0		200.00
201.00	Negative Cost Centers	1	0	0	0	1 0	201. 00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 151333		Peri od:	Worksheet B	
				From 01/01/2014 To 12/31/2014		
		CAPI TAL			3/20/2013 7.2	z piii
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
	col. 7)	1.00	4.00	4A	5. 00	
202.00 TOTAL (sum lines 118-201)	29, 134, 069					202. 00

Provi der CCN: 151333

				10	12/31/2014	5/28/2015 7: 2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	0.00	10.00	44.00	
	GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10.00	11. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	1, 853, 899					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	16, 296	160, 785				8. 00
9.00	00900 HOUSEKEEPI NG	13, 548	897				9. 00
10.00	01000 DI ETARY	71, 188	l		413, 425	500 055	10.00
11.00	01100 CAFETERI A	38, 668	0	,	0	592, 055	
13. 00 16. 00	01300 NURSI NG ADMINI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY	16, 031 100, 767	0	4, 905 30, 832	0	4, 294 41, 215	•
17. 00	01700 SOCIAL SERVICE	100, 767	0	30, 832	0	41, 213	1
17. 00	01700 300 AE SERVICE	4, 339	0	1, 328	0	0	1
.,, .	I NPATIENT ROUTINE SERVICE COST CENTERS	1,7007		1,7020	<u> </u>		1
30.00	03000 ADULTS & PEDIATRICS	210, 430	35, 304	64, 386	337, 343	81, 065	30.00
31.00	03100 INTENSIVE CARE UNIT	68, 488	27, 266	20, 955	76, 082	52, 331	31. 00
41.00	1 1	0	0	0	0	0	1
42. 00	04200 SUBPROVI DER	0	0	0	0	0	1
43. 00		0	0	0	0	0	43. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	225, 015	25, 535	68, 848	O	37. 483	E0 00
50. 00 51. 00	05100 RECOVERY ROOM	55, 326	25, 535		0	4, 093	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	35, 320	0	10, 420	0	4, 093	52.00
53. 00	+ I	0	0	Ö	Ö	7, 665	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	75, 672	12, 192	23, 153	Ö	59, 555	
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	3, 375	0	1, 033	o	0	1
57.00	05700 CT SCAN	31, 821	0	9, 736	0	13, 404	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60.00	06000 LABORATORY	59, 592	0	18, 234	0	66, 818	
60. 01 64. 00	06001   BLOOD LABORATORY   06400   I NTRAVENOUS THERAPY	0	0	0	0	0	
65. 00	06500 RESPIRATORY THERAPY	16, 465	0	5, 038	0	27, 410	
66. 00	06600 PHYSI CAL THERAPY	77, 504	4, 445		0	27,410	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 110	20, , , , ,	ő	0	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	o	0	1
69. 00	06900 ELECTROCARDI OLOGY	2, 411	0	738	o	4, 174	69. 00
69. 01	06901 CARDI AC REHAB	17, 429	0	5, 333	0	8, 187	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS 07301 ONCOLOGY	18, 707	U F 170	5, 724 35, 958	0	12, 681	1
73. 01	OUTPATIENT SERVICE COST CENTERS	117, 522	5, 172	35, 958	<u> </u>	18, 902	73. 01
88. 00		0	0	0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	O	Ö	0	
90.00	09000 CLI NI C	3, 905	0	1, 195	o	0	90.00
91.00		144, 738	39, 539	44, 286	o	84, 274	
92.00							92.00
	OTHER REIMBURSABLE COST CENTERS		г		_1		
99. 10	09910 CORF	0	0	0	0	0	99. 10
100 0	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	1 0		O	O	0	109. 00
	0 11000   NTESTINAL ACQUISITION	0	0		o		110.00
	11100 I SLET ACQUI SI TI ON	0		0	Ö		111.00
	11300 INTEREST EXPENSE		_	1	آ	_	113. 00
	0 11400 UTILIZATION REVIEW-SNF						114. 00
118.00		1, 389, 237	151, 017	415, 936	413, 425	523, 551	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 499		3, 518	0		190. 00
	D 19200 PHYSI CI ANS' PRI VATE OFFI CES	432, 985	l		0		192.00
	0 19300 NONPALD WORKERS	0	0	0	0		193. 00
	1 19301 DME 2 19302 LACTATION CONSULTING	0	0		U		193. 01 193. 02
	2 19302 LACTATION CONSULTING 3 19303 DI ABETI C COUNSELING				0		193. 02
	007950 VACANT SPACE				٥		194. 00
	1 07951 BOARD OF HEALTH	20, 178	ا م	6, 174	ol		194. 00
	2 07952 PUTNAM/HENRY PRENATAL	0	0	0, , , ,	ol		194. 02
200.00				]	آ ا		200.00
201.00		0	0	0	o		201. 00
202.00	TOTAL (sum lines 118-201)	1, 853, 899	160, 785	539, 706	413, 425	592, 055	202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | To 12/31/2014 | Part | To 2015/10014 | Part | P Provi der CCN: 151333

			To	12/31/2014	Date/Time Pre 5/28/2015 7:2	
Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	UTI LI ZATI ON	Subtotal	Z piii
·	ADMI NI STRATI ON	RECORDS &		REVI EW		
	12.00	LI BRARY	17.00	17.01	24.00	
GENERAL SERVICE COST CENTERS	13. 00	16. 00	17. 00	17. 01	24. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						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						9. 00
10. 00   01000 DI ETARY						10. 00
11. 00   01100   CAFETERI A						11. 00
13.00 O1300 NURSING ADMINISTRATION	520, 419					13. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	950, 788				16. 00
17. 00 01700 SOCIAL SERVICE	0	0	140	124 055		17.00
17. 01 01701 UTI LI ZATI ON REVI EW I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	134, 055		17. 01
30. 00 03000 ADULTS & PEDIATRICS	114, 966	543, 742	114	109, 385	3, 292, 581	30.00
31. 00   03100   NTENSI VE CARE UNI T	74, 215	543, 742 N	26	24, 670	1, 529, 287	31.00
41. 00   04100   SUBPROVI DER -   RF	74,219	0	0	24, 070	1, 327, 207	41. 00
42. 00   04200   SUBPROVI DER		0	Ö	o	0	42. 00
43. 00   04300   NURSERY	o	0	Ō	o	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	53, 157	194, 811	0	0	2, 130, 013	50.00
51.00   05100   RECOVERY ROOM	5, 805	0	0	0	280, 899	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	10, 871	0	0	0	396, 188	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	84, 460	138		0	1, 511, 171	54.00
54. 01   05401   NUCLEAR   MEDICINE-DI AGNOSTI C	0	0	Ĭ	0	170, 690	54. 01
57. 00 05700 CT SCAN	19, 009	0	0	0	488, 533	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   60. 00   06000   LABORATORY	0	U EE0	0	0	2, 452, 955	59. 00 60. 00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY		550	0	0	2, 452, 955	60.00
64. 00 06400   NTRAVENOUS THERAPY		0	0	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY		0	0	0	702, 318	65. 00
66. 00   06600   PHYSI CAL THERAPY		3, 126	o o	o	710, 529	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0	Ō	o	130, 724	•
68. 00 06800 SPEECH PATHOLOGY	O	0	0	O	4, 245	68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0	0	o	181, 801	69. 00
69. 01   06901   CARDI AC   REHAB	11, 610	575	0	0	174, 545	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	183, 808	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	3, 634, 692	73. 00
73. 01 07301 0NCOLOGY	26, 806	11, 704	0	0	730, 290	73. 01
0UTPATIENT SERVICE COST CENTERS  88.00 08800 RURAL HEALTH CLINIC	0	0	0	ol	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	89. 00
90. 00   09000  CLI NI C		0	0	0	13, 717	
91. 00 09100 EMERGENCY	119, 520	196, 142	0	0	3, 082, 795	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	117,020	.,,,		J	0,002,770	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0		0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300   I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	500 440	050 700	440	404.055	04 004 704	114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	520, 419	950, 788	140	134, 055	21, 801, 781	1118.00
NONREIMBURSABLE COST CENTERS  190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	ol	30, 257	100 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	7, 194, 738	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19301 DME		0	o o	0		193. 01
193. 02 19302 LACTATION CONSULTING	0	0	o o	0		193. 02
193. 03 19303 DI ABETI C COUNSELI NG		0	ĺ	ol		193. 03
194. 00 07950 VACANT SPACE		0	o	ō	49, 426	
194. 01 07951 BOARD OF HEALTH	0	0	0	o	53, 094	194. 01
194.02 07952 PUTNAM/HENRY PRENATAL	0	0	0	o		194. 02
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	520, 419	950, 788	140	134, 055	29, 134, 069	202.00

PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 151333

			To 12/31/2014 Date/	11 me Prepared: '2015 7:22 pm
Cost Center Description	Intern &	Total		
	Residents Cost & Post			
	Stepdown			
	Adjustments	27.00		
GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1. 00 00100 NEW CAP REL COSTS-BLDG & FLXT				1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT				5. 00 7. 00
8.00   O0800 LAUNDRY & LINEN SERVICE				8.00
9. 00   00900   HOUSEKEEPI NG				9. 00
10. 00 01000 DI ETARY				10.00
11. 00   01100   CAFETERI A				11.00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 16. 00   01600   MEDI CAL   RECORDS & LI BRARY				13. 00 16. 00
17. 00 01700 SOCIAL SERVICE				17. 00
17. 01 01701 UTILIZATION REVIEW				17. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 202 501		20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT	0	3, 292, 581 1, 529, 287		30. 00 31. 00
41. 00   04100   SUBPROVI DER -	Ö	0		41. 00
42. 00   04200   SUBPROVI DER	0	0		42. 00
43. 00 04300 NURSERY	0	0		43. 00
ANCILLARY SERVICE COST CENTERS 50. 00   05000   0PERATING ROOM	0	2, 130, 013		50.00
51. 00   05100   RECOVERY ROOM	o o	280, 899		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	O	0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	396, 188		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C	0	1, 511, 171 170, 690		54. 00 54. 01
57. 00   05700   CT   SCAN	o	488, 533		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	O	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		59.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	0	2, 452, 955 0		60. 00
64. 00 06400 I NTRAVENOUS THERAPY	o	Ö		64. 00
65. 00 06500 RESPI RATORY THERAPY	0	702, 318		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	710, 529		66.00
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	130, 724 4, 245		67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	Ö	181, 801		69. 00
69. 01   06901   CARDI AC   REHAB	0	174, 545		69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	103 000		71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS	0	183, 808 3, 634, 692		72. 00 73. 00
73. 01 07301 ONCOLOGY	o	730, 290		73. 01
OUTPATIENT SERVICE COST CENTERS				
88.00   08800   RURAL HEALTH CLINIC 89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0		88. 00 89. 00
90. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0 13, 717		90.00
91. 00   09100   EMERGENCY	o o	3, 082, 795		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92. 00
OTHER REIMBURSABLE COST CENTERS  99. 10 09910 CORF	0	0		99. 10
SPECIAL PURPOSE COST CENTERS	j vj	U U		99. 10
109. 00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 ISLET ACQUISITION 113.00 11300 INTEREST EXPENSE	0	0		111.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				113. 00 114. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	O	21, 801, 781		118. 00
NONREI MBURSABLE COST CENTERS				
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	30, 257		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0	7, 194, 738		192. 00 193. 00
193. 01 19301 DME	Ö	O		193. 01
193. 02 19302 LACTATION CONSULTING	0	0		193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	40, 434		193. 03
194. 00 07950 VACANT_SPACE 194. 01 07951 BOARD_OF_HEALTH		49, 426 53, 094		194. 00 194. 01
194.02 07952 PUTNAM/HENRY PRENATAL	j ő	4, 773		194. 02
200.00 Cross Foot Adjustments	0	0		200. 00
201.00 Negative Cost Centers	0	20 124 040		201. 00
202.00   TOTAL (sum lines 118-201)	ı V	29, 134, 069		202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: | To 2014 | Part | Par Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151333

				11	o 12/31/2014	Date/lime Pre 5/28/2015 7:2	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		0	1.00	2A	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS					1	1 00
17. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01701 UTILIZATION REVIEW INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0 0 0 0 0	0 380, 082 247, 485 18, 647 15, 502 81, 456 44, 245 18, 343 115, 302 0 4, 965	247, 485 18, 647 15, 502 81, 456 44, 245 18, 343 2 115, 302		380, 082 24, 185 1, 885 6, 852 4, 172 7, 065 6, 460 10, 149 2 1, 675	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00
30. 00	03000 ADULTS & PEDIATRICS	0	240, 782	240, 782	C	23, 428	30. 00
31. 00 41. 00 42. 00	03100   INTENSI VE CARE UNIT 04100   SUBPROVI DER - I RF 04200   SUBPROVI DER 04300   NURSERY ANCI LLARY SERVI CE COST CENTERS	0 0 0	78, 367 0 0	1	0	,	31. 00 41. 00 42. 00 43. 00
52. 00 53. 00 54. 00 54. 01 57. 00 58. 00 60. 00 60. 01 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 NUCLEAR MEDI CINE-DI AGNOSTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 PHYSI CAL THERAPY 06600 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0 0 0 0 0 0 0 0 0 0 0 0	257, 471 63, 306 0 86, 587 3, 862 36, 411 0 0 68, 188 0 18, 840 88, 683 0 0 2, 758	63, 306 0 86, 587 3, 862 36, 411 0 0 68, 68, 188 0 0 18, 840 88, 683 0 0 0 2, 758		0 4, 927 16, 385 2, 169 5, 408 0 0 30, 106 0 0 8, 524 7, 850 1, 705 55 2, 276	50. 00 51. 00 52. 00 53. 00 54. 01 57. 00 58. 00 59. 00 60. 01 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00
71. 00 72. 00 73. 00 73. 01	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07301 ONCOLOGY 0UTPATIENT SERVICE COST CENTERS	0 0 0	19, 943 0 0 21, 405 134, 473	0 0 0 21, 405	( ( ( (	1, 714 0 2, 398 46, 933 6, 708	69. 01 71. 00 72. 00 73. 00 73. 01
88. 00 89. 00 90. 00 91. 00 92. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS	0 0 0 0	0 0 4, 469 165, 615	0 4, 469	0	0 0 112 32, 018	88. 00 89. 00 90. 00 91. 00 92. 00
	09910 CORF	0	0	0	C	0	99. 10
109. 00 110. 00 111. 00 113. 00 114. 00 118. 00	SPECIAL PURPOSE COST CENTERS  10900 PANCREAS ACQUISITION  11000 INTESTINAL ACQUISITION  11100 ISLET ACQUISITION  11300 INTEREST EXPENSE  11400 UTILIZATION REVIEW-SNF  SUBTOTALS (SUM OF LINES 1-117)	0 0 0	0 0 0 2, 217, 187	0 0 0 0 0 2, 217, 187	C C	0	109. 00 110. 00 111. 00 113. 00 114. 00 118. 00
190. 00 192. 00 193. 00 193. 01 193. 02 193. 03 194. 00 194. 01 194. 02 200. 00 201. 00	Negative Cost Centers	0 0 0 0 0 0 0	13, 158 495, 440 0 0 0 0 42, 673 23, 088	495, 440 0 0 0 0 0 0 0 0 42, 673		85, 714 0 0 0 0 0 0 645 349 62	193. 00 193. 01 193. 02 193. 03 194. 00 194. 01 194. 02 200. 00 201. 00
202. 00	TOTAL (sum lines 118-201)	0	2, 791, 546	2, 791, 546	(	380, 082	202. 00

Provi der CCN: 151333

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					12/31/2014	Date/lime Pre 5/28/2015 7:2	
	Cost Center Description	OPERATION OF	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT 7. 00	8. 00	9. 00	10.00	11.00	
1 00	GENERAL SERVICE COST CENTERS			I			1 00
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT	271, 670					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 388	22, 920				8. 00
9.00	00900 HOUSEKEEPI NG	1, 985	128		07 140		9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	10, 432 5, 666	95	987 536	97, 142 0	57, 512	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 349	0	222	0	417	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	14, 766	0	1, 398	0	4, 004	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
17. 01	01701 UTI LI ZATI ON REVI EW	636	0	60	0	0	17. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	30, 836	5, 033	2, 919	79, 265	7, 875	30.00
31. 00	03100 INTENSIVE CARE UNIT	10, 036	3, 887		17, 877	5, 083	31.00
41. 00	04100 SUBPROVI DER – I RF	0	0		0	0	41.00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43. 00	04300 NURSERY	0	0	0	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	32, 974	3, 640	3, 121	0	3, 641	50.00
51. 00	05100 RECOVERY ROOM	8, 107	3, 040	767	0	3, 041	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	745	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 089	1, 738		0	5, 785	54.00
54. 01 57. 00	05401   NUCLEAR MEDICINE-DIAGNOSTIC   05700   CT SCAN	495	0	47	0	1 202	54. 01 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	4, 663	0	441 0	0	1, 302	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	o o	0	Ö	59.00
60.00	06000 LABORATORY	8, 733	0	827	0	6, 491	60. 00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 413 11, 357	0 634		0	2, 663 0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	034	1,079	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	Ō	Ö	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	353	0	33	0	405	69. 00
69. 01	06901 CARDI AC REHAB	2, 554	0	242	0	795	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	2, 741	0	259	0	0 1, 232	72. 00 73. 00
73. 01	07301 ONCOLOGY	17, 222	737		0		73. 00
	OUTPATIENT SERVICE COST CENTERS			,			
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	1	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 91. 00	09000   CLI NI C   09100   EMERGENCY	572 21, 210	5, 636	54 2, 008	0	0 8, 186	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	21,210	3, 030	2,000	J	0, 100	92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	0	0	0	99. 10
100.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION		0		0	0	109. 00
	11000   NTESTINAL ACQUISITION	0	0	0	0		1109.00
	11100 I SLET ACQUI SI TI ON	0	0	o o	Ö		111.00
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
118.00		203, 577	21, 528	18, 854	97, 142	50, 858	118. 00
190 00	NONREIMBURSABLE COST CENTERS   19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 685	0	160	0	0	190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	63, 451	1, 392		0		192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	19301   DME	0	0	0	0	l	193. 01
	2 19302 LACTATION CONSULTING	0	0	0	0		193. 02
	3 19303 DIABETIC COUNSELING 07950 VACANT SPACE	0	0	0	0		193. 03 194. 00
	107950 VACANT SPACE	2, 957	0	280	0		194. 00
	207952 PUTNAM/HENRY PRENATAL	2, 737	o	0	0		194. 02
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0	0		201. 00
202. 00	TOTAL (sum lines 118-201)	271, 670	22, 920	24, 467	97, 142	57, 512	J202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part | I | To 12/31/2014 | Date/Time Prepared: | To 2014 | Part | Par Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151333

