This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1333 Worksheet S Peri od: From 01/01/2016 Parts I-III AND SETTLEMENT SUMMARY 12/31/2016 Date/Time Prepared: 5/17/2017 12:50 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/17/2017 Time: 12:50 pm use only] Manually submitted cost report] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low.

[1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
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[19] 19. NPR Date

(4) Reopened (5) Amended

(3) Settled with Audit

Contractor use only

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

CERTIFICATION BY 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 (15-1333) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 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 aned) Officer or Administrator of Provider(s) Title

number of times reopened = 0-9.

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-79, 762	321, 163	0	-2, 180	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
4.00	SUBPROVI DER I						4. 00
5.00	Swing bed - SNF	0	-69, 663	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
10.00	RURAL HEALTH CLINIC I	0		34, 362		0	10.00
10. 01	RURAL HEALTH CLINIC II	0		32, 892		0	10. 01
10. 02	RURAL HEALTH CLINIC III	0		11, 796		0	10. 02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	-149, 425	400, 213	0	-2, 180	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. 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 Provider CCN: 15-1333 Period: Worksheet S-2
From 01/01/2016 Part I

.J. 1 1	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTITION	TON BATTA	Provid			Period: From 01/01 To 12/31		Part I Date/Ti	me Pre	! epared
	1.00		2. 00		2 00			4 00	5/17/20	017 9:5	7 am
	Hospital and Hospital Health Care Co	mnlex Addr			3. 00			4. 00			
00	Street: 1542 SOUTH BLOOMINGTON ST		0 Box:								1.
	City: GREENCASTLE		tate: IN	Zip Cod	e: 46135-	Cour	nty: PUTNAM				2.
		Compo	nent Name	CCN	CBSA	Provi de			nt Syst		
				Number	Number	Туре	Certi fi ed		0, or		1
			4.00	0.00	0.00	1.00	F 00	V	XVIII		4
	Hospital and Hospital-Based Componer		1.00	2.00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
00	Hospi tal		JNTY HOSPITAL	151333	26900	1	12/31/2005	i N	0	0	3.
00	Subprovider - IPF	I OTNAM COO	MIII HOSHTIAL	131333	20700	'	12/31/2003	'l '\			4.
00	Subprovider - IRF										5.
00	Subprovider - (Other)										6.
00	Swing Beds - SNF	PUTNAM COU	JNTY HOSPITAL	15Z333	26900		12/31/2005	i N	0	N	7.
00	Swing Beds - NF										8.
00	Hospital-Based SNF										9.
. 00	Hospital-Based NF										10.
. 00	Hospi tal -Based OLTC										11.
. 00	Hospi tal -Based HHA										12.
. 00	Separately Certified ASC										13.
	Hospital-Based Hospice Hospital-Based Health Clinic - RHC	PPI M		158515	26900		02/23/2015	s N	0	l N	15.
	Hospital-Based Health Clinic - RHC	FMC		158513	26900		02/25/2015		0	N N	15.
01	II	I WC		130313	20700		02/23/2013	'l '\		I IN	13.
02	Hospital-Based Health Clinic - RHC	NPFH		158514	26900		03/17/2015	s N	0	N	15.
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00	Hospital-Based Health Clinic - FQHC										16.
00	Hospital-Based (CMHC) I										17.
10	Hospital-Based (CORF) I										17.
00	Renal Dialysis										18.
00	0ther						<u> </u>	Ш,			19
							From		To		-
00	Cost Reporting Period (mm/dd/yyyy)						1.00		2. (20.
											1 20.
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00	Type of Control (see instructions)						01/01/2	2016	12/31,		
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	Inpatient PPS Information	lance with	42 CFR §412.10	06? In co	olumn 1,	enter "Y	e N	2016	12/31/	72010	21.
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61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.00			61. 02
ACA). (see instructions) 61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0. 00			61. 03
instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00			61. 04
current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0. 00	0.00			61. 05
61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. 00	0.00	61. 10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0. 00	0.00	61. 20
					1.00	
ACA Provisions Affecting the Health Resources and Se	rvi ces	Admi ni strati on	(HRSA)		1.00	
62.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru	trai ned			od for which	0.00	62. 00
62.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro Teaching Hospitals that Claim Residents in Nonprovid	gram. (s	see instruction		your hospital	0.00	62. 01
63.00 Has your facility trained residents in nonprovider s	ettings	during this co		eriod? Enter	N	63. 00
"Y" for yes or "N" for no in column 1. If yes, compl	ete iine	es 64-67. (see	Unwei ghted	Unwei ghted	Ratio (col. 1/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
			1. 00	2. 00	3.00	
Section 5504 of the ACA Base Year FTE Residents in N			This base year	is your cost r	reporting	
period that begins on or after July 1, 2009 and befo 64.00 Enter in column 1, if line 63 is yes, or your facili			0.00	0.00	0. 000000	64. 00
in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighte resident FTEs that trained in your hospital. Enter i of (column 1 divided by (column 1 + column 2)). (see	n-priman all non d non-po n column	ry care nprovider rimary care n 3 the ratio	5.00	3. 66	3. 333300	
Program Name		ogram Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
1.00		2. 00	3. 00	4. 00	5. 00	
00						

HUSPITAL AND HUSPITAL HEALTH	CARL COWIFE	LA IDENTITICATION DA	TA FLOVI del	F	rom 01/01/ o 12/31/		pared:	
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n (5/17/2017 9:5 Ratio (col. 3/ (col. 3 + col. 4))	
		1. 00	2. 00	3. 00	4.00		5. 00	
is yes, or your facili trained residents in t year period, the prograssociated with primar FTEs for each primary program in which you t residents. Enter in co the program code, ente column 3, the number o unweighted primary car residents attributable rotations occurring in non-provider settings. column 4, the number o unweighted primary car resident FTEs that tra your hospital. Enter i 5, the ratio of (colum divided by (column 3 +	ty he base am name y care care rained lumn 2, r in f e FTE to all Enter in f e ined in n column			0.00	O.	0. 00	0. 000000	65. OC
4)). (see instructions)			Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n (Ratio (col. 1/ (col. 1 + col. 2))	
				1. 00	2. 00		3. 00	
Section 5504 of the AC			n Nonprovider Settir	ngsEffective f	or cost re	portir	ng periods	
beginning on or after 5.00 Enter in column 1 the FTEs attributable to r Enter in column 2 the FTEs that trained in y (column 1 divided by (number of u otations oc number of u our hospita	nweighted non-primar curring in all nonpr nweighted non-primar I. Enter in column 3	rovider settings. Ty care resident If the ratio of	0. 00	ס	0. 00	0. 000000	66. 00
		Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweigh FTEs i Hospita	n (Ratio (col. 3/ (col. 3 + col. 4))	
I		1.00	2. 00	3. 00	4.00		5. 00	
7.00 Enter in column 1, the name associated with e your primary care progwhich you trained resi Enter in column 2, the code. Enter in column number of unweighted p care FTE residents att to rotations occurring non-provider settings. column 4, the number o unweighted primary car resident FTEs that tra your hospital. Enter i 5, the ratio of (colum divided by (column 3 + 4)). (see instructions	ach of rams in dents. program 3, the rimary ributable in all Enter in f e ined in n column n 3 column			0.00		0. 00	0. 000000	
						1 00	2.00 2.00	
Inpatient Psychiatric	Facility PF	'S				1. 00	2.00 3.00	
0.00 Is this facility an In	pati ent Psy		PF), or does it con	tain an IPF sub	provi der?	N		70.00
Enter "Y" for yes or " 1f line 70 yes: Column recent cost report fil 42 CFR 412.424(d)(1)(i program in accordance Column 3: If column 2 (see instructions)	1: Did the ed on or be ii)(c)) Col with 42 CFR is Y, indic	fore November 15, 20 umn 2: Did this faci 412.424 (d)(1)(iii) ate which program ye	004? Enter "Y" for lity train resident (D)? Enter "Y" for	yes or "N" for s in a new teac yes or "N" for	no. (see hi ng no.		0	71. 00
Inpatient Rehabilitati 5.00 Is this facility an In			(IRF), or does it	contain an IRF		N		75. 00
subprovider? Enter "Y 6.00 If line 75 yes: Column recent cost reporting no. Column 2: Did this CFR 412.424 (d)(1)(iii indicate which program	." for yes a 1: Did the period endi facility t)(D)? Enter	nd "N" for no. facility have an ap ng on or before Nove rain residents in a "Y" for yes or "N"	proved GME teaching mber 15, 2004? Ente new teaching progra for no. Column 3: I	program in the r "Y" for yes o m in accordance f column 2 is Y	r "N" for with 42	14	o	76. 00

Health Financial Systems PUTNAM COUNTY				eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-1333	Period: From 01/01/2016 To 12/31/2016	Date/Time Pi	repared:
				5/17/2017 9:	: 57 am
Long Term Care Hospital PPS				1.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part o "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 00 86. 00
87.00 Is this hospital a "subclause (II)" LTCH classified under se for yes or "N" for no.	ction 1886(d)	(1)(B)(iv)(II)? Enter "Y"	N	87. 00
			V 1. 00	XI X 2. 00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospita	L services? F	nter "V" for	N	Υ	90.00
yes or "N" for no in the applicable column.					
91.00 Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl	icable column	l.	N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica		ion)? (see		N	92.00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	N	N	94. 00
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app	licable colum	in.	0. 00	0.00	97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CA 106.00 of this facility qualifies as a CAH, has it elected the all-		hod of paymer	nt Y		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see inst 25 and the p	ructions) If rogram is cos			107. 00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	2 N		108. 00
	Physi cal 1.00	Occupationa 2.00	Speech 3.00	Respiratory 4.00	
109.00 on this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Υ Υ	Y	N N	109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"	l Demonstrati for no.	on project (4	10A Demo)for	N	110. 00
			1.0	0 2.00 3.00	0
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider	If column 2 t for long te	is "E", enter rm care (incl	in column udes	0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insurno.	,		"N" for Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the policy	is 2		118. 00
praisi made. Enter E in the period in cooking cooking		Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		206, 9	253 (0 118. 01

Health Financial Systems	PUTNAM COU	NTY HOSPITAL			In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPL	OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1333 Per Fro To					Worksheet S- Part I Date/Time Pro 5/17/2017 9:	epared:
						1, 00	_
Mul ti campus						1.00	
165.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	ampus hospital that has o	one or more campu	uses in di	fferent CE	BSAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 166. 00
						1.00	+
Health Information Technology (HI	T) incentive in the Amer	ican Recovery and	d Rei nves	tment Act		1.00	
167.00 Is this provider a meaningful use						Υ	167. 00
168.00 If this provider is a CAH (line 1 reasonable cost incurred for the	HIT assets (see instructi	ons)		, .			0168.00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "I	√" for no. (see i	nstructio	ons)	•		168. 01
169.00 If this provider is a meaningful transition factor. (see instructi		nd is not a CAH ((line 105				0169. 00
				Ве	gi nni ng	Endi ng	
470.005					1. 00	2.00	170.67
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	beginning date and ending	g date for the re	eporti ng	01,	/01/2014	12/31/2014	170. 00
					1. 00	2.00	+
171.00 If line 167 is "Y", does this pro- section 1876 Medicare cost plans "Y" for yes and "N" for no in col 1876 Medicare days in column 2.	reported on Wkst. S-3, P umn 1. If column 1 is ye	t. I, line 2, col	. 6? Ente		N N		0 171. 00

	Financial Systems PUTNAM COUNT TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1333	Peri od:	u of Form CMS- Worksheet S-2	
		1.101.46.	J. 10 1000	From 01/01/2016 To 12/31/2016	Part II	epared:
				Y/N	Date) alli
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	_		
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	heainning of	the cost	N		1.0
. 00	reporting period? If yes, enter the date of the change in c	olumn 2 (see	instructions)			1.0
	proper tring period. Tr year enter the date of the change the	0. 4	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
3. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board	N			3.00
			Y/N	Type	Date	
			1.00	2. 00	3. 00	
	Financial Data and Reports					
1.00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	N N			4.00
5. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.00
	those on the fired financial statements? If yes, submit rec	onci i i a ti on.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities				2.00	
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		ne provider is			6.00
. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.	and/or renewed	· ·	N N		7. 00 8. 00
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	S.		N		9.00
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N N		10.00
1. 00	Teaching Program on Worksheet A? If yes, see instructions.	a K III ali App	, oved	**		'''
					Y/N	
	L				1. 00	
2 00	Bad Debts				N	10.0
2. 00 3. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N N	12.0
4. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? If	yes, see ins	structi ons.	N	14. 0
5. 00	Did total beds available change from the prior cost reporti		yes, see inst t A		N t B	15. 0
		Y/N	Date	Y/N	Date	
	DC+D Do+o	1.00	2.00	3. 00	4. 00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. 0
7. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	N		N		17. 0
8. 00	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 0
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 0

	D HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CO	CN: 15-1333	Peri od:	u of Form CM Worksheet S	
				From 01/01/2016 To 12/31/2016		repare
		Descri	nti on	Y/N	5/17/2017 9 Y/N	7:57 am
		003011	•	1.00	3. 00	
	ne 16 or 17 is yes, were adjustments made to PS&R			N	N	20
Repor	t data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
	the cost report prepared only using the provider's rds? If yes, see instructions.	N		N		21
					1. 00	
COMPL	ETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)		1. 00	
	al Related Cost					
	assets been relifed for Medicare purposes? If yes, see				N	22
	changes occurred in the Medicare depreciation expense ting period? If yes, see instructions.	due to apprais	als made dur	ing the cost	N	23
	new leases and/or amendments to existing leases enterees, see instructions	d into during	this cost re	porting period?	N	24
	there been new capitalized leases entered into during ructions.	the cost repor	ting period?	'If yes, see	N	25
00 Were	assets subject to Sec. 2314 of DEFRA acquired during thructions.	e cost reporti	ng period? I	f yes, see	N	26
1	the provider's capitalization policy changed during the	cost reportin	g period? If	yes, submit	N	27
	est Expense new Loans, mortgage agreements or Letters of credit en	tered into dur	ing the cost	reporting	N	28
1.	od? If yes, see instructions. The provider have a funded depreciation account and/or	bond funds (De	bt Service R	Reserve Fund)	Υ	29
	ed as a funded depreciation account? If yes, see instrexisting debt been replaced prior to its scheduled matu		debt? If yes	, see	N	30
00 Has	ructions. Bebt been recalled before scheduled maturity without is	suance of new	debt? If yes	, see	N	31
	ructi ons. ased Servi ces					
00 Have	changes or new agreements occurred in patient care ser		d through co	ntractual	N	32
00 If Ii	ngements with suppliers of services? If yes, see instru ne 32 is yes, were the requirements of Sec. 2135.2 app		g to competi	tive bidding? If		33
	see instructions. der-Based Physicians					
00 Are s	services furnished at the provider facility under an ar	rangement with	provi der-ba	sed physi ci ans?	Y	34
	es, see instructions. ne 34 is yes, were there new agreements or amended exi	sting agreemen	ts with the	provi der-based	N	35
	cians during the cost reporting period? If yes, see in					
				Y/N	Date	
Home	Office Costs			1. 00	2. 00	
	home office costs claimed on the cost report?			N		36
	ne 36 is yes, has a home office cost statement been pr	epared by the	home office?			37
lf y∈	es, see instructions. ne 36 is yes , was the fiscal year end of the home off					38
	provider? If yes, enter in column 2 the fiscal year end ne 36 is yes, did the provider render services to othe			i,		39
00 If Ii	nstructions. ne $36\ \text{is}$ yes, did the provider render services to the	home office?	If yes, see			40
nstr	ructi ons.					
6		1.	00	2.	00	
00 Enter		TI NA		SEVERS		41
respe	by the cost report preparer in columns 1, 2, and 3, ectively.					
00 Enter	. , , , , , , , , , , , , , , , , , , ,	BLUE & CO., LL	С			42
		317-713-7649		TSEVERS@BLUEANI	OCO COM	43

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT (QUESTI ONNAI RE	Provi der		Period: From 01/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Pre 5/17/2017 9:5	pared:
				2.00			
				3. 00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the ti	tle/position	MANAGER				41.00
	held by the cost report preparer in column	ns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cos	st report					42.00
	preparer.						
43.00	Enter the telephone number and email addre	ess of the cost					43.00
	report preparer in columns 1 and 2, respec	cti vel y.					
	1. oper t proparer corumno i una z, respec		l		1		1

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Health Financial Systems PUTNAI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1333

				To	12/31/2016		
						5/17/2017 9:57 I/P Days / O/P	/ alli
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	Component	Line Number	No. or beas	Avai I abl e	OAIT HOULS	little v	
		1.00	2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00			38, 352. 00	0	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					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		19	6, 954	38, 352. 00	0	7. 00
	beds) (see instructions)		,	0.40/			
8.00	I NTENSI VE CARE UNIT	31. 00	6	2, 196	9, 048. 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)	42.00					12.00
13.00	NURSERY	43. 00		0.150	47 400 00	0	13.00
14.00	Total (see instructions)		25	9, 150	47, 400. 00	0	14.00
15.00	CAH visits					١	15. 00 16. 00
16. 00 17. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF	41. 00	0	0		o	17. 00
18. 00	SUBPROVI DER	42. 00				0	18. 00
19. 00	SKILLED NURSING FACILITY	42.00	0	J			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	CWHC - CWHC						25. 00
25. 10	CMHC - CORF	99. 10				o	25. 10
26.00	RURAL HEALTH CLINIC	88. 00				o	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01				o	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02				0	26. 02
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

Provider CCN: 15-1333

| Period: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: | 5/17/2017 9:57 am

		_				5/17/2017 9:5	7 am
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7. 00	8.00	9, 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 010	3	1, 598			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)	181	19				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	456	0	494			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	59			6. 00
7.00	Total Adults and Peds. (exclude observation	1, 466	3	2, 151			7. 00
0.00	beds) (see instructions)	222		277			0.00
8.00	INTENSIVE CARE UNIT	223	0	377			8.00
9.00	CORONARY CARE UNIT						9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		0	0			13.00
14. 00	Total (see instructions)	1, 689	3	2, 528	0.00	271. 81	
15. 00	CAH visits	1,009	0	2, 320	0.00	271.01	15. 00
16. 00	SUBPROVIDER - IPF	١	ĭ				16.00
17. 00	SUBPROVIDER - I RF	0	0	Ō	0.00	0.00	
18. 00	SUBPROVI DER	J	o	C	0.00	0.00	
19. 00	SKILLED NURSING FACILITY		آ	_			19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	0	0	C)		24. 10
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0	0	C	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	1, 196	0	9, 031		3. 87	26. 00
26. 01	RURAL HEALTH CLINIC II	1, 630	0	7, 610			1
26. 02	RURAL HEALTH CLINIC III	430	0	3, 220		2. 26	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	C			
27. 00	Total (sum of lines 14-26)				0.00	281. 48	
28. 00	Observation Bed Days		0	1, 091			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30. 00	Employee discount days (see instruction)			C			30.00
31. 00	Employee discount days - IRF	_	_	C			31.00
32. 00	Labor & delivery days (see instructions)	0	0	O			32.00
32. 01	Total ancillary labor & delivery room			C	'		32. 01
22 00	outpatient days (see instructions)	o					33.00
SS. 00	LTCH non-covered days	ı Y	I		1	I	J 33.00

 Heal th Financial
 Systems
 PUTNAM

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider CCN: 15-1333

				T	o 12/31/2016	Date/Time Pre 5/17/2017 9:5	
		Full Time		Di sch	arges	07 177 2017 7. 0	7 (311)
		Equi val ents)		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(0 405	1	719	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)				-		2 00
2.00	HMO and other (see instructions)			54	o 0		2. 00 3. 00
3. 00 4. 00	HMO IPF Subprovider				0		4.00
5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				U		5.00
6. 00	Hospital Adults & Peds. Swing Bed SNI						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0. 00	(0 405	1	719	14. 00
15.00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0.00	(0	0	0	17. 00
18. 00	SUBPROVI DER	0. 00	(0	0	0	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0.00					25. 00
25. 10 26. 00	CMHC - CORF RURAL HEALTH CLINIC	0. 00 0. 00					25. 10 26. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC III	0.00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambul ance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days (see l'histraction)						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
	•	· '			· '		