			1	o 12/31/2014	Date/lime Pre   5/28/2015 7:2	
Cost Center Description	NURSI NG ADMI NI STRATI ON	MEDI CAL RECORDS &	SOCIAL SERVICE	UTI LI ZATI ON REVI EW	Subtotal	2 piii
	13. 00	16. 00	17. 00	17. 01	24. 00	
GENERAL SERVICE COST CENTERS	10.00	10.00	177.00	17101	21100	
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT						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 8.00   00800   LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000 DI ETARY						10.00
11. 00   01100   CAFETERI A						11. 00
13.00 01300 NURSING ADMINISTRATION	27, 791					13. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	o	145, 619				16. 00
17. 00   01700   SOCI AL SERVI CE	0	0	2			17. 00
17. 01   01701   UTI LI ZATI ON REVI EW	0	0	0	7, 336		17. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	( 120	02 270	1 2	E 00/	405 542	20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT	6, 139 3, 963	83, 278 0		· · ·	485, 543 136, 975	30.00
41. 00   04100   SUBPROVI DER -   1 RF	3, 703	0		1, 330	130, 473	41.00
42. 00   04200   SUBPROVI DER	o	Ö		o	0	42. 00
43. 00   04300   NURSERY	o	0	Ö	o	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	2, 839	29, 836	0	0	353, 419	1
51. 00   05100   RECOVERY ROOM	310	0	0	-	75, 481	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	580	0	0	0	6, 252	1
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C	4, 510	21		0	127, 165 6, 573	1
57. 00   05700 CT SCAN	1, 015	0		0	49, 240	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1,015	0		0	17, 240	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	0	o o	o	0	59.00
60. 00   06000   LABORATORY	o	84	0	O	114, 429	1
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	32, 668	1
66. 00   06600   PHYSI CAL THERAPY	0	479	1	0	110, 078	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	1, 705	1
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY		0		0	55 E 02E	1
69. 00   06900   ELECTROCARDI OLOGY 69. 01   06901   CARDI AC   REHAB	620	88		0	5, 825 25, 956	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	020	00			25, 750	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	o	0	o o	o	2, 398	1
73.00 07300 DRUGS CHARGED TO PATIENTS	O	O	0	0	72, 570	1
73. 01 07301 ONCOLOGY	1, 431	1, 793	0	0	165, 830	73. 01
OUTPATIENT SERVICE COST CENTERS			T =			
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC		0		0	0 5, 207	
91. 00   09100   EMERGENCY	6, 384	30, 040		0	271, 097	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0, 304	30, 040	,		271,077	92.00
OTHER REIMBURSABLE COST CENTERS	1					
99. 10 09910 CORF	0	C	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100   SLET ACQUI SI TI ON	0	O	0	O	0	111.00
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF						113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	27, 791	145, 619	2	7, 336	2, 048, 466	114.00
NONREI MBURSABLE COST CENTERS	21, 191	140, 019	1	7, 330	2, 040, 400	1116.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	o	15, 202	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	O	O	o o	O	657, 824	
193.00 19300 NONPALD WORKERS	o	0	0	0	0	193. 00
193. 01 19301 DME	0	0	0	0		193. 01
193. 02 19302 LACTATI ON CONSULTI NG	0	0	0	0		193. 02
193. 03 19303 DI ABETI C COUNSELI NG		0	0	0		193. 03
194. 00 07950 VACANT SPACE	0	0	0	0		194. 00
194.01 07951 BOARD OF HEALTH		0	0	0	26, 674	194. 01 194. 02
194.02 07952 PUTNAM/HENRY PRENATAL 200.00  Cross Foot Adjustments		Ü	,	ا		200. 00
201.00 Negative Cost Centers		0				200.00
202.00   TOTAL (sum lines 118-201)	27, 791	145, 619	2	7, 336	2, 791, 546	
1 1 (3)		, ,		., ., ., .,	, ., .,	

In Lieu of Form CMS-2552-10 Health Financial Systems PUTNAM COUNTY HOSPITAL

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151333 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/28/2015 7:22 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adj ustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01701 UTILIZATION REVIEW 17.01 17.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 485, 543 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 136, 975 31.00 04100 SUBPROVIDER - IRF 41 00 41 00 04200 SUBPROVI DER 42.00 0 42.00 43.00 04300 NURSERY 43.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50 00 0 353.419 05100 RECOVERY ROOM 51.00 75, 481 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 000000000000000000 6, 252 53.00 05400 RADI OLOGY-DI AGNOSTI C 127, 165 54 00 54 00 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 6, 573 54.01 05700 CT SCAN 57.00 57.00 49, 240 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 60.00 06000 LABORATORY 114, 429 60.00 06001 BLOOD LABORATORY 60.01 60.01 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 64.00 64.00 65.00 32, 668 65 00 06600 PHYSI CAL THERAPY 110,078 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 1, 705 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 55 06900 ELECTROCARDI OLOGY 5, 825 69.00 69.00 69.01 06901 CARDI AC REHAB 25, 956 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 2, 398 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 72, 570 73.00 07301 ONCOLOGY 165, 830 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 90.00 09000 CLI NI C 5, 207 90.00 0 09100 EMERGENCY 91 00 271, 097 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 0 0 99. 10 99.10 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 I SLET ACQUISITION Ω 111 00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 2,048,466 118.00 118.00 0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15, 202 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 657, 824 193. 00 19300 NONPALD WORKERS 0000000000 0 193.00 193. 01 19301 DME l193. 01 Ω 193. 02 19302 LACTATION CONSULTING 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG 193. 03 194.00 07950 VACANT SPACE 43.318 194.00 194. 01 07951 BOARD OF HEALTH 26, 674 194. 01 194. 02 194. 02 07952 PUTNAM/HENRY PRENATAL 62 200.00 Cross Foot Adjustments 0 200.00 201. 00 201.00 Negative Cost Centers

2, 791, 546

202.00

TOTAL (sum lines 118-201)

202.00

	Financial Systems	PUTNAM COUNT				u of Form CMS-2	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet B-1 Date/Time Pre 5/28/2015 7:2	pared: 2 pm
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)		
		1.00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	101, 201					1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	12, 552, 402				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	13, 779	1, 712, 054				5. 00
7.00	00700 OPERATION OF PLANT	8, 972	224, 339	0	1, 600, 612	76, 903	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	676	22, 507	0	124, 748	676	8. 00
9.00	00900 HOUSEKEEPI NG	562	277, 196	0	453, 498	562	9. 00
10. 00	01000 DI ETARY	2, 953	87, 168	1	,	2, 953	10. 00
11. 00	01100 CAFETERI A	1, 604	224, 220		467, 566	1, 604	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	665	102, 045	1	427, 534	665	13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	4, 180	354, 803	1	671, 684	4, 180	16.00
17. 00	01700 SOCIAL SERVICE	0	74.074	0	121	0	17. 00
17. 01	O1701 UTI LI ZATI ON REVI EW	180	74, 374	0	110, 847	180	17. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	8, 729	1, 000, 139	0	1, 550, 490	8, 729	30.00
31. 00	03100   NTENSI VE CARE UNI T	2, 841	720, 734	•		2, 841	31.00
41. 00	04100 SUBPROVI DER – I RF	2,011	, 20, , 01			2, 311	41.00
42. 00	04200 SUBPROVI DER		0	0	0	0	42.00
43.00	04300 NURSERY	O	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	9, 334	408, 528	0	1, 316, 790	9, 334	50.00
51. 00	05100 RECOVERY ROOM	2, 295	79, 015	0	171, 593	2, 295	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	_	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	562, 294			0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 139	596, 010	0	1, 084, 401	3, 139	54.00
54. 01 57. 00	05401   NUCLEAR MEDICINE-DIAGNOSTIC   05700   CT SCAN	140 1, 320	140, 066		143, 564 357, 924	140 1, 320	54. 01 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 320	140, 000		337, 924	1, 320	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		0	0	59.00
60. 00	06000 LABORATORY	2, 472	515, 698	o o	1, 992, 465	2, 472	60.00
60. 01	06001 BLOOD LABORATORY	0	0	Ö	0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	o	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	683	332, 921	0	564, 134	683	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 215	0	0	519, 528	3, 215	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	112, 864	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY	100	50.242	0	3, 665	0	68. 00
69. 00	O6900   ELECTROCARDI OLOGY   O6901   CARDI AC REHAB	100 723	50, 342 72, 345		150, 640 113, 457	100 723	69. 00 69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	723	72, 343		113, 437	723	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT		0		158, 695	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	776	126, 010				73. 00
73. 01	07301 ONCOLOGY	4, 875	234, 718			4, 875	73. 01
	OUTPATIENT SERVICE COST CENTERS				1		
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	-	0	89. 00
90. 00 91. 00	09000 CLI NI C 09100 EMERGENCY	162 6, 004	2, 435		.,	162	90.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6,004	1, 144, 475	0	2, 118, 980	6, 004	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			1			72.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	11100   SLET ACQUI SITI ON	0	0	0	0	0	111.00
	11300 INTEREST EXPENSE  11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
118.00		80, 379	9, 064, 436	-3, 980, 411	19, 398, 748	57, 628	
110.00	NONREI MBURSABLE COST CENTERS	00,077	7,001,100	0, 700, 111	17, 676, 716	07,020	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	477	0	0	13, 158	477	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	17, 961	3, 487, 966	0	5, 671, 870	17, 961	192. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	19301 DME	0	0	0	0		193. 01
193. 02	19302 LACTATION CONSULTING	0	0	0	0		193. 02
	19303 DIABETIC COUNSELING 07950 VACANT SPACE	0 1, 547	0		42 473		193. 03 194. 00
	07950 VACANT SPACE	837	0		42, 673 23, 088		194. 00
	207951 BOARD OF HEALTH	037	0		4, 121		194. 01
200.00			Ö		., .2		200.00
201.00							201. 00
					·		

Health Financial Systems		PUTNAM COUNT	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der	CCN: 151333	Peri od:	Worksheet B-1			
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 7:2			
		CAPI TAL							
	Cost Center Description	RELATED COSTS  NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliati	ON ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)			
		1.00	4. 00	5A	5. 00	7. 00			
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 791, 546	3, 277, 990		3, 980, 411	1, 853, 899	202. 00		
203. 00	Unit cost multiplier (Wkst. B, Part I)	27. 584174	0. 261144		0. 158244	24. 106979	203. 00		
204. 00	Cost to be allocated (per Wkst. B, Part II)		0		380, 082	271, 670	204. 00		
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000000		0. 015110	3. 532632	205. 00		

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		eriod: com 01/01/2014	Worksheet B-1	
				To		Date/Time Pre 5/28/2015 7:2	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	<u> Р</u>
		LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(PATIENT DAYS)	(MANHOURS)	ADMI NI STRATI ON	
		LAUNDRY)				(DI RECT	
		8. 00	9.00	10.00	11. 00	NRSI NG HRS) 13.00	
	GENERAL SERVICE COST CENTERS	0.00	9.00	10.00	11.00	13.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	168, 976	l .				8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	943 701	73, 170 2, 953				9. 00 10. 00
11. 00	01100 CAFETERI A	0			14, 753		11. 00
13.00	01300 NURSING ADMINISTRATION	0	665		107	9, 144	13.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	4, 180		1, 027 0	0	16. 00 17. 00
	01701 UTILIZATION REVIEW	0			0	0	17. 01
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS  03000 ADULTS & PEDI ATRI CS	37, 102	8, 729	2, 248	2. 020	2, 020	30. 00
31. 00	03100   NTENSI VE CARE UNIT	28, 655			1, 304	1, 304	31. 00
41. 00	04100 SUBPROVI DER - I RF	0			0	0	41. 00
42.00	04200 SUBPROVI DER	0	-	1	0	0	42.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	<u> </u>	0	U	0	43. 00
50.00	05000 OPERATING ROOM	26, 836	9, 334	1	934	934	50. 00
51.00	05100 RECOVERY ROOM	0	_,	1	102	102	51.00
52. 00 53. 00	05200   DELIVERY ROOM & LABOR ROOM   05300   ANESTHESIOLOGY	0	1	1	0 191	0 191	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	12, 813	1	Ö	1, 484	1, 484	54. 00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0			0	0	54. 01
57. 00 58. 00	05700   CT SCAN   05800   MAGNETIC RESONANCE IMAGING (MRI)	0	1, 320		334 0	334	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	Ö	Č		Ö	0	59. 00
60.00	06000 LABORATORY	0	2, 472	0	1, 665	0	60.00
60. 01 64. 00	06001   BLOOD LABORATORY   06400   I NTRAVENOUS THERAPY	0			0	0	60. 01 64. 00
65. 00	06500 RESPI RATORY THERAPY	Ö	-	1	683	0	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 671	3, 215	1	0	0	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	C	1	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	100		104	0	69. 00
69. 01 71. 00	06901 CARDI AC REHAB	0	723		204	204	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		C		0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	776		316	0	73. 00
73. 01	07301 ONCOLOGY   OUTPATIENT SERVICE COST CENTERS	5, 435	4, 875	0	471	471	73. 01
88. 00	08800 RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90.00	09000 CLI NI C 09100 EMERGENCY	0 41, 554	162 6, 004		0 2, 100	0 2, 100	90. 00 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	41, 554	0,004		2, 100	2, 100	92.00
	OTHER REIMBURSABLE COST CENTERS	i	i				
99. 10	09910   CORF   SPECIAL PURPOSE COST CENTERS	0	C	0	0	0	99. 10
109. 00	10900 PANCREAS ACQUISITION	0	С	0	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	C	0	O		110. 00
	11100  SLET ACQUISITION   11300  INTEREST EXPENSE	0	C	0	0	0	111. 00 113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
118. 00	<u> </u>	158, 710	56, 390	2, 755	13, 046	9, 144	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	477	'l ol	ol	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	10, 266			1, 707		190.00
	19300 NONPALD WORKERS	0	C	0	0		193. 00
	19301 DME 19302 LACTATION CONSULTING	0	C		0		193. 01 193. 02
	19303 DI ABETI C COUNSELI NG	0			0		193. 02
194.00	07950 VACANT SPACE	0	C	1	0	0	194. 00
	07951 BOARD OF HEALTH 07952 PUTNAM/HENRY PRENATAL	0	837		0		194. 01 194. 02
200.00				<u> </u>		U	200. 00
201.00	Negative Cost Centers					50-	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	160, 785	539, 706	413, 425	592, 055	520, 419	202.00
-	1. 4. 5 . 7	I .	1	I			<u> </u>

Heal th Finar	ncial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - STATISTICAL BASIS		Provi der		Period: From 01/01/2014	Worksheet B-1		
					To 12/31/2014			
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG		
		LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS	) (MANHOURS)	ADMI NI STRATI ON		
		(POUNDS OF						
		LAUNDRY)				(DI RECT		
						NRSING HRS)		
		8. 00	9. 00	10.00	11.00	13.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 951526	7. 376056	150. 06352	1 40. 131160	56. 913714	203. 00	
204. 00	Cost to be allocated (per Wkst. B,	22, 920	24, 467	97, 14	2 57, 512	27, 791	204. 00	
	Part II)							
205. 00	Unit cost multiplier (Wkst. B, Part	0. 135641	0. 334386	35. 26025	4 3. 898326	3. 039261	205. 00	
	[11)							

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151333

Peri od: From 01/01/2014 To 12/31/2014 Worksheet B-1 Date/Time Prepared: 5/28/2015 7: 22 pm

					5/28/2015 7:	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	UTI LI ZATI ON		
		RECORDS &	ć <b>-</b>	REVI EW		
		LI BRARY	(PATI ENT	(PATIENT DAYS)		
		(TIME SPENT) 16.00	DAYS) 17. 00	17. 01		
GF	NERAL SERVICE COST CENTERS	10.00	17.00	17.01		
	0100 NEW CAP REL COSTS-BLDG & FIXT					1.00
	0400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00 00	D500 ADMINISTRATIVE & GENERAL					5. 00
	0700 OPERATION OF PLANT					7. 00
4	D800 LAUNDRY & LINEN SERVICE					8. 00
1	0900 HOUSEKEEPI NG					9.00
	1000 DI ETARY					10.00
1	I100 CAFETERIA I300 NURSING ADMINISTRATION					11. 00 13. 00
4	1600 MEDICAL RECORDS & LIBRARY	152, 069		•		16. 00
	1700 SOCIAL SERVICE	0	2, 755			17. 00
	1701 UTILIZATION REVIEW	0	0	l I		17. 01
IN	IPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS	86, 966	2, 248			30. 00
	3100 INTENSIVE CARE UNIT	0	507	1		31. 00
	1100 SUBPROVI DER - I RF	0	0	_		41.00
1	1200 SUBPROVI DER	0	0	0		42. 00
	1300 NURSERY ICILLARY SERVICE COST CENTERS	l d	0	ıl O		43. 00
	5000 OPERATING ROOM	31, 158	0	0		50.00
	5100 RECOVERY ROOM	0	0			51. 00
	5200 DELIVERY ROOM & LABOR ROOM	0	0	0		52. 00
53. 00 05	ANESTHESI OLOGY	0	0	0		53. 00
	7400 RADI OLOGY-DI AGNOSTI C	22	0	0		54. 00
	NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0		54. 01
	5700 CT SCAN	0	0	0		57. 00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58. 00
	5900 CARDI AC CATHETERI ZATI ON 5000 LABORATORY	88	0			59. 00 60. 00
	5000 LABORATORY	0	0			60. 01
1	5400 I NTRAVENOUS THERAPY		0	0		64. 00
1	5500 RESPI RATORY THERAPY	o	0	o		65. 00
66. 00 06	6600 PHYSI CAL THERAPY	500	0	0		66. 00
67. 00 06	5700 OCCUPATI ONAL THERAPY	0	0	0		67. 00
	SPEECH PATHOLOGY	0	0	0		68. 00
4	5900 ELECTROCARDI OLOGY	0	0	0		69. 00
	5901 CARDI AC REHAB	92	0	0		69. 01
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 MPL. DEV. CHARGED TO PATIENT	0	0			71. 00 72. 00
	7300 DRUGS CHARGED TO PATIENTS	0	0	0		73. 00
	7301 ONCOLOGY	1, 872	0			73. 01
	ITPATIENT SERVICE COST CENTERS	.,	-			
88. 00 08	3800 RURAL HEALTH CLINIC	0	0	0		88. 00
	3900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89. 00
	9000 CLI NI C	0	0	_		90.00
	P100 EMERGENCY	31, 371	0	0		91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
99. 10 09	THER REIMBURSABLE COST CENTERS	O	0	O		99. 10
	PECIAL PURPOSE COST CENTERS	<u> </u>				77.10
	0900 PANCREAS ACQUISITION	0	0	0		109. 00
	1000 INTESTINAL ACQUISITION	0	0	O		110.00
111. 00 11	1100 ISLET ACQUISITION	0	0	0		111. 00
1	1300 INTEREST EXPENSE					113. 00
	1400 UTI LI ZATI ON REVI EW-SNF					114. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	152, 069	2, 755	2, 755		118. 00
	ONREI MBURSABLE COST CENTERS		0	J ol		100.00
1	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2200 PHYSICIANS' PRIVATE OFFICES	0 0	0			190. 00 192. 00
	9300 NONPALD WORKERS	0	0	0		193. 00
193. 01 19		0	0	0		193. 01
	9302 LACTATION CONSULTING	0	0	ő		193. 02
	9303 DIABETIC COUNSELING	0	0	O		193. 03
	7950 VACANT SPACE	0	0	0		194. 00
	7951 BOARD OF HEALTH	0	0	0		194. 01
	7952 PUTNAM/HENRY PRENATAL	0	0	0		194. 02
200.00	Cross Foot Adjustments					200. 00
201.00	Negative Cost Centers	050 70-	a	40: 0==		201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	950, 788	140	134, 055		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	6. 252346	0. 050817	48. 658802		203. 00
200.00	1 C GGGC mar cr p. r of (moc. b, r di t 1)	3. 2020 40	2. 000017	.5. 555552		

Heal th Financia	al Systems	PUTNAM COUNT	Y HOSPITAL			In Lie	u of Form CMS-	2552-10
COST ALLOCATION	N - STATISTICAL BASIS		Provi der		Peri		Worksheet B-1	
						01/01/2014	D . (T) D	
					То	12/31/2014		
					_		5/28/2015 7:2	22 pm
Cos	st Center Description	MEDI CAL	SOCIAL SERVICE	UTILIZATION				
		RECORDS &		REVI EW				
		LI BRARY	(PATI ENT	(PATIENT DAYS	5)			
		(TIME SPENT)	DAYS)					
		16. 00	17. 00	17. 01				
204. 00 Cos	st to be allocated (per Wkst. B,	145, 619	2	7, 33	36			204.00
Par	rt II)							
205. 00 Uni	it cost multiplier (Wkst. B, Part	0. 957585	0. 000726	2. 66279	95			205. 00

Date/Time Prepared: 12/31/2014 5/28/2015 7:22 pm Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3, 292, 581 30 00 03000 ADULTS & PEDIATRICS 3, 292, 581 0 0 03100 INTENSIVE CARE UNIT 1, 529, 287 1, 529, 287 0 0 31.00 31.00 04100 SUBPROVIDER - IRF 0 41.00 0 0 0 41.00 04200 SUBPROVI DER 0 42.00 42.00 0 0 0 04300 NURSERY 0 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 130, 013 2, 130, 013 0 50.00 05100 RECOVERY ROOM 280, 899 280, 899 Ω 51.00 51 00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 53.00 05300 ANESTHESI OLOGY 396, 188 396, 188 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 511, 171 1, 511, 171 54.00 0 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 170,690 170, 690 0 54.01 57.00 05700 CT SCAN 488, 533 488, 533 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 C 0 58.00 0 05900 CARDIAC CATHETERIZATION 59.00 59 00 0 60.00 06000 LABORATORY 2, 452, 955 2, 452, 955 0 60.00 60. 01 06001 BLOOD LABORATORY 0 60.01 C 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 702, 318 702, 318 65 00 0 65 00 66.00 06600 PHYSI CAL THERAPY 710, 529 710, 529 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 130, 724 130, 724 0 67.00 68 00 06800 SPEECH PATHOLOGY 4, 245 4, 245 68 00 0 69.00 06900 ELECTROCARDI OLOGY 181,801 181, 801 0 69.00 06901 CARDI AC REHAB 174, 545 174, 545 0 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 183, 808 183, 808 72 00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 634, 692 3, 634, 692 0 73.00 07301 ONCOLOGY 730, 290 730, 290 0 0 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 88. 00 88 00 08800 RURAL HEALTH CLINIC 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 09000 CLI NI C 90.00 13, 717 13, 717 0 90.00 91.00 09100 EMERGENCY 3, 082, 795 3, 082, 795 ol 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 897, 682 897.682 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 99 10 09910 CORF 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS 0 109. 00 109.00 10900 PANCREAS ACQUISITION 0 O 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00

22, 699, 463

21, 801, 781

897, 682

22, 699, 463

21, 801, 781

897, 682

0 200. 00

0 201. 00

0 202. 00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

					0 12/01/2011	5/28/2015 7:2	2 pm
			Ti tl	e XVIII	Hospi tal	Cost	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		·	+ col. 7)	Ratio	Inpati ent	
				·		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	1, 205, 679		1, 205, 679			30. 00
31.00	03100 INTENSIVE CARE UNIT	1, 340, 913		1, 340, 913	3		31. 00
41.00	04100 SUBPROVI DER - I RF	0		(			41.00
42.00	04200 SUBPROVI DER	0		(			42.00
43.00	04300 NURSERY	0		(	)		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	962, 287	2, 897, 611	3, 859, 898	0. 551831	0.000000	50.00
51.00	05100 RECOVERY ROOM	59, 608	421, 770	481, 378	0. 583531	0.000000	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0.000000	0. 000000	52. 00
53.00	05300 ANESTHESI OLOGY	27, 310	399, 763	427, 073	0. 927682	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	476, 815	4, 638, 077	5, 114, 892	0. 295445	0.000000	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	37, 053	494, 823	531, 87 <i>6</i>	0. 320921	0.000000	54. 01
57.00	05700 CT SCAN	502, 234	11, 740, 925	12, 243, 159	0. 039903	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	0.000000	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0.000000	0.000000	59. 00
60.00	06000 LABORATORY	1, 463, 962	11, 939, 606	13, 403, 568	0. 183008	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(	0.000000	0.000000	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0	0	(	0.000000	0.000000	64.00
65.00	06500 RESPIRATORY THERAPY	1, 027, 136	492, 416	1, 519, 552	0. 462188	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	456, 433	1, 413, 258	1, 869, 691	0. 380025	0.000000	66. 00
67.00	06700 OCCUPATIONAL THERAPY	270, 587	208, 393	478, 980	0. 272922	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	5, 141	11, 625	16, 766	0. 253191	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	39, 219	987, 615	1, 026, 834	0. 177050	0.000000	69. 00
69. 01	06901 CARDI AC REHAB	0	213, 577	213, 577	0. 817246	0.000000	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	0.000000	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	215, 347	338, 574	553, 921	0. 331831	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 479, 152	4, 949, 920	6, 429, 072	0. 565353	0.000000	73. 00
	07301 ONCOLOGY	1, 104	538, 062	539, 166	1. 354481	0.000000	73. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	(	)		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(			89. 00
90.00	09000 CLI NI C	o	4, 137	4, 137	3. 315688	0.000000	90.00
91.00	09100 EMERGENCY	124, 364	6, 712, 195	6, 836, 559	0. 450928	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	13, 400	1, 604, 879	1, 618, 279	0. 554714	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09910 CORF	0	0	(	)		99. 10
	SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	(			109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	(			110. 00
	11100   SLET ACQUISITION	0	0	(			111. 00
	11300   NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
200.00	Subtotal (see instructions)	9, 707, 744	50, 007, 226	59, 714, 970	)		200. 00
201.00	Less Observation Beds						201. 00
202. 00	Total (see instructions)	9, 707, 744	50, 007, 226	59, 714, 970	)		202. 00

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333 Period:
From 01/01/2014 To 12/31/2014 Date/Time Prepared:
5/28/2015 7: 22 pm

					5/28/2015 7:22 pm
			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				30.00
31. 00	03100 INTENSIVE CARE UNIT				31.00
41.00	04100 SUBPROVI DER - I RF				41.00
42.00	04200 SUBPROVI DER				42. 00
43.00	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0. 000000			50.00
51.00	05100 RECOVERY ROOM	0. 000000			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000			54. 01
57.00	05700 CT SCAN	0. 000000			57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60.00	06000 LABORATORY	0. 000000			60.00
60. 01	06001 BLOOD LABORATORY	0. 000000			60. 01
64.00	06400 I NTRAVENOUS THERAPY	0. 000000			64. 00
65.00	06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000			69. 00
69. 01	06901 CARDI AC REHAB	0. 000000			69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
73. 01	07301 ONCOLOGY	0. 000000			73. 01
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90.00	09000 CLI NI C	0. 000000			90.00
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92. 00
	OTHER REIMBURSABLE COST CENTERS				
99. 10	09910 CORF				99. 10
,,,,,	SPECIAL PURPOSE COST CENTERS				771.10
109 00	10900 PANCREAS ACQUISITION				109. 00
	11000 INTESTINAL ACQUISITION				110.00
	11100 I SLET ACQUI SI TI ON				111.00
	11300 I NTEREST EXPENSE				113.00
	11400 UTI LI ZATI ON REVI EW-SNF				114. 00
200.00	1 1				200. 00
201.00	,				201.00
202.00	+ I				202. 00
202.00	1.000. (000 1.100. 000. 010)	1			1202.00

			T	o 12/31/2014	Date/Time Pre 5/28/2015 7:2	pared: 2 pm
-		Ti t	le XIX	Hospi tal	Cost	<u> </u>
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS	3, 292, 581		3, 292, 581	0	3, 292, 581	30.00
31. 00   03100   NTENSI VE CARE UNI T	1, 529, 287		1, 529, 287	0	1, 529, 287	31.00
41. 00   04100   SUBPROVI DER -   RF	1,027,207		0	0	0	41. 00
42. 00   04200   SUBPROVI DER	0		o o	0	Ö	42. 00
43. 00   04300   NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS	<u>-</u>					
50. 00 05000 OPERATI NG ROOM	2, 130, 013		2, 130, 013	0	2, 130, 013	50.00
51. 00   05100   RECOVERY ROOM	280, 899		280, 899	0	280, 899	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	l .	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	396, 188		396, 188	0	396, 188	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 511, 171		1, 511, 171	0	1, 511, 171	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	170, 690		170, 690	0	170, 690	54. 01
57. 00 05700 CT SCAN	488, 533		488, 533	0	488, 533	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60. 00   06000   LABORATORY	2, 452, 955		2, 452, 955	0	2, 452, 955	60.00
60. 01   06001   BL00D   LABORATORY	0		0	0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	0		0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	702, 318	0	702, 318	0	702, 318	65. 00
66. 00   06600 PHYSI CAL THERAPY	710, 529	0	710, 529	0	710, 529	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	130, 724	0	130, 724	0	130, 724	67. 00
68.00   06800   SPEECH PATHOLOGY	4, 245	0	4, 245	0	4, 245	68. 00
69. 00   06900   ELECTROCARDI OLOGY	181, 801		181, 801	0	181, 801	
69. 01   06901   CARDI AC REHAB	174, 545		174, 545	0	174, 545	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	183, 808	l .	183, 808	0	183, 808	ł
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 634, 692		3, 634, 692	0	3, 634, 692	
73. 01 07301 0NC0L0GY	730, 290		730, 290	0	730, 290	73. 01
OUTPATIENT SERVICE COST CENTERS	_	T	_	_	_	
88. 00 08800 RURAL HEALTH CLINIC	0		0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
90. 00   09000   CLI NI C	13, 717	l .	13, 717	0	13, 717	90.00
91. 00 09100 EMERGENCY	3, 082, 795		3, 082, 795	0	3, 082, 795	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	897, 682		897, 682		897, 682	92. 00
99. 10   09910   CORF	T 0		0		0	99. 10
SPECIAL PURPOSE COST CENTERS			0		0	77.10
109. 00 10900 PANCREAS ACQUISITION	0		0		0	109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON	0		Ö			110.00
111. 00 11100   SLET ACQUISITION	0		0			111. 00
113. 00 11300   INTEREST EXPENSE			_		_	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
200.00 Subtotal (see instructions)	22, 699, 463	0	22, 699, 463	0	22, 699, 463	
201.00 Less Observation Beds	897, 682		897, 682		897, 682	
202.00 Total (see instructions)	21, 801, 781	0	21, 801, 781	0		
				•		