	AL-BASED RHC/FQHC STATISTICAL DATA		TY HOSPITAL Provi der C	CN: 15-1333	Peri od:	eu of Form CMS- Worksheet S-8		
				CCN: 15-8515	From 01/01/2016 To 12/31/2016			
					RHC I	Cost		
					1	. 00	4	
	Clinic Address and Identification					. 00		
. 00	Street				1200	INGTON ST., STE	1. 0	
				i ty	State	ZIP Code	_	
2. 00	City, State, ZIP Code, County		GREENCASTLE	. 00	2. 00	3. 00 N 46135	2. (
00	orty, state, zir sode, sodirty		OKEENONOTEE			10100	2.0	
						1. 00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rura	al or "U" for u		- + Al		3. (
					nt Award 1.00	2. 00	+	
	Source of Federal Funds				1.00	2.00		
1. 00	Community Health Center (Section 330(d), PHS	Act)				T	4.0	
5. 00	Migrant Health Center (Section 329(d), PHS Ad	ct)					5. 0	
5. 00	Health Services for the Homeless (Section 340)(d), PHS Act)					6.0	
7. 00 3. 00	Appal achi an Regional Commission Look-Alikes						7. 0	
9. 00	OTHER (SPECIFY)			•			9. (
. 00	TOTHER (OF EOTT 1)						1	
					1. 00	2. 00		
0. 00	Does this facility operate as other than a hoyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type or	N	C	10.0				
	hours.)			1 .				
		from	nday to	from	Monday to	Tuesday from		
		1.00	2.00	3.00	4. 00	5. 00		
	Facility hours of operations (1)			•				
1.00	Clinic			07: 00	17: 00	07: 00	11. 0	
					1.00	2.00		
	Have you received an approval for an exception				1. 00 N	2. 00		
12 NN	Ols this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and							
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapteı enter in colur	r 9, section mn 2 the	**			
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. 1 umn 1. If yes,	100-04, chapteı enter in colur	r 9, section mn 2 the ders and	**	CCN number		
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	100-04, chapteı enter in colur	r 9, section mn 2 the ders and	N		13.0	
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 1 umn 1. If yes, List the names	100-04, chapter enter in colur s of all provid	r 9, section mn 2 the ders and	ider name	CCN number 2.00	13.0	
12. 00 13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. 1 Jumn 1. If yes, List the names	100-04, chapter enter in colurs of all provid	r 9, section nn 2 the ders and Provi	ider name 1.00	CCN number 2.00 Total Visits	13.0	
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. 1 Jumn 1. If yes, List the names Y/N 1.00	100-04, chapter enter in colur s of all provid	r 9, section mn 2 the ders and	ider name	CCN number 2.00	14. 0	
14. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	d in CMS Pub. 1 Jumn 1. If yes, List the names Y/N 1.00	100-04, chapter enter in colurs of all provid	Provi XVIII 3.00	ider name 1.00	CCN number 2.00 Total Visits	14. (
4. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. 1 Jumn 1. If yes, List the names Y/N 1.00	100-04, chapter enter in colurs of all provid	Provi XVIII 3.00	ider name 1.00	CCN number 2.00 Total Visits	14. (
14. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. 1 Jumn 1. If yes, List the names Y/N 1.00	V 2.00	Provi XVIII 3.00	ider name 1.00	CCN number 2.00 Total Visits	14. (
14. 00 15. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. 1 Jumn 1. If yes, List the names Y/N 1.00	100-04, chapter enter in colurs of all provide V 2.00	Provi XVIII 3.00	ider name 1.00 XIX 4.00	CCN number 2.00 Total Visits 5.00	14. (
14. 00 15. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. 1 Jumn 1. If yes, List the names Y/N 1.00	100-04, chapter enter in colurs of all provide V 2.00	Provi XVIII 3.00	ider name 1.00 XIX 4.00	CCN number 2.00 Total Visits	12. C 13. C 14. C 15. C 2. C	
13. 00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. 1 Jumn 1. If yes, List the names Y/N 1.00	V 2.00 Cou PUTNAM Wedn	Provi XVIII 3.00 unty .00	ider name 1.00 XIX 4.00	CCN number 2.00 Total Visits 5.00	14. 0	

Health Financial Systems	PUTNAM COUNT	TY HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C			Worksheet S-8	
		Component		From 01/01/2016 To 12/31/2016		
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 Cl i ni c	07: 00	17: 00				11. 00

Heal th I	Financial Systems	PUTNAM COUNT	TY HOSPI TAL		In Lie	u of Form CMS-	2552-10
	L-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1333	Peri od:	Worksheet S-8	
			Component	CCN: 15-8513	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/17/2017 9:5	
					RHC II	Cost	
							1
- 10	Clinic Address and Identification				1.	00	
_	Street				51 E. MARKET S	TRFFT	1.00
			Ci	ty	State	ZIP Code	1
		_		00	2. 00	3. 00	
2.00	City, State, ZIP Code, County		CLOVERDALE		IN	46120	2. 00
						1. 00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for u	ırban		1.00	3.00
					nt Award	Date	J
					1. 00	2. 00	
	Source of Federal Funds	A 12		T			4 00
	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4. 00 5. 00
	Health Services for the Homeless (Section 34)						6.00
1	Appal achi an Regional Commission	-(-),					7. 00
	Look-Alikes						8. 00
9.00	OTHER (SPECIFY)	_					9.00
					1. 00	2. 00	-
10. 00 I	Does this facility operate as other than a h	ospital-based F	RHC or FOHC? Fr	nter "Y" for	1.00 N	2.00	10.00
3	yes or "N" for no in column 1. If yes, indic 2.(Enter in subscripts of line 11 the type o hours.)	_					
	nour s.)	Sun	nday	1	Monday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4. 00	5. 00	
	Facility hours of operations (1)			loo 00	10.00	00.00	11 00
11.00	CIT I II C			08: 00	18: 00	08: 00	11.00
					1.00	2. 00	
13. 00	Have you received an approval for an exception to the productivity standard? N Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and						12. 00 13. 00
	numbers below.			Prov	ider name	CCN number	
					1. 00	2. 00	
14. 00 I	RHC/FQHC name, CCN number						14.00
		Y/N 1.00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.		2.00	3.00	4.00	5.00	15.00
	(see instructions)						
	<u> </u>	1	Соц	unty			
				00			
2.00	City, State, ZIP Code, County	Tuocday	PUTNAM	ocdov	TI	cday	2.00
		Tuesday to	from Wedn	esday to	Thur from	sday to	
		6.00	7. 00	8. 00	9. 00	10. 00	
F	Facility hours of operations (1)			3.00			
11. 00	Clinic	18: 00	08: 00	18: 00	08: 00	18: 00	11. 00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Peri od:	Worksheet S-8	
				From 01/01/2016		
		Component	CCN: 15-8513	To 12/31/2016		
					5/17/2017 9:5	7 am
				RHC II	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11.00 Clinic	08: 00	18: 00				11. 00

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	eu of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Peri od:	Worksheet S-8	
		Component	CCN: 15-8514	From 01/01/2016 To 12/31/2016	Date/Time Pre	
				RHC III	5/17/2017 9:5 Cost	o/ alli
		-				
				1.	00	
Clinic Address and Identification 1.00 Street				440 E. PAT RAD	V WAV	1.00
1.00 311 ee t		Ci	ty	State	ZIP Code	1.00
	_		00	2.00	3. 00	
2.00 City, State, ZIP Code, County		BAI NBRI DGE		IN	46105	2. 00
					1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	ıl or "U" for ι	ırban		0	3.00
				nt Award	Date	
				1. 00	2. 00	
Source of Federal Funds 4.00 Community Health Center (Section 330(d), PHS	Act)		I		Ī	4.00
5.00 Migrant Health Center (Section 329(d), PHS A						5. 00
6.00 Health Services for the Homeless (Section 34						6. 00
7.00 Appalachian Regional Commission						7. 00
8.00 Look-Alikes 9.00 OTHER (SPECIFY)						8. 00 9. 00
7.00 OTHER (SPECIFI)						7.00
				1. 00	2. 00	
10.00 Does this facility operate as other than a hyes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o	ate number of c	ther operation	s in column	N	0	10.00
hours.)	Sun	day	I	londay	Tuesday	
	from	to	from	to	from	
	1.00	2. 00	3. 00	4. 00	5. 00	
Facility hours of operations (1) 11.00 Clinic			08: 00	17: 00	08: 00	11 00
11.00 CITIII C			06.00	17.00	.08.00	11. 00
	_			1. 00	2. 00	
12.00 Have you received an approval for an exception 13.00 Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. 1 umn 1. If yes,	00-04, chapter enter in colum	9, section in 2 the	N N	o	12.00
·			Prov	ider name	CCN number	
14 00 DHC/FOHC name CCN symbox				1. 00	2. 00	14.00
14.00 RHC/FQHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14. 00
	1.00	2.00	3.00	4. 00	5. 00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15. 00
			inty			
2.00 City, State, ZIP Code, County		PUTNAM	00			2. 00
2.00 orty, State, 211 code, county	Tuesday		esday	Thur	sday	2.00
	to	from	to	from	to	
	6. 00	7. 00	8. 00	9. 00	10.00	
Facility hours of operations (1) 11.00 Clinic	17: 00	08: 00	17: 00	08: 00	17: 00	11. 00
·	1	•	•	1	*	

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Peri od:	Worksheet S-8	
				From 01/01/2016		
		Component	CCN: 15-8514	To 12/31/2016		
					5/17/2017 9:5	<u>7 am </u>
				RHC III	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13. 00	14. 00		
Facility hours of operations (1)						
11.00 Clinic	08: 00	17: 00				11. 00

llool +h	Financial Customs	PUTNAM COUNTY HOSPITAL		la lio	u of Form CMC 3	DEE2 10	
	Financial Systems FAL UNCOMPENSATED AND INDIGENT CARE DATA		CN: 15-1333	Peri od:	u of Form CMS-2 Worksheet S-10		
позы	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN. 13-1333	From 01/01/2016	WOLKSHEEL 3-10	U	
				To 12/31/2016	Date/Time Pre	pared:	
					5/17/2017 9:5	7 am	
					1. 00		
1 00	Uncompensated and indigent care cost computation		202!	- 0)	0.075441	1 00	
1. 00	Cost to charge ratio (Worksheet C, Part I line :	202 column 3 divided by li	ne 202 coi un	n 8)	0. 375441	1. 00	
2. 00	Medicaid (see instructions for each line) Net revenue from Medicaid				0	2. 00	
3. 00	Did you receive DSH or supplemental payments from	om Medicaid?			U	3.00	
4. 00	If line 3 is "yes", does line 2 include all DSH		from Medicai	d2		4.00	
5. 00			TT OIL MCGT CGT	u.	0	5. 00	
6. 00	11 1 3						
7. 00	Medicaid cost (line 1 times line 6)				0	6. 00 7. 00	
8.00	Difference between net revenue and costs for Me	dicaid program (line 7 min	nus sum of li	nes 2 and 5; if	0	8. 00	
	< zero then enter zero)	1 3 (
	Children's Health Insurance Program (CHIP) (see	instructions for each lin	ne)				
9.00	Net revenue from stand-alone CHIP				0	9. 00	
10.00	Stand-alone CHIP charges				0	10. 00	
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11. 00	
12. 00	Difference between net revenue and costs for st	and-alone CHIP (line 11 mi	nus line 9;	if < zero then	0	12. 00	
	enter zero)		I:	`			
13. 00	Other state or local government indigent care pure Net revenue from state or local indigent care p				0	13. 00	
14. 00	Charges for patients covered under state or local	9 (′	0	14. 00	
14.00	10)	ar murgem care program	(Not Therauec	III IIIles o oi	U	14.00	
15. 00	State or local indigent care program cost (line	1 times line 14)			0	15. 00	
16. 00	Difference between net revenue and costs for sta		e program (Li	ne 15 minus line	0	16. 00	
	13; if < zero then enter zero)	are en reed. That gent ear	, p. 09. a (ŭ.	10.00	
	Uncompensated care (see instructions for each li	ine)					
17.00	Private grants, donations, or endowment income	restricted to funding cha	rity care		0	17. 00	
18. 00	Government grants, appropriations or transfers	for support of hospital op	oerati ons		0	18. 00	
19. 00	Total unreimbursed cost for Medicaid , CHIP and	state and Local indigent	care program	s (sum of lines	0	19. 00	
	8, 12 and 16)		1				
			Uni nsured	Insured	Total (col. 1		
			patients	pati ents	+ col . 2)		
20. 00	Charity care charges for the entire facility (se	ae instructions)	1.00	2. 00	3. 00 724, 885	20. 00	
21. 00	Cost of patients approved for charity care (line	*	272. 1		272, 152		
22. 00	1		2/2, 1	0 0	272, 132	22. 00	
23. 00	1	y care	272, 1		272, 152		
20.00	just of charty care (iffice 2) minus iffice 22)			02	2,2,102	20.00	
					1. 00		
24. 00	Does the amount in line 20 column 2 include cha	rges for patient days beyo	ond a Length	of stay limit		24. 00	
	imposed on patients covered by Medicaid or othe	r indigent care program?		_			
25. 00	If line 24 is "yes," charges for patient days	3 1	9	th of stay limit	0	25. 00	
26. 00	Total bad debt expense for the entire hospital)		0	26. 00	
27. 00		,			485, 270		
28. 00	Non-Medicare and non-reimbursable Medicare bad		,		-485, 270		
29. 00	Cost of non-Medicare and non-reimbursable Medica		e 1 times lin	e 28)	-182, 190		
30.00					89, 962		
31.00	Total unreimbursed and uncompensated care cost	(Time 19 plus line 30)		l	89, 962	31.00	

Heal th F	Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASS	IFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CC	1	Period: From 01/01/2016 To 12/31/2016	Worksheet A Date/Time Pre 5/17/2017 9:5	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	SENERAL SERVICE COST CENTERS				.1		
	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	27 (20	2, 749, 936				1. 00 4. 00
	00500 ADMINISTRATIVE & GENERAL	27, 629 2, 220, 908	4, 247, 052 2, 912, 685			4, 292, 597 5, 014, 310	5. 00
	00700 OPERATION OF PLANT	284, 706	994, 446				7. 00
	00800 LAUNDRY & LINEN SERVICE	27, 750	90, 595			118, 345	8. 00
9.00 0	00900 HOUSEKEEPI NG	343, 252	92, 226	435, 478	8 0	435, 478	9. 00
	01000 DI ETARY	314, 731	408, 889			213, 036	
	01100 CAFETERI A	(4 041	0 00 00 0		510, 584	510, 584	
	01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY	66, 841 364, 409	86, 086 169, 182			152, 927 533, 591	13. 00 16. 00
	01700 SOCIAL SERVICE	304, 409	109, 102	333, 34	0	0 0	17. 00
	01701 UTILIZATION REVIEW	69, 744	9, 468	79, 21:	2 0	79, 212	17. 01
I	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	1, 024, 242	51, 155			1, 076, 293	30. 00
	03100 I NTENSI VE CARE UNI T	734, 415	40, 847	775, 26	2 536		1
	04100 SUBPROVI DER - I RF	0	0		0	0	41.00
	04200 SUBPROVI DER 04300 NURSERY	0	0		0 0	0	42.00
	NCILLARY SERVICE COST CENTERS	<u> </u>	0	<u> </u>	<u>J</u>	0	43.00
	05000 OPERATI NG ROOM	481, 555	774, 721	1, 256, 27	6 -134, 463	1, 121, 813	50.00
51.00 0	05100 RECOVERY ROOM	55, 270	8, 503	63, 77	3 0	63, 773	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52. 00
	05300 ANESTHESI OLOGY	562, 465	94, 594	657, 05		657, 067	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	786, 742	223, 475			1, 011, 598	1
	05401 NUCLEAR MEDICINE-DIAGNOSTIC 05700 CT SCAN	0 158, 304	171, 861 230, 112	171, 86 ⁻ 388, 41		171, 861 388, 416	1
	05800 MAGNETIC RESONANCE IMAGING (MRI)	130, 304	230, 112	300, 411	0	0	1
	05900 CARDI AC CATHETERI ZATI ON	o	0		0	0	59. 00
	06000 LABORATORY	726, 396	1, 549, 019	2, 275, 41	5 0	2, 275, 415	60.00
	06001 BLOOD LABORATORY	0	0	(0 0	0	60. 01
	06400 I NTRAVENOUS THERAPY	0	0	100 17	0	0	64.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	334, 823	103, 650 533, 921	438, 473 533, 92		439, 431	
	06700 OCCUPATIONAL THERAPY		92, 917			534, 016 92, 917	
	06800 SPEECH PATHOLOGY	o	55, 556			55, 556	
69.00 0	06900 ELECTROCARDI OLOGY	64, 303	71, 171	135, 47		135, 474	
	06901 CARDI AC REHAB	252, 043	11, 452			263, 495	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21, 230	21, 23			71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	121 ((1	1 245 047	1 407 50	150, 192	150, 192 1, 498, 241	
	07300 DRUGS CHARGED TO PATIENTS 07301 ONCOLOGY	131, 661 293, 693	1, 365, 867 2, 932, 011	1, 497, 528 3, 225, 70			
	OUTPATIENT SERVICE COST CENTERS	273,073	2, 732, 011	3, 223, 70	T 30	5, 225, 762	73.01
	08800 RURAL HEALTH CLINIC	970, 131	296, 668	1, 266, 79	9 -122, 785	1, 144, 014	88. 00
	08801 RURAL HEALTH CLINIC II	833, 863	271, 744			1, 003, 876	
	08802 RURAL HEALTH CLINIC III	419, 178	130, 074	549, 25	2 -11, 031	538, 221	1
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
	09100 EMERGENCY	2, 664, 418	1, 159, 105	3, 823, 52	3 856	0 3, 824, 379	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,004,410	1, 134, 103	3, 623, 52.	3 650	3,024,379	92.00
_	THER REIMBURSABLE COST CENTERS	<u>I</u>					72.00
99. 10 0	09910 CORF	0	0	(0 0	0	99. 10
	SPECIAL PURPOSE COST CENTERS						
	0900 PANCREAS ACQUISITION	0	0	(0		109. 00
	1000 INTESTINAL ACQUISITION 1100 ISLET ACQUISITION	0	0		0		110. 00 111. 00
	1300 INTEREST EXPENSE	٩	0		0		113.00
	1400 UTI LI ZATI ON REVI EW-SNF	o	0		0		114. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	14, 213, 472	21, 950, 218	36, 163, 69	160, 434		
	IONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	2, 494, 890	533, 761				
	9300 NONPALD WORKERS 9301 DME	5, 169	0	5, 16	0		193. 00 193. 01
	9301 DME 19302 LACTATION CONSULTING		0				193. 01
	9303 DI ABETI C COUNSELI NG	l ol	0		o o		193. 02
	07950 VACANT SPACE	ol ol	0		o o	0	194. 00
	07951 BOARD OF HEALTH	0	0		0 0		194. 01
	07952 PUTNAM/HENRY PRENATAL	0	0	20 407 54	0		194. 02
200. 00	TOTAL (SUM OF LINES 118-199)	16, 713, 531	22, 483, 979	39, 197, 510	0	39, 197, 510	J∠UU. UU

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lieu	of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O		Provi der CCI	N: 15-1333	Peri od:	Vorksheet A
				From 01/01/2016 To 12/31/2016	Date/Time Prepared:
				10 12/31/2010 5	5/17/2017 9:57 am
Cost Center Description	Adjustments	Net Expenses			
		For Allocation			
CENEDAL CEDIMACE COCT CENTEDO	6.00	7. 00			
1.00 GENERAL SERVICE COST CENTERS 1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT	-400, 315	2, 824, 371			1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	-22, 158				4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	-834, 567	4, 179, 743			5. 00
7.00 00700 OPERATION OF PLANT	-3, 710				7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	0	118, 345			8. 00
9. 00 00900 HOUSEKEEPI NG	0	435, 478			9. 00
10. 00 01000 DI ETARY	0	213, 036			10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	-63, 103 0	447, 481 152, 927			11. 00 13. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	-45	533, 546			16. 00
17. 00 01700 SOCI AL SERVI CE	0	0			17. 00
17. 01 01701 UTI LI ZATI ON REVI EW	l o	79, 212			17. 01
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	0				30.00
31. 00 03100 INTENSI VE CARE UNI T	0	775, 798			31.00
41. 00 04100 SUBPROVI DER - I RF	0	0			41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	0	0			42. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS	0	0			45.00
50. 00 05000 OPERATI NG ROOM	0	1, 121, 813			50.00
51. 00 05100 RECOVERY ROOM	0	63, 773			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			52. 00
53. 00 05300 ANESTHESI OLOGY	-485, 165	· · · · · · · · · · · · · · · · · · ·			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	-3, 981	1, 007, 617			54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 57. 00 05700 CT SCAN	0	171, 861			54. 01 57. 00
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	388, 416			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0				59.00
60. 00 06000 LABORATORY	0	2, 275, 415			60.00
60. 01 06001 BL00D LABORATORY	0	O			60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	0			64. 00
65. 00 06500 RESPI RATORY THERAPY	0	439, 431			65. 00
66. 00 06600 PHYSI CAL THERAPY	-690	533, 326			66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	92, 917 55, 556			67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	135, 474			69.00
69. 01 06901 CARDI AC REHAB	0	263, 495			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	150, 192			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	-78, 615				73. 00
73. 01 07301 ONCOLOGY	-265, 913	2, 959, 849			73. 01
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	0	1, 144, 014			88. 00
88. 01 08801 RURAL HEALTH CLINIC II	-100				88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0				88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89. 00
90. 00 09000 CLINIC	0	0			90.00
91. 00 09100 EMERGENCY	-1, 928, 251	1, 896, 128			91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)					92. 00
OTHER REIMBURSABLE COST CENTERS 99. 10 O9910 CORF	0	0			99. 10
SPECIAL PURPOSE COST CENTERS	0	0			77. 10
109. 00 10900 PANCREAS ACQUISITION	0	0			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0			110.00
111.00 11100 ISLET ACQUISITION	0	O			111. 00
113. 00 11300 I NTEREST EXPENSE	0	0			113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0			114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-4, 086, 613	32, 237, 511			118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	O			190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	2, 868, 217			192.00
193. 00 19300 NONPALD WORKERS	0	5, 169			193. 00
193. 01 19301 DME	0	0			193. 01
193. 02 19302 LACTATION CONSULTING	0	O			193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	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 200.00 TOTAL (SUM OF LINES 118-199)	-4, 086, 613	35, 110, 897			194. 02 200. 00
200.00 TOTAL (30M OF LINES 110-177)	4,000,013	33, 110, 07/			J200. 00

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

RECLASS	I FI CATI ONS			Provi der (CCN: 15-1333	From 01/01/2016 To 12/31/2016	Worksheet A-6 Date/Time Prep 5/17/2017 9:5	pared:
		Increases		'				
	Cost Center	Li ne #	Sal ary	0ther				
	2 00	3.00	4 00	5.00				

						5/17/2017 9:57 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	D - CLINIC RECLASS					
1.00	NEW CAP REL COSTS-BLDG &	1. 00	0	337, 605		1. 00
	FIXT		_			
2.00	ADMI NI STRATI VE & GENERAL	5. 00	0	2, 181		2. 00
3. 00	OPERATION OF PLANT	7. 00	0	22, 598		3. 00
4.00		0.00		0		4. 00
	0		0	362, 384		
	E - PHYS PRACT LABOR DIST	- aal	ما	05 500		
1. 00	ADMI NI STRATI VE & GENERAL			25, 520		1.00
	0		O	25, 520		
	F - CAFETERIA RECLASS	44.00	000 070	000 544		
1. 00	CAFETERI A	1100	222, 073	288, 511		1.00
	0		222, 073	288, 511		
	G - EMPLOYEE PROMOTIONS		ام	47.04		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		1 <u>7, 9</u> 16		1.00
	U LNGUBANGE BEGLACC		0	17, 916		
4 00	H - INSURANCE RECLASS	4 00	ما	400.040		1.00
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	129, 068		1.00
	FIXT	+	+	129, 068		
	J - PPO DEPRECIATION		U	129, 000		
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	8, 077		1, 00
1.00	FIXT	1.00	٩	8,077		1.00
2.00	1171	0.00	o	0		2.00
3.00		0.00	o	0		3.00
4. 00		0.00	o	0		4.00
4.00			— —	— — 8, 07 7		4.00
	K - IMPLANTABLE DEVICES		9	0,011		
1.00	I MPL. DEV. CHARGED TO	72.00	0	150, 192		1.00
	PATI ENT	72.00	٦	.00, .,2		
	0			150, 192		
	L - MED SUPPLY RECLASS	<u>'</u>				
1.00	ADULTS & PEDIATRICS	30.00	0	896		1.00
2.00	INTENSIVE CARE UNIT	31.00	o	536		2. 00
3.00	OPERATING ROOM	50.00	O	15, 729		3.00
4.00	ANESTHESI OLOGY	53.00	o	8		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	o	1, 381		5. 00
6.00	RESPIRATORY THERAPY	65.00	o	958		6. 00
7.00	PHYSI CAL THERAPY	66.00	o	95		7. 00
8.00	DRUGS CHARGED TO PATIENTS	73. 00	o	713		8. 00
9.00	ONCOLOGY	73. 01	0	58		9. 00
10.00	EMERGENCY	91.00	0	856		10.00
	0			21, 230	 	
	M - RHC DOC RECLASS					
1.00	RURAL HEALTH CLINIC III	88. 02	28, 119	0	 <u> </u>	1.00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3.00
	TOTALS		28, 119	0		
500.00	Grand Total: Increases		250, 192	1, 002, 898		500.00

						10 12/31/2010	5/17/2017 9:57 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	D - CLINIC RECLASS						
1.00	RURAL HEALTH CLINIC	88. 00	0	111, 864	10)	1. 00
2.00	RURAL HEALTH CLINIC II	88. 01	O	90, 243	C		2.00
3.00	RURAL HEALTH CLINIC III	88. 02	O	37, 945	C		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	O	122, 332	. c		4.00
				362, 384			
	E - PHYS PRACT LABOR DIST	·	,			'	
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	25, 520) (1.00
	0			25, 520			
	F - CAFETERIA RECLASS						
1.00	DI ETARY	10.00	222, 073	288, 511	C		1.00
	0		222, 073	288, 511		1	
	G - EMPLOYEE PROMOTIONS		222,070	200, 011			
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17, 916	C		1.00
1.00	O O O O O O O O O O O O O O O O O O O		— —	17, 916		4	1.00
	H - INSURANCE RECLASS		<u> </u>	17, 710	II.		
1.00	ADMINISTRATIVE & GENERAL	5. 00	ol	129, 068	12		1.00
1.00	O GENERAL		— — — —	129, 068		-	1.00
	J - PPO DEPRECIATION		U	129, 000	1		
1 00	RURAL HEALTH CLINIC	88. 00	٥	1, 891		\	1.00
1.00	RURAL HEALTH CLINIC	88. 00 88. 01	0	3, 014			1.00
2.00			-			1	2.00
3.00	RURAL HEALTH CLINIC III	88. 02	0	1, 205			3.00
4. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00				<u>)</u>	4.00
	U LANDI ANTARI E DEVI OEC		0	8, 077			
4 00	K - IMPLANTABLE DEVICES	50.00	ما	450,400		N.	1.00
1.00	OPERATING ROOM	<u>50.</u> 00	0	150, 192		<u>)</u>	1.00
	O DEPOSITOR OF STANCE		ō	150, 192			
	L - MED SUPPLY RECLASS				_		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	21, 230	C)	1.00
	PATI ENTS						
2.00		0.00	0	0			2.00
3. 00		0. 00	0	0	C	1	3.00
4.00		0.00	0	0	C)	4.00
5. 00		0.00	0	0)	5. 00
6.00		0. 00	0	0	C)	6. 00
7.00		0.00	0	0	C)	7. 00
8.00		0.00	0	0		1	8. 00
9.00		0.00	0	0	C)	9. 00
10.00		0.00	0	0)	10.00
	0		0	21, 230			
	M - RHC DOC RECLASS						
1.00	RURAL HEALTH CLINIC	88. 00	9, 030	0	C)	1.00
2.00	RURAL HEALTH CLINIC II	88. 01	8, 474	0	C)	2.00
3.00	PHYSICIANS' PRIVATE OFFICES	192.00	10, 615	0	O C		3.00
	TOTALS		28, 119				
500 00	Grand Total: Decreases		250, 192	1, 002, 898			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS PUTNAM COUNTY HOSPITAL

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 01/01/2016 Part I Provider CCN: 15-1333

				Ť	o 12/31/2016	Date/Time Pre 5/17/2017 9:5	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	159, 364	0	C	0	0	1. 00
2.00	Land Improvements	298, 404	31, 440	C	31, 440	0	2. 00
3.00	Buildings and Fixtures	29, 076, 778	1, 874, 257	C	1, 874, 257	0	3. 00
4.00	Building Improvements	0	0	C	0	0	4. 00
5.00	Fixed Equipment	0	0	C	0	0	5. 00
6.00	Movable Equipment	21, 280, 016	626, 534	C	626, 534	0	6. 00
7.00	HIT designated Assets	0	0	C	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	50, 814, 562	2, 532, 231	C	2, 532, 231	0	8. 00
9.00	Reconciling Items	0	0	C	0	0	9. 00
10.00	Total (line 8 minus line 9)	50, 814, 562	2, 532, 231	C	2, 532, 231	0	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART 1 ANALYSIS OF SUANOFS IN SARITAL ASSE	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		0				1 4 00
1.00	Land	159, 364	0				1.00
2.00	Land Improvements	329, 844	0				2.00
3.00	Buildings and Fixtures	30, 951, 035	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fi xed Equipment	0	0				5. 00
6.00	Movable Equipment	21, 906, 550	0				6. 00
7.00	HIT designated Assets	50.04/ 700	0				7. 00
8.00	Subtotal (sum of lines 1-7)	53, 346, 793	0				8. 00
9.00	Reconciling Items	50.04/ 700	0				9.00
10. 00	Total (line 8 minus line 9)	53, 346, 793	0				10. 00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-1333	Peri od:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		nared·
					10 12/31/2010	5/17/2017 9:5	7 am
			SL	JMMARY OF CAP	I TAL		
	Cook Cooker December 1	D	1	1		T (
	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	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 749, 936	0		0 0	0	1. 00
3.00	Total (sum of lines 1-2)	2, 749, 936	0		0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
	Cost Conton Decemintion	Othor	Total (1) (oum				
	Cost Center Description	Other Capi tal -Rel ate	Total (1) (sum of cols. 9				
		d Costs (see	through 14)				
		instructions)	till ough 11)				
		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 & FIXT	0	2, 749, 936				1. 00
3.00	Total (sum of lines 1-2)	0	2, 749, 936				3. 00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider Co		Period: From 01/01/2016 Fo 12/31/2016		oared:
		COME	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	/ dili
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col	Ratio (see instructions)	Insurance	
		1, 00	2.00	2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		2.00	0.00		0.00	
1.00	NEW CAP REL COSTS-BLDG & FLXT	30, 951, 035	0	30, 951, 03	1. 000000	0	1. 00
3.00	Total (sum of lines 1-2)	30, 951, 035	0	30, 951, 03	1. 000000	o	3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		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	INIEKS	0		2, 432, 957	337, 605	1. 00
3. 00	Total (sum of lines 1-2)	0	0		2, 432, 957		3. 00
0.00	10141 (3411 01 111103 1 2)	<u> </u>	SI	JMMARY OF CAPI		007,000	0.00
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		44.00	10.00	10.00	instructions)	45.00	
	DADT III DECONCILIATION OF CADITAL COCTE OF	11. 00	12.00	13.00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CENEW CAP REL COSTS-BLDG & FIXT	-75, 259	120.040			2 024 271	1. 00
3.00	Total (sum of lines 1-2)	- 75, 259 - 75, 259			0 0	2, 824, 371 2, 824, 371	3. 00
3.00	Total (Suil Of Titles 1-2)	-75,259	129,000	l '	기	2,024,3/1	3.00

| Period: | Worksheet A-8 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 15-1333

				To	12/31/2016	Date/Time Prep 5/17/2017 9:57	
				Expense Classification on		371772017 4.3	/ aiii
				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 & FIXT (chapter	1		FLXT			
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)						
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6.00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter				2.23		
8. 00	21) Television and radio service		0		0. 00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician	A-8-2	-2, 678, 434		0.00	o	10. 00
11. 00	adjustment Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
	transactions (chapter 10)	A-0-1	O				
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 patients						
17. 00	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
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)		O			Ŭ	
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty						
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	RESPIRATORY 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	-690	PHYSI CAL THERAPY	66. 00		24. 00
05.00	limitation (chapter 14)			LITELL ZATLON, DEVILEN, ONE	444.00		05.00
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 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	Ö	OCCUPATI ONAL THERAPY	67. 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	0	32. 00
33. 00	Depreciation and Interest DISCOUNTS	В	-1, 991	ADMINISTRATIVE & GENERAL	5. 00	О	33. 00
					<u> </u>	<u> </u>	

Provider CCN: 15-1333 Peri od: Worksheet A-8 From 01/01/2016
To 12/31/2016 Date/Time Prepared:

) 12/31/2016	5/17/2017 9:5	
				Expense Classification on	Worksheet A	371772017 9.3	/ aiii
				To/From Which the Amount is			
				Top I Tom III of the Fill of t	to bo haj dotod		
	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	-14. 954	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	PHARMACY REBATE	В		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	MEDICAL RECORDS FEES	В	· ·	MEDICAL RECORDS & LIBRARY	16. 00	Ö	33. 04
33. 05	CAFETERI A SALES	В		CAFETERI A	11. 00	0	33. 05
33. 06	MISC REVENUE - CBO	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33. 00	PHARMACY MISC REV	В		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 00
	PHARMACY WISC REV	В	-1, 101	DRUGS CHARGED TO PATTENTS		-	
33. 08	•		0		0.00	0	33. 08
33. 09			0		0.00	0	33. 09
33. 10			0		0.00	0	33. 10
33. 11	OTHER MISC INCOME	В	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
33. 12	NON-ALLOWABLE INTEREST EXP	A	-73, 990	NEW CAP REL COSTS-BLDG &	1.00	11	33. 12
				FLXT			
33. 13	INVESTMENT INCOME	В	-1, 269	NEW CAP REL COSTS-BLDG &	1.00	11	33. 13
				FIXT			
33. 14	LOBBYING OFFSET	A	-656	ADMINISTRATIVE & GENERAL	5.00	o	33. 14
33. 15	ADVERTISING OFFSET	l A		ADMINISTRATIVE & GENERAL	5.00	0	33. 15
33. 16	ADVERTISING OFFSET	l A		ONCOLOGY	73. 01	0	33, 16
33. 17	ADVERTISING OFFSET	A		RURAL HEALTH CLINIC II	88. 01	0	33. 17
33. 18	COMMUNITY RELATIONS OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	Ö	33. 18
33. 19	COMMUNITY RELATIONS OFFSET	A	· ·	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 19
33. 20	TELEPHONE WAGES	Ä		ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 20	TELEPHONE BENEFITS	1		EMPLOYEE BENEFITS DEPARTMENT		ĭ	33. 20
	II	A		l e e e e e e e e e e e e e e e e e e e	4.00	0	
33. 22	TELEPHONE OTHER	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 23	TELEPHONE OFFSET	A	· ·	OPERATION OF PLANT	7. 00	0	33. 23
33. 24	PHYSICIAN RECRUITMENT	A	-19, 675	ADMINISTRATIVE & GENERAL	5. 00	0	33. 24
33. 25			0		0. 00	0	33. 25
33. 26	HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 26
33. 27	EHR DEPRECIATION	A	-325, 056	NEW CAP REL COSTS-BLDG &	1.00	9	33. 27
				FLXT			
33. 28	WATERS BANK FEE OFFSET	A	-240	ADMINISTRATIVE & GENERAL	5.00	0	33. 28
33. 29			0		0.00	0	33. 29
33. 30			0		0.00	o	33. 30
33. 31	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 31
	(3)						
33. 32	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 32
	(3)		_				
33. 33	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 33
55. 55	(3)		0		0.00		55.55
33. 34	OTHER ADJUSTMENTS (SPECIFY)		^		0.00	0	33. 34
33. 34	(3)		U		0.00	١	33.34
33. 35	OTHER ADJUSTMENTS (SPECIFY)		^		0.00	0	33. 35
აა. აა	(3)		Ü		0.00	l "	33. 33
50. 00	` ,		1 004 (12				50. 00
ou. 00	TOTAL (sum of lines 1 thru 49)		-4, 086, 613				30.00
	(Transfer to Worksheet A,						
(4)	column 6, line 200.)						

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

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

B. Amount Received - if cost cannot be determined.

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

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

Provider CCN: 15-1333

					'	0 12/31/2010	5/17/2017 9:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
				·	·		Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00		EMERGENCY	2, 269, 445	1, 928, 251	341, 194	0	0	1. 00
2.00	60.00	LABORATORY	24, 637	0	24, 637	0	0	2. 00
3.00	73. 01	ONCOLOGY	265, 018	265, 018	0	0	0	3. 00
4.00	53. 00	ANESTHESI OLOGY	596, 109	485, 165	110, 943	0	0	4. 00
5.00	0. 00		0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	l o	0	0	l 0	10.00
200.00			3, 155, 209	2, 678, 434	476, 774		0	1
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier		Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Continuing	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8.00	9. 00	12. 00	13. 00	14. 00	
1.00	91. 00	EMERGENCY	0	0	0	0	0	1. 00
2.00	60.00	LABORATORY	0	0	0	0	0	2. 00
3.00		ONCOLOGY	0	0	0	0	0	1
4.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	4. 00
5.00	0. 00		0	0	0	0	0	5. 00
6.00	0. 00		0	0	0	0	0	6. 00
7.00	0. 00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14			_		
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		EMERGENCY	0		_	1, 928, 251		1. 00
2.00		LABORATORY	0		0	0		2. 00
3.00		ONCOLOGY	0	0	0	265, 018		3. 00
4.00		ANESTHESI OLOGY	0	0	0	485, 165		4. 00
5.00	0. 00		0	0	0	0		5. 00
6. 00	0. 00		0	0	0	0		6. 00
7. 00	0. 00		0	0	0	0		7. 00
8. 00	0. 00		0	0	0	0		8. 00
9. 00	0. 00		0	0	0	0		9. 00
10. 00	0. 00		0	0	0	0		10. 00
200.00			0	0	0	2, 678, 434		200. 00

Financial Systems		_	I. 15 1222			
	FURNI SHED BY	Provider CC	N: 15-1333		Parts I-VI Date/Time Prep	pared:
				Physical Therapy	Cost	
					1 00	
PART I - GENERAL INFORMATION					1.00	
Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis	sor or therapist	was on provid			52 780 288	2. 00 3. 00
		n provider sit	e but neitn	er supervisor	265	4.0
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						
					0.00	7.00
Optional travel expense rate per mile					0.00	
	Supervi sors	Therapi sts			Trai nees	
Total hours worked						9.00
	0. 00	80. 10			0.00	
one-half of column 2, line 10; column 3, one-half of column 3, line 10)	40. 05	40. 05	30.	04		11. 00
	0	0		0		12. 0
` ′	- 1					12. 0°
	0	Ö		0		13. 0
					1.00	
Part II - SALARY FOULVALENCY COMPUTATION					1.00	
	line 10)				0	14.00
					240, 540	
		atory therapy	or lines 14	-16 for all	194, 326 434, 866	
					0	18.00
		nerany or line	s 17 and 18	for all others)		19. 00 20. 00
If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than	therapy or colu line 2, make no	umns 1-3 for p	hysical the	rapy, speech path	ol ogy or	20.0
		divided by sum	of columns	1 and 2, line 9	0.00	21. 0
for respiratory therapy or columns 1 thru 3,	line 9 for all	others)				
	ees (line 2 times	s line 21)			0 434 866	
, , , , , , , , , , , , , , , , , , ,	ANCE AND TRAVEL	EXPENSE COMPU	TATION - PR	OVIDER SITE	434, 000	23.0
						24. 00 25. 00
	sum of lines 24	and 25 for al	l others)		19, 495	
Standard travel expense (line 7 times line 3				3 and 4 for all	0	27. 00
	travel expense	at the provide	r site (sum	of lines 26 and	19, 495	28. 0
		0 11 17 1				
		2, Tine 12)				29. 00 30. 00
,	,	and 30 for al	l others)		Ö	31. 0
Optional travel expense (line 8 times columns				y or sum of	0	32. 0
	ovnonco (Lino	20)			10 405	22 0
			31)		19, 495	33.00
Optional travel allowance and optional travel	expense (sum o	flines 31 and	32)		0	
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	NCE AND TRAVEL E	EXPENSE COMPUT	ATION - SER	VICES OUTSIDE PRO	VI DER SI TE	1
Ctdd Td F						
Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36. 0
	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week Number of unduplicated days in which therapy nor therapist was on provider site (see instrumber of unduplicated offsite visits - super Number of unduplicated offsite visits - super Number of unduplicated offsite visits - therapsistant and on which supervisor and/or theinstructions) Standard travel expense rate optional travel expense rate per mile Total hours worked AHSEA (see instructions) Standard travel expense rate per mile Total hours worked AHSEA (see instructions) Standard travel expense rate per mile Total hours worked allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10) Number of travel hours (offsite) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (offsite) Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 3, Subtotal allowance amount (sum of lines 14 arothers) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li 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 than the amount from line 20. Otherwise complete Weighted average rate excluding aides and trained for respiratory therapy or columns 1 thrus, Weighted allowance excluding aides and trained travel allowance excluding aides and trained travel standard travel expense (line 7 times line 3 others) Total standard travel allowance Therapists (line 3 times column 2, line 11) Assistants (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard travel optional travel allowanc	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) (see instruction 1 multiplied by 15 hours per week Number of unduplicated days in which therapy assistant was on nor therapist was on provider site (see instructions) Number of unduplicated days in which therapy assistant was on nor therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or therapist was not provider site (see instructions) Number of unduplicated offsite visits - therapy assistants (in assistant and on which supervisor and/or therapist was not prinstructions) Standard travel expense rate Optional travel expense rate per mile Total hours worked	ABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY E SUPPLIERS PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) (see instructions) Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervisor or therapist was on provid Number of unduplicated days in which supervisors or therapists was on provider sit on the supervisor and/or therapy assistant was on provider sit (see instructions) Number of unduplicated offsite visits - supervisors or therapists (see instructions) Number of unduplicated offsite visits - supervisors or therapists (see instructions) Standard travel expense rate Optional travel expense rate per mile Supervisors Total hours worked AUSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 3, line 10) Number of travel hours (provider site) Number of travel hours (provider site) Number of travel hours (provider site) Number of firavel hours (provider site) Number of miles driven (provider site) Number of miles driven (provider site) Number of miles driven (offsite) Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 2, line 9 times column 1, line 10) Therapists (column 4, line 9 times column 1, line 10) Therapists (column 4, line 9 times column 1, line 10) Trainees (column 5, line 9 times column 1, line 10) Trainees (column 4, line 9 times column 5, line 10) Subtotal allowance amount (sum of lines 17-19 for respiratory therapy or line fit he sum of columns 1 and 2 for respiratory therapy or columns 1-3 for p occupational therapy, line 9, is greater than line 2, make no entries on it the amount from line 20. Otherwise complete lines 21-23. Meighted average rate excluding aides and trainees (line 17 divided by sum for respiratory therapy or columns 1 and 2 for respiratory therapy or columns 1-3 for p occupational therapy, line 9, is greater than line 2, make no entries on it he amount from line 20. Otherwise complete lines 21-23. Meighted average rate excluding aides and trainees (line 17 divided by	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aides) (see instructions) Line 1 multiplied by 15 hours per week Number of unduplicated days in which therapy assistant was on provider site (see Number of unduplicated days in which therapy assistant was on provider site but neith nor therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or therapists (see instructions) Number of unduplicated offsite visits - supervisors or therapists (see instructions) Number of unduplicated offsite visits - therapy assistants (include only visits made assistant and on which supervisor and/or therapist was not present during the visit(s Instructions) Standard travel expense rate Optional travel expense rate per mile Supervisors Therapists Assistants 1.00 2.00 3.00 .00 3.003 Arista (see instructions) Total hours worked Arista (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 2, line 10; column 3, one-half of column 2, line 10; Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site) Number of miles driven (provider site) Number of miles driven (offsite) Number of miles driven (offsite) Part II - SALARY EQUIVALENCY COMPUTATION Subtotal allowance amount (sum of lines 17-4 and 15 for respiratory therapy or lines 14 others) Addes (column 5, line 9 times column 3, line 10) Total allowance amount (sum of lines 17-4 and 15 for respiratory therapy or lines 17 and 18 If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical the occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and the amount from line 20. Otherwise couplete lines 21-23. Weighted average rate excluding aides and trainees (line 17 divided by sum of columns for respiratory therapy or columns 1-10. Total allowance excluding aides and trainees (line 17 divided by sum of columns for respiratory therapy or columns 1-10. Tota	ABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY Provider CCN: 15-1333 Promotive SUPPLIERS E SUPPLIERS PART I - GENERAL INFORMATION Total number of weeks worked (excluding aldes) (see instructions) Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervisor or therapist was on provider site (see instructions) Number of unduplicated days in which supervisors or therapist was on provider site (see instructions) Number of unduplicated offsite visits - supervisors or therapists (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 Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy Instructions) Standard travel expense rate Optional travel expense rate per mile Supervisors Therapists Assistants Aldes 1.00 2.00 3.00.30 0.3, 238.00 0.00 AINSEA (see instructions) Standard travel allowance (columns 1 and 2, 40.05 40.05 30.04 0.00 AINSEA (see instructions) Total hours worked 0.00 3.00.30 0.3, 238.00 0.00 Number of inles driven (orfsite) O 0 0 0 0 Number of travel hours (offsite) Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 2, line 10) Tranes (column 2, line 9 times column 3, line 10) Tranes (column 4, line 9 times column 4, line 10) Tranes (column 5, line 9 times column 4, line 10) Tranes (column 5, line 9 times column 4, line 10) Tranes (column 5, line 9 times column 4, line 10) Tranes (column 5, line 9 times column 1, line 10) Tranes (column 6, line 9 times column 1, line 10) Tranes (column 6, line 9 times column 1, line 10) Tranes (column	### ARLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY ESUPPLIERS Provider CCK: 15-1333