Cost Center Description						.0 12,01,2011	5/28/2015 7: 2	2 pm
Impatient   Outpatient   Total (col. 6   cost or Other Ratio   Impatient   Cost (col. 7)   Cost (col. 7)   Ratio   Impatient   Ratio   Impatient   Ratio   Cost (col. 7)   Cost (col. 7)   Ratio   Cost (col. 7)   Ratio   Cost (col. 7)   C				Ti t	le XIX	Hospi tal		
INPATIENT ROUTINE SERVICE COST CENTERS	·			Charges		·		
IMPATI ENT ROUTINE SERVICE COST CENTERS   1, 205, 679   1, 205, 679   30.00   30000  ADULTS & PEDI ATRICS   1, 205, 679   1, 205, 679   31.00   31.0	Cost (	Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
INPATI ENT ROUTINE SERVICE COST CENTERS   1, 205, 679   1, 205, 679   30. 00   3000   ADULTS & PEDI ATRI CS   1, 205, 679   1, 340, 913   31. 00   310   00   310   00   310   00   310   01   310   01   310   01   310   01   310   01   310   01   310   01   310   01   310   01   310   01   310   31. 00   310   01   310   31. 00   310   31. 00   310   31. 00   310   31. 00   310   31. 00   310   31. 00   310   31. 00   310   31. 00		·		•	+ col. 7)	Ratio	Inpati ent	
INPATI ENT ROUTINE SERVICE COST CENTERS   1, 205, 679   1, 205, 679   33.0.00   30.00   30.10   AULTS & PEDIATRICS   1, 340, 913   1, 340, 913   31.00   41.00   410.00   41					· ·		Rati o	
30.00     3000   ADULTS & PEDIATRICS   1,205,679   1,205,679   1,205,679   30.00   31.00   3			6.00	7. 00	8. 00	9. 00	10.00	
31.00   03100   INTERSIVE CARE UNIT   1,340,913   1,340,913   0,00000   41.0	I NPATI ENT R	OUTINE SERVICE COST CENTERS						
1.00	30. 00   03000 ADULTS	S & PEDIATRICS	1, 205, 679		1, 205, 679	9		30.00
42.00   04200   SUBPROVI DER   0   0   42.00   0   43.00	31.00 03100 INTENS	SIVE CARE UNIT	1, 340, 913		1, 340, 913	3		31.00
43.00     A3.00     A3.00   A3.0	41. 00   04100   SUBPRO	OVIDER - IRF	0		(			41.00
ANCI LLARY SERVICE COST CENTERS	42. 00 04200 SUBPRO	OVI DER	0		(			42.00
50.00	43. 00 04300 NURSEF	RY	0		(			43.00
51.00   05100   RECOVERY ROOM   CONTRIVER ROOM   CONTRIVERROOM   CONTRIVER ROOM   CONTRIVER ROOM   CONTRIVER ROOM   CONTRIV	ANCI LLARY SI	ERVICE COST CENTERS						
52.00		TING ROOM	962, 287	2, 897, 611	3, 859, 898	0. 551831	0.000000	50. 00
53.00   08.300   AMSTHESI OLOGY   27, 310   399, 763   427, 073   0.927682   0.000000   53.00	51. 00   05100 RECOVE	ERY ROOM	59, 608	421, 770	481, 378	0. 583531	0.000000	51.00
54.01 05400 RADIOLOGY-DIAGNOSTIC			0	0	(	0. 000000	0.000000	52. 00
54.01   OSAO1   NUCLEAR MEDICINE-DIAGNOSTIC   37,053   494,823   531,876   0,320921   0,000000   54,01	53. 00 05300 ANESTH	HESI OLOGY	27, 310	399, 763	427, 073	0. 927682	0.000000	53.00
57.00   05700   CT SCAN   502,234   11,740,925   12,243,159   0.039903   0.000000   57.00	54. 00 05400 RADI OL	LOGY-DI AGNOSTI C	476, 815	4, 638, 077	5, 114, 892	0. 295445	0.000000	54.00
SB 00   05900   CARDIAC CATHETERI ZATION   0   0   0   0   0   0   0   0   0	54. 01   05401 NUCLEA	AR MEDICINE-DIAGNOSTIC	37, 053	494, 823	531, 876	0. 320921	0.000000	54. 01
59.00   05900   05900   05900   05900   05000   0500000   0500000   059.00   060.0	57. 00   05700   CT   SCA	AN	502, 234	11, 740, 925	12, 243, 159	0. 039903	0.000000	57. 00
60.00   06000   LABORATORY   1, 463, 962   11, 939, 606   13, 403, 568   0, 18300B   0, 000000   60. 00   60.	58. 00   05800   MAGNET	TIC RESONANCE IMAGING (MRI)	0	0	(	0. 000000	0.000000	58. 00
60.01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0	59. 00   05900   CARDI A	AC CATHETERIZATION	0	0	(	0.000000	0.000000	59. 00
64.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0	60. 00   06000   LABORA	ATORY	1, 463, 962	11, 939, 606	13, 403, 568	0. 183008	0.000000	60.00
65.00   06500   RESPIRATORY THERAPY   1,027,136   492,416   1,519,552   0.462188   0.000000   65.00   66.00   06600   PHYSI CAL THERAPY   456,433   1,413,258   1,869,691   0.380025   0.000000   66.0	60. 01 06001 BL00D	LABORATORY	0	0	(	0.000000	0.000000	60. 01
66. 00   0.6600   PHYSICAL THERAPY   456, 433   1, 413, 258   1, 869, 691   0.380025   0.000000   66. 00   67. 00   0.0000000   0.0000000   0.0000000   0.00000000	64. 00   06400   I NTRA\	VENOUS THERAPY	0	0	(	0. 000000	0.000000	64. 00
67. 00   06700   OCCUPATI ONAL THERAPY   270, 587   208, 393   478, 980   0. 272922   0. 000000   67. 00   68. 00   06800   SPEECH PATHOLOGY   5, 141   11, 625   16, 766   0. 253191   0. 000000   68. 00   69. 01   06901   CARDI AC REHAB   0   213, 577   213, 577   0. 817246   0. 000000   69. 01   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0. 000000   0. 000000   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   215, 347   338, 574   553, 921   0. 331831   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1, 479, 152   4, 949, 920   6, 429, 072   0. 565353   0. 000000   73. 00   73. 01   07301   ONCOLOGY   1, 104   538, 062   539, 166   1. 354481   0. 000000   73. 01   88. 00   08800   RURAL HEALTH CLINI C   0   0   0   0. 000000   0. 000000   73. 01   89. 00   08900   CLINI C   0   0   0   0. 000000   0. 000000   99. 00   90. 00   09000   CLINI C   0   4, 137   4, 137   3. 315688   0. 000000   99. 00   90. 00   09000   CLINI C   0   0   0   0. 563741   0. 000000   99. 00   91. 00   09100   EMERGENCY   124, 364   6, 712, 195   6, 836, 559   0. 450928   0. 000000   99. 00   92. 00   09100   EMERGENCY   124, 364   6, 712, 195   6, 836, 559   0. 450928   0. 000000   99. 00   99. 10   OP910   CORF   0   0   0   0   0. 554714   0. 000000   99. 00   99. 10   OP910   CORF   0   0   0   0   0. 554714   0. 000000   99. 00   99. 10   OP910   CORF   0   0   0   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   0   0   0   0   110. 01   1100   LESE ACQUI SI TI ON   0   0   0   0   0   0   0   0   0	65. 00 06500 RESPLE	RATORY THERAPY	1, 027, 136	492, 416	1, 519, 552	0. 462188	0.000000	65. 00
68.00   06800   SPEECH PATHOLOGY   5, 141   11, 625   16, 766   0. 253191   0. 000000   68.00   69.00   06900   CARDI ACR REHAB   0   213,577   213,577   0. 817246   0. 000000   69. 01   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0. 000000   0. 000000   71. 00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENT   215, 347   338, 574   553, 921   0. 331831   0. 000000   72. 00   73. 01   07300   DRUGS CHARGED TO PATI ENT   1, 479, 152   4, 949, 920   6, 429, 072   0. 565353   0. 000000   73. 00   73. 01   07301   ONCOLOGY   1, 104   538, 062   539, 166   1. 354481   0. 000000   73. 00   88. 00   08900   RURAL HEALTH CLINIC   0   0   0. 000000   0. 000000   0. 000000   0. 000000   89. 00   08900   EDEFRALLY QUALIFIED HEALTH CENTER   0   0   0. 000000   0. 000000   0. 000000   0. 000000   90. 00   09000   CLI NI C   0   4, 137   4, 137   3. 315688   0. 000000   91. 00   91. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   13, 400   1, 604, 879   1, 618, 279   0. 554714   0. 000000   92. 00   99. 10   OPTIONE REIMBURSABLE COST CENTERS   0   0   0   0   0   110. 00   11000   INTESTI NAL ACQUI SITION   0   0   0   0   111. 00   111.00   INTESTI NAL ACQUI SITION   0   0   0   0   111. 00   111.00   INTESTI NAL ACQUI SITION   0   0   0   0   111. 00   114.00   UTILIZATION REVIEW-SNF   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	66. 00 06600 PHYSI (	CAL THERAPY	456, 433	1, 413, 258	1, 869, 69 <sup>-</sup>	0. 380025	0.000000	66. 00
69. 00   06900   CARDI AC REHAB   0   213,577   213,577   0.817246   0.000000   69. 00   69. 01   06901   CARDI AC REHAB   0   213,577   213,577   0.817246   0.000000   69. 01   71. 00   07100   MEDIC CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0.000000   0.000000   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   215,347   338,574   553,921   0.331831   0.000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   1,479,152   4,949,920   6,429,072   0.565353   0.000000   73. 00   73. 01   07301   ONCOLOGY   1,104   538,062   539,166   1.354481   0.000000   73. 01   00TPATIENT SERVICE COST CENTERS	67. 00 06700 OCCUPA	ATIONAL THERAPY	270, 587	208, 393	478, 980	0. 272922	0.000000	67.00
69. 01   06901   CARDI AC REHAB   0   213, 577   213, 577   0. 817246   0. 000000   69. 01   71. 00   07100   MEDI CAR SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0. 000000   0. 000000   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   215, 347   338, 574   553, 921   0. 331831   0. 000000   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   1, 479, 152   4, 949, 920   6, 429, 072   0. 565353   0. 000000   73. 00   73. 01   07301   ONCOLOGY   1, 104   538, 062   539, 166   1. 354481   0. 000000   73. 01   88. 00   08900   RURAL HEALTH CLINIC   0   0   0   0. 000000   0. 000000   88. 00   89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0. 000000   0. 000000   89. 00   90. 00   09000   CLINIC   0   4, 137   4, 137   3. 315688   0. 000000   90. 00   91. 00   09100   EMERGENCY   124, 364   6, 712, 195   6, 836, 559   0. 450928   0. 000000   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   13, 400   1, 604, 879   1, 618, 279   0. 554714   0. 000000   99. 10   OP910   CORF   0   0   0   0   99. 10   OP910   CORF   0   0   0   0   110. 00   11000   INTESTI NAL ACQUI SI TI ON   0   0   0   111. 00   11100   INTESTI NAL ACQUI SI TI ON   0   0   0   111. 00   11400   UTI LI ZATI ON REVI EW-SNF   114. 00   114. 00   Less Observation Beds   9, 707, 744   50, 007, 226   59, 714, 970   200. 00   201. 00   Less Observation Beds   201. 00	68. 00 06800 SPEECH	H PATHOLOGY	5, 141	11, 625	16, 766	0. 253191	0.000000	68. 00
71. 00	69. 00 06900 ELECTI	ROCARDI OLOGY	39, 219	987, 615	1, 026, 834	0. 177050	0.000000	69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   215, 347   338, 574   553, 921   0. 331831   0. 000000   72. 00   73. 00   7300   07300   DRUGS CHARGED TO PATIENTS   1, 479, 152   4, 949, 920   6, 429, 072   0. 565353   0. 000000   73. 00   73. 01   07301   0NCOLOGY   1, 104   538, 062   539, 166   1. 354481   0. 000000   73. 01   000000000000000000000000000000000	69. 01   06901 CARDI A	AC REHAB	0	213, 577	213, 57	0. 817246	0.000000	69. 01
73. 00	71. 00 07100 MEDICA	AL SUPPLIES CHARGED TO PATIENTS	0	0	(	0.000000	0.000000	71. 00
73. 01 07301 0ROLOGY 0UTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0.000000 0.000000 89.00 99.00 99.00 09000 CLINIC 0 0 4, 137 4, 137 3.315688 0.000000 99.00 99.00 09100 EMERGENCY 124, 364 6, 712, 195 6, 836, 559 0.450928 0.000000 99.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 13, 400 1, 604, 879 1, 618, 279 0.554714 0.000000 99.00 010 09910 CORF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00 07200 I MPL.	DEV. CHARGED TO PATIENT	215, 347	338, 574	553, 92°	0. 331831	0.000000	72. 00
73. 01 07301 0ROLOGY 0UTPATIENT SERVICE COST CENTERS  88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0.000000 0.000000 89.00 99.00 99.00 09000 CLINIC 0 0 4, 137 4, 137 3.315688 0.000000 99.00 99.00 09100 EMERGENCY 124, 364 6, 712, 195 6, 836, 559 0.450928 0.000000 99.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 13, 400 1, 604, 879 1, 618, 279 0.554714 0.000000 99.00 010 09910 CORF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73. 00 07300 DRUGS	CHARGED TO PATIENTS	1, 479, 152	4, 949, 920	6, 429, 072	0. 565353	0.000000	73. 00
SB. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   0   0			1, 104	538, 062	539, 166	1. 354481	0.000000	73. 01
88. 00	OUTPATIENT :	SERVICE COST CENTERS						
90. 00   09000   CLINIC   0   4, 137   4, 137   3. 315688   0. 000000   90. 00   91. 00   92. 00   09100   EMERGENCY   124, 364   6, 712, 195   6, 836, 559   0. 450928   0. 000000   91. 00   92. 00   09200	88. 00 08800 RURAL	HEALTH CLINIC	0	0	(	0.000000	0.000000	88. 00
91. 00   09100   EMERGENCY   124, 364   6, 712, 195   6, 836, 559   0. 450928   0. 000000   91. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   13, 400   1, 604, 879   1, 618, 279   0. 554714   0. 000000   92. 00   0   0   0   0   0   0   0   0   0	89. 00 08900 FEDERA	ALLY QUALIFIED HEALTH CENTER	0	0	(	0. 000000	0.000000	89. 00
92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   13, 400   1, 604, 879   1, 618, 279   0. 554714   0. 000000   92. 00	90. 00 09000 CLINI	C	0	4, 137	4, 13	3. 315688	0.000000	90.00
99. 10   OTHER REIMBURSABLE COST CENTERS   O O O O O O O O O O O O O O O O O O	91. 00 09100 EMERGE	ENCY	124, 364	6, 712, 195	6, 836, 559	0. 450928	0.000000	91.00
99. 10   09910   CORF	92. 00 09200 OBSER\	VATION BEDS (NON-DISTINCT PART)	13, 400	1, 604, 879	1, 618, 279	0. 554714	0.000000	92.00
SPECIAL PURPOSE COST CENTERS   109.00   10900   PANCREAS ACQUISITION   0 0 0 0 0 109.00   110.00   1	OTHER REIMBI	URSABLE COST CENTERS						
109. 00   10900   PANCREAS ACQUISITION	99. 10 09910 CORF		0	0	(			99. 10
110.00   11000   INTESTINAL ACQUISITION	SPECIAL PURI	POSE COST CENTERS						
111. 00	109. 00 10900 PANCRE	EAS ACQUISITION	0	0	(	D		109. 00
113.00   11300   INTEREST EXPENSE   113.00   11400   UTILIZATION REVIEW-SNF   200.00   Subtotal (see instructions)   9,707,744   50,007,226   59,714,970   200.00   201.00   Less Observation Beds	110. 00 11000 I NTEST	TINAL ACQUISITION	0	0	(			110.00
114.00	111. 00 11100 I SLET	ACQUI SI TI ON	o	0	(			111. 00
200.00   Subtotal (see instructions)   9,707,744   50,007,226   59,714,970   200.00   201.00   Less Observation Beds   201.00	113. 00 11300 I NTER	EST EXPENSE						113. 00
201.00 Less Observation Beds 201.00	114. 00 11400 UTI LI 2	ZATION REVIEW-SNF						114. 00
	200. 00 Subto	tal (see instructions)	9, 707, 744	50, 007, 226	59, 714, 970			
202 00   Total (see instructions)   9 707 744   50 007 226   59 714 970   202 00	201.00 Less (	Observation Beds						201. 00
202.00	202. 00 Total	(see instructions)	9, 707, 744	50, 007, 226	59, 714, 970			202. 00

Heal th Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333
Period:
From 01/01/2014
To 12/31/2014
Part I
Date/Time Prepared:

5/28/2015 7:22 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 42.00 04200 SUBPROVI DER 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 53 00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54. 01 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.000000 57. 00 05700 CT SCAN 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 60. 00 | 06000 | LABORATORY 0.000000 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06400 INTRAVENOUS THERAPY 0.000000 64.00 64 00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 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 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 73. 01 07301 ONCOLOGY 0.000000 73.01 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 90 00 09000 CLI NI C 0.000000 90.00 09100 EMERGENCY 91.00 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 99. 10 09910 CORF SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110 00 111.00 11100 | SLET ACQUISITION 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 200.00 Subtotal (see instructions) 200. 00 201.00 Less Observation Beds 201. 00

202.00

202.00

Total (see instructions)

Health Financial Systems PUTNAM COUNTY HO				Y HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMENT OF	INPATIENT ANCILLARY SERVICE CA	API TAL	COSTS		Provi der		Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/28/2015 7:2	
					Ti tl	e XVIII	Hospi tal	Cost	
Cost	Center Description		Capital Related Cost (from Wkst. B,	(from Part	Wkst. C,	9	Program	Capital Costs (column 3 x column 4)	

							07 207 2010 7. 27	2 0111
				Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal			Ratio of Cost		Capital Costs	
		Related Cost				Program	(column 3 x	
		(from Wkst. B,	Part		(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							
	05000 OPERATI NG ROOM	353, 419		3, 859, 898		•		
51. 00		75, 481	1	481, 378				
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1	0	0. 00000		0	
53.00	05300 ANESTHESI OLOGY	6, 252		427, 073		· ·		
54.00	05400 RADI OLOGY-DI AGNOSTI C	127, 165		5, 114, 892				
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	6, 573		531, 876		· ·		
57.00	05700 CT SCAN	49, 240	1	2, 243, 159			1, 173	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0.00000		0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0.00000		0	59. 00
60.00	06000 LABORATORY	114, 429	1	3, 403, 568	0. 00853	7 786, 775	6, 717	60.00
60. 01	06001 BLOOD LABORATORY	0		0	0. 00000	0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0		0	0. 00000	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	32, 668	3	1, 519, 552	0. 02149	8 646, 703	13, 903	65. 00
66.00	06600 PHYSI CAL THERAPY	110, 078	3	1, 869, 691	0. 05887	5 133, 654	7, 869	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 705		478, 980	0. 00356	0 69, 800	248	67.00
68.00	06800 SPEECH PATHOLOGY	55		16, 766	0. 00328	0 4, 063	13	68. 00
69.00	06900 ELECTROCARDI OLOGY	5, 825		1, 026, 834	0. 00567	3 23, 207	132	69.00
69. 01	06901 CARDI AC REHAB	25, 956		213, 577		o o	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	o l	0	0. 00000	o o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	2, 398		553, 921	0. 00432	9 215, 347	932	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	72, 570	o l	6, 429, 072	0. 01128	8 732, 950	8, 274	73. 00
73. 01	07301 ONCOLOGY	165, 830	o l	539, 166	0. 30756	1, 085	334	73. 01
	OUTPATIENT SERVICE COST CENTERS		•					
88. 00	08800 RURAL HEALTH CLINIC	0		0	0.00000	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	ol .	0	0. 00000	o o	0	89. 00
90.00	09000 CLI NI C	5, 207	1	4, 137	1. 25864	2 0	0	90.00
91.00	09100 EMERGENCY	271, 097	1	6, 836, 559		4 5, 366	213	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	169, 028		1, 618, 279			0	92.00
200.00	Total (lines 50-199)	1, 594, 976		7, 168, 378		3, 500, 234	78, 735	200.00
				•	•	1		•

Health Financial Systems	PUTNAM COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 151333	From 01/01/2014	Worksheet D Part IV Date/Time Prepared:

Non Physician   Nor Physician   Anesthetist   Cost   Anesthetist   Cos					'	0 12/31/2014	5/28/2015 7: 2	pareu. 2 pm
Anesthetist   Cost   Education Cost				Ti tl	e XVIII	Hospi tal		
ANCILLARY SERVICE COST CENTERS   1.00   2.00   3.00   4.00   5.00		Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
ANCI LLARY SERVI CE COST CENTERS   1.00   2.00   3.00   4.00   5.00			Anesthetist			Medi cal		
1.00   2.00   3.00   4.00   5.00			Cost			Education Cost	through col.	
ANCILLARY SERVICE COST CENTERS								
S0.00		T	1. 00	2. 00	3. 00	4. 00	5. 00	
51. 00				_	_	_	_	
52. 00         05200 DELIVERY ROOM & LABOR ROOM         0         0         0         0         0         52. 00           53. 00         05300 ANESTHESI OLOGY         0         0         0         0         0         53. 00           54. 00         05400 RADI OLOGY-DI AGNOSTI C         0         0         0         0         0         54. 00           54. 01         05401 NUCLEAR MEDI CI NE-DI AGNOSTI C         0         0         0         0         0         54. 00           57. 00         05700 CT SCAN         0         0         0         0         0         54. 01         57. 00           58. 00         05800 MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0         0         0         57. 00           59. 00         05900 CARDI AC CATHETERI ZATI ON         0         0         0         0         0         57. 00           60. 00         06000 LABORATORY         0			0	0	C	0	0	
53.00         05300         ANESTHESI OLOGY         0         0         0         0         0         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         0         54.00           54.01         05401         NUCLEAR MEDI CI NE-DI AGNOSTI C         0         0         0         0         0         54.01           57.00         05700         CT SCAN         0         0         0         0         0         57.00         0         0         0         0         57.00         0         0         0         0         0         0         0         0         0         0         0         57.00         0         0         0         0         0         0         57.00         0         0         0         0         0         0         57.00         0			0	0	C	0	0	
54. 00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       0       54. 00         54. 01       05401       NUCLEAR MEDI CI NE-DI AGNOSTI C       0       0       0       0       0       0       54. 01         57. 00       05700       CT SCAN       0       0       0       0       0       0       0       57. 00         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       0       0       0       0       0       0       0       57. 00         59. 00       05900       CARDI AC CATHETERI ZATI ON       0		1	0	0	C	0	0	
54. 01         05401         NUCLEAR MEDICINE-DIAGNOSTIC         0         0         0         0         54. 01           57. 00         05700         CT SCAN         0         0         0         0         0         57. 00           58. 00         05800         MAGNETIC RESONANCE IMAGING (MRI)         0         0         0         0         0         57. 00           59. 00         05900         CARDI AC CATHETERI ZATION         0         0         0         0         0         59. 00           60. 00         06000         LABORATORY         0         0         0         0         0         0         0         0         0         0         60. 00         60. 00         60. 00         0 <td></td> <td></td> <td>0</td> <td>0</td> <td>C</td> <td>0</td> <td>0</td> <td></td>			0	0	C	0	0	
57. 00         05700         CT SCAN         0         0         0         0         0         57. 00           58. 00         05800         MAGNETIC RESONANCE I MAGI NG (MRI)         0         0         0         0         0         58. 00           59. 00         05900         CARDI AC CATHETERI ZATI ON         0         0         0         0         0         0         0         59. 00           60. 01         060001         LABORATORY         0 <t< td=""><td></td><td>1</td><td>0</td><td>0</td><td>C</td><td>0</td><td>0</td><td></td></t<>		1	0	0	C	0	0	
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)   0   0   0   0   0   58. 00   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   0   60. 01   06001   BLOOD LABORATORY   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   66. 00   06500   PHYSI CAL THERAPY   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   69. 01   06901   CARDI AC REHAB   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   73. 01   07301   ONGOLOGY   0   0   0   0   00   073. 01   00TPATIENT SERVICE COST CENTERS			0	0	C	0	0	
59. 00         05900   CARDI AC CATHETERI ZATI ON         0         0         0         0         59. 00           60. 00         06000   LABORATORY         0         0         0         0         0         0         60. 00           60. 01         06001   BLOOD LABORATORY         0         0         0         0         0         0         0         60. 01           64. 00         06400   INTRAVENOUS THERAPY         0         0         0         0         0         0         0         64. 00         64. 00           65. 00         06500   RESPI RATORY THERAPY         0         0         0         0         0         0         0         0         65. 00           66. 00         06600   PHYSI CAL THERAPY         0         0         0         0         0         0         0         65. 00           67. 00         06700   OCCUPATI ONAL THERAPY         0         0         0         0         0         0         0         67. 00           68. 00         06800   SPEECH PATHOLOGY         0         0         0         0         0         0         0         68. 00           69. 01         06900   CARDI AC REHAB         0         0         0			0	0	[ C	0	0	
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0			0	0	C	0	0	
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 60. 01 64. 00 65. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 64. 00 65. 00 6500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 65. 00 66. 00 6600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 65. 00 66. 00 6600 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 66. 00 68. 00 69. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 0 0 0 0 0 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 71. 00 72. 00 73. 01 07301 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 73. 01 07301 ONCOLOGY 0 0 0 0 0 0 0 0 0 73. 01 0UTPATI ENT SERVI CE COST CENTERS		1	0	0	C	0	0	
64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   69. 01   06901   CARDI AC REHAB   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   73. 01   07301   ONCOLOGY   0   0   0   0   00   073. 01   0000   0000   0000   0000   00   073. 01   0000   0000   0000   00   0000   0000   0000   0000   073. 01   0000   0000   0000   0   0   0000   073. 01   0000   0000   0000   0   0   0000			0	0	C	0	0	
65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   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   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 01   07301   ONCOLOGY   0   0   0   0   0   0000   073. 01   0000   0000   0000   0   0000   073. 01   0000   0000   0   0   0000   073. 01   0000   0000   0000   0   0   0   0000   0000   0		1	0	0	C	0	0	
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   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   0   69. 01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   73. 01   07301   ONCOLOGY   0   0   0   0   0   0UTPATI ENT SERVI CE COST CENTERS			0	0	[ C	0	0	
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 67. 00 68. 00 688. 00 6800 SPEECH PATHOLOGY 0 0 0 0 0 0 688. 00 69. 00 69. 00 69. 01 06901 CARDI AC REHAB 0 0 0 0 0 0 0 69. 01 69. 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 0 0 0 0 0 0 0 73. 00 73. 01 07301 ONCOLOGY 0 0 0 0 0 0 0 73. 01 0000 OTATI ENT SERVICE COST CENTERS			0	0	C	0	0	
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   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   73. 01   07301   ONCOLOGY   0   0   0   0   00   00   00   0   00   00   00   0   0			0	0	[ C	0	0	
69. 00 06900   ELECTROCARDI OLOGY   0 0 0 0 0 0 69. 00 69. 01 69. 01 06901   CARDI AC REHAB   0 0 0 0 0 0 0 69. 01 71. 00 07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0 0 0 0 0 0 0 71. 00 72. 00 07200   IMPL. DEV. CHARGED TO PATI ENTS   0 0 0 0 0 0 0 72. 00 73. 00 07300   DRUGS CHARGED TO PATI ENTS   0 0 0 0 0 0 0 0 73. 00 73. 01 07301   ONCOLOGY   0 0 0 0 0 0 0 73. 01 0000000000000000000000000000000000			0	0	C	0	0	
69. 01 06901 CARDIAC REHAB 0 0 0 0 0 0 69. 01 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 72. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 73. 01 07301 ONCOLOGY 0 0 0 0 0 0 73. 01 OUTPATIENT SERVICE COST CENTERS			0	0	C	0	0	
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 01   07301   ONCOLOGY   0   0   0   0   0UTPATIENT SERVICE COST CENTERS		l l	0	0	C	0	0	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   0   0   0   0   72. 00   073. 00   073. 00   073. 01			0	0	[ C	0	0	
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   73. 00   73. 01   07301   ONCOLOGY   0   0   0   0   0    OUTPATIENT SERVICE COST CENTERS			0	0	C	0	0	
73. 01 07301 0NCOLOGY 0 0 0 0 73. 01 OUTPATIENT SERVICE COST CENTERS			0	0	C	0	0	
OUTPATIENT SERVICE COST CENTERS			0	0	C	0	0	
	73. 01		0	0	C	0	0	73. 01
		08800 RURAL HEALTH CLINIC	0	0	C	0	0	00.00
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0 0 0 0 89.00			0	0	[ C	0	0	
90. 00   09000  CLINIC   0   0   0   0   90. 00			0	0	[ C	0	0	
91. 00   09100   EMERGENCY   0   0   0   0   91. 00			0	0	[ C	0	0	
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   92.00			0	0	[ C	0	_	
200. 00   Total (lines 50-199)   0  0  0  0  0 200. 00	200.00	Total (lines 50-199)	0	0	[ C	0	0	200. 00

Heal th	Financial Systems	PUTNAM COUNT	ry hospit	ĀI		In lie	eu of Form CMS-2	2552-10
APPOR	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER CH COSTS					Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV	pared:
					e XVIII	Hospi tal	Cost	
	Cost Center Description	Total			Ratio of Cost		I npati ent	
		Outpati ent	(from Wk			Ratio of Cost	Program	
		Cost (sum of			(col. 5 ÷ col		Charges	
		col. 2, 3 and	8)		7)	(col. 6 ÷ col.		
		4)				7)		
		6. 00	7.0	00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS							
50. 00	05000 OPERATI NG ROOM	0		359, 898				
51. 00	05100 RECOVERY ROOM	0	) 4	181, 378			·	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0. 00000			52. 00
53.00	05300 ANESTHESI OLOGY	0	l l	127, 073			·	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		14, 892			·	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	5	31, 876	0. 00000	0. 000000	15, 553	54. 01
57.00	05700  CT SCAN	0	12, 2	243, 159			291, 678	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0.00000	0. 000000	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0.00000	0. 000000	0	59. 00
60.00	06000 LABORATORY	0	13, 4	103, 568	0.00000	0. 000000	786, 775	60.00
60. 01	06001 BLOOD LABORATORY	0		0	0. 00000	0. 000000	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0		0	0. 00000	0. 000000	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	1, 5	519, 552	0. 00000	0. 000000	646, 703	65. 00
66.00	06600 PHYSI CAL THERAPY	0	1, 8	369, 691	0. 00000	0. 000000	133, 654	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	4	178, 980	0.00000	0. 000000	69, 800	67. 00
68.00	06800 SPEECH PATHOLOGY	0		16, 766	0.00000	0. 000000	4, 063	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1,0	26, 834	0. 00000	0. 000000	23, 207	69. 00
69. 01	06901 CARDI AC REHAB	0	2	213, 577	0. 00000	0. 000000	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0. 00000	0. 000000	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	5	53, 921	0. 00000	0. 000000	215, 347	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 4	129, 072	0. 00000	0. 000000	732, 950	73. 00
70 04	07004 00001 0004	1	.1 –	-00 4//	0 00000	0 000000	4 005	

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539, 166

4, 137

6, 836, 559

1, 618, 279

57, 168, 378

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0 92.00

3, 500, 234 200. 00

5, 366

73.01

90.00

91.00

07301 ONCOLOGY

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

08800 RURAL HEALTH CLINIC

OUTPATIENT SERVICE COST CENTERS

73.01

88.00

200.00

08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50-199)

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 151333 Period: From 01/01/2014 To 12/31/2014 Date/Time Prepared:

Title XVII   Hospital   Cost   Cost   Center Description   Program   Program   Pass Through   Costs (col. a   x col. 10)   Title XVII   Program   Pass Through   Costs (col. a   x col. 10)   Title XVII   Program   Pass Through   Costs (col. a   x col. 10)   Title XVII   Program   Pass Through   Costs (col. a   x col. 10)   Title XVII   Program   Pass Through   Costs (col. a   x col. 10)   Title XVII   Title XVII   Program   Pass Through   Costs (col. a   x col. 12)   Title XVII   Title XVII   Program   Pass Through   Costs (col. a   x col. 12)   Title XVII					10 12/31/2014	5/28/2015 7:	
Program   Pass-Through   Costs (col. 8   x col. 10)   To. 00   T			Ti tl	e XVIII	Hospi tal		
Pass - Through Costs (col. 8	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
Costs (col. 8   x col. 12)		Program	Program	Program			
X COL. 10			Charges				
ANCILLARY SERVICE COST CENTERS					9		
ANCILLARY SERVICE COST CENTERS							
50. 00   05000   0PERATI NG ROOM   0   0   0   0   0   0   0   0   0		11. 00	12.00	13. 00			
51.00				T			
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 53. 00 53.00 05300 AMESTHESI OLOGY 0 0 0 0 53.00 53.00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 0 53.00 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 0 0 0 54.01 55.00 554.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 0 0 0 554.01 57.00 05700 CT SCAN 0 0 0 0 0 0 55.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 59.00 CARDIAC CATHETERIZATION 0 0 0 0 59.00 6AND LABORATORY 0 0 0 0 0 59.00 6AND LABORATORY 0 0 0 0 0 59.00 6AND LABORATORY 0 0 0 0 0 60.01 60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 60.01 64.00 64.00 INTRAVENOUS THERAPY 0 0 0 0 0 66.00 65.00 RSPIRATORY THERAPY 0 0 0 0 0 66.00 65.00 RSPIRATORY THERAPY 0 0 0 0 0 66.00 66.		0	(		0		
53. 00         05300         ANESTHESI OLOGY         0         0         0         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         0         0         0         0         54. 01           57. 00         05700         CT SCAN         0         0         0         0         57. 00           58. 00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0         0         0         0         58. 00           60. 00         06000         LABORATORY         0         0         0         0         59. 00           60. 01         06001         BLOOD LABORATORY         0         0         0         0         60. 00           64. 00         06400         INTRAVENOUS THERAPY         0         0         0         60. 01           65. 00         06500         RESPI RATORY THERAPY         0         0         0         65. 00           66. 00         06600         PHYSI CAL THERAPY         0         0         0         66. 00           67. 00         06700         0CEPATIONAL THERAPY         0         0         0         66. 00           69. 01         06900         ELECTROCARDI OLOGY         0		0	(		0		
54. 00   05400   RADI DLOGY-DI AGNOSTI C   0   0   0   0   54. 00   54. 01   05401   NUCLEAR MEDI CI NE-DI AGNOSTI C   0   0   0   0   55. 00   57. 00   05700   CT SCAN   0   0   0   0   0   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0   0   0   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   60. 01   06001   BLOOD LABORATORY   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   67. 00   06600   PHYSI CAL THERAPY   0   0   0   0   68. 00   06800   PHYSI CAL THERAPY   0   0   0   0   69. 00   06900   CEUCHATIONAL THERAPY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   69. 01   06901   CARDI AC REHAB   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   73. 01   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   74. 00   07400   SURGS CHARGED TO PATI ENTS   0   0   0   75. 00   09000   CLINI C   0   0   0   76. 00   09900   CLINI C   0   0   77. 00   09900   CLINI C   0   0   78. 00   09900   CLINI C   0   0   79. 00   09900   CLINI C   0   79. 00   09900   CLINI C   0   0   79. 00   09900   CLINI C   0   79. 00   09900   CLINI C   0   0   79. 00   09900   CLINI C   0   79. 00   09900   09900   CLINI C   79. 00   09900   09900   CLINI C		0	(		0		
54. 01		0	(		0		
57. 00 05700 CT SCAN 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 58.00   58.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 59.00   60. 00 06000 LABORATORY 0 0 0 0 0 60.01   60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 60.01   64. 00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 65.00   65. 00 06500 RESPIRATORY 1 0 0 0 0 0 0 66.00   66. 00 06600 PHYSICAL THERAPY 0 0 0 0 0 0 66.00   67. 00 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 66.00   68. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 67.00   69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 69.01   69. 01 06901 CARDIAC REHAB 0 0 0 0 0 69.01   71. 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   73. 01 07301 ONCOLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	(		0		
58. 00       05800 MAGNETIC RESONANCE IMAGING (MRI)       0       0       0       58. 00         59. 00       05900 CARDIAC CATHETERIZATION       0       0       0       0       0         60. 00       06000 LABORATORY       0       0       0       0       0         60. 01       06001 BLOD LABORATORY       0       0       0       0       0         64. 00       06400 INTRAVENOUS THERAPY       0       0       0       0       64. 00         65. 00       06500 RESPI RATORY THERAPY       0       0       0       0       64. 00         66. 00       06600 PHYSI CAL THERAPY       0       0       0       0       65. 00         66. 00       06600 PHYSI CAL THERAPY       0       0       0       0       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0       0       0       0       67. 00         68. 00       06800 SPEECH PATHOLOGY       0       0       0       0       68. 00         69. 01       06900 LECTROCARDI OLOGY       0       0       0       69. 00         69. 01       06901 CARDI AC REHAB       0       0       0       0       69. 01         71. 00<		0	(		0		
59.00       05900 CARDI AC CATHETERI ZATI ON       0       0       0       0       0       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.00       60.01       60.01       60.01       60.01       60.01       60.01       60.00		0	(		0		
60. 00   06000   LABORATORY   0   0   0   0   0   0   0   0   0		0	(		0		
60. 01		0	(		0		
64. 00		0	(		0		
65. 00		0	(		0		
66. 00		0	(		0		
67. 00   06700   0CCUPATI 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. 00   69. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0		0	(		0		
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   68. 00   69. 0		0	(		0		
69. 00   06900   ELECTROCARDI OLOGY   0 0 0 0 0   69. 00   69. 01   06901   CARDI AC REHAB   0 0 0 0 0 0   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0 0 0 0 0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENT   0 0 0 0 0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0 0 0 0 0   73. 01   07301   ONCOLOGY   0 0 0 0   73. 01   OUTPATI ENT SERVI CE COST CENTERS   88. 00   08800   RURAL HEALTH CLINI C   0 0 0 0   89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0 0 0 0   90. 00   09000   CLINI C   0 0 0 0   91. 00   09100   EMERGENCY   0 0 0 0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0 0 0 0   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0 0 0 0   95. 00   09000   00   00   96. 00   09000   00   00   97. 00   09200   00   00   97. 00   09200   00   00   97. 00   09200   00   00   97. 00   09200   00   97. 00   09200   00   97. 00   09200   00   97. 00   09200   00   97. 00   09200   00   97. 00   09200   00   97. 00   00   00   97. 00   00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   00   97. 00   97. 00   00   97. 00   00   97. 00   00   97. 00   97. 00   00   97. 00		0	(		0		
69. 01		0	(		0		68. 00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   72. 00   72. 00   72. 00   73. 00   73. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   0   0   73. 00   73. 01   07301   ONCOLOGY   0   0   0   0   0   0   0   0   0	69. 00   06900   ELECTROCARDI OLOGY	0	(		0		69. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENT   0   0   0   0   72. 00   73. 00   73. 00   73. 00   73. 00   73. 01   07301   ONCOLOGY   0   0   0   0   0   0   73. 01   07301   ONCOLOGY   0   0   0   0   0   0   0   0   0	69. 01  06901  CARDI AC REHAB	0	(		0		69. 01
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   73. 00   73. 01   07301   ONCOLOGY   0   0   0   0   0   0   0   0   0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(		0		71. 00
73. 01   07301   0NCOLOGY   0   0   0   0   73. 01		0	(		0		
SECTION   OUTPATIENT SERVICE COST CENTERS		0	(		0		
88. 00   08800   RURAL HEALTH CLINIC   0 0 0 0   88. 00   89. 00   90. 00   90. 00   90. 00   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0 0 0 0 0   92. 00   92. 00   08800   RURAL HEALTH CLINIC   0 0 0 0 0   94. 00   95. 00		0	(		0		73. 01
89. 00     08900   FEDERALLY QUALIFIED HEALTH CENTER     0     0     0     0     89. 00       90. 00     09000   CLINIC     0     0     0     90. 00       91. 00     09100   EMERGENCY     0     0     0     91. 00       92. 00     09200   OBSERVATION BEDS (NON-DISTINCT PART)     0     0     0     92. 00							
90. 00   09000   CLINIC   0   0   0   90. 00   91. 00   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   92. 00   92. 00   0   0   0   0   0   0   0   0   0		0	(		0		
91. 00   09100   EMERGENCY   0   0   0   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   92. 00		0	(		0		
92.00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   0   0   0   92.00		0	(		0		
		0	(	P	0		
		0	-		0		
200.00   Total (lines 50-199)   0  0  0   200.00	200.00   Total (lines 50-199)	0	(	P	0		200. 00

					To 12/31/2014	Date/Time Pre 5/28/2015 7:2	
			Ti tl	e XVIII	Hospi tal	Cost	2 0111
			<u> </u>	Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	, , , , , , , , , , , , , , , , , , ,		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	,	
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 551831	0	945, 91	2 0	0	50. 00
51.00	05100 RECOVERY ROOM	0. 583531	0	115, 98	4 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 927682	0	73, 24	7 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 295445	0	1, 173, 94	6 0	0	54. 00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 320921	0	192, 56	6 0	0	54. 01
57.00	05700 CT SCAN	0. 039903	0	3, 249, 05	4 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60.00	06000 LABORATORY	0. 183008	0	4, 424, 40	7 0	0	60. 00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	., ,	o	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		o o	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 462188	0	301, 86	1 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 380025	0	492, 11		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 272922	0	42, 74		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 253191	0	3, 37		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 177050	0	305, 66		0	69. 00
69. 01	06901 CARDI AC REHAB	0. 817246	0	82, 91		0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	1	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 331831	0	79, 70	3 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 565353	0	2, 287, 80		0	73. 00
	07301 ONCOLOGY	1. 354481	0				73. 01
	OUTPATIENT SERVICE COST CENTERS		-		-		
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00	09000 CLI NI C	3. 315688	0		0	0	90.00
91. 00	09100 EMERGENCY	0. 450928	0	1, 413, 06	8 0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 554714	0	666, 01		0	1
200.00			n	16, 024, 22		_	200. 00
201.00			· ·		0 0		201. 00
2000	Only Charges				-		
202.00			0	16, 024, 22	3 0	0	202. 00
	1 322 ( 2 22 2 22 2 2 2 2 2 2 2 2 2 2 2 2	'	_	,,	1	•	•

Health Financial Systems	PUTNAM COUNTY H	OSPI TAL	In Lie	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151333	Peri od: From 01/01/2014	Worksheet D Part V