29.00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0	29. 00
30.00	Assistants (column 3, line 10 times column 3, line 12)	0	30. 00
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31. 00
32.00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	0	32. 00
	columns 1-3, line 13 for all others)		
33.00	Standard travel allowance and standard travel expense (line 28)	19, 495	33. 00
34.00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
35.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PRO	OVI DER SITE	
	Standard Travel Expense		
36.00	Therapists (line 5 times column 2, line 11)	0	36. 00
37.00	Assistants (line 6 times column 3, line 11)	0	37. 00
38.00	Subtotal (sum of lines 36 and 37)	0	38. 00
39.00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39. 00
	Optional Travel Allowance and Optional Travel Expense		
40.00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40. 00
41.00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41. 00
42.00	Subtotal (sum of lines 40 and 41)	0	42.00
43.00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line	es 44, 45,	
	or 46, as appropriate.		l
44.00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44. 00
45.00	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	0	45. 00
MCRI F3	2 - 10. 5. 160. 1		

Heal th	Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der CO		Period: From 01/01/2016 To 12/31/2016		pared:
					Physical Therapy		
						1. 00	
46. 00	Optional travel allowance and optional travel	expense (sum o	of lines 42 an	d 43 - see in	structions)		46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
		1.00	2. 00	3. 00	4. 00	5. 00	
47.00	PART V - OVERTIME COMPUTATION	0.00	0.00	0.0	0.00	0.00	47.00
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0.00	0.0	0.00	0.00	47. 00
48. 00	Overtime rate (see instructions)	0. 00	0.00	0.0	0. 00		48. 00
49. 00	Total overtime (including base and overtime	0.00	0.00			l e	49. 00
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT				_		
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0.00	0.00	50. 00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0.0	0.00	0.00	51. 00
52. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	80. 10	60. 07	0.0	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 respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56. 00
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	es (from lines your records)	44, 45, or 46)		434, 866 19, 495 0 0 0 0 454, 361 455, 051 690	59. 00 60. 00 61. 00 62. 00 63. 00
100.01	00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 00.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 00.02 Line 33 = line 28 = sum of lines 26 and 27						
101.01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				ımns 1-3, line		102. 00 102. 01
102. 02	13 for all others Line 35 = sum of lines 31 and 32					0	102. 02

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CCN:		Period: From 01/01/2016 To 12/31/2016	Worksheet A-8 Parts I-VI Date/Time Pre 5/17/2017 9:5	pared:
					Occupati onal Therapy	Cost	, aiii
						1. 00	
	PART I - GENERAL INFORMATION					1. 00	
. 00 . 00 . 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervis Number of unduplicated days in which therapy	sor or therapist assistant was or	was on provide	•	,	52 780 235 0	2. 0 3. 0
. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - super Number of unduplicated offsite visits - thera assistant and on which supervisor and/or ther instructions)	rvisors or therap apy assistants (i	nclude only vi	sits made b		0	5. (6. (
. 00	Standard travel expense rate					0.00	
. 00	Optional travel expense rate per mile	Supervi sors	Therapists	Assi stants	Ai des	0.00 Trai nees	8. 0
		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 37. 97	1, 476. 00 75. 93 37. 97	0. 0 0. 0 0. 0	0.00	0. 00 0. 00	9. 0 10. 0 11. 0
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		12. C 12. C 13. C
			·			1 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1. 00	
4. 00	Supervisors (column 1, line 9 times column 1,						14. (
	Therapists (column 2, line 9 times column 2,					112, 073	
	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 am		atory therapy o	r lines 14-	16 for all	0 112, 073	
	others)					_	
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, li					0	
0. 00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 112,073 If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23						
1. 00	the amount from line 20. Otherwise complete Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,	ainees (line 17 d		of columns	1 and 2, line 9	0.00	21. (
	Weighted allowance excluding aides and traine					0	
3. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPUTA	ATION - PRO	VIDER SLTE	112, 073	23. (
	Standard Travel Allowance	7110 110112	EXI ENGE COM OT		TIDEN OITE		
	Therapists (line 3 times column 2, line 11)					8, 923	
	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for all	others)		0 8, 923	
	Standard travel expense (line 7 times line 3				and 4 for all	0	1
8. 00	others) Total standard travel allowance and standard	travel expense a	at the provider	site (sum	of lines 26 and	8, 923	28. (
	27) Optional Travel Allowance and Optional Travel	Expense					
	Therapists (column 2, line 10 times the sum of		2, line 12)			0	
	Assistants (column 3, line 10 times column 3,		and 20 for all	others)		0	
	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns				or sum of	0	32.
2 00	columns 1-3, line 13 for all others)		20)			0.000	22.
	Standard travel allowance and standard travel Optional travel allowance and standard travel			31)		8, 923 0	33. (
	Optional travel allowance and optional travel					0	1
3. UU	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				ICES OUTSIDE PRO	OVI DER SITE	
3.00	Standard Travel Expense					0	36.
	Therapists (Time 5 times corumn 2, Time 11)					0	37.
6. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)						38.
6. 00 7. 00 8. 00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)					0	1
6. 00 7. 00 8. 00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum		6)			0	1
6. 00 7. 00 8. 00 9. 00	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	Expense				0	39.
66. 00 77. 00 88. 00 99. 00	Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum	Expense O1 times column 2					39. (40. (
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00	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 Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	Expense 01 times column 2 n 3, line 10)	2, line 10)			0 0 0	40. (41. (42. (
6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00	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 Therapists (sum of columns 1 and 2, line 12.0 Assistants (column 3, line 12.01 times column	Expense Of times column 2 of 3, line 10) of columns 1-3,	2, line 10)	of the City		0 0 0	39. 40. 41. 42.

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provider Co		Peri od: From 01/01/2016 To 12/31/2016	Worksheet A-8 Parts I-VI Date/Time Pre 5/17/2017 9:5	pared:	
					Occupati onal Therapy	Cost		
						1. 00		
45. 00	Optional travel allowance and standard travel					0		
46. 00	Optional travel allowance and optional travel		of lines 42 an				46. 00	
		Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4. 00	Total 5. 00		
	PART V - OVERTIME COMPUTATION							
7. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0. 00	O. C	0.00	0.00	47.00	
8. 00	Overtime rate (see instructions)	0. 00	0.00				48. 00	
9. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0.00	0.0	0.00		49. 00	
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0. 00	0.0	0.00	0.00	50. 00	
1. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0.00	0.00	51.00	
2. 00	DETERMINATION OF OVERTIME ALLOWANCE Adjusted hourly salary equivalency amount	75. 93	0.00	0.0	0.00		52. OC	
3. 00	(see instructions) Overtime cost limitation (line 51 times line	73. 73	0.00		0 0		53. 00	
4. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00	
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00	
6. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56.00	
	respiratory therapy and columns 1 through 3 for all others.)							
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND FYCESS COST	AD HISTMENT			1. 00		
7. 00	Salary equivalency amount (from line 23)	IND EXCESS COST	ADSOSTMENT			112, 073	57.00	
8. 00	Travel allowance and expense - provider site					8, 923	58. 00	
9. 00 0. 00	Travel allowance and expense - Offsite service Overtime allowance (from column 5, line 56)	es (from lines	44, 45, or 46)		0	59. 00 60. 00	
	Equipment cost (see instructions)					0		
	Supplies (see instructions)					0		
3. 00	Total allowance (sum of lines 57-62)					120, 996		
4. 00	Total cost of outside supplier services (from	,				92, 833 0	1	
5.00	.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero) LINE 33 CALCULATION							
00.00	Line 26 = line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	II others		8, 923	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 su	m of lines 3 a	ind 4 for all	others		100. 01 100. 02	
	Line 27 = line 7 times line 3 for respiratory				others		101.00	
01. 02	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION						101. 01 101. 02	
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line 13 for all others				ımns 1-3, line		102. 00 102. 01	
	Line 35 = sum of lines 31 and 32						102. 02	

Hoal th	Financial Systems	PUTNAM COUNTY F	INT ID201	In Lie	u of Form CMS-2	2552 10	
REASON	REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS Provider CCN: 15-1333 Period: From 01/01/2016 To 12/31/2016						
				Speech Pathology	Cost		
					1. 00		
	PART I - GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aide	es) (see instructio	ons)		52	1. 00	
2.00	Line 1 multiplied by 15 hours per week				780	2. 00	
3.00	3.00 Number of unduplicated days in which supervisor or therapist was on provider site (see instructions)						
4. 00							

8.00	Optional travel expense rate per mile					0.00	8.00
		Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	
		1.00	2.00	3. 00	4. 00	5. 00	
9.00	Total hours worked	0.00	954.00	0.00	0.00	0.00	9. 00
10.00	AHSEA (see instructions)	0.00	72. 98	0.00	0.00	0.00	10.00
11. 00	Standard travel allowance (columns 1 and 2,	36. 49	36. 49	0.00			11.00
	one-half of column 2, line 10; column 3,						
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0	0			12.00
12. 01	Number of travel hours (offsite)	0	0	0			12.01
13.00	Number of miles driven (provider site)	o	0	0			13.00
13. 01	Number of miles driven (offsite)	o	0	0			13.01
	<u> </u>						

0.00

7.00

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

		1. 00				
	Part II - SALARY EQUIVALENCY COMPUTATION					
14.00	Supervisors (column 1, line 9 times column 1, line 10)	0	14. 00			
15.00	Therapists (column 2, line 9 times column 2, line 10)	69, 623	15. 00			
16.00	Assistants (column 3, line 9 times column 3, line10)	0	16. 00			
17.00	Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all	69, 623	17. 00			
	others)	·				
18.00	Aides (column 4, line 9 times column 4, line 10)	0	18. 00			
19.00	Trainees (column 5, line 9 times column 5, line 10)	0	19. 00			
20.00	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)	69, 623	20. 00			
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or					
	occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on line 23					
	the amount from line 20. Otherwise complete lines 21-23.					
21.00	Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9	0. 00	21. 00			
	for respiratory therapy or columns 1 thru 3, line 9 for all others)					
22. 00	Weighted allowance excluding aides and trainees (line 2 times line 21)	0	22. 00 23. 00			
23.00	Total salary equivalency (see instructions)					
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - PROVIDER SITE					
	Standard Travel Allowance					
24. 00	Therapists (line 3 times column 2, line 11)	7, 444				
25. 00	Assistants (line 4 times column 3, line 11)	0	25. 00			
26. 00	Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	7, 444				
27. 00	Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all	0	27. 00			
	others)					
28. 00	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and	7, 444	28. 00			
	27)					
00.00	Optional Travel Allowance and Optional Travel Expense	0	00.00			
29. 00	Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)	0				
30.00	Assistants (column 3, line 10 times column 3, line 12)	0				
31.00	Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	0 00			
32. 00	Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	0	32. 00			
22 00	columns 1-3, line 13 for all others)	7, 444	33. 00			
33. 00	Standard travel allowance and standard travel expense (line 28)	· ·				
34. 00 35. 00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0				
33.00	Optional travel allowance and optional travel expense (sum of lines 31 and 32) Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROVIDER SITE					
	Standard Travel Expense	WIDER SITE				
36. 00	Therapists (line 5 times column 2, line 11)	0	36. 00			
37. 00	Assistants (line 6 times column 3, line 11)	0				
38. 00	Subtotal (sum of lines 36 and 37)	0	38.00			
39. 00	Standard travel expense (line 7 times the sum of lines 5 and 6)	0				
37.00	Optional Travel Allowance and Optional Travel Expense	U	37.00			
40. 00	Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00			
41. 00	Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00			
42. 00	Subtotal (sum of lines 40 and 41)	0	42.00			
43. 00	Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0				
+3.00	Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45,					
	or 46, as appropriate.					
44. 00	Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)	0	44. 00			
	Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)	Ö				
10.00	population of arts. directions and standard traver expenses (sum of 177165 of and 12 366 first detrois)	١	10.00			

5.00 6.00

7.00

instructions)

Standard travel expense rate

	E SUPPLI ERS		Provi der CC		Period: From 01/01/2016 To 12/31/2016 Speech Pathology	Date/Time Prep 5/17/2017 9:5	pare
					ppeech l'athorogy		
-00			6.11. 40	1 40		1. 00	1.
. 00	Optional travel allowance and optional travel						46
		Therapists 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4. 00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
	Overtime hours worked during reporting	0. 00	0.00	0.0	0.00	0.00	47
	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)						
	Overtime rate (see instructions)	0. 00	0.00	0. 0			48
	Total overtime (including base and overtime	0. 00	0.00	0. 0	0.00		49
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT		1				L
00	Percentage of overtime hours by category	0. 00	0. 00	0. 0	0.00	0. 00	50
	(divide the hours in each column on line 47						
	by the total overtime worked - column 5, line 47)						
	Allocation of provider's standard work year	0. 00	0.00	0.0	0.00	0.00	51
00	for one full-time employee times the	0.00	0.00	0.0	0.00	0.00	٦
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE						
	Adjusted hourly salary equivalency amount	72. 98	0.00	0.0	0.00		52
	(see instructions)		5. 55				
00	Overtime cost limitation (line 51 times line	o	0		0		53
	52)						
00	Maximum overtime cost (enter the Lesser of	0	0		0		54
	line 49 or line 53)						
	Portion of overtime already included in	0	0		0		55
	hourly computation at the AHSEA (multiply						
00	line 47 times line 52)		0		0	0	<u>ا</u> ۔ ا
00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	٩	0		U U	ا	56
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
	Tot all others.						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
00	Salary equivalency amount (from line 23)					69, 623	5
	Travel allowance and expense - provider site					7, 444	5
	Travel allowance and expense - Offsite service	ces (from lines	44, 45, or 46))		0	
	Overtime allowance (from column 5, line 56)					0	
	Equipment cost (see instructions)					0	
	Supplies (see instructions)					0	
- 1	Total allowance (sum of lines 57-62)					77, 067	
- 1	Total cost of outside supplier services (from	-				55, 481	
	Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			0	6
	LINE 33 CALCULATION	6.1.	1.05.6			7.444	1
	Line 26 = line 24 for respiratory therapy or				- 41	7, 444	
1	Line 27 = line 7 times line 3 for respiratory	rinerapy or sum	i oi iines 3 ai	10 4 101 all	others	7, 444	100
- 1	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					7, 444	1100
	Line 27 = line 7 times line 3 for respiratory	thorany or sum	of lines 2 ar	ad 4 for all	othors		101
1	Line 31 = line 29 for respiratory therapy or				Julier 2		10
	Line 34 = sum of lines 27 and 31	Sum of Titles 27	and 50 ron an	others			10
	LINE 34 = Sum Of Titles 27 and 31					U	1'0
	Line 31 = line 29 for respiratory therapy or	sum of lines 20	and 30 for al	Lothers		0	102
	Line 32 = line 8 times columns 1 and 2, line	13 for resnirat	ory therany or	ר פווש חל כחלייי	mns 1₋3 lin≏ ∣	l Oi	10

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1333

					Т	o 12/31/2016	Date/Time Pre 5/17/2017 9:5	
		Cost Center Description	Net Expenses for Cost Allocation	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	7 dill
			(from Wkst A col. 7)					
	1		0	1.00	4.00	4A	5. 00	
1. 00		AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT	2, 824, 371	2, 824, 371				1. 00
4. 00	00400	EMPLOYEE BENEFITS DEPARTMENT	4, 270, 439					4. 00
5.00	1	ADMINISTRATIVE & GENERAL	4, 179, 743				5, 150, 361	5. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	1, 298, 040 118, 345				278, 926 24, 874	7. 00 8. 00
9. 00	00900	HOUSEKEEPI NG	435, 478			541, 408	l	9. 00
10. 00 11. 00	1	DI ETARY CAFETERI A	213, 036 447, 481	98, 303 45, 664			57, 601 94, 554	10. 00 11. 00
13. 00		NURSING ADMINISTRATION	152, 927	18, 932			l	13.00
16. 00		MEDICAL RECORDS & LIBRARY	533, 546			739, 414	l	16. 00
17. 00 17. 01		SOCIAL SERVICE UTILIZATION REVIEW	79, 212	0 9, 480		0 106, 560	0 18, 318	17. 00 17. 01
17.01		IENT ROUTINE SERVICE COST CENTERS	17,212	7, 400	17,000	100, 300	10,310	17.01
30.00		ADULTS & PEDIATRICS	1, 076, 293				259, 199	30.00
31. 00 41. 00		INTENSIVE CARE UNIT SUBPROVIDER - IRF	775, 798 0	80, 880 0	1		179, 611 0	31. 00 41. 00
42. 00		SUBPROVI DER	0	0			0	42. 00
43. 00		NURSERY	0	0	C	0	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	1, 121, 813	244, 007	123, 371	1, 489, 191	255, 999	50. 00
51. 00	05100	RECOVERY ROOM	63, 773	65, 336			l	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0 171, 902	0		_	0 54, 322	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	1, 007, 617	86, 289	,		222, 697	54. 00
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	171, 861	3, 986		,	30, 229	54. 01
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	388, 416	37, 579 0	40, 556	466, 551	80, 202	57. 00 58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	0	Ö	0	Ö	59. 00
60.00		LABORATORY	2, 275, 415			2, 532, 969	1	•
60. 01 64. 00		BLOOD LABORATORY INTRAVENOUS THERAPY	0	0] 0	0	0	60. 01 64. 00
65.00	06500	RESPI RATORY THERAPY	439, 431	19, 928			93, 712	65. 00
66.00	1	PHYSI CAL THERAPY	533, 326	91, 528	i e		l	•
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	92, 917 55, 556	0		92, 917 55, 556	15, 973 9, 550	
69. 00	06900	ELECTROCARDI OLOGY	135, 474	2, 847		154, 795	26, 610	
69. 01 71. 00	1	CARDIAC REHAB MEDICAL SUPPLIES CHARGED TO PATIENTS	263, 495	23, 145 0	1	351, 211	60, 375 0	69. 01 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENT	150, 192	0		150, 192		•
73. 00	07300	DRUGS CHARGED TO PATIENTS	1, 419, 626					•
73. 01	OUTPA	ONCOLOGY TIENT SERVICE COST CENTERS	2, 959, 849	138, 273	75, 242	3, 173, 364	545, 517	73. 01
88. 00	08800	RURAL HEALTH CLINIC	1, 144, 014	151, 455				
88. 01 88. 02		RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III	1, 003, 776 538, 221	71, 030 36, 042			221, 115 118, 418	
89. 00	1	FEDERALLY QUALIFIED HEALTH CENTER	0 0	0 36,042			0	89. 00
90. 00	1	CLINIC	0	4, 612			793	
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	1, 896, 128	165, 290	682, 605	2, 744, 023 0		91. 00 92. 00
	OTHER	REIMBURSABLE COST CENTERS				-		
99. 10		CORF AL PURPOSE COST CENTERS	0	0	C	0	0	99. 10
109.00		PANCREAS ACQUISITION	0	0	C	0	0	109. 00
		INTESTINAL ACQUISITION	0	0	C	0		110. 00
	1	ISLET ACQUISITION INTEREST EXPENSE	0	0	C	0	0	111. 00 113. 00
		UTILIZATION REVIEW-SNF						114. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	32, 237, 511	2, 467, 997	3, 637, 020	31, 243, 362	4, 485, 516	118. 00
190.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 580	С	13, 580	2. 334	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	2, 868, 217	282, 981	636, 451	3, 787, 649	651, 112	192. 00
193. 00 193. 01		NONPALD WORKERS	5, 169	0	1, 324			193. 00 193. 01
		LACTATION CONSULTING		0		0		193. 01
		DI ABETI C COUNSELI NG	0	0	0	0		193. 03
		VACANT SPACE BOARD OF HEALTH	0	40, 084 19, 729		40, 084 19, 729	6, 891	194. 00 194. 01
		PUTNAM/HENRY PRENATAL	0	0				194. 02
			_		_		_	