12/31/2014 Date/Time Prepared: 5/28/2015 7:22 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 521, 984 50.00 51.00 05100 RECOVERY ROOM 67,680 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 53.00 05300 ANESTHESI OLOGY 67, 950 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 346, 836 54.00 54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 61, 798 0 54.01 0 57.00 05700 CT SCAN 129, 647 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 06000 LABORATORY 809, 702 0 60 00 60 00 60.01 06001 BLOOD LABORATORY 0 60.01 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 65.00 139, 517 65.00 Ol 66.00 06600 PHYSI CAL THERAPY 66.00 187, 015 67.00 06700 OCCUPATIONAL THERAPY 11, 667 0 67.00 68.00 06800 SPEECH PATHOLOGY 856 68.00 69.00 06900 ELECTROCARDI OLOGY 54, 117 0 69.00 69.01 06901 CARDI AC REHAB 0 69.01 67, 761 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 26, 448 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 293, 417 0 73.00 73.00 07301 ONCOLOGY 235, 472 0 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 0 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 637, 192 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 369, 445 92.00 200.00 Subtotal (see instructions) 5, 028, 504 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 5, 028, 504 0 202.00

Health Financial Systems		PUTNAM CO	OUNTY HOSPITAL		In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES	AND VACCINE COS	OST Provider CC	N: 151333		Worksheet D
					From 01/01/2014	Part V

		Component		rom 01/01/2014 o 12/31/2014	Part V Date/Time Pre 5/28/2015 7:2	
		Ti tl	e XVIII Si	wing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1	_	1 -	_		
50. 00   05000   OPERATI NG ROOM	0. 551831			_	0	
51. 00   05100   RECOVERY   ROOM	0. 583531		0	0	0	1
52. 00   05200   DELI VERY ROOM & LABOR ROOM	0. 000000		0	0	0	
53. 00   05300   ANESTHESI OLOGY	0. 927682		0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 295445	0	0	0	0	
54. 01   05401   NUCLEAR   MEDICINE-DI AGNOSTI C	0. 320921	0	0	0	0	54. 01
57. 00   05700   CT   SCAN	0. 039903		0	0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000		0	0	0	00.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000		0	0	0	59. 00
60. 00   06000   LABORATORY	0. 183008		0	0	0	
60. 01 06001 BLOOD LABORATORY	0. 000000		0	0	0	00.0.
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000		0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 462188		0	0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 380025		0	0	0	1 00.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 272922	0	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 253191	0	0	0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 177050	l .	0	0	0	1 07.00
69. 01   06901   CARDI AC REHAB	0. 817246		0	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	l .	0	0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 331831	l .	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 565353		0	1	0	
73. 01 07301 0NC0L0GY	1. 354481	0	0	0	0	73. 01
OUTPATIENT SERVICE COST CENTERS	1	1	T		_	
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	l .			0	
90. 00   09000   CLI NI C	3. 315688		0	0	0	1
91. 00   09100   EMERGENCY	0. 450928		0	0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	0. 554714	0	0	0	0	
200.00 Subtotal (see instructions)		0	0	0	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges					_	202.00
202.00   Net Charges (line 200 +/- line 201)	1	0	0	0	0	202. 00

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151333 Period: From 01/01/2014 Part V

Component CCN: 152333 To 12/31/2014 Date/Time Prepared:

		Component	t CCN: 15Z333	To 12/31/201	4 Date/Time Prep 5/28/2015 7:22	
		Ti tl	e XVIII	Swing Beds - SN		<u>- p</u>
	Cos			, J		
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subj ect To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOTHER OF THE STATE OF THE STA	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						F0 00
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00   05100   RECOVERY ROOM	0	0				51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01   05401   NUCLEAR   MEDICINE-DIAGNOSTIC	0	0				54. 01
57. 00 05700 CT SCAN	0	0				57. 00 58. 00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)	0	0				59.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	0	0				60.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	0	0	1			60. 00
64. 00   06400   NTRAVENOUS THERAPY	0	0				64. 00
65. 00   06500   RESPI RATORY   THERAPY	0	0				65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0				66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0				69. 00
69. 01   06901 CARDI AC REHAB	0	0				69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0	,			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	Ö	,			73. 00
73. 01   07301   0NCOLOGY	0	0	)			73. 01
OUTPATIENT SERVICE COST CENTERS	•					
88. 00 08800 RURAL HEALTH CLINIC	0	0	1			88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
90. 00  09000 CLI NI C	0	0				90.00
91. 00   09100   EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0				:	201. 00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	0	0	1		:	202. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151333	Period: From 01/01/2014	Worksheet D-1	
			Date/Time Prep 5/28/2015 7:22	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				

		Title XVIII	Hospi tal	5/28/2015 7: 2 Cost	2 pm
	Cost Center Description	THE AVITE	nospi tai	COST	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		3, 072	1. 00
2.00	Inpatient days (including private room days, excluding swing-be	d and newborn days)		2, 367	2. 00
3.00	Private room days (excluding swing-bed and observation bed days)		vate room days,	0	3. 00
	do not complete this line.				
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		. 21 of the cost	1, 543 649	4. 00 5. 00
5.00	reporting period	days) thi ough beceilibe	31 OF THE COST	049	5.00
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	-			
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	56	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room of	davs) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber s	i or the cost		0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	957	9. 00
40.00	newborn days)	Z: 1 1:		50/	40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instruction		oom days)	596	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, enti-	er O on this line)	<b>3</b> ,		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	n room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar yea			U	13.00
14.00	Medically necessary private room days applicable to the Program			0	14. 00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00
17.00	reporting period	thi odgir becember 31 0	the cost		17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00
40.00	reporting period			400.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	123. 32	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ne cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions)			3, 292, 581	
22. 00	Swing-bed cost applicable to SNF type services through December $5 \times 1$ ine 17)	31 of the cost report	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	6, 906	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	neriod (line 8	0	25. 00
23.00	x line 20)	or the cost reporting	perrod (Trie o		23.00
26.00	Total swing-bed cost (see instructions)			713, 933	
27. 00	General inpatient routine service cost net of swing-bed cost (	ine 21 minus line 26)		2, 578, 648	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed	and observation had ch	arge)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed on	ai ges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
33. 00 34. 00	Average per diem private room charge differential (line 32 minus	s line 33)(see instruc	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line		5115)	0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	·		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost di	fferential (line	2, 578, 648	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see in			1, 089. 41	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	3)		1, 042, 565	39. 00
40.00	Medically necessary private room cost applicable to the Program			0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 +	1111e 4U)		1, 042, 565	41.00

	Financial Systems	PUTNAM COUNT					eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi	der C	CCN: 151333	Peri od: From 01/01/2014	Worksheet D-1	
						To 12/31/2014	Date/Time Pre	
-			Т	Title	XVIII	Hospi tal	5/28/2015 7: 2 Cost	∠ µm
	Cost Center Description	Total	Total		Average Per	Program Days		
		Inpatient Cost	Inpatient D	)ays D		÷	(col. 3 x col.	
		1.00	2.00		col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0		0	0.0			42. 00
	Intensive Care Type Inpatient Hospital Units							
43. 00	INTENSIVE CARE UNIT	1, 529, 287		507	3, 016. 3	35	1, 058, 739	43. 00 44. 00
44. 00 45. 00	BURN INTENSIVE CARE UNIT							45. 00
46. 00	1							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)	)			1, 290, 323	48. 00
	Total Program inpatient costs (sum of lines				ıs)		3, 391, 627	1
	PASS THROUGH COST ADJUSTMENTS							
50. 00	Pass through costs applicable to Program inp.	atient routine	services (f	rom	Wkst. D, sum	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services	(fro	om Wkst. D, s	um of Parts II	0	51.00
	and IV)							
52.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu-		lated non	nhvo	ط+ممعم مماما	atiot and	0	
53. 00	medical education costs (line 49 minus line		erated, non-	-pnys	arcian anestr	etist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION							
	Program di scharges						0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						0.00	1
57. 00	, ,	ing cost and ta	rget amount	t (li	ne 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	S	Ü	,		ŕ	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 1996	s, up	dated and co	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	dated by th	ne ma	rket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line					the amount by	0	1
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target								
amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)					0	62. 00		
63.00   Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00		
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of	the	cost reporti	ng period (See	649, 288	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of th	ne co	st reporting	period (See	0	65. 00
	instructions)(title XVIII only)							
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus lir	ne 65	(title XVII	I only). For	649, 288	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	n December 3	31 of	the cost re	portina period	0	67. 00
	(line 12 x line 19)	· ·						
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	December 31	of t	he cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + I	i ne	68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N							
70.00	Skilled nursing facility/other nursing facil	•			, ,			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	,	ine /0 ÷ li	ne 2	!)			71. 00 72. 00
73. 00	Medically necessary private room cost applic		n (line 14 >	< lin	ie 35)			73. 00
74. 00	Total Program general inpatient routine serv	,						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (fro	om Wo	rksheet B, P	art II, column		75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77. 00	Program capital -related costs (line 9 x line	. *						77. 00
	Inpatient routine service cost (line 74 minu				`			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.					us line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		,55t 11111 tal	011	(1110 70 mill	11110 17)		81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .					82. 00
83.00	Reasonable inpatient routine service costs (		ıs)					83.00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)					84. 00 85. 00
	Total Program inpatient operating costs (sum							86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST						
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)				824 1, 089. 42	
	Observation bed cost (line 87 x line 88) (se	•	,				897, 682	

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014		
				To 12/31/2014	Date/Time Prep 5/28/2015 7: 2:	
		T: +1	- \/\/	11		Ζ μιιι
			e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	485, 543	2, 578, 648	0. 18829	4 897, 682	169, 028	90.00
91.00 Nursing School cost	0	2, 578, 648	0.00000	0 897, 682	0	91.00
92.00 Allied health cost	0	2, 578, 648	0.00000	0 897, 682	0	92.00
93.00 All other Medical Education	0	2, 578, 648	0.00000	0 897, 682	0	93. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151333	Peri od: From 01/01/2014	Worksheet D-1	
			Date/Time Prep 5/28/2015 7: 2:	
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	

Date 1. All peoplings Colemonways  1.00    Post Int All peoplings Colemonways   1.00   Impatient days (including private room days and seing-bed days, excluding newborn)   3.072   1.00   1.00   Impatient days (including private room days and seing-bed days, excluding nemborn days)   2.30   2.00   2.00   Impatient days (including private room days, excluding seing-bed and observation bed days)   17 you have only private room days.   2.30   2.00   2.00   Semi-private room days (sectuding seing-bed and observation bed days)   17 you have only private room days.   1.543   4.00   2.00   Semi-private room days (sectuding seing-bed and observation bed days)   1.540   4.00   2.00   Total seing-bed Semi-pype impatient days (including private room days) through becember 31 of the cost reporting period   1.00   1.			Title XIX	Hospi tal	Cost	
IMPATENT DAYS   IMPATENT DAY		Cost Center Description			1 00	
Inpatient days (including private room days and saing-bed days, excluding newborn)   3,072   1.00		PART I - ALL PROVIDER COMPONENTS		I.	1.00	
Inpatient days (including private room days, excluding seing-bed and newborn days)   1, 2, 2, 2, 2, 2, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,	4 00			T	0.070	1
Private room days (excluding seleg-bed and observation bed days). If you have only private room days, do not complete this line.   1,943 4,00						•
do not complete this line.  4. 00 Seller, private room days (excluding swing-bed and observation bed days)  5. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  7. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  7. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  8. 00 Total swing-bed M Type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  9. 00 Total swing-bed SM Type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)  10. 00 Swing-bed SM Type inpatient days applicable to this line)  10. 00 Swing-bed SM Type inpatient days applicable to the program (excluding private room days)  10. 00 Swing-bed SM Type inpatient days applicable to the SW PW (including private room days)  10. 00 Swing-bed SM Type inpatient days applicable to the SW PW (including private room days)  10. 00 Swing-bed SM Type inpatient days applicable to the SW PW (including private room days)  10. 00 Swing-bed SM Type inpatient days applicable to the SW PW (including private room days)  10. 00 Swing-bed SW Type inpatient days applicable to the SW PW (including private room days)  10. 00 Swing-bed SW Type inpatient days applicable to the SW PW (including private room days)  10. 00 Swing-bed SW Type inpatient days applicable to the SW PW (including private room days)  10. 00 Swing-bed SW Type inpatient days applicable to the SW PW (including private room days)  10. 00 Swing-bed SW Type inpatient days applicable to swing-bed SW (including private room days)  10. 00 Swing-bed SW Type inpatient days applicable to swing-bed SW (including private room da				ivate room days,		
5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost of Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.01 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.01 Iotal inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.02 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and next on next on the program (excluding swing-bed and next on next on the program (excluding swing-bed and next on next on the program (excluding swing-bed and next on next on the program (excluding private room days)  11.00 Swing-bed SNF type inpatient days applicable to title SVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days)  13.00 Swing-bed SNF type inpatient days applicable to titles Vor XIX only (including private room days)  14.00 Medically necessory privater room days applicable to services after December 31 of the cost reporting period (including private room days)  15.00 No Nursery days (title Vor XIX only)  16.00 Medically necessory privater room days applicable to services through December 31 of the cost reporting period (including swing-bed SNF services applicable to services through December 31 of the cost reporting period (including swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 2 x line 18)  18.00 Medical rate for swing-bed SNF services after Decembe		do not complete this line.		<i>y</i> .		
reporting period (if calendar year, enter 0 on this line)  7. 00 Total saing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Proporting period (if calendar year, enter 0 on this line)  7. 00 Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  8. 00 Proporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (if calendar year)  11. 00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days)  12. 00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days)  13. 00 Swing-bed SNF type inpatient days applicable to titles XVIII only (including private room days)  14. 00 Medically necessary private room days applicable to titles XVIII only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Neuropeable SNF services applicable to the Program (excluding swing-bed days)  17. 00 Total nursery days (title V or XIX only)  18. 00 Medical rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line or exporting p				r 21 of the cost		
10   Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)   7.00   Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)   7.00   Total inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line)   7.00   Total inpatient days including private room days applicable to the Program (excluding swing-bed and say on sexborn days)   7.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   7.00	5.00		days) thi dugit beceilibe	i si di the cost	U	3.00
7.00 Total swing-bed NF type inpatient days (including private room days) through Becember 31 of the cost lotal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 Including private room days applicable to the Program (excluding swing-bed and private room days) applicable to the Program (excluding swing-bed and private room days) applicable to the Program (excluding swing-bed and private room days) applicable to the program (excluding swing-bed and private room days) after period (see instructions)  8.00 Excluding Private room days applicable to the Program (excluding private room days) after period becember 31 of the cost reporting period (see instructions)  10.00 Swing-bed NF type inpatient days applicable to the title X or XIX only (including private room days) after period through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  11.00 Swing-bed NF type inpatient days applicable to title X or XIX only (including private room days) after period through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  13.00 Total nursery days (title V or XIX only)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Nedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line SNF MB BED ADJUSTNEWN)  16.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (line 2) and the period (line SNF MB BED ADJUSTNEWN)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (line 2) and the period (line SNF MB BED ADJUSTNEWNEWN)  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost (line 2) and the period (line SNF MB BED ADJUSTNEWNEWNEW	6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Sting-bed Still inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed Still report of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed Still reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed Still reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed Still reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Edical nursery days (title V or XIX only)  17. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  18. 00 Total nursery days (title V or XIX only)  19. 00 Nedical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  19. 00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medical drate for swing-bed SNF services through December 31 of the cost reporting period (line S x line 17)  20. 00 Swing-bed cost applicable to SNF type services safter December 31 of the cost	7 00		daya) +brayab Dagambar	21 of the cost	F./	7 00
10.00   Total swing-bed NF type inpatient days (Including private room days) arter December 31 of the cost reporting pariod (if calendar year, enter 0 on this line)   10.00   Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newborn days)   10.00   Swing-bed SMF type inpatient days applicable to title XVIII only (Including private room days)   10.00   Swing-bed SMF type inpatient days applicable to title XVIII only (Including private room days) after   11.00   Swing-bed SMF type inpatient days applicable to title XVIII only (Including private room days) after   11.00   Swing-bed SMF type inpatient days applicable to title XVIII only (Including private room days)   12.00   through December 31 of the cost reporting period   12.00   through December 31 of the cost reporting period   13.00   swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   13.00   13.00   swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   13.00   14.00   through December 31 of the cost reporting period   14.00   through December 31 of the cost reporting period   14.00   through December 31 of the cost reporting days applicable to the Program (excluding swing-bed days)   0.16.00   through days (title V or XIX only)   0.16.00   through days (title V or XIX only)   0.16.00   through days (title V or XIX only)   0.16.00   through days   0.16.00   through	7.00		uays) tili ougii becellibei	31 Of the Cost	50	7.00
Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)   0.00	8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
newborn days    10.00   Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)   0   10.00	0.00		+l D (l.:-l.:		22	0.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 17.00 Nursery days (title V or XIX only) 18.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 19.00 Modically necessary private room days applicable to the Program (excluding swing-bed days) 19.00 Modical pursery days (title V or XIX only) 19.00 Modicare rote for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Modicare rote for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 6 x line 17) 20.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 21.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 22.00 Swing-bed cost applicable to NF type services after December 31 of the cost	9.00		the Program (excluding	swing-bed and	32	9.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x ine 17) 19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x ine 17) 19.00 Medicare rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x ine 17) 19.00 Medicare rate for swing-bed cost (see instructions) 19.00 Swing-bed cost applicable to N	10.00		y (including private r	oom days)	0	10.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00   Innoy-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   12.00   Innoy-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   Innoy-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   14.00   Innoy-bed NF type inpatient days applicable to the Program (excluding swing-bed days)   14.00   Innoy-bed NF type inpatient days applicable to the Program (excluding swing-bed days)   14.00   Innoy-bed NF type services applicable to the Program (excluding swing-bed days)   15.00   Innoy-bed NF type services applicable to services through December 31 of the cost reporting period (acid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (acid rate for swing-bed NF services applicable to services after December 31 of the cost (acid rate for swing-bed NF services applicable to services after December 31 of the cost (acid rate for swing-bed NF services applicable to services after December 31 of the cost (acid rate for swing-bed NF services applicable to services after December 31 of the cost (acid rate for swing-bed NF services applicable to services after December 31 of the cost (acid rate for swing-bed NF services after December 31 of the cost (acid rate for swing-bed NF services after December 31 of the cost (acid rate for swing-bed NF services after December 31 of the cost (acid rate for swing-bed Loss of the cost (acid rate for swing-bed Loss of the cost (acid rate for swing-bed Loss of the cost (acid rate for swing-bed Loss) (acid rate for swing-b	44.00				0	44.00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 28)  28.00 General inpatient routin service cost net of swing-bed cost (line 21 minus line 26)  29.	11.00			oom days) arter	0	11.00
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   13.00   Arter December 31 of the cost reporting period (if call endar year, enter 0 on this line)   14.00   14.00   15.0	12.00			e room days)	0	12. 00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  15.00 Total nursery days (title V or XIX only)  16.00 Nursery days (title V or XIX only)  17.00 Medical rare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost applicable to service cost (see instructions)  20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  20.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  20.00 Control swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19)  20.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  20.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  20.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 30)  20.00 Total swing-bed cost applicable to NF type serv	40.00					40.00
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16.00 Nursery days (title V or XIX only)  17.00 SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period  18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  20.00 Medicard rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (long syling-bed cost applicable to SNF type services through December 31 of the cost reporting period (line syline 18)  22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line syline 18)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line syline 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line syline 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line syline 18)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Sweni-private room charges (excluding swing-bed charges)  30.00 Sweni-private room charges (excluding swing-bed charges)  30.00 Average period mprivate room cost differential (line 27 + line 28)  30.00 Average period mprivate room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 3 x line 31)	14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14. 00
SWING BED ADJUSTMENT  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 20.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost 0.00 20.00 reporting period 21.00 Total general inpatient routine service cost (see instructions) 3.292.581 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 22.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3, 292,581 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Company of the cost reporting period (line 8 x line 20) 29.00 Private room charges (excluding swing-bed charges) 0.30.00 Seni-private room charges (excluding swing-bed cost and private room cost differential disement (line 3 x line 31) 0.00 35.00 Average periden p		]				
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x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	23 00		1 of the cost reporting	a period (line 6	0	23 00
7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8		x line 18)				
x line 20)  26.00  Total swing-bed cost (see instructions)  Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  RRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  30.00  Semi-private room charges (excluding swing-bed charges)  31.00  General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00  Average private room per diem charge (line 29 + line 3)  Average semi-private room per diem charge (line 30 + line 4)  34.00  Average per diem private room charge differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  O Average per diem private room cost differential (line 3 x line 35)  Average inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581)  38.00  Adjusted general inpatient routine service cost per diem (see instructions)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40.00	24. 00		31 of the cost reporti	ng period (line	0	24. 00
Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581)  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O define a line and supplicable to the Program (line 14 x line 35)  O define a line and supplicable to the Program (line 14 x line 35)  O define a line and supplicable to the Program (line 14 x line 35)  O define a line and supplicable to the Program (line 14 x line 35)  O define a line and supplicable to the Program (line 14 x line 35)  O define a line and supplicable and observation bed charges  27 note and observation bed charges  O define a line and observation bed charges  O define a line and observation bed charges  O define and observat	25. 00	] 3	of the cost reporting	period (line 8	0	25. 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average private room per diem charge (line 29 ÷ line 3)  30.00 Average semi-private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost (line 9 x line 38)  44,513 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00	26. 00				0	26. 00
28. 00 29. 00 29. 00 29. 00 30	27. 00		ine 21 minus line 26)		3, 292, 581	27. 00
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 Private room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00	28 00		and observation bed ch	arges)	0	28 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  44,513 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 0.00 32.00  0.00 32.00  0.00 32.00  0.00 33.00  0.00 35.00  0.00 35.00  0.00 35.00  0.00 36.00  0.00				a. goo,		1
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 32.00 32.00 33.00 34.00 35.00 Private room cost differential (line 3, 292, 581) 0.00 35.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 36.00 37.00 47.00					-	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  44, 513 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			line 28)			1
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  44, 513 39.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  37.00 35.00  37.00 36.00  37.00 3						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 .00 35.00 36.00 37.00 36.0		, , , , , , , , , , , , , , , , , , , ,	- 1: 22) / :	±:>		
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 292, 581)  27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 36.00 37.00 37.00 37.00 37.00 37.00		, , ,		tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 391.04  38.00 Program general inpatient routine service cost (line 9 x line 38)  44, 513  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		,	31)			1
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,391.04 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		· · · · · · · · · · · · · · · · · · ·	d private room cost di	fferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  38.00 40.00	37.00	27 minus line 36)			5, 272, 501	] 57.00
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,391.04 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,391.04 38.00 40.00			THENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 44,513 39.00 40.00	20 00			T	1 201 04	20 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						1
		, ,	•			1
		, , , , , , , , , , , , , , , , , , , ,	•			1

Heal th	Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 151333	Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	oared:
			т:	tle XIX	Haani tal	5/28/2015 7: 22	2 pm
	Cost Center Description	Total	Total	Average Per	Hospital Program Days	Cost Program Cost	
				sDiem (col. 1		(col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00	5. 00	42. 00
12.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		0.1	50 0	0	12. 00
43.00	INTENSIVE CARE UNIT	1, 529, 287	50	3, 016.	35 6	18, 098	43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	1						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description	<u>.</u>		•			
48. 00	Program inpatient ancillary service cost (Wkst.	D-3 col 3	line 200)			1. 00 69, 331	48. 00
	Total Program inpatient costs (sum of lines 41			ons)		131, 942	
	PASS THROUGH COST ADJUSTMENTS						
50. 00	Pass through costs applicable to Program inpation	ent routine s	ervices (fro	om Wkst. D, sur	m of Parts I and	0	50. 00
51. 00		ent ancillary	services (f	rom Wkst D 🤄	sum of Parts II	o	51. 00
01.00	and IV)	o a	00.7.000 (.	Tom Mitoti By	Jam 61 1 41 16 11		000
52. 00	Total Program excludable cost (sum of lines 50 a					0	52.00
53. 00	Total Program inpatient operating cost excluding medical education costs (line 49 minus line 52)	g capital rel	ated, non-ph	ıysician anesth	netist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	54.00
55. 00							55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operating	cost and tar	det amount (	line 56 minus	line 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	cost and tar	get amount (	11110 00 11111103	11110 00)	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repor	ting period e	ndi ng 1996,	updated and co	ompounded by the	0. 00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cos	t roport und	atod by the	markat baskat		0.00	60. 00
61. 00	. ,				the amount by	0.00	61. 00
	which operating costs (line 53) are less than ex		(lines 54 x	( 60), or 1% of	f the target ´		
62. 00	amount (line 56), otherwise enter zero (see ins Relief payment (see instructions)	tructions)				0	62. 00
63. 00		(see instruc	tions)				63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST	(					
64. 00		through Decem	ber 31 of th	ne cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs a	after Decembe	r 31 of the	cost reporting	period (See	o	65. 00
	instructions)(title XVIII only)				,		
66. 00	9 1	costs (line 6	4 plus line	65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine of	osts through	December 31	of the cost re	eporting period	0	67. 00
07.00	(line 12 x line 19)	oo to tiii ougi.	2000201	0. 1 0001	sportring porrou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routine co	osts after De	cember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient rou	tine costs (	ine 67 + lir	ne 68)		n	69. 00
27.00	PART III - SKILLED NURSING FACILITY, OTHER NURSI						50
70.00	Skilled nursing facility/other nursing facility.				·		70.00
71. 00 72. 00	Adjusted general inpatient routine service cost Program routine service cost (line 9 x line 71)	per diem (li	ne /U ÷ line	2)			71. 00 72. 00
73. 00	Medically necessary private room cost applicable	e to Program	(line 14 x l	ine 35)			73. 00
74. 00	Total Program general inpatient routine service	costs (line	72 + line 73	3)			74.00
75. 00	Capital -related cost allocated to inpatient rou	tine service	costs (from	Worksheet B, F	Part II, column		75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ line :	2)					76. 00
77. 00	Program capital related costs (line 9 x line 76)	*					77. 00
78.00	Inpatient routine service cost (line 74 minus li	,	oud dom	ado.)			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess control Program routine service costs for companis			*.	nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limitati			( 70 m)			81. 00
82. 00	Inpatient routine service cost limitation (line	9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine services (see		)				83. 00 84. 00
84. 00 85. 00	Program inpatient ancillary services (see instruutilization review - physician compensation (see		s)				84. 00 85. 00
86. 00							86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS TH	HROUGH COST				00.1	07.00
87. 00 88. 00	,	m (line 27 ÷	line 2)			824 1, 391. 04	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see in	•	/			1, 146, 217	
					'	•	

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014	D 1 /T' D	
				To 12/31/2014	Date/Time Prep 5/28/2015 7: 2:	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	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	485, 543	3, 292, 581	0. 14746	6 1, 146, 217	169, 028	90.00
91.00 Nursing School cost	0	3, 292, 581	0.00000	0 1, 146, 217	0	91.00
92.00 Allied health cost	0	3, 292, 581	0.00000	0 1, 146, 217	0	92.00
93.00 All other Medical Education	0	3, 292, 581	0.00000	0 1, 146, 217	0	93.00

Health Financial Systems	PUTNAM COUNTY HOS	SPI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 151333	Period: From 01/01/2014	Worksheet D-3	
					Date/Time Prep 5/28/2015 7:23	pared: 2 pm
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	The state of the s	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				J. J	2)	
			1.00	2. 00	3. 00	
INDATIENT DOUTINE SERVICE COST CENTERS				•		

	TI LIC AVIII	nospi tai	0031	
Cost Center Description	Ratio of Cost	Inpati ent	Inpati ent	
·	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
		g	2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00  03000  ADULTS & PEDI ATRI CS		768, 428		30.00
31.00 03100 INTENSIVE CARE UNIT		553, 485		31.00
41. 00   04100   SUBPROVI DER - I RF		0		41.00
42. 00   04200   SUBPROVI DER		0		42.00
43. 00   04300   NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 551831	307, 464	169, 668	50.00
51. 00   05100   RECOVERY ROOM	0. 583531	31, 048	18, 117	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 927682	13, 809	12, 810	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 295445	221, 732	65, 510	
54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C	0. 320921	15, 553	· ·	54. 01
57. 00   05700   CT   SCAN	0. 039903	291, 678		
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0.000000	271, 070	11,037	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0.000000	0	0	59. 00
60. 00   06000   LABORATORY	0. 183008	786, 775	143, 986	60.00
60. 01   06001   BLOOD LABORATORY	0. 000000	700, 773	143, 700	60. 01
64. 00   06400   NTRAVENOUS THERAPY	0. 000000	0	0	64. 00
65. 00   06500   RESPI RATORY THERAPY	0. 462188	646, 703	298, 898	65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 462 168	133, 654		
67. 00 06700 OCCUPATI ONAL THERAPY	0. 272922	69, 800	· ·	
68. 00   06800   SPEECH PATHOLOGY	0. 253191	4, 063	1, 029	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 177050	23, 207	4, 109	
69. 01   06901   CARDI AC   REHAB	0. 817246	0	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	71. 00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 331831	215, 347		72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 565353	732, 950		
73. 01   07301   0NC0L0GY	1. 354481	1, 085	1, 470	73. 01
OUTPATIENT SERVICE COST CENTERS	0.000000		0	00.00
88. 00   08800   RURAL HEALTH CLINIC	0.000000		0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	_	0	89. 00
90. 00   09000   CLI NI C	3. 315688	0	0	90. 00
91. 00   09100   EMERGENCY	0. 450928	5, 366		
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 554714	0	0	92. 00
200.00 Total (sum of lines 50-94 and 96-98)		3, 500, 234	1, 290, 323	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)	0		201. 00
202.00 Net Charges (line 200 minus line 201)	1	3, 500, 234		202. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 151333	Peri od:	Worksheet D-3

Provi der CCN: 151333 | Peri od: | From 01/01/2014 | Component CCN: 15Z333 | To 12/31/2014 | Date/Time Prepared: | 5/28/2015 7: 22 pm | Swi na Beds - SNF | Cost

	Cost Center Description	Ratio of Cost	I npati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS		C	J	30.00
31. 00					31.00
41. 00	04100 SUBPROVI DER - I RF				41. 00
42. 00	04200 SUBPROVI DER				42.00
43. 00			C	'	43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS				43.00
50. 00	05000 OPERATING ROOM	0. 551831	59, 943	33, 078	50.00
51. 00	05100 RECOVERY ROOM	0. 583531	37, 743	33,078	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00	05300 ANESTHESI OLOGY	0. 927682			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 927082	19, 645	5, 804	54. 00
54. 00	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 320921	1, 990		54. 00
57. 00		0. 039903	18, 132	•	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000	10, 132	1	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0.000000			59.00
60.00	06000 LABORATORY	0. 183008	123, 083	1	
60. 00	06001 BLOOD LABORATORY	0. 000000	123, 003	22, 323	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0.000000			64. 00
65. 00		0. 462188	146, 435	1	1
66. 00			•		l
	06600 PHYSI CAL THERAPY	0. 380025	204, 599	•	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 272922	154, 164		67.00
68. 00	06800 SPEECH PATHOLOGY	0. 253191	615	•	1
69. 00		0. 177050	1, 554	1	ı
69. 01	06901 CARDI AC REHAB	0. 817246	C	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	C	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0. 331831	C	1	72. 00
73. 00		0. 565353	254, 478		
73. 01	07301 ONCOLOGY	1. 354481	19	26	73. 01
	OUTPATIENT SERVICE COST CENTERS			_	
88. 00		0.000000		0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89. 00
90.00	09000 CLI NI C	3. 315688	C		90.00
91. 00	09100 EMERGENCY	0. 450928	178	1	
92. 00		0. 554714	C	0	92.00
200.00			984, 835	394, 685	1
201.00			C	)	201. 00
202. 00	Net Charges (line 200 minus line 201)		984, 835	1	202. 00

Health Financial Systems	PUTNAM COUNTY HOSPI	I TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	P	Provi der		Peri od:	Worksheet D-3	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 5/28/2015 7:23	pared: 2 pm
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS				17, 457		30.00
31.00 03100 INTENSIVE CARE UNIT				4, 690		31.00
41. 00   04100   SUBPROVI DER - I RF				0		41.00
42. 00   04200   SUBPROVI DER				0		42.00

Cost Center Description	Ratio of Cost	Inpati ent	Inpati ent	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1	
30. 00   03000   ADULTS & PEDI ATRI CS		17, 457		30. 00
31.00  03100 INTENSIVE CARE UNIT		4, 690		31. 00
41. 00   04100   SUBPROVI DER - I RF		0		41. 00
42. 00   04200  SUBPROVI DER		0		42. 00
43. 00   04300  NURSERY		0		43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00   05000   OPERATI NG ROOM	0. 551831	48, 694		50.00
51.00   05100   RECOVERY ROOM	0. 583531	1, 229	717	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 927682	343	318	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 295445	7, 211	2, 130	54.00
54. O1   05401   NUCLEAR MEDICINE-DIAGNOSTIC	0. 320921	2, 165	695	54. 01
57. 00  05700  CT SCAN	0. 039903	21, 452	856	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 000000	0	0	59.00
60. 00   06000   LABORATORY	0. 183008	29, 245	5, 352	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0	0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0.000000	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 462188	3, 653	1, 688	65. 00
66. 00   06600 PHYSI CAL THERAPY	0. 380025	9, 137	3, 472	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 272922	1, 241	339	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 253191	.,	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0. 177050	2, 628		69. 00
69. 01   06901   CARDI AC   REHAB	0. 817246	2, 526	0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	Ö	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 331831	0	Ö	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 565353	28, 207	15, 947	73. 00
73. 01   07301   0NCOLOGY	1. 354481	20, 207	13, 747	73. 00
OUTPATIENT SERVICE COST CENTERS	1. 334401			73.01
88. 00 08800 RURAL HEALTH CLINIC	0.000000	0	0	88. 00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	ĺ	89. 00
90. 00   09000   CLI NI C	3. 315688	0	Ö	90.00
91. 00   09100   EMERGENCY	0. 450928	6, 760	1	
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0. 554714	13, 400		
200.00 Total (sum of lines 50-94 and 96-98)	0. 554714	175, 365		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		170, 300		200.00
202.00 Net Charges (line 200 minus line 201)		175, 365		201.00
202. 00	l l	170, 300	I	1202.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151333	From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Prepared: 5/28/2015 7:22 pm
	T: 11 \0.0111	11	0 1

			10 12/31/2014	5/28/2015 7: 2	
		Title XVIII	Hospi tal	Cost	
	DART R. MEDICAL AND OTHER HEALTH CERVICOES			1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			E 020 E04	1.00
1. 00 2. 00	Medical and other services (see Histractions)  Medical and other services reimbursed under OPPS (see instructi	one)		5, 028, 504 0	1
3. 00	PPS payments	0113)		0	
4. 00	Outlier payment (see instructions)			o o	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	
6.00	Line 2 times line 5	ŕ		0	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
10. 00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			5, 028, 504	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
12 00	Reasonable charges			0	12 00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1 4)		0	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	11. 4)		0	1
14.00	Customary charges			0	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	3	•	Ō	
	had such payment been made in accordance with 42 CFR §413.13(e)	. 3	J		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)		> . /	_	
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	rif line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		5, 078, 789	21. 00
22. 00	Interns and residents (see instructions)	Thistructrons)		0,070,707	1
23. 00	Cost of physicians' services in a teaching hospital (see instru	ictions)		Ö	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	.51.51		o o	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
25. 00	Deductibles and coinsurance (for CAH, see instructions)			28, 442	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			2, 365, 490	1
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23} (for	2, 684, 857	27. 00
20.00	CAH, see instructions)	. FO)			20.00
28. 00 29. 00	Direct graduate medical education payments (from Wkst. E-4, lin ESRD direct medical education costs (from Wkst. E-4, line 36)	le 50)		0	1
30.00	Subtotal (sum of lines 27 through 29)			2, 684, 857	
31. 00	Primary payer payments			3, 151	1
32. 00	Subtotal (line 30 minus line 31)			2, 681, 706	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	-		0	33. 00
34.00	Allowable bad debts (see instructions)			288, 076	34. 00
35.00	Adjusted reimbursable bad debts (see instructions)			218, 938	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıcti ons)		201, 890	1
37. 00	Subtotal (see instructions)			2, 900, 644	1
38. 00	MSP-LCC reconciliation amount from PS&R			0	1
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 30	Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replace		tions)		39. 98
39. 99	!	d devices (see ilistide	tions)	0	39. 99
40.00					
40. 01					1
41. 00					1
42.00					1
43.00	· · · · · · · · · · · · · · · · · · ·				43.00
44.00					44. 00
	§115. 2			1	
00.05	TO BE COMPLETED BY CONTRACTOR			_	00.00
90.00	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions)			0.00	
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	1
	Total (sum of lines 91 and 93)				94.00
, 1. 00	1.000. (Sam of Fillos / Glad /0)			,	, , , , , , ,