Health Financial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CCN: 15-1333		Peri od: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Pro 5/17/2017 9:			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL		
	0	1.00	4.00	4A	5. 00		
200.00 Cross Foot Adjustments		0		0	l	200.00	
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	35, 110, 897	0 2, 824, 371	4, 274, 79	0 95 35, 110, 897		201.00	
202100 101112 (04111 111100 110 201)	0070707.7	2, 32 ., 37 .	., _, ., .	00,,	0, 100, 00.	1202.00	

Provider CCN: 15-1333

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2016	Part
To 12/31/2016	Date/Time Prepared:
5/17/2017 9:57 am	

			10	12/31/2016	5/17/2017 9:5	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	0.00	10.00	11 00	
GENERAL SERVICE COST CENTERS	7.00	8. 00	9. 00	10. 00	11. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FIXT			I			1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL					ļ	5. 00
7.00 00700 OPERATION OF PLANT	1, 901, 485				ļ	7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	16, 889	186, 462				8. 00
9. 00 00900 HOUSEKEEPI NG	15, 789	1, 046				9. 00
10. 00 01000 DI ETARY	86, 266	773		512, 014	400 440	10.00
11. 00 01100 CAFETERI A	40, 073	0		0	699, 668	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 16. 00 01600 MEDI CAL RECORDS & LI BRARY	16, 614 98, 733	0	6, 220 36, 965	U O	6, 729 32, 218	13. 00 16. 00
17. 00 01700 SOCIAL SERVICE	76, 733	0	30, 703	0	32, 210	17. 00
17. 01 01701 UTI LI ZATI ON REVI EW	8, 319	0	l "	o	0	17. 01
I NPATIENT ROUTINE SERVICE COST CENTERS				-'		
30. 00 03000 ADULTS & PEDI ATRI CS	148, 399	40, 563	55, 559	435, 657	75, 469	30. 00
31. 00 03100 I NTENSI VE CARE UNI T	70, 977	31, 323	26, 573	76, 357	46, 865	31. 00
41. 00 04100 SUBPROVI DER - RF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	U U	U	U	U _I	U	43. 00
50. 00 05000 OPERATING ROOM	214, 130	26, 429	80, 168	O	37, 782	50.00
51.00 05100 RECOVERY ROOM	57, 336	2, 908	21, 466	o	3, 971	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	o	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	7, 038	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	75, 724	13, 949		0	72, 616	54.00
54. 01 05401 NUCLEAR MEDICINE-DI AGNOSTI C	3, 498	0	1, 309	0	12 240	54. 01
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	32, 978	0	12, 346	0	12, 340 0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY	62, 707	0	23, 477	0	70, 642	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	ō	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	0	0	0	o	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	17, 488	0	6, 547	0	24, 015	65. 00
66. 00 06600 PHYSI CAL THERAPY	80, 321	5, 149	· ·	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	2 400	0	935	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	2, 498 20, 311	0	7, 604	0	4, 541 13, 791	69. 00 69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	20, 311	0	7,004	Ö	13, 771	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	Ō	ō	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	22, 385	0	8, 381	o	14, 457	73. 00
73. 01 07301 ONCOLOGY	121, 343	5, 994	45, 429	0	21, 185	73. 01
OUTPATIENT SERVICE COST CENTERS	100.040	4 474	40.7/0	ما	57,070	00.00
88.00 08800 RURAL HEALTH CLINIC 88.01 08801 RURAL HEALTH CLINIC II	132, 910 62, 333	4, 174	49, 760 0	0	57, 279 0	88. 00 88. 01
88. 02 08802 RURAL HEALTH CLINIC III	31, 629	0	0	0	0	88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	01,027	0	ő	ol	0	89. 00
90. 00 09000 CLI NI C	4, 047	0	1, 515	0	0	90.00
91. 00 09100 EMERGENCY	145, 052	45, 401	54, 306	0	95, 775	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF	0	0	0	ol	0	99. 10
SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	υ	0	77. 10
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	o	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	4 500 740	477 700	·	540.044	50/ 740	114. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	1, 588, 749	177, 709	547, 396	512, 014	596, 713]118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 917	0	4, 462	ol	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	248, 330	8, 753		0	102, 907	
193. 00 19300 NONPALD WORKERS	0	0,700	0	o		193. 00
193. 01 19301 DME	0	0	0	o	0	193. 01
193. 02 19302 LACTATION CONSULTING	0	0	0	o		193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	0	0	0		193. 03
194. 00 07950 VACANT SPACE	35, 176	0	0	O		194. 00
194.01 07951 BOARD OF HEALTH	17, 313	0	6, 482	O		194. 01 194. 02
194.02 07952 PUTNAM/HENRY PRENATAL 200.00 Cross Foot Adjustments		0		٥	0	194. 02 200. 00
201.00 Negative Cost Centers	n	0	n	n	n	200.00
202.00 TOTAL (sum lines 118-201)	1, 901, 485	186, 462	651, 314	512, 014		
	· •			'		-

Provider CCN: 15-1333

			1	0 12/31/2010	Date/lime Pre 5/17/2017 9:5	
Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	UTI LI ZATI ON	Subtotal	, dill
	ADMI NI STRATI ON	RECORDS &		REVI EW		
	13. 00	16. 00	17. 00	17. 01	24. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						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 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 01300 NURSI NG ADMI NI STRATI ON	251, 033					13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	1, 034, 439	1			16.00
17. 00 01700 SOCIAL SERVICE 17. 01 01701 UTILIZATION REVIEW		0	0	136, 312		17. 00 17. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>		,1	130, 312		17.01
30. 00 03000 ADULTS & PEDIATRICS	53, 133	577, 348	0	115, 984	3, 269, 112	30.00
31.00 03100 INTENSIVE CARE UNIT	32, 995	0	0	20, 328	1, 529, 858	31. 00
41. 00 04100 SUBPROVI DER - RF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	J U		<u> </u>	l U	0	43.00
50. 00 05000 OPERATI NG ROOM	26, 600	263, 349	0	0	2, 393, 648	50.00
51.00 05100 RECOVERY ROOM	2, 796	0	ō	· ·	256, 375	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	4, 955	0	0	0	382, 316	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	42, 520	0	0	0	1, 751, 319 210, 883	
57. 00 05700 CT SCAN	3, 616	0	0	0	608, 033	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0,010	Ö	o o	ő	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 06000 LABORATORY	0	0	0	0	3, 125, 225	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 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		0	686, 900 847, 811	1
67. 00 06700 OCCUPATI ONAL THERAPY		0		0	108, 890	
68. 00 06800 SPEECH PATHOLOGY	O	0	o o	o	65, 106	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	189, 379	69. 00
69. 01 06901 CARDI AC REHAB	9, 709	0	0	0	463, 001	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	176, 011 1, 778, 311	72.00
73. 00 07300 DROGS CHARGED TO PATTENTS 73. 01 07301 0NCOLOGY	14, 915	36, 307		· ·	3, 964, 054	
OUTPATIENT SERVICE COST CENTERS	14, 715	30, 307		<u> </u>	3, 704, 034	73.01
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	2, 050, 843	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	0	1, 569, 712	1
88. 02 08802 RURAL HEALTH CLINIC III	0	0	0	0	838, 904	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	10.047	
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0 59, 794	157, 435	0	0	10, 967 3, 773, 497	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	37, 774	137, 433	,		3, 773, 477	92.00
OTHER REIMBURSABLE COST CENTERS	1					1
99. 10 09910 CORF	0	C	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS						
109. 00 10900 PANCREAS ACQUISITION	0	0	0			109.00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0	0	0	0		110. 00 111. 00
113. 00 11300 INTEREST EXPENSE		U	,	U	Ü	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	251, 033	1, 034, 439	0	136, 312	30, 050, 155	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	· ·		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	4, 891, 725	
193. 00 19300 NONPALD WORKERS 193. 01 19301 DME	0	0		0		193. 00 193. 01
193. 02 19302 LACTATI ON CONSULTI NG		0		0		193. 01
193. 03 19303 DI ABETI C COUNSELI NG	O	0	o o	o		193. 03
194. 00 07950 VACANT SPACE	0	0	0	o	82, 151	194. 00
194. 01 07951 BOARD OF HEALTH	0	0	0	0	46, 916	
194. 02 07952 PUTNAM/HENRY PRENATAL	0	0	0	0		194. 02
200.00 Cross Foot Adjustments		_	,			200. 00 201. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	251, 033	1, 034, 439	0	136, 312	0 35, 110, 897	
202.00 10 ME (3dill 111103 110-201)	201,000	1, 004, 407	1	130, 312	55, 110, 677	1202.00

Heal th FinancialSystemsPUTNAM COUNTY HOSPITALIn Lieu of Form CMS-2552-10COST ALLOCATION- GENERAL SERVICE COSTSProvider CCN: 15-1333Period:Worksheet B

Provider CCN: 15-1333 Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/17/2017 9:57 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 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 3, 269, 112 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 1, 529, 858 31.00 04100 SUBPROVIDER - IRF 41 00 41 00 04200 SUBPROVI DER 42.00 0 42.00 04300 NURSERY 0 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 50 00 2, 393, 648 05100 RECOVERY ROOM 0 51.00 256, 375 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 000000000000000000 382, 316 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 751, 319 54 00 54 00 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 210, 883 54.01 05700 CT SCAN 57.00 608, 033 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 0 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 60.00 06000 LABORATORY 3, 125, 225 60.00 06001 BLOOD LABORATORY 60.01 60.01 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 64.00 64.00 686, 900 65.00 65 00 06600 PHYSI CAL THERAPY 847, 811 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 108, 890 67.00 06800 SPEECH PATHOLOGY 65, 106 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 189, 379 69.00 69.01 06901 CARDI AC REHAB 463,001 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 176, 011 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 778, 311 73.00 07301 ONCOLOGY 3, 964, 054 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 2,050,843 88.00 08801 RURAL HEALTH CLINIC II 0 0 0 1, 569, 712 88.01 88. 02 08802 RURAL HEALTH CLINIC III 838, 904 88.02 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 90.00 09000 CLI NI C 10, 967 90.00 09100 EMERGENCY 0 91.00 3, 773, 497 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 99. 10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I 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 SUBTOTALS (SUM OF LINES 1-117) 30, 050, 155 118.00 NONREI MBURSABLE COST CENTERS 0 32, 293 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 4, 891, 725 192.00 193. 00 19300 NONPALD WORKERS 0000000 7, 657 193.00 193. 01 19301 DME 193. 01 193. 02 19302 LACTATION CONSULTING 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG 193. 03 C 194.00 07950 VACANT SPACE 194.00 82, 151 194. 01 07951 BOARD OF HEALTH 46, 916 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 194. 02 Ω 200.00 Cross Foot Adjustments 200.00 0 201.00 Negative Cost Centers 201.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC	CN: 15-1333	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/17/2017 9:5		
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total					
202.00 TOTAL (sum lines 118-201)	25.00	26. 00 35, 110, 897				202. 00	

| Peri od: | Worksheet B | From 01/01/2016 | Part | I | To | 12/31/2016 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1333

			1	o 12/31/2016	Date/Time Pre 5/17/2017 9:5	
Cost Center Description	Directly Assigned New Capital	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	, am
	Related Costs 0	1.00	2A	4. 00	5. 00	
GENERAL SERVI CE COST CENTERS			I			
1. 00	0 0 0 0 0 0 0 0	401, 639 251, 580 19, 245 17, 992 98, 303 45, 664 18, 932 112, 509	401, 639 251, 580 19, 245 17, 992 98, 303 45, 664 18, 933 112, 509	580 74 5 7 2 90 8 24 58 2 17 9 95	402, 219 21, 783 1, 943 7, 268 4, 498 7, 384 2, 537 9, 927 0	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	169, 105	169, 105	267	20, 242	30.00
31. 00	0 0 0	80, 880 0 0) 192) 0) 0	14, 027 0 0	31. 00 41. 00 42. 00 43. 00
50.00 O5000 OPERATING ROOM	0					50. 00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	000000000000000000000000000000000000000	65, 336 0 0 86, 289	86, 289	0 147 205	4, 242 17, 392	52. 00 53. 00 54. 00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 57. 00 05700 CT SCAN	0	3, 986 37, 579			2, 361 6, 263	54. 01 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		(0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0 71, 457	71, 457	0 7 190	0 34, 005	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	0	71, 437	71, 437	0	0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	10.029	10.029	0	7 210	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY		19, 928 91, 528			7, 318 8, 389	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	. (1, 247	67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0 2, 847	2, 847	0	746 2, 078	68. 00 69. 00
69. 01 06901 CARDI AC REHAB	0	23, 145	1			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 MPL. DEV. CHARGED TO PATIENT	0	0	(0	0	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATTENTS		25, 508	25, 508	34	2, 016 19, 854	72.00
73. 01 07301 0NCOLOGY	0				42, 602	73. 01
0UTPATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC	1 0	151, 455	151, 455	251	20, 697	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	71, 030	71, 030	215	17, 268	88. 01
88.02 08802 RURAL HEALTH CLINIC III 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	36, 042	36, 042	117	9, 248	88. 02 89. 00
90. 00 09000 CLINIC	0	4, 612	4, 612	0	62	90.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	165, 290	165, 290		36, 839	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS				/		72.00
99. 10 09910 CORF	0	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	l	110.00
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	0	0		0	0	111. 00 113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	2, 467, 997	2, 467, 997	3, 707	350, 297	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 580	13, 580	0	182	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	282, 981	282, 981	648		
193. 00 19300 NONPALD WORKERS 193. 01 19301 DME		0		0		193. 00 193. 01
193.02 19302 LACTATION CONSULTING	0	0	(0	0	193. 02
193. 03 19303 DI ABETI C COUNSELI NG 194. 00 07950 VACANT SPACE	0	0 40, 084	40, 084) 0 0		193. 03 194. 00
194.01 07951 BOARD OF HEALTH	0	19, 729			265	194. 01
194.02 07952 PUTNAM/HENRY PRENATAL 200.00 Cross Foot Adjustments	0	0	(0	194. 02 200. 00
200.00 Cross Foot Adjustments	<u> </u>	<u>I</u>	1	<u>'</u>	l	1200.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der Co		Peri od: Worksheet B			
				From 01/01/2016 To 12/31/2016		pared: 7 am	
		CAPI TAL					
		RELATED COSTS					
Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE		
	Assigned New	FLXT		BENEFITS	& GENERAL		
	Capi tal			DEPARTMENT			
	Related Costs						
	0	1. 00	2A	4. 00	5. 00		
201.00 Negative Cost Centers		0		0	0	201. 00	
202.00 TOTAL (sum lines 118-201)	0	2, 824, 371	2, 824, 37	1 4, 356	402, 219	202. 00	

Provider CCN: 15-1333

					12/31/2010	5/17/2017 9:5	
Со	st Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
05115011	OFFICE COOT OFFITEDS	7. 00	8. 00	9. 00	10. 00	11. 00	
	SERVI CE COST CENTERS	T		ı			
	W CAP REL COSTS-BLDG & FIXT						1.00
	MPLOYEE BENEFITS DEPARTMENT						4. 00
1 1	OMINISTRATIVE & GENERAL	070 407					5. 00
	PERATION OF PLANT	273, 437					7. 00
	NUNDRY & LINEN SERVICE	2, 429	23, 624				8. 00
	DUSEKEEPI NG	2, 271	133				9. 00
10. 00 01000 DI		12, 405	98		116, 704		10.00
11. 00 01100 CA		5, 763	0		0	59, 508	11. 00
	IRSING ADMINISTRATION	2, 389	0	265	0	572	13. 00
	DICAL RECORDS & LIBRARY	14, 198	0	1, 575	0	2, 740	16. 00
	OCIAL SERVICE	0	0	0	0	0	17. 00
	ILIZATION REVIEW	1, 196	0	133	0	0	17. 01
I NPATI EN	NT ROUTINE SERVICE COST CENTERS			1			
	OULTS & PEDIATRICS	21, 340	5, 139		99, 300	6, 419	30. 00
	ITENSIVE CARE UNIT	10, 207	3, 968		17, 404	3, 986	31. 00
	JBPROVI DER - I RF	0	0	0	0	0	41. 00
	JBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NU		0	0	0	0	0	43. 00
	RY SERVICE COST CENTERS						
	PERATING ROOM	30, 792	3, 348	3, 416	0	3, 213	50.00
	COVERY ROOM	8, 245	368	915	0	338	51.00
52. 00 05200 DE	ELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 AN	IESTHESI OLOGY	0	0	0	0	599	53.00
54. 00 05400 RA	ADI OLOGY-DI AGNOSTI C	10, 889	1, 767	1, 208	0	6, 176	54.00
54. 01 05401 NU	ICLEAR MEDICINE-DIAGNOSTIC	503	0	56	0	0	54. 01
57. 00 05700 CT	SCAN	4, 742	0	526	0	1, 050	57. 00
58. 00 05800 MA	AGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 05900 CA	ARDIAC CATHETERIZATION	0	0	0	0	0	59. 00
60. 00 06000 LA	ABORATORY	9, 017	0	1, 000	0	6, 008	60.00
60. 01 06001 BL	OOD LABORATORY	0	0	0	0	0	60. 01
64. 00 06400 I N	ITRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RE	SPI RATORY THERAPY	2, 515	0	279	0	2, 043	65. 00
66. 00 06600 PH	IYSI CAL THERAPY	11, 550	652	1, 281	0	0	66. 00
67. 00 06700 0C	CCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00 06800 SP	PEECH PATHOLOGY	0	0	0	0	0	68. 00
	ECTROCARDI OLOGY	359	0	40	ol	386	69. 00
	ARDI AC REHAB	2, 921	0	324	o	1, 173	•
	DICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	IPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
	RUGS CHARGED TO PATIENTS	3, 219	0	357	o	1, 230	73. 00
73. 01 07301 ON		17, 449	759		o	1, 802	73. 01
	ENT SERVICE COST CENTERS	.,, .,,	, , , ,	.,,,,,	<u> </u>	1,002	, , , , , ,
	IRAL HEALTH CLINIC	19, 113	529	2, 120	0	4, 872	88. 00
	JRAL HEALTH CLINIC II	8, 964	027	2, 120	o o	0	88. 01
	JRAL HEALTH CLINIC III	4, 548	0	o o	o o	0	88. 02
1 1	DERALLY QUALIFIED HEALTH CENTER	0	0	o o	o o	0	89. 00
90. 00 09000 CL		582	0	65		0	90.00
91. 00 09100 EM		20, 859	5, 754		0	8, 146	1
	SSERVATION BEDS (NON-DISTINCT PART)	20,037	3, 734	2, 514	٩	0, 140	92.00
	EIMBURSABLE COST CENTERS						72.00
99. 10 09910 CO		0	0	0	O	0	99. 10
	PURPOSE COST CENTERS	<u> </u>	0		<u> </u>	0	77.10
	NCREAS ACQUISITION	0	0	0	ol		109. 00
	ITESTINAL ACQUISITION	0	0	_	0		1109.00
		0	0	0	0		111.00
	SLET ACQUISITION	U	U	٥	٩	Ü	•
113. 00 11300 I N							113.00
	TILIZATION REVIEW-SNF	220 4/5	22 515	22 225	11/ 704	FO 7F2	114.00
118. 00 SU	JBTOTALS (SUM OF LINES 1-117)	228, 465	22, 515	23, 325	116, 704	50, 753	1118.00
100 00 10000 CL	BURSABLE COST CENTERS FT, FLOWER, COFFEE SHOP & CANTEEN	1 714	0	100	ام		100 00
		1, 714	4 400	190	U		190. 00
	YSICIANS' PRIVATE OFFICES	35, 710	1, 109	3, 963	0		192. 00
193. 00 19300 NO		0	0	0	0		193. 00
193. 01 19301 DM		0	0	0	0		193. 01
	ACTATION CONSULTING	0	0	0	0		193. 02
	ABETI C COUNSELI NG	0	0	0	0		193. 03
194. 00 07950 VA		5, 058	0	0	0		194. 00
194. 01 07951 B0		2, 490	0	276	0		194. 01
	JTNAM/HENRY PRENATAL	0	0	0	0	0	194. 02
	ross Foot Adjustments						200. 00
	egative Cost Centers	0	0	0	0		201. 00
202. 00 T0	OTAL (sum lines 118-201)	273, 437	23, 624	27, 754	116, 704	59, 508	202. 00

Provider CCN: 15-1333

			1	0 12/31/2010	Date/lime Pre 5/17/2017 9:5	
Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	UTI LI ZATI ON	Subtotal	, diii
	ADMI NI STRATI ON	RECORDS &		REVI EW		
	13.00	16. 00	17. 00	17. 01	24. 00	
GENERAL SERVICE COST CENTERS	15.00	10.00	17.00	17.01	24.00	
1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9. 00 10. 00
11. 00 01100 CAFETERI A						11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	24, 712					13. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	141, 044				16. 00
17. 00 01700 SOCIAL SERVICE	0	O	0			17. 00
17. 01 01701 UTILIZATION REVIEW	0	0	0	12, 258		17. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	5, 230	78, 721	1		418, 561	30.00
31. 00 03100 I NTENSI VE CARE UNIT	3, 248	0	0	1, 828	136, 872	31.00
41. 00 04100 SUBPROVI DER - 1 RF 42. 00 04200 SUBPROVI DER	0	0		0	0	41.00
43. 00 04300 NURSERY	0	0		0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>		,,	<u> </u>		43.00
50. 00 05000 OPERATING ROOM	2, 619	35, 907	' 0	0	343, 420	50.00
51. 00 05100 RECOVERY ROOM	275	0	0	0	77, 414	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	o	0	52.00
53. 00 05300 ANESTHESI OLOGY	488	0	0	0	5, 476	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 186	0	0	0	128, 112	1
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	0	0	6, 906	1
57. 00 05700 CT SCAN	356	0	0	0	50, 557	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	0		0	0	58. 00 59. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY		0		0	121, 677	1
60. 01 06001 BLOOD LABORATORY	0	0		0	121, 677	1
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	o	0	o o	o	32, 170	1
66. 00 06600 PHYSI CAL THERAPY	0	O	0	O	113, 400	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	O	1, 247	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	746	1
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	5, 727	
69. 01 06901 CARDI AC REHAB	956	0	0	0	33, 300	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	2, 016 50, 202	
73. 00 07300 DROGS CHARGED TO FATTENTS 73. 01 07301 0NCOLOGY	1, 468	4, 950		- I	209, 316	
OUTPATIENT SERVICE COST CENTERS	1, 100	1, 700	,	٥	207,010	70.01
88. 00 08800 RURAL HEALTH CLINIC	0	C	0	0	199, 037	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0	0	o	97, 477	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	0	0	0	49, 955	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00 09000 CLI NI C	0	0	0	0	5, 321	
91. 00 09100 EMERGENCY	5, 886	21, 466	0	0	267, 252	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			<u> </u>			92.00
99. 10 09910 CORF	0	C	0	ol	0	99. 10
SPECIAL PURPOSE COST CENTERS	<u> </u>		,	٩		77.10
109. 00 10900 PANCREAS ACQUISITION	0	C	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	24, 712	141, 044	. 0	12, 258	2, 356, 161	118. 00
NONREI MBURSABLE COST CENTERS	1					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 193.00 19300 NONPAID WORKERS	0	0	0	0	384, 012	192.00
193. 01 19301 DME		0		0		193. 00
193. 02 19302 LACTATI ON CONSULTI NG		0				193. 01
193. 03 19303 DI ABETI C COUNSELI NG	o o	Ö		o		193. 03
194.00 07950 VACANT SPACE	o	0	o o	l ol		194. 00
194.01 07951 BOARD OF HEALTH	0	0	0	o		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)	24, 712	141, 044	. 0	12, 258	2, 824, 371	202. 00

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1333 Period: Worksheet B

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1333 Worksheet B From 01/01/2016 Part II Date/Time Prepared: 12/31/2016 5/17/2017 9:57 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 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 0 418, 561 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 136, 872 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 0 50 00 343, 420 05100 RECOVERY ROOM 0 51.00 77, 414 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 000000000000000000 5, 476 53.00 05400 RADI OLOGY-DI AGNOSTI C 128, 112 54 00 54 00 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 6, 906 54.01 05700 CT SCAN 57.00 50, 557 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 60.00 06000 LABORATORY 121, 677 60.00 06001 BLOOD LABORATORY 60.01 60.01 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 64.00 64.00 65.00 32, 170 65 00 06600 PHYSI CAL THERAPY 113, 400 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 1, 247 67.00 06800 SPEECH PATHOLOGY 68.00 746 68.00 06900 ELECTROCARDI OLOGY 5, 727 69.00 69.00 69.01 06901 CARDI AC REHAB 33, 300 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 2.016 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 50, 202 73.00 07301 ONCOLOGY 209, 316 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 RURAL HEALTH CLINIC 199, 037 88.00 08801 RURAL HEALTH CLINIC II 0 0 0 97, 477 88.01 49, 955 88. 02 08802 RURAL HEALTH CLINIC III 88.02 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 90.00 09000 CLI NI C 5, 321 90.00 09100 EMERGENCY 0 91.00 267, 252 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 99. 10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111. 00 0 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114 00 SUBTOTALS (SUM OF LINES 1-117) 0 2, 356, 161 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 15, 666 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 384, 012 193. 00 19300 NONPALD WORKERS 0000000 92 193.00 193. 01 19301 DME 193. 01 0 193. 02 19302 LACTATION CONSULTING 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG 0 193. 03 194.00 07950 VACANT SPACE 194.00 45, 680 194. 01 07951 BOARD OF HEALTH 22, 760 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 194. 02 Ω 200.00 Cross Foot Adjustments 200.00 0 201.00 Negative Cost Centers 201.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CC	CN: 15-1333	Peri od: From 01/01/2016	Worksheet B		
					Date/Time Pre 5/17/2017 9:5		
Cost Center Description	Intern &	Total					
	Residents Cost						
	& Post						
	Stepdown						
	Adjustments						
	25.00	26.00					
202.00 TOTAL (sum Lines 118-201)	0	2, 824, 371				202.00	

	Financial Systems	PUTNAM COUNTY		011 45 4000 5		u of form CMS	
COST A	LLOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Pre 5/17/2017 9:5	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SOUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		ADMINISTRATIVE & GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	
	TOTAL OFFICE OF SOUTH	1. 00	4. 00	5A	5. 00	7. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT	99, 209		I			1.00
4.00 5.00 7.00 8.00 9.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	153 14, 108 8, 837 676 632	16, 685, 902 2, 220, 908 284, 706 27, 750 343, 252	-5, 150, 361 C C	1, 622, 559 144, 699 541, 408	676 632	4. 00 5. 00 7. 00 8. 00 9. 00
10.00	01000 DI ETARY	3, 453	92, 658	1	,	3, 453	•
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	1, 604 665	222, 073 66, 841	1	550, 038 188, 983	1, 604 665	1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	3, 952	364, 409	1	739, 414	3, 952 0	16. 00
	01701 UTI LI ZATI ON REVI EW	333	69, 744	1	_		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	5, 940	1, 024, 242	1		5, 940	ı
31.00	03100 I NTENSI VE CARE UNI T	2, 841	734, 415	1		2, 841	1
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0	0		_	0	41. 00 42. 00
43. 00	04300 NURSERY		0	1		_	ı
10.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>			· <u>·</u>		10.00
50.00	05000 OPERATING ROOM	8, 571	481, 555	(1, 489, 191	8, 571	50.00
51. 00	05100 RECOVERY ROOM	2, 295	55, 270	l .		2, 295	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	52.00
53.00	05300 ANESTHESI OLOGY	0	562, 465	l .		0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	3, 031	786, 742		1, 295, 463 175, 847	3, 031 140	
57. 00	05700 CT SCAN	1, 320	158, 304			1, 320	ı
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 320	0		0	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0	C	0	0	59. 00
60.00	06000 LABORATORY	2, 510	726, 396	C	2, 532, 969	2, 510	•
60. 01	06001 BL00D LABORATORY	0	0		0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	0		_	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	700 3, 215	334, 823		545, 138 624, 854	700 3, 215	•
67. 00	06700 OCCUPATIONAL THERAPY	3, 213	0			3, 215	1
68. 00	06800 SPEECH PATHOLOGY		0			ő	1
69. 00	06900 ELECTROCARDI OLOGY	100	64, 303	C		100	69. 00
69. 01	06901 CARDI AC REHAB	813	252, 043	C	351, 211	813	1
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0	0	
	07200 I MPL. DEV. CHARGED TO PATIENT	0	121 //1	1			
	07300 DRUGS CHARGED TO PATIENTS 07301 ONCOLOGY	896 4, 857	131, 661 293, 693				73. 00 73. 01
73.01	OUTPATIENT SERVICE COST CENTERS	4,657	273, 073		3, 173, 304	4,007	73.01
88. 00	08800 RURAL HEALTH CLINIC	5, 320	961, 101	(1, 541, 695	5, 320	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 495	825, 389			2, 495	
88. 02	08802 RURAL HEALTH CLINIC III	1, 266	447, 297		688, 857	1, 266	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	
	09100 EMERGENCY	162 5, 806	2, 664, 418			162 5 806	90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3,000	2,004,410		2, 144, 023	3,000	92. 00
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>		•	•		
99. 10	09910 CORF	0	0	(0	0	99. 10
400.00	SPECIAL PURPOSE COST CENTERS			1			
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION	0	0				109. 00 110. 00
	11100 I SLET ACQUISITION		0				111.00
	11300 NTEREST EXPENSE		O			Ĭ	113.00
	11400 UTILIZATION REVIEW-SNF						114. 00
118.00	,	86, 691	14, 196, 458	-5, 150, 361	26, 093, 001	63, 593	118. 00
400.00	NONREI MBURSABLE COST CENTERS			1	10.500		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	477 9, 940	0 2, 484, 275		1		190. 00 192. 00
	19300 NONPALD WORKERS	7, 740	5, 169				193. 00
193. 01	19301 DME		0, 107		-,		193. 01
193. 02	19302 LACTATION CONSULTING	0	0		0	0	193. 02
	19303 DI ABETI C COUNSELI NG	0	0	C	_		193. 03
	07950 VACANT SPACE	1, 408	0				194. 00
	07951 BOARD OF HEALTH 07952 PUTNAM/HENRY PRENATAL	693	0	1			194. 01 194. 02
194. 02	O 7 7 5 2 FUTIVAIN/ HEINKT PRENATAL	<u>ı</u>	0	'I C	ή Ο	<u> </u>	1174. UZ

Health Finar	ncial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2016 To 12/31/2016		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW BLDG &		Reconciliation	ADMI NI STRATI VE		
		FLXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE FEET)	
		FEET)	(GROSS		COST)		
			SALARI ES)				
		1.00	4.00	5A	5. 00	7.00	
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 824, 371	4, 274, 795		5, 150, 361	1, 901, 485	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	28. 468899	0. 256192	2	0. 171905	24. 983051	203. 00
204.00	Cost to be allocated (per Wkst. B,		4, 356		402, 219	273, 437	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part		0. 000261		0. 013425	3. 592608	205. 00
	11)						

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: Wo From 01/01/2016 Provi der CCN: 15-1333

1.00 00	Cost Center Description NERAL SERVICE COST CENTERS 1100 NEW CAP REL COSTS-BLDG & FIXT	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERI A (MANHOURS)	5/17/2017 9:5 NURSING ADMINISTRATION	7 am
1.00 00						(DI RECT	
1.00 00			0.00	10.00		NRSING HRS)	
1.00 00		8.00	9. 00	10.00	11. 00	13. 00	
7. 00 00 8. 00 00 9. 00 00 10. 00 01 11. 00 01 13. 00 01 16. 00 01 17. 00 01	0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 000 DIETARY 100 CAFETERIA 300 NURSING ADMINISTRATION 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE	178, 565 1, 002 740 0 0 0	69, 634 3, 453 1, 604 665 3, 952	0 0 0 0	29, 426 283 1, 355 0	14, 996 0 0	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00
	701 UTILIZATION REVIEW PATIENT ROUTINE SERVICE COST CENTERS	0	333	0	0	0	17. 01
30. 00 03 31. 00 03 41. 00 04 42. 00 04 43. 00 04	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT 1100 SUBPROVIDER - IRF 1200 SUBPROVIDER 1300 NURSERY	38, 845 29, 996 0 0	5, 940 2, 841 0 0 0	377 0 0	3, 174 1, 971 0 0 0	3, 174 1, 971 0 0 0	30. 00 31. 00 41. 00 42. 00 43. 00
	ICILLARY SERVICE COST CENTERS SOOO OPERATING ROOM	25, 310	8, 571	O	1, 589	1, 589	50.00
51. 00 05 52. 00 05 53. 00 05	5100 RECOVERY ROOM 5200 DELIVERY ROOM & LABOR ROOM 5300 ANESTHESIOLOGY 5400 RADIOLOGY-DIAGNOSTIC	2, 785 0 0 13, 358	2, 295 0 0 3, 031		167 0 296 3, 054	167 0 296 2, 540	51. 00 52. 00 53. 00 54. 00
54. 01 05 57. 00 05 58. 00 05	3401 NUCLEAR MEDICINE-DIAGNOSTIC 3700 CT SCAN 3800 MAGNETIC RESONANCE IMAGING (MRI) 3900 CARDIAC CATHETERIZATION	0 0 0	140 1, 320 0 0		0 519 0 0	0 216 0 0	54. 01 57. 00 58. 00 59. 00
60. 01 06 64. 00 06 65. 00 06 66. 00 06 67. 00 06	ABORATORY ABORATORY BLOOD LABORATORY BLOOD LABORATORY BLOOD INTRAVENOUS THERAPY BLOOD RESPIRATORY THERAPY BLOOD PHYSI CAL THERAPY BLOOD OCCUPATI ONAL THERAPY	0 0 0 0 4, 931	2, 510 0 0 700 3, 215	0 0 0	2, 971 0 0 1, 010 0	0 0 0 0 0 0 0	60. 00 60. 01 64. 00 65. 00 66. 00 67. 00
69. 00 06 69. 01 06 71. 00 07 72. 00 07 73. 00 07	1800 SPEECH PATHOLOGY 1900 ELECTROCARDIOLOGY 1901 CARDIAC REHAB 1700 MEDICAL SUPPLIES CHARGED TO PATIENTS 17200 IMPL. DEV. CHARGED TO PATIENT 17300 DRUGS CHARGED TO PATIENTS 17301 ONCOLOGY	0 0 0 0 0 0 5,740	0 100 813 0 0 896 4, 857	0 0 0	0 191 580 0 0 608 891	0 580 0 0 0 891	68. 00 69. 00 69. 01 71. 00 72. 00 73. 00 73. 01
	TPATIENT SERVICE COST CENTERS	0.00=	5 000				
88. 01 08 88. 02 08 89. 00 08 90. 00 09 91. 00 09 92. 00 09	1800 RURAL HEALTH CLINIC 1801 RURAL HEALTH CLINIC II 1802 RURAL HEALTH CLINIC III 1800 FEDERALLY QUALIFIED HEALTH CENTER 1800 CLINIC 1800 CLINIC 1800 CMERGENCY 1800 OBSERVATION BEDS (NON-DISTINCT PART)	3, 997 0 0 0 0 0 43, 479	0 0 0 162	0 0 0 0	2, 409 0 0 0 0 0 4, 028	0 0 0 0 0 3, 572	88. 00 88. 01 88. 02 89. 00 90. 00 91. 00 92. 00
99. 10 09	HER REIMBURSABLE COST CENTERS 0910 CORF	0	0	0	0	0	99. 10
	PECIAL PURPOSE COST CENTERS 0900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11 111. 00 11 113. 00 11	000 INTESTINAL ACQUISITION 100 INTESTINAL ACQUISITION 100 INTEREST EXPENSE 400 UTILIZATION REVIEW-SNF	0	0	0	0	0	110.00 111.00 113.00 114.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	170, 183	58, 524	2, 528	25, 096	14, 996	
190. 00 19 192. 00 19	NREIMBURSABLE COST CENTERS OOO GIFT, FLOWER, COFFEE SHOP & CANTEEN OOO PHYSICIANS' PRIVATE OFFICES OOO NONPAID WORKERS OOO DME	8, 382 0	477 9, 940 0 0		0 4, 328 2 0	0 0	190. 00 192. 00 193. 00 193. 01
193. 03 19 194. 00 07 194. 01 07	2302 LACTATION CONSULTING 2303 DIABETIC COUNSELING 2950 VACANT SPACE 2951 BOARD OF HEALTH 2952 PUTNAM/HENRY PRENATAL Cross Foot Adjustments Negative Cost Centers	0 0 0 0 0	0 0 0 693 0	0 0 0 0 0	0 0 0 0	0 0 0	193. 02 193. 03 194. 00 194. 01 194. 02 200. 00 201. 00

Health Fir	nancial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-1		
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co		Period: From 01/01/2016	Worksheet B-1	
					To 12/31/2016		pared: 7 am
	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	
202. 00	Cost to be allocated (per Wkst. B, Part I)	186, 462	651, 314	512, 01	4 699, 668	251, 033	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 044225	9. 353391	202. 53718	4 23. 777204	16. 739997	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	23, 624	27, 754	116, 70	4 59, 508	24, 712	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part II)	0. 132299	0. 398570	46. 16455	7 2. 022293	1. 647906	205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Period: From 01/01/2016 To 12/31/2016 Worksheet B-1 Date/Time Prepared: 5/17/2017 9:57 am Provi der CCN: 15-1333