Health Financial Systems PUTANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/28/2015 7: 22	2 pm
			le XVIII	Hospi tal	Cost	
		Inpatie	nt Part A	Par	⁻t B	
		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, 841, 23	2	3, 654, 155	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,					
0.00	write "NONE" or enter a zero					0.00
3. 00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER	08/04/2014	144, 70	ol	0	3. 01
3. 02				O	0	3. 02
3.03				o	0	3. 03
3.04				o	0	3. 04
3.05				0	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		1	0	0	3. 50
3. 51				0	0	3. 51
3. 52			1	0	0	3. 52
3.53			1	0	0	3. 53
3.54			1	0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		144, 70	O	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		2, 985, 93	2	3, 654, 155	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		2, 700, 73	2	3, 054, 155	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	L	1			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	ı				
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				0	0	5. 02
5. 03	Dravidor to Dragram			0	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			ol	1 0	5. 50
5. 51	TENTATI VE TO TROURAW		1	0		5. 51
5. 52			1	0		5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1	Ö		5. 99
	5. 50-5. 98)					, ,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER		56, 82	0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	811, 524	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 042, 75		2, 842, 631	7. 00
				Contractor	NPR Date	
			0	Number	(Mo/Day/Yr)	
0.00	Name of Contractor		0	1. 00	2.00	0.00
8. 00	Name of Contractor	l			1	8. 00

Health Financial Systems PUTANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/28/2015 7: 2	2 pm
				wing Beds - SNF		
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		931, 000		0	1. 00
2.00	Interim payments payable on individual bills, either		C	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					ļ
	Program to Provider	I			1	
3. 01	ADJUSTMENTS TO PROVIDER	08/04/2014	27, 400		0	3. 01
3. 02			C		0	3. 02
3. 03			C		0	3. 03
3.04			C		0	3. 04
3. 05			C		0	3. 05
	Provider to Program	1		1	1	
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52			C		0	3. 52
3. 53			C		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		27, 400	)	0	3. 99
4 00	3. 50-3. 98)		050 400			4 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		958, 400		0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					1
5. 01	TENTATI VE TO PROVI DER		C	1	0	5. 01
5. 02	TENTATI VE TO TROVIDER		ď		0	5. 02
5. 03			ď		0	5. 03
0.00	Provider to Program					0.00
5. 50	TENTATI VE TO PROGRAM		С		0	5.50
5. 51			l d	)	0	5. 51
5. 52			l d	)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C	)	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6.01	SETTLEMENT TO PROVIDER		67, 030		0	6. 01
6.02	SETTLEMENT TO PROGRAM		C		0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 025, 430		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8.00	Name of Contractor				1	8.00

Health Fi	nancial Systems PUTNAM COUNTY	HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
CALCULATI	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 151333   Period: From 01/01/2014   To 12/31/2014				pared: 2 pm	
		Title XVIII	Hospi tal	Cost		
				1. 00		
	BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS					
	ALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
	tal hospital discharges as defined in AARA §4102 from Wkst		14	514 1, 308	1. 00 2. 00	
	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
	dicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0.40		237	3. 00	
	tal inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		2, 050	4. 00	
	tal hospital charges from Wkst C, Pt. I, col. 8 line 200			59, 714, 970		
	tal hospital charity care charges from Wkst. S-10, col. 3			1, 417, 849		
	H only - The reasonable cost incurred for the purchase of ne 168	certified HII technology	WKSt. S-2, Pt. I	0	7. 00	
8. 00 Ca	Iculation of the HIT incentive payment (see instructions)			0	8. 00	
9. 00 Se	questration adjustment amount (see instructions)			0	9. 00	
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)						
I NF	PATIENT HOSPITAL SERVICES UNDER PPS & CAH					
30. 00 In	30.00 Initial/interim HIT payment adjustment (see instructions)					
	her Adjustment (specify)			0	31. 00	
32. 00 Ba	32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 0 3:					

Не	ealth Financial Systems		PUTNAM COUNTY HO	SPI TAL				In Lie	u of Form C	MS-2552-10
C	ALCULATION OF REIMBURSEMENT SETTLEMENT	-	SWING BEDS	Provi der	CCN:	151333	Perio	od:	Worksheet	E-2
								01/01/2014		
				Component	CCN	l: 15Z333	To	12/31/2014	Date/Time	Prepared:
				1			1		5/28/2015	7·22 nm

		Component Con. 132333	10 12/31/2014	5/28/2015 7: 2	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		655, 781	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A,	and sum of Wkst. D,	398, 632	0	3. 00
	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instruc				
4.00	Per diem cost for interns and residents not in approved teaching	, program (see		0.00	4. 00
	instructions)				
5. 00	Program days		596	0	5. 00
6. 00	Interns and residents not in approved teaching program (see inst			0	6. 00
7.00	Utilization review - physician compensation - SNF optional metho	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		1, 054, 413	0	
9.00	Primary payer payments (see instructions)		0	0	,,
10.00	Subtotal (line 8 minus line 9)		1, 054, 413	0	10. 00
11. 00	Deductibles billed to program patients (exclude amounts applicate	ole to physician	0	0	11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		1, 054, 413	0	
13. 00	Coinsurance billed to program patients (from provider records) (	excl ude coi nsurance	8, 056	0	13. 00
	for physician professional services)			_	
	80% of Part B costs (line 12 x 80%)			0	1
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		1, 046, 357	0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16. 50
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	1
	Adjusted reimbursable bad debts (see instructions)		0	0	1
	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)	0	0	1
	Total (see instructions)		1, 046, 357	0	1
	Sequestration adjustment (see instructions)		20, 927	0	
	Interim payments		958, 400	0	20.00
	Tentative settlement (for contractor use only)		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, and		67, 030	0	
23. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0	0	23. 00
	§115. 2				

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151333	From 01/01/2014	Worksheet E-3 Part V Date/Time Pre 5/28/2015 7:2	pared:
	Title XVIII	Hospi tal	Cost	
			1. 00	

				5/28/2015 7: 2:	2 pm
		Title XVIII	Hospi tal	Cost	
	<u> </u>				
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR V - CALCULA	ART A SERVICES - COST	RELMBURSEMENT	11.00	
1.00	Inpatient services	THE PERSON SERVINGES SOUTH	RETINDOROEMENT	3, 391, 627	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	c)		3, 371, 027	2.00
		5)		0	
3.00	Organ acqui si ti on			•	3. 00
4.00	Subtotal (sum of lines 1 through 3)			3, 391, 627	
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 425, 543	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9.00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	
10.00	Customary charges				10.00
11. 00	Aggregate amount actually collected from patients liable for pa	umont for sorvices on	a chargo basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for			0	
12.00		payment for services of	ii a ciiaiye basis	U	12.00
40.00	had such payment been made in accordance with 42 CFR 413.13(e)			0.000000	40.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	
14. 00	Total customary charges (see instructions)			0	
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)			_	
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3, 425, 543	19. 00
20.00	Deductibles (exclude professional component)			331, 872	20. 00
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			3, 093, 671	
23. 00	Coi nsurance			3, 344	•
24. 00	Subtotal (line 22 minus line 23)			3, 090, 327	
		a) (ass instructions)			
25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see mstructions)		19, 108	
26. 00	Adjusted reimbursable bad debts (see instructions)			14, 522	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		6, 935	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			3, 104, 849	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Recovery of Accelerated Depreciation			0	29. 99
30.00	Subtotal (see instructions)			3, 104, 849	30. 00
30. 01	Sequestration adjustment (see instructions)			62, 097	
31. 00	Interim payments			2, 985, 932	
32. 00	Tentative settlement (for contractor use only)			0	32. 00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, an	4 33)		56, 820	
34. 00	Protested amounts (nonallowable cost report items) in accordance	•	chantor 1	0 0	34. 00
34.00	§115. 2	e with two Pub. 15-2,	chapter I,	Ü	34.00
	[3113. 2		١		

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151333	Peri od: Worksheet E-3 From 01/01/2014 Part VII To 12/31/2014 Date/Time Prepared: 5/28/2015 7: 22 pm

			10 12/31/2014	5/28/2015 7: 2	
		Title XIX	Hospi tal	Cost	
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services	131, 942		1.00	
2.00	Medical and other services		0	2. 00	
3.00	Organ acquisition (certified transplant centers only)				3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		131, 942	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		131, 942	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		22, 148		8. 00
9.00	Ancillary service charges		175, 365	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)		197, 513	0	12.00
40.00	CUSTOMARY CHARGES	<u>.</u>			40.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
14. 00	basis	normant for compless on	0	0	14. 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		U	Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		197, 513	0.000000	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	65, 571	0	
17.00	line 4) (see instructions)	TT TTHE TO EXCEEDED	00,071	· ·	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16	)	131, 942	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co	ompleted for PPS provid	ers.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	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)		131, 942	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30. 00 31. 00	Excess of reasonable cost (from line 18)		0 131, 942	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) Deductibles		131, 942	0	
33. 00			0	0	
	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review		0	Ü	35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		131, 942	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		131, 742	0	
	Subtotal (line 36 ± line 37)		131, 942	0	
	Direct graduate medical education payments (from Wkst. E-4)		0	O	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		131, 942	0	
41. 00	Interim payments		126, 238	0	
42. 00	Balance due provider/program (line 40 minus line 41)		5, 704	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	0	0		
	chapter 1, §115.2	•			
	• • • • • • • •				

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

| Period: | Worksheet G | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: 5/28/2015 7:22 pm | Provi der CCN: 151333

					5/28/2015 7: 2	2 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund	2.22	4.00	
	CHRRENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	4, 262, 126	.1 (		0	1.00
2.00	Temporary investments	4, 202, 120			l	2.00
3.00	Notes recei vabl e	0		1	Ö	3. 00
4. 00	Accounts recei vable	10, 270, 750			Ö	4. 00
5. 00	Other recei vable	0		0	Ō	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-5, 351, 982	2	0	0	6. 00
7.00	Inventory	931, 913	3	0	0	7. 00
8.00	Prepai d expenses	237, 144	. (	0	0	8. 00
9.00	Other current assets	1, 248, 592	2	0	0	9. 00
10. 00	Due from other funds	0	1	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	11, 598, 543	(	0	0	11. 00
40.00	FI XED ASSETS					
12.00	Land	0				12.00
13.00	Land improvements	457, 767		-		13.00
14.00	Accumulated depreciation	-239, 030	1	0	0	14.00
15.00	Buildings	29, 717, 966		0	0	15.00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-18, 721, 097		-		16. 00 17. 00
18. 00	Accumulated depreciation	0			0	18.00
19. 00	Fi xed equipment	0			0	19.00
20. 00	Accumulated depreciation	0			0	20.00
21. 00	Automobiles and trucks	0			Ö	21.00
22. 00	Accumulated depreciation	0	1		Ö	22. 00
23. 00	Major movable equipment	20, 070, 625	1		Ö	23. 00
24. 00	Accumulated depreciation	-15, 559, 822	1	0	o o	24. 00
25. 00	Mi nor equi pment depreci abl e	0		0	o o	25. 00
26. 00	Accumul ated depreciation	0		0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumulated depreciation	0		0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0		0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	15, 726, 409	) (	0	0	30.00
	OTHER ASSETS					
31.00	Investments	23, 357	(	0		31. 00
32. 00	Deposits on Leases	0	) (	0		32. 00
33. 00	Due from owners/officers	0	)	0	0	33. 00
34. 00	Other assets	250, 386		1	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	273, 743	1	٥ -	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	27, 598, 695	5	0	0	36. 00
07.00	CURRENT LI ABI LI TI ES	0 (04 50)				07.00
37. 00	Accounts payable	2, 634, 536	1	0		37. 00
38. 00	Salaries, wages, and fees payable Payroll taxes payable	0	1	0	0	38. 00
39. 00 40. 00	Notes and Loans payable (short term)	2 710	1	0	0	39. 00 40. 00
41. 00	Deferred income	2, 718				41.00
42. 00	Accel erated payments	0		0	l	42.00
43. 00	Due to other funds	0		0	0	43. 00
44. 00	Other current liabilities	0			Ö	
45. 00	Total current liabilities (sum of lines 37 thru 44)	2, 637, 254	1	o o		
10.00	LONG TERM LIABILITIES	2/00//201		<u>,                                      </u>		10.00
46.00	Mortgage payable	0		0	0	46. 00
47.00	Notes payable	0		0	0	47. 00
48.00	Unsecured Loans	0		0	0	48. 00
49.00	Other long term liabilities	13, 505, 753		0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	13, 505, 753		0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	16, 143, 007	'	0	0	51. 00
	CAPITAL ACCOUNTS					
52.00	General fund balance	11, 455, 688				52. 00
53. 00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0	_	56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	11, 455, 688	,	o	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	27, 598, 695				60.00
50.00	[59]	27, 370, 093	]		l	55. 55
	· ·	•	•	1		

					То	12/31/2014	Date/Time Pre 5/28/2015 7:2	
		General	Fund	Speci al	Purp	ose Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CHANGE IN RESTRICTED FUNDS  Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)  Total deductions (sum of lines 12-17) Fund balance at end of period per balance	50, 035 0 0 0 0 0	10, 718, 611 687, 042 11, 405, 653 50, 035 11, 455, 688		000000000000000000000000000000000000000	0 0 0	0 0 0 0 0 0	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
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		Endowment Fund	Prant	Fund				
		6.00	7. 00	8. 00				
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	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) CHANGE IN RESTRICTED FUNDS  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			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 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			13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES 

			T	12/31/2014	Date/Time Prep 5/28/2015 7: 2:		
	Cost Center Description		Inpati ent	Outpati ent	Total	_ piii	
			1, 00	2.00	3. 00		
	PART I - PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		1, 820, 625		1, 820, 625	1.00	
2.00	SUBPROVIDER - I PF		,, -		,,	2. 00	
3.00	SUBPROVI DER - I RF		0		0	3. 00	
4.00	SUBPROVI DER		0		0	4. 00	
5. 00	Swing bed - SNF	i	0		0	5. 00	
6.00	Swing bed - NF		0		0	6. 00	
7. 00	SKILLED NURSING FACILITY				_	7. 00	
8.00	NURSING FACILITY					8. 00	
9.00	OTHER LONG TERM CARE	i				9. 00	
10. 00	Total general inpatient care services (sum of lines 1-9)	i	1, 820, 625		1, 820, 625	10. 00	
	Intensive Care Type Inpatient Hospital Services		1, 020, 020		1,020,020		
11. 00	INTENSIVE CARE UNIT		2, 344, 246		2, 344, 246	11. 00	
12. 00	CORONARY CARE UNIT		_, _, _, _, _		_, ,	12. 00	
13. 00	BURN INTENSIVE CARE UNIT					13. 00	
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00	
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00	
16. 00	Total intensive care type inpatient hospital services (sum of I	ines	2, 344, 246		2, 344, 246	16. 00	
10.00	11-15)	11105	2,011,210		2,011,210	10.00	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		4, 164, 871		4, 164, 871	17. 00	
18. 00	Ancillary services	i	7, 008, 655	42, 829, 570	49, 838, 225	18. 00	
19. 00	Outpatient services		193, 485	11, 681, 759	11, 875, 244		
20. 00	RURAL HEALTH CLINIC		0	0	0	20.00	
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00	
22. 00	HOME HEALTH AGENCY		J	Ĭ	o ,	22. 00	
23. 00	AMBULANCE SERVICES					23. 00	
24. 00	CMHC					24. 00	
24. 10	CORF	•	0	0	0	24. 10	
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		O	o o	O	25. 00	
26. 00	HOSPI CE					26. 00	
27. 00	PHYSI CI ANS PRI VATE OFFI CE		419, 237	5, 999, 577	6, 418, 814	27. 00	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	n Wkst	11, 786, 248		72, 297, 154	28. 00	
20.00	G-3, line 1)	o wkst.	11, 700, 240	00, 310, 700	72, 277, 154	20.00	
	PART II - OPERATING EXPENSES						
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			34, 258, 839		29. 00	
30. 00	ADD (SPECIFY)		0	- 1,,		30. 00	
31. 00		i	0			31. 00	
32. 00		i	0			32. 00	
33. 00			0			33. 00	
34. 00			0			34. 00	
35. 00			0			35. 00	
36. 00	Total additions (sum of lines 30-35)		J	0		36. 00	
37. 00	DEDUCT (SPECIFY)		0	Š		37. 00	
38. 00	DEBOOT (SEESTED)		0			38. 00	
39. 00			0			39. 00	
40. 00			0			40. 00	
41. 00			0			41. 00	
42. 00	Total deductions (sum of lines 37-41)		O	n		42. 00	
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		34, 258, 839		43. 00	
	to Wkst. G-3, line 4)			3., 233, 007			
		1		ļ	ļ		

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10						
STATEMENT OF REVENUES AND EXPENSES  Provider CCN: 151333   Period:				Worksheet G-3		
			From 01/01/2014 To 12/31/2014	Date/Time Pre 5/28/2015 7:2:		
1.00	T + 1	201		1.00	1 00	
1. 00 2. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			72, 297, 154 41, 634, 215	1. 00 2. 00	
2. 00 3. 00	Less contractual allowances and discounts on patients' accounts Net patient revenues (line 1 minus line 2)			30, 662, 939	3.00	
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43	)		34, 258, 839		
5. 00	Net income from service to patients (line 3 minus line 4)	)		-3, 595, 900		
3.00	OTHER I NCOME			-3, 373, 700	3.00	
6.00	Contributions, donations, bequests, etc			0	6. 00	
7. 00	Income from investments			0	7. 00	
8. 00	Revenues from telephone and other miscellaneous communication s	0	8. 00			
9.00	Revenue from television and radio service	0	9. 00			
10.00					10. 00	
11. 00	1.00 Rebates and refunds of expenses				11. 00	
12.00	2.00 Parking lot receipts				12.00	
13.00	.00 Revenue from Laundry and Linen service				13. 00	
14.00	00 Revenue from meals sold to employees and guests				14. 00	
15. 00	10 Revenue from rental of living quarters				15. 00	
16. 00	00 Revenue from sale of medical and surgical supplies to other than patients				16. 00	
17. 00	No Revenue from sale of drugs to other than patients				17. 00	
	Revenue from sale of medical records and abstracts			0	18. 00	
	Tuition (fees, sale of textbooks, uniforms, etc.)				19. 00	
	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00	
21. 00	1			0	21. 00	
22. 00				0	22. 00	
23. 00				0	23. 00	
24. 00				4, 282, 942		
25. 00				4, 282, 942		
	Total (line 5 plus line 25)			687, 042		
	OTHER EXPENSES (SPECIFY)			0	27. 00	
	70 Total other expenses (sum of line 27 and subscripts)			0	28. 00	
29.00	Net income (or loss) for the period (line 26 minus line 28)		ļ	687, 042	29. 00	