Social Service Cost Center Description RECORDS & LIBRARY (TIME SPENT) Charlent Days) CAPTION C	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
LIBRARY CATHENT DAYS DAYS	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
CTIME SPENT DAYS 16.00 17.01	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
GENERAL SERVICE COST CENTERS	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
SENERAL SERVICE COST CENTERS	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
1. 00 00100 NEW CAP REL COSTS-BLOS & FIXT 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
7. 00 07000 0PERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 10900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 011000 CAFETERI A 13. 00 1300 NURSI NG ADMINI STRATI ON 16. 00 01600 MEDI CAL RECORDS & LI BRARY 149, 638 17. 00 1700 SOCI AL SERVICE 9 0 0 0 17. 01 1701 UTI LI ZATI ON REVI EW 10 0 0 0 0 2, 528 1NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I INTENSI VE CARE UNI T 00 04100 SUBPROVI DER - I RF 00 0 0 0 0 143. 00 04100 SUBPROVI DER - I RF 00 0 0 0 0 142. 00 04200 SUBPROVI DER - I RF 00 0 0 0 0 151. 00 05200 DELI VERY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 51. 00 05000 PERATI NG ROOM 51. 00 05000 DECOVERY ROOM 52. 00 05000 DELI VERY ROOM & LABOR ROOM 53. 00 05000 DELI VERY ROOM & LABOR ROOM 54. 00 05400 RAID I SUBPROVI DER 0 0 0 0 54. 00 05400 RAID I SUBPROVI DER 0 0 0 0 55. 00 05500 DELI VERY ROOM & LABOR ROOM 56. 00 05000 DELI VERY ROOM & LABOR ROOM 57. 00 05000 DELI VERY ROOM & LABOR ROOM 58. 00 05500 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI VERY ROOM & LABOR ROOM 59. 00 05000 DELI DELI VERY ROOM & LOO 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION 16. 00 01600 MEDI CAL RECORDS & LIBRARY 149, 638 17. 00 01700 SOCI AL SERVICE 0 0 0 0 2, 528 18 18 18 18 18 18 18 18 18 18 18 18 18	8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 1300 NURSING ADMINISTRATION 16. 00 01600 MEDI CAL RECORDS & LI BRARY 149, 638 17. 00 01700 SOCI AL SERVICE 0 0 0 17. 01 01701 UTI LI ZATION REVI EW 0 0 2,528 INPATI ENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRICS 83,517 0 2,151 31. 00 03100 INTENSI VE CARE UNIT 0 0 0 377 41. 00 04100 SUBPROVI DER 1 FF 0 0 0 0 42. 00 04200 SUBPROVI DER 0 0 0 0 43. 00 04300 NURSERY 0 0 0 0 0 43. 00 04300 NURSERY 0 0 0 0 0 43. 00 05000 PERATING ROOM 38,095 0 0 0 51. 00 05000 PERATING ROOM 38,095 0 0 0 51. 00 05000 PERATING ROOM 0 0 0 0 53. 00 05200 DELI VERY ROOM LABOR ROOM 0 0 0 0 54. 00 05200 DELI VERY ROOM 0 0 0 0 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 0 0 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 0 0 55. 00 05700 C T SCAN 0 0 0 0 55. 00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 55. 00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 55. 00 05900 CARDI AC CATHETERI ZATION 0 0 0 0 60. 00 06000 LABORATORY 0 0 0 0 64. 00 06400 PHYSI CAL THERAPY 0 0 0 0 0 65. 00 06500 PERSPIRATORY THERAPY 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0	9. 00 10. 00 11. 00 13. 00 16. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMINI STRATI ON 16. 00 01500 MEDI CAL RECORDS & LI BRARY 149, 638 17. 00 01700 SOCI AL SERVI CE 0 0 0 17. 01 01701 UTILIZATI ON REVI EW 0 0 2, 528 INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 83, 517 31. 00 03100 I NITENSI VE CARE UNI T 0 0 377 41. 00 04100 SUBPROVI DER - I RF 0 0 0 0 377 41. 00 04200 SUBPROVI DER - I RF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10. 00 11. 00 13. 00 16. 00 17. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
11. 00	11. 00 13. 00 16. 00 17. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
13. 00	13. 00 16. 00 17. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
16.00	16. 00 17. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
17. 00	17. 00 17. 01 30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
17. 01	30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 33, 517 0 2, 151	30. 00 31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
30. 00	31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
31. 00	31. 00 41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
41. 00	41. 00 42. 00 43. 00 50. 00 51. 00 52. 00
42. 00	42. 00 43. 00 50. 00 51. 00 52. 00
43. 00	43. 00 50. 00 51. 00 52. 00
ANCILLARY SERVICE COST CENTERS 50. 00	50. 00 51. 00 52. 00
50. 00 05000 OPERATING ROOM 38,095 0 0 51. 00 05100 RECOVERY ROOM 0 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 53. 00 05300 ANESTHESI OLOGY 0 0 0 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 0 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 0 57. 00 05700 CT SCAN 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 60. 01 06000 LABORATORY 0 0 0 60. 01 06001 BLOOD LABORATORY 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 0 65. 00 06500 RESPI RATORY THERAPY <t< td=""><td>51. 00 52. 00</td></t<>	51. 00 52. 00
51. 00 05100 RECOVERY ROOM 0 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 53. 00 05300 ANESTHESI OLOGY 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 57. 00 05700 CT SCAN 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 60. 01 06000 LABORATORY 0 0 64. 00 064001 INTRAVENOUS THERAPY 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0	51. 00 52. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 53. 00 05300 ANESTHESI OLOGY 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 57. 00 05700 CT SCAN 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 60. 01 06000 LABORATORY 0 0 60. 01 06400 I NTRAVENOUS THERAPY 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0	52. 00
53. 00 05300 ANESTHESI OLOGY 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 57. 00 05700 CT SCAN 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 60. 00 06000 LABORATORY 0 0 60. 01 06001 BLOOD LABORATORY 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0	I
54. 00 05400 RADI OLOGY - DI AGNOSTI C 0 0 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 0 0 57. 00 05700 CT SCAN 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 60. 00 06000 LABORATORY 0 0 60. 01 06001 BLOOD LABORATORY 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0	52 NO
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 57. 00 05700 CT SCAN 0 0 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 59. 00 05900 CARDIAC CATHETERIZATION 0 0 60. 00 06000 LABORATORY 0 0 60. 01 06001 BLOOD LABORATORY 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 0 65. 00 06500 RESPIRATORY THERAPY 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0	•
57. 00 05700 CT SCAN 0 0 0 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 60. 00 06000 LABORATORY 0 0 0 60. 01 06001 BLOOD LABORATORY 0 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0	54.00
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 60. 01 06000 LABORATORY 0 0 60. 01 06001 BLOOD LABORATORY 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0	54. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 60. 00 06000 LABORATORY 0 0 0 60. 01 06001 BLOOD LABORATORY 0 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0	57. 00
60. 00 06000 06000 06000 06001 000000	58. 00
60. 01 06001 BL00D LABORATORY 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0 0 65. 00 06500 RESPI RATORY THERAPY 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0	59.00
64. 00 06400 NTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60.00
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60. 01
66. 00 06600 PHYSI CAL THERAPY 0 0 0	64.00
	65. 00
67. 00 06700 0CCUPATI ONAL THERAPY OI OI OI	66. 00
	67. 00
68. 00 06800 SPEECH PATHOLOGY 0 0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0	69. 00
69. 01 06901 CARDI AC REHAB 0 0	69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0	73. 00
73. 01 07301 0NC0L0GY 5, 252 0 0	73. 01
OUTPATLENT SERVICE COST CENTERS	
88. 00 08800 RURAL HEALTH CLINIC 0 0 0	88. 00
88. 01 08801 RURAL HEALTH CLINI C I 0 0 0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III 0 0 0	88. 02
89.00 OB900 FEDERALLY QUALIFIED HEALTH CENTER O O O	89. 00
90. 00 09000 CLI NI C 0 0 0	90. 00
91. 00 09100 EMERGENCY 22, 774 0 0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92. 00
OTHER REIMBURSABLE COST CENTERS	
99. 10 <u>09910 CORF 0 0 0 0 0 </u>	99. 10
SPECIAL PURPOSE COST CENTERS	
109. 00 10900 PANCREAS ACQUISITION 0 0 0	109. 00
110.00 11000 INTESTINAL ACQUISITION 0 0 0	110. 00
111.00 11100 ISLET ACQUISITION 0 0 0	111. 00
113. 00 11300 I NTEREST EXPENSE	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	114. 00
118.00	118. 00
NONREI MBURSABLE COST CENTERS	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0	192. 00
193. 00 19300 NONPALD WORKERS 0 0 0	193. 00
193. 01 19301 DME 0 0 0	193. 01
193. 02 19302 LACTATION CONSULTING 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	194. 00
194. 01 07951 BOARD OF HEALTH 0 0 0	194. 01
194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0	194. 02
200.00 Cross Foot Adjustments	200. 00
201.00 Negative Cost Centers	∠00. 00
	201. 00

Heal th Financial	Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION -	STATISTICAL BASIS		Provi der	CCN: 15-1333	Peri od: From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/17/2017 9:5	
Cost	Center Description	MEDI CAI	SOCIAL SERVI	CE UTILIZATION	J .		

					5/1//201/ 9:5	/ am
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	UTI LI ZATI ON		
		RECORDS &		REVI EW		
		LI BRARY	(PATI ENT	(PATIENT DAYS)		
		(TIME SPENT)	DAYS)			
		16. 00	17. 00	17. 01		
202.00	Cost to be allocated (per Wkst. B,	1, 034, 439	0	136, 312		202. 00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 912943	0. 000000	53. 920886		203. 00
204.00	Cost to be allocated (per Wkst. B,	141, 044	0	12, 258		204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 942568	0.000000	4. 848892		205. 00
	11)					

| Peri od: | Worksheet C | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: | Part | Part | Prepared: | Part Provider CCN: 15-1333

				1	0 12/31/2016	Date/IIme Pre 5/17/2017 9:5	
			Title	XVIII	Hospi tal	Cost	, <u></u>
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	3, 269, 112		3, 269, 112	O	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 529, 858		1, 529, 858	١	0	
41. 00	04100 SUBPROVI DER – I RF	1, 324, 636		1, 529, 656	1	0	
42. 00	04200 SUBPROVI DER			ĺ	-	0	
43. 00	04300 NURSERY			0		0	
10.00	ANCILLARY SERVICE COST CENTERS	91			٥١		10.00
50.00	05000 OPERATI NG ROOM	2, 393, 648		2, 393, 648	0	0	50.00
51.00	05100 RECOVERY ROOM	256, 375		256, 375	О	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	o	0	52. 00
53.00	05300 ANESTHESI OLOGY	382, 316		382, 316	o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 751, 319		1, 751, 319	0	0	54. 00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	210, 883		210, 883	0	0	54. 01
57.00	05700 CT SCAN	608, 033		608, 033	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	
60.00	06000 LABORATORY	3, 125, 225		3, 125, 225	0	0	
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
64. 00	06400 NTRAVENOUS THERAPY	0	_	0	0	0	
65. 00	06500 RESPI RATORY THERAPY	686, 900	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	847, 811	0	847, 811	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	108, 890	0	,	· · · · · · · · · · · · · · · · · · ·	0	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	65, 106 189, 379	0	65, 106 189, 379		0	68. 00 69. 00
69. 00	06901 CARDI AC REHAB	463, 001		463, 001	0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	403,001		403,001	0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	176, 011		176, 011	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 778, 311		1, 778, 311	l ő	0	
73. 01	07301 ONCOLOGY	3, 964, 054		3, 964, 054	0	0	73. 01
	OUTPATIENT SERVICE COST CENTERS	97.10.7.00.1		27 . 2 . 7 2 2 .	-1		
88. 00	08800 RURAL HEALTH CLINIC	2, 050, 843		2, 050, 843	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 569, 712		1, 569, 712	o	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	838, 904		838, 904	0	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89. 00
90.00	09000 CLI NI C	10, 967		10, 967	0	0	
91. 00	09100 EMERGENCY	3, 773, 497		3, 773, 497	0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 117, 806		1, 117, 806		0	92. 00
	OTHER REIMBURSABLE COST CENTERS				I		
99. 10	09910 CORF	0		0		0	99. 10
100.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION	O		0		0] 109. 00
	11000 NTESTINAL ACQUISITION						1109.00
	11100 I SLET ACQUI SI TI ON						111.00
	11300 I NTEREST EXPENSE	١				U	113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
200.00		31, 167, 961	0	31, 167, 961	0	n	200.00
201.00		1, 117, 806	O	1, 117, 806	-		201. 00
202.00	1	30, 050, 155	0				202. 00
					1		

| In Lieu of Form CMS-2552-10 | Period: Worksheet C | From 01/01/2016 Part | Part I | To 12/31/2016 Date/Time Prepared: 5/17/2017 9:57 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1333

						5/17/2017 9:5	7 am
			Title	xVIII	Hospi tal	Cost	
			Charges		·		
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	odst deliter beserretten	1 inpati ont	outputtont	+ col . 7)	Ratio	Inpati ent	
				1 001. 7)	Ratio	Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INDATIONE DOUBLING CODYLOG COCT CONTEDC	0.00	7.00	0.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
	03000 ADULTS & PEDIATRICS	1, 608, 002		1, 608, 00			30. 00
	03100 INTENSIVE CARE UNIT	690, 751		690, 75	1		31.00
41.00	04100 SUBPROVI DER - I RF	0			C		41.00
42.00	04200 SUBPROVI DER	0			O		42.00
43.00	04300 NURSERY	ol			0		43.00
	ANCILLARY SERVICE COST CENTERS	'		•	•		İ
	05000 OPERATING ROOM	884, 609	3, 513, 223	4, 397, 83	0. 544279	0.000000	50.00
	05100 RECOVERY ROOM	53, 186	430, 667			0. 000000	51.00
	05200 DELIVERY ROOM & LABOR ROOM	00, 100	0		0. 000000	0. 000000	52. 00
	05300 ANESTHESI OLOGY	14, 863	346, 440	1		0. 000000	53.00
			· ·				1
	05400 RADI OLOGY-DI AGNOSTI C	633, 141	6, 890, 353			0.000000	54.00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	57, 613	1, 481, 391			0. 000000	54. 01
	05700 CT SCAN	519, 010	15, 808, 925			0. 000000	57. 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, 264, 873	15, 150, 705	16, 415, 57	0. 190382	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	o	0		0.000000	0. 000000	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	l ol	0		0.000000	0.000000	64.00
	06500 RESPI RATORY THERAPY	813, 348	664, 799	1, 478, 14		0. 000000	65. 00
	06600 PHYSI CAL THERAPY	442, 676	1, 875, 900			0. 000000	66. 00
	06700 OCCUPATI ONAL THERAPY	165, 150	250, 853			0. 000000	67. 00
	06800 SPEECH PATHOLOGY	66, 914	171, 843			0. 000000	68. 00
	06900 ELECTROCARDI OLOGY	36, 794	1, 092, 823			0. 000000	
	06901 CARDI AC REHAB					0. 000000	69. 01
	03100 MEDICAL CURRILES CHARGED TO DATIENTS	1, 739	619, 046				1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	005.400		0.000000	0. 000000	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	157, 446	225, 100			0. 000000	1
	07300 DRUGS CHARGED TO PATIENTS	1, 367, 147	3, 103, 412			0. 000000	73. 00
	07301 ONCOLOGY	6, 166	5, 097, 211	5, 103, 37	7 0. 776751	0. 000000	73. 01
	OUTPAȚIENT SERVICE COST CENTERS	,					
	08800 RURAL HEALTH CLINIC	0	1, 963, 014				88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	1, 583, 747	1, 583, 74	7		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	679, 520	679, 52	O		88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		O		89. 00
90. 00	09000 CLI NI C	l ol	2, 832	2, 83	2 3. 872528	0. 000000	90.00
	09100 EMERGENCY	123, 628	8, 166, 406			0.000000	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 014, 301	2, 014, 30		0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	-1	_, _, ,, ,, ,, ,,	_, _, _, ,, ,,			
	09910 CORF	l ol	0		O		99. 10
	SPECIAL PURPOSE COST CENTERS	٩			5		77.10
	10900 PANCREAS ACQUISITION	O	0		O		109. 00
	11000 INTESTINAL ACQUISITION		0	1			110.00
		0	0	l .			111.00
	11100 SLET ACQUISITION	١	U		J		
	11300 I NTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF				_		114. 00
200.00	Subtotal (see instructions)	8, 907, 056	71, 132, 511	80, 039, 56	7		200. 00
201. 00	Less Observation Beds						201. 00
202. 00	Total (see instructions)	8, 907, 056	71, 132, 511	80, 039, 56	7		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: 15-1333
Period: From 01/01/2016 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

5/17/2017 9:57 am Title XVIII 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 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.000000 54.01 57. 00 05700 CT SCAN 0.000000 57.00 58.00 |05800 | MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 06000 LABORATORY 0.000000 60.00 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 88.00 08801 RURAL HEALTH CLINIC II 88. 01 88. 01 88 02 08802 RURAL HEALTH CLINIC III 88 02 08900 FEDERALLY QUALIFIED HEALTH CENTER 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) 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 99.10 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)

Date/Time Prepared: 12/31/2016 5/17/2017 9:57 am Title XIX 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 30 00 03000 ADULTS & PEDIATRICS 3, 269, 112 3, 269, 112 3, 269, 112 03100 INTENSIVE CARE UNIT 1, 529, 858 1, 529, 858 0 1, 529, 858 31.00 31.00 04100 SUBPROVIDER - IRF o 41.00 0 0 41.00 04200 SUBPROVI DER 42.00 42.00 0 0 0 0 04300 NURSERY 0 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 2, 393, 648 2, 393, 648 2, 393, 648 50.00 05100 RECOVERY ROOM 0 256, 375 51 00 256, 375 256, 375 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 Ω 52.00 53.00 05300 ANESTHESI OLOGY 382, 316 382, 316 0 0 0 382, 316 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 751, 319 1, 751, 319 1, 751, 319 54.00 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 210.883 210, 883 210, 883 54.01 57.00 05700 CT SCAN 608, 033 608, 033 608, 033 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 C 0 0 0 58.00 0 0 05900 CARDIAC CATHETERIZATION 59 00 59 00 0 60.00 06000 LABORATORY 3, 125, 225 3, 125, 225 3, 125, 225 60.00 06001 BLOOD LABORATORY 60.01 60.01 C 0 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 06500 RESPIRATORY THERAPY 686, 900 686, 900 686, 900 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 847, 811 847, 811 847, 811 66.00 06700 OCCUPATI ONAL THERAPY 67.00 108, 890 108, 890 0 108, 890 67.00 68 00 06800 SPEECH PATHOLOGY 65, 106 65, 106 65, 106 68 00 69.00 06900 ELECTROCARDI OLOGY 189, 379 189, 379 189, 379 69.00 0 06901 CARDI AC REHAB 463, 001 463, 001 463, 001 69.01 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 72 00 176, 011 176, 011 176, 011 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 778, 311 1, 778, 311 1, 778, 311 73.00 07301 ONCOLOGY 3, 964, 054 3, 964, 054 3, 964, 054 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 88 00 2, 050, 843 08800 RURAL HEALTH CLINIC 2 050 843 2, 050, 843 0 88 00 0 88.01 08801 RURAL HEALTH CLINIC II 1, 569, 712 1, 569, 712 1, 569, 712 88.01 08802 RURAL HEALTH CLINIC III 838, 904 0 88.02 838, 904 838, 904 88.02 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 C 0 10, 967 09000 CLI NI C 0 10, 967 90.00 90.00 10, 967 91.00 09100 EMERGENCY 3, 773, 497 3, 773, 497 3, 773, 497 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 117, 806 1, 117, 806 1, 117, 806 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 99.10 09910 CORF 0 0 0 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION C 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 31, 167, 961 200. 00 200.00 Subtotal (see instructions) 31, 167, 961 31, 167, 961

1, 117, 806

30, 050, 155

1, 117, 806

30, 050, 155

1, 117, 806 201. 00

30, 050, 155 202. 00

201.00

202.00

Less Observation Beds

Total (see instructions)

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: | 5/17/2017 9:57 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1333

				V(1.)(7 aiii
				e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	oost contor bescription	I inpati cire	output i ont		Ratio	Inpati ent	
				+ col . 7)	Ratio		
						Ratio	
		6.00	7.00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	1, 608, 002		1, 608, 002			30.00
	03100 NTENSI VE CARE UNIT	690, 751		690, 751			31. 00
		1		1			
	04100 SUBPROVI DER - I RF	0		0			41. 00
	04200 SUBPROVI DER	0		0			42.00
43.00	04300 NURSERY	0		0			43.00
	ANCILLARY SERVICE COST CENTERS						1
	05000 OPERATING ROOM	884, 609	3, 513, 223	4, 397, 832	0. 544279	0.000000	50.00
	05100 RECOVERY ROOM	53, 186	430, 667			0. 000000	
		33, 100		1			
	05200 DELIVERY ROOM & LABOR ROOM		0	1		0. 000000	
	05300 ANESTHESI OLOGY	14, 863	346, 440			0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	633, 141	6, 890, 353	7, 523, 494	0. 232780	0.000000	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	57, 613	1, 481, 391	1, 539, 004	0. 137026	0.000000	54. 01
	05700 CT SCAN	519, 010	15, 808, 925			0. 000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	10,000,720			0. 000000	
		٥	-	1			
	05900 CARDI AC CATHETERI ZATI ON	0	0	1		0. 000000	
	06000 LABORATORY	1, 264, 873	15, 150, 705	16, 415, 578		0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0	C	0. 000000	0.000000	60. 01
64. 00	06400 INTRAVENOUS THERAPY	l ol	0	d d		0. 000000	64.00
	06500 RESPIRATORY THERAPY	813, 348	664, 799	1, 478, 147		0. 000000	
	06600 PHYSI CAL THERAPY	442, 676	1, 875, 900			0. 000000	
	06700 OCCUPATI ONAL THERAPY	165, 150	250, 853			0. 000000	
	06800 SPEECH PATHOLOGY	66, 914	171, 843	238, 757		0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	36, 794	1, 092, 823	1, 129, 617	0. 167649	0.000000	69. 00
69. 01	06901 CARDI AC REHAB	1, 739	619, 046	620, 785	0. 745831	0.000000	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	, ,	0			0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENT	157, 446	225, 100	1		0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	1, 367, 147	3, 103, 412			0. 000000	73. 00
	07301 ONCOLOGY	6, 166	5, 097, 211	5, 103, 377	0. 776751	0. 000000	73. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	1, 963, 014	1, 963, 014	1. 044742	0.000000	88. 00
	08801 RURAL HEALTH CLINIC II		1, 583, 747				88. 01
	08802 RURAL HEALTH CLINIC III		679, 520			0. 000000	
			077, 320	1			
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	· ·	1 ~		0.000000	
	09000 CLI NI C	0	2, 832			0. 000000	
91.00	09100 EMERGENCY	123, 628	8, 166, 406	8, 290, 034	0. 455185	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 014, 301	2, 014, 301	0. 554935	0.000000	92.00
Ī	OTHER REIMBURSABLE COST CENTERS			•			1
	09910 CORF	0	0	C			99. 10
	SPECIAL PURPOSE COST CENTERS	<u> </u>		1			77.10
				J			100 00
	10900 PANCREAS ACQUISITION	0	0	_			109. 00
	11000 INTESTINAL ACQUISITION	0	0	1			110. 00
111.00	11100 SLET ACQUISITION	0	0	C			111. 00
113.00	11300 INTEREST EXPENSE			1			113.00
	11400 UTI LI ZATI ON REVI EW-SNF			1			114. 00
200.00	Subtotal (see instructions)	8, 907, 056	71, 132, 511	80, 039, 567			200.00
		0, 907, 050	11, 132, 311	00, 039, 307			
201.00	Less Observation Beds	0.007	74 400				201. 00
202.00	Total (see instructions)	8, 907, 056	71, 132, 511	80, 039, 567			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: 15-1333 Period: Worksheet C
From 01/01/2016 Part I

12/31/2016 Date/Time Prepared: 5/17/2017 9:57 am 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 0.000000 05000 OPERATING ROOM 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 I MAGING (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 06000 LABORATORY 0.000000 60.00 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 08801 RURAL HEALTH CLINIC II 0.000000 88. 01 88. 01 88 02 08802 RURAL HEALTH CLINIC III 0.000000 88 02 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 09910 CORF 99.10 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 I	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT ANCILLAR	/ SERVICE CAPITAL COSTS	Provider CCN: 15-1333	Peri od:	Worksheet D

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co	CN: 15-1333	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 5/17/2017 9:5	pared: 7 am
				XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,			. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		1			T	
	05000 OPERATING ROOM	343, 420				27, 604	
	05100 RECOVERY ROOM	77, 414				4, 551	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000		0	
	05300 ANESTHESI OLOGY	5, 476				188	
	05400 RADI OLOGY-DI AGNOSTI C	128, 112				6, 883	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	6, 906				182	
	05700 CT SCAN	50, 557				940	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 00000		0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000		0	59. 00
	06000 LABORATORY	121, 677	16, 415, 578				60.00
	06001 BLOOD LABORATORY	0	0	0. 00000		0	
	06400 I NTRAVENOUS THERAPY	0	0	0.00000		0	64. 00
	06500 RESPI RATORY THERAPY	32, 170				l	65.00
	06600 PHYSI CAL THERAPY	113, 400				8, 690	
	06700 OCCUPATI ONAL THERAPY	1, 247				l	
	06800 SPEECH PATHOLOGY	746				106	
	06900 ELECTROCARDI OLOGY	5, 727					
	06901 CARDI AC REHAB	33, 300				93	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.0000		0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENT	2, 016		l .		830	
	07300 DRUGS CHARGED TO PATIENTS	50, 202				7, 589	
	07301 ONCOLOGY	209, 316	5, 103, 377	0. 04101	5 4, 062	167	73. 01
	OUTPATIENT SERVICE COST CENTERS		T	T		Т	
	08800 RURAL HEALTH CLINIC	199, 037				0	
	08801 RURAL HEALTH CLINIC II	97, 477		l .		0	88. 01
	08802 RURAL HEALTH CLINIC III	49, 955				0	88. 02
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.0000		0	
	09000 CLI NI C	5, 321				0	, , , , ,
	09100 EMERGENCY	267, 252				1, 363	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	143, 118				0	,
200.00	Total (lines 50-199)	1, 943, 846	77, 740, 814		3, 486, 189	74, 201	200. 00

Health Financial Systems	PUTNAM COUNTY H	IOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1333		Worksheet D
			From 01/01/201/	Dorst IV

THROUGH COSTS From 01/01/2016 To 12/31/2016 Part IV Date/Time Prepared: 5/17/2017 9:57 am Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursing School Allied Health Total Cost All Other Anestheti st Medi cal (sum of col 1 Cost Education Cost through col. 1.00 2.00 3.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 0 0 05100 RECOVERY ROOM 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 54.01 0 54.01 57.00 05700 CT SCAN 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 Oi 05900 CARDIAC CATHETERIZATION 0 59.00 59 00 0 60.00 06000 LABORATORY 0 0 60.00 60.01 06001 BLOOD LABORATORY 60.01 06400 I NTRAVENOUS THERAPY 0 0 64.00 64.00 0 06500 RESPIRATORY THERAPY 0 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 68 00 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 69.01 06901 CARDI AC REHAB 0 0 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72 00 0 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 07301 ONCOLOGY 0 0 0 73.01 0 0 73.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 0 0 0 0 0 0 0 0 88. 01 08801 RURAL HEALTH CLINIC II 0 0 0 0 0 0 0 88.01 08802 RURAL HEALTH CLINIC III 0 0 88. 02 88.02 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89. 00 89 00 0 09000 CLI NI C 0 90.00 0 90.00 0 91.00 09100 EMERGENCY 0 0 91.00 0

0

92.00

0 200.00

0

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50-199)

200.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PAS	S Provider CO		Period: From 01/01/2016 To 12/31/2016		pared: 7 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	to Charges	Ratio of Cost	Inpatient Program Charges	
	6. 00	7.00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						

	Cost Center Description	Total		Ratio of Cost	Outpati ent	Inpatient	
		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	4, 397, 832	0.000000	0.000000	353, 494	50.00
51.00	05100 RECOVERY ROOM	0	483, 853	0.000000	0.000000	28, 447	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000		0	52.00
	05300 ANESTHESI OLOGY	0	361, 303			12, 437	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	7, 523, 494	0.000000	0.000000	404, 190	54.00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	1, 539, 004			40, 637	54. 01
	05700 CT SCAN	0	16, 327, 935	0.000000	0.000000	303, 774	57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000		0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000	0.000000	0	59. 00
60.00	06000 LABORATORY	0	16, 415, 578	0.000000	0. 000000	744, 869	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.000000	0. 000000	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0	0	0.000000	0. 000000	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	1, 478, 147	0.000000	0. 000000	421, 663	65. 00
66.00	06600 PHYSI CAL THERAPY	0	2, 318, 576	0.000000	0.000000	177, 671	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	416, 003	0.000000	0.000000	51, 929	67.00
68.00	06800 SPEECH PATHOLOGY	0	238, 757	0.000000	0.000000	34, 007	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	1, 129, 617	0.000000	0.000000	31, 740	69. 00
69. 01	06901 CARDI AC REHAB	0	620, 785	0.000000	0.000000	1, 738	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	382, 546	0.000000	0.000000	157, 446	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4, 470, 559	0.000000	0.000000	675, 821	73.00
73. 01	07301 ONCOLOGY	0	5, 103, 377	0.000000	0.000000	4, 062	73. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	1, 963, 014	0.000000	0.000000	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	1, 583, 747	0.000000	0.000000	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	679, 520	0.000000	0.000000	0	88. 02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89. 00
90.00	09000 CLI NI C	0	2, 832	0.000000	0.000000	0	90. 00
91.00	09100 EMERGENCY	0	8, 290, 034	0.000000	0. 000000	42, 264	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 014, 301	0.000000	0. 000000	0	92.00
200.00	Total (lines 50-199)	0	77, 740, 814			3, 486, 189	200. 00
		•	•		· '		•

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1333 Period: From 01/01/2016 From 01/01/2016 Part IV Date/Time Prepared:

				То	12/31/2016	Date/Time Pro 5/17/2017 9:5	
		Title	XVIII		Hospi tal	Cost	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent				
	Program	Program	Program				
	Pass-Through	Charges	Pass-Through	า			
	Costs (col. 8		Costs (col.	9			
	x col. 10)		x col. 12)				
	11. 00	12.00	13. 00				
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATI NG ROOM	0	0)	0			50. 00
51.00 05100 RECOVERY ROOM	0	0)	0			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)	0			52.00
53. 00 05300 ANESTHESI OLOGY	0	0)	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)	0			54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0			54. 01
57. 00 05700 CT SCAN	0	0)	0			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0			59. 00
60. 00 06000 LABORATORY	o	0		0			60.00
60. 01 06001 BLOOD LABORATORY	o	0		0			60. 01
64. 00 06400 I NTRAVENOUS THERAPY	o	0		0			64. 00
65. 00 06500 RESPIRATORY THERAPY	o	0		0			65. 00
66. 00 06600 PHYSI CAL THERAPY	o	0		0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0		0			67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0		0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0		0			69. 00
69. 01 06901 CARDI AC REHAB	o	0		0			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0		0			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0		0			73. 00
73. 01 07301 ONCOLOGY	o	0		0			73. 01
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		'				
88. 00 08800 RURAL HEALTH CLINIC	0	0)	0			88. 00
88.01 08801 RURAL HEALTH CLINIC II	o	0		0			88. 01
88. 02 08802 RURAL HEALTH CLINIC III	o	0		0			88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0		0			89. 00
90. 00 09000 CLI NI C	l ol	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 Total (lines 50-199)	0	0		0			200.00
			•	1			•

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1333 Peri od: Worksheet D From 01/01/2016 Part V 12/31/2016 Date/Time Prepared: 5/17/2017 9:57 am Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Ratio From 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 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 544279 1, 526, 523 0 50.00 51.00 05100 RECOVERY ROOM 0.529861 113, 629 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52 00 0 52 00 0 53.00 05300 ANESTHESI OLOGY 1.058159 0 85,069 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 232780 1, 915, 184 0 54.00 54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.137026 0 495, 546 0 54.01 57.00 05700 CT SCAN 0.037239 4, 539, 543 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0 59.00 06000 LABORATORY 5, 592, 667 0 190382 60 00 60 00 0 60.01 06001 BLOOD LABORATORY 0.000000 0 60.01 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 64.00 06500 RESPIRATORY THERAPY 65.00 0.464703 217, 219 65.00 0 66.00 06600 PHYSI CAL THERAPY 622, 167 66.00 0.365660 0 67.00 06700 OCCUPATIONAL THERAPY 0. 261753 70, 282 0 67.00 06800 SPEECH PATHOLOGY 0. 272687 37, 153 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 398, 120 0 69.00 0.167649 06901 CARDI AC REHAB 0.745831 0 69.01 69.01 217, 326 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 72.00 0.460104 54, 249 0 07300 DRUGS CHARGED TO PATIENTS 0. 397783 73.00 0 873.085 0 73.00 07301 ONCOLOGY 0. 776751 73.01 73.01 2, 677, 330 Ω OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0. 000000 0 88.00 08801 RURAL HEALTH CLINIC II 0.000000 88.01 88.01 0 08802 RURAL HEALTH CLINIC III 88.02 0.000000 0 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 90.00 09000 CLI NI C 3.872528 581 0 90.00 0 1, 781, 022 91 00 09100 EMERGENCY 0.455185 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0. 554935 975, 384 Ω 92.00 0 0 200.00 200.00 Subtotal (see instructions) 22, 192, 079 Less PBP Clinic Lab. Services-Program 201.00 201.00 C Only Charges

0

22, 192, 079

0 202.00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	PUTNAM COUNTY H	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1333	Peri od: From 01/01/2016	Worksheet D Part V

12/31/2016 Date/Time Prepared: 5/17/2017 9:57 am 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 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 830, 854 50.00 51.00 05100 RECOVERY ROOM 60, 208 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 53.00 05300 ANESTHESI OLOGY 90,017 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 445, 817 54.00 54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 67, 903 0 54.01 0 57.00 05700 CT SCAN 169, 048 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 06000 LABORATORY 0 60 00 1,064,743 60 00 60.01 06001 BLOOD LABORATORY 0 60.01 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 65.00 100, 942 65.00 0 66.00 06600 PHYSI CAL THERAPY 227, 502 66.00 67.00 06700 OCCUPATIONAL THERAPY 18, 397 0 67.00 68.00 06800 SPEECH PATHOLOGY 10, 131 68.00 69.00 06900 ELECTROCARDI OLOGY 66, 744 0 69.00 69.01 06901 CARDI AC REHAB 162,088 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 24, 960 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 347, 298 0 73.00 73.00 2, 079, 619 07301 ONCOLOGY 0 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 88.00 08801 RURAL HEALTH CLINIC II 88.01 0 0 88.01 08802 RURAL HEALTH CLINIC III 0 88.02 0 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 90.00 09000 CLI NI C 2, 250 90.00 91 00 09100 EMERGENCY 810, 694 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 541, 275 0 92.00 0 200. 00 200.00 Subtotal (see instructions) 7, 120, 490 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

7, 120, 490

0

202.00

202.00

Net Charges (line 200 +/- line 201)

| Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | Normal | N

				Date/Time Pre 5/17/2017 9:5		
		Title	XVIII	Swing Beds - SNF		, <u>u</u>
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
2001 201101 20001 1 211 011		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. 544279	0		0	0	50. 00
51.00 O5100 RECOVERY ROOM	0. 529861	0		0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	1. 058159	0		0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 232780	0		0	0	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 137026	0		0	0	54. 01
57. 00 05700 CT SCAN	0. 037239	0		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60. 00 06000 LABORATORY	0. 190382	0		0	l o	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	l o	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0	l o	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 464703	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 365660	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 261753	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 272687	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 167649	0		0	0	69. 00
69. 01 06901 CARDI AC REHAB	0. 745831	0		0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 460104	0		0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 397783	0		0	0	73. 00
73. 01 07301 0NCOLOGY	0. 776751	0		0	0	73. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000				0	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00 09000 CLI NI C	3. 872528	0		0	0	90. 00
91. 00 09100 EMERGENCY	0. 455185	0		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 554935	0		0	0	92. 00
200.00 Subtotal (see instructions)		0		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	1	0	0	202. 00

Health Financial Systems	PUTNAM COUN	ITY HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1333	Peri od: From 01/01/2016	Worksheet D
		Component CCN: 15-Z333		

		Component	CCN: 15-Z333	To 12/31/2016	Date/Time Prepa 5/17/2017 9:57	ared: am
		Ti tl e	XVIII	Swing Beds - SNF	Cost	
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost	1			
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0)		Į	50. 00
51.00 05100 RECOVERY ROOM	0	0)		Ĺ	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0)		Ĺ	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0)		1	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0)			54. 00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0			í	54. 01
57. 00 05700 CT SCAN	0	0			Í	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			[58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			[59. 00
60. 00 06000 LABORATORY	0	Ö			(60.00
60. 01 06001 BLOOD LABORATORY	0	Ö			(60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	Ö			(64. 00
65. 00 06500 RESPIRATORY THERAPY	0	o	o		(65. 00
66. 00 06600 PHYSI CAL THERAPY	0	o	o		(66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ó	ol .		(67. 00
68. 00 06800 SPEECH PATHOLOGY	0	O			(68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
69. 01 06901 CARDI AC REHAB	0	Ó			(69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ó				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	Ó				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	Ó				73. 00
73. 01 07301 ONCOLOGY	0	Ó				73. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	C			3	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	Ö			8	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	Ö			8	88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O			8	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	Ó				92. 00
200.00 Subtotal (see instructions)	0	Ó			20	00.00
201.00 Less PBP Clinic Lab. Services-Program	0					01. 00
Only Charges					[~	
202.00 Net Charges (line 200 +/- line 201)	0	O			20	02. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1333	Peri od: From 01/01/2016	Worksheet D-1
			Date/Time Prepared: 5/17/2017 9:57 am
	Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	5/17/2017 9:5 Cost	7 am
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			3, 242 2, 689	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day		vate room days,	2, 009	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ed days)		1, 598	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period		31 of the cost	494	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	59	7. 00
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	l of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	1, 010	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	456	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private ro	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI) through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15.00
16. 00	SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost		18. 00
19. 00	Medical d rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	134. 09	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions			3, 269, 112	
22. 00	Swing-bed cost applicable to SNF type services through December 5 x line 17)	·		0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December \mathbf{x} line 18)		, , , ,	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	•			24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x,y) line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		514, 049 2, 755, 063	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	l and observation had she	argos)	0	28. 00
29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	arges)	0	28.00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	- line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	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 mir		tions)	0.00	34. 00
35. 00 36. 00	Average per diem private room cost differential (line 34 x line)	ne 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	ferential (line	0 2, 755, 063	36. 00 37. 00
37.00	27 minus line 36)	private room cost ur	. S. Gitti di Ci i ile	2, 755, 005	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 024. 57	38. 00
39. 00	Program general inpatient routine service cost per drem (see			1, 034, 816	39. 00
40. 00	Medically necessary private room cost applicable to the Progra			0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 034, 816	41.00

Heal th	n Financial Systems PUTNAM COUNT	Y HOSPI TAL	In Lie	eu of Form CMS-2	2552-10		
COMPUT	TATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1333	Peri od: From 01/01/2016	Worksheet D-1			
			To 12/31/2016	Date/Time Prep 5/17/2017 9:5			
		Title XVIII	Hospi tal	Cost	7 4111		
	Cost Center Description Total	Total Average Per Inpatient Days Diem (col. 1	Program Days	Program Cost (col. 3 x col.			
		col . 2)		4)			
42. 00	NURSERY (title V & XIX only) 0	2.00 3.00	4.00	5. 00 0	42. 00		
	Intensive Care Type Inpatient Hospital Units	077		221 222			
43. 00 44. 00		377 4, 057. 9	223	904, 930	43. 00 44. 00		
45.00	BURN INTENSIVE CARE UNIT				45. 00		
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				46. 00 47. 00		
	Cost Center Description	<u>'</u>		1.00			
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3	, line 200)		1. 00 1, 127, 472	48. 00		
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(PASS THROUGH COST ADJUSTMENTS	see instructions)		3, 067, 218	49. 00		
50.00	Pass through costs applicable to Program inpatient routine	services (from Wkst. D, sum	of Parts I and	0	50. 00		
51. 00	Pass through costs applicable to Program inpatient ancillar	y services (from Wkst. D, s	um of Parts II	0	51. 00		
52. 00	and IV) Total Program excludable cost (sum of lines 50 and 51)			0	52. 00		
53. 00	Total Program inpatient operating cost excluding capital re medical education costs (line 49 minus line 52)	lated, non-physician anesth	etist, and	0	53. 00		
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge			0 0. 00	54. 00 55. 00		
56.00			1: 52)	0	56.00		
57. 00 58. 00	,	rget amount (Tine 56 minus	Tine 53)	0	57. 00 58. 00		
59. 00	1 91	ending 1996, updated and co	mpounded by the	0. 00	59. 00		
60.00				0.00	60. 00		
61. 00	If line 53/54 is less than the lower of lines 55, 59 or 60 which operating costs (line 53) are less than expected cost			0	61. 00		
	amount (line 56), otherwise enter zero (see instructions)						
62. 00 63. 00	62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions)						
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						
04.00	instructions)(title XVIII only)	·		467, 204			
65. 00	Medicare swing-bed SNF inpatient routine costs after Decemb instructions)(title XVIII only)	er 31 of the cost reporting	period (See	0	65. 00		
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line CAH (see instructions)	64 plus line 65)(title XVII	I only). For	467, 204	66. 00		
67. 00	Title V or XIX swing-bed NF inpatient routine costs through (line 12 x line 19)	December 31 of the cost re	porting period	0	67. 00		
68. 00	12	ecember 31 of the cost repo	rting period	0	68. 00		
69. 00				0	69. 00		
70. 00	Skilled nursing facility/other nursing facility/ICF/IID rou	tine service cost (line 37)			70. 00		
71. 00 72. 00		ine 70 ÷ line 2)			71. 00 72. 00		
73. 00	Medically necessary private room cost applicable to Program				73. 00		
74. 00 75. 00	Capital-related cost allocated to inpatient routine service		art II, column		74. 00 75. 00		
76. 00					76. 00		
77. 00 78. 00					77. 00 78. 00		
79. 00	Aggregate charges to beneficiaries for excess costs (from p	· · · · · · · · · · · · · · · · · · ·	75		79. 00		
80. 00 81. 00	,	ost limitation (line 78 min	us line /9)		80. 00 81. 00		
82. 00	Inpatient routine service cost limitation (line 9 x line 81	•			82. 00		
83. 00 84. 00	,	S)			83. 00 84. 00		
85.00	Utilization review - physician compensation (see instruction				85. 00		
86. 00	Total Program inpatient operating costs (sum of lines 83 th PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	r ougn 85)			86. 00		
87. 00 88. 00		line 2)		1, 091 1, 024. 57	87. 00 88. 00		
	Observation bed cost (line 87 x line 88) (see instructions)	2)		1, 117, 806			

Health Financial Systems	PUTNAM COUNTY	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016		
				To 12/31/2016	Date/Time Prep 5/17/2017 9:5	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	418, 561	3, 269, 112	0. 12803	5 1, 117, 806	143, 118	90.00
91.00 Nursing School cost	O	3, 269, 112	0.00000	0 1, 117, 806	0	91.00
92.00 Allied health cost	O	3, 269, 112	0.00000	0 1, 117, 806	0	92.00
93.00 All other Medical Education	0	3, 269, 112	0.00000	0 1, 117, 806	0	93.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1333	Peri od: From 01/01/2016	Worksheet D-1		
		To 12/31/2016	Date/Time Pre 5/17/2017 9:5		
	Title XIX	Hospi tal	Cost		
Cost Center Description					

		Title XIX	Hospi tal	5/17/2017 9:5 Cost	7 am
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 242	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-berivate room days (excluding swing-bed and observation bed day		vate room days.	2, 689 0	2. 00 3. 00
	do not complete this line.	, , ,			
4.00	Semi-private room days (excluding swing-bed and observation be		04 6 11	1, 598	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through December	31 of the cost	494	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)	, daya) through Dagambar	21 of the cost	59	7 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	r days) through becember	31 Of the Cost	59	7. 00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3°	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line)	. +ba Dragram (avaluding	awing had and	2	9. 00
9.00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	Swing-bed and	3	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom davel after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		Join days) arter	O	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI>	only (including private	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 XI>	only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this line	e) , ,	O	13.00
14.00	Medically necessary private room days applicable to the Progra	nm (excluding swing-bed o	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	as after December 31 of t	the cost		18. 00
10.00	reporting period	s arter becember 51 or	the cost		10.00
19. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	;)		3, 269, 112	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	noried (line 6	0	23. 00
23.00	x line 18)	31 of the cost reporting	g perrou (Trile o	O	23.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			507, 363	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2, 761, 749	
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	l and observation had ch	argos)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed cha	ii ges)	0	29.00
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	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	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 mir		tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x line)	ne 31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost did	Fforontial (lima	2 761 740	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	ina private room cost ari	referrial (TINE	2, 761, 749	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		,		
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 027. 05	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			3, 081	
40.00	Medically necessary private room cost applicable to the Progra	,		2 091	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ ITTIE 40)	I	3, 081	41. 00

Heal th	Financial Systems PL	JTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 15-1333	Peri od: From 01/01/2016	Worksheet D-1	
					To 12/31/2016		
			Ti	tle XIX	Hospi tal	5/17/2017 9:5 Cost	/ am
	Cost Center Description	Total	Total	Average Per		Program Cost (col. 3 x col.	
	Πρε	iti ent costin	іраті епт ва	ysDiem (col. 1 col. 2)	-	4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		0. 0	50 0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 529, 858	3	77 4, 057. ⁴	98 0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
40.00	Drogram inputiont annillary compiles cost (West 1	D 2 and 2	line 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wkst. Total Program inpatient costs (sum of lines 41 tl			i ons)			48. 00 49. 00
F0 00	PASS THROUGH COST ADJUSTMENTS						F0 00
50. 00	Pass through costs applicable to Program inpatien [III]	nt routine se	ervices (fr	om WKST. D, Sun	n of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpatie	nt ancillary	services (from Wkst. D, s	sum of Parts II	0	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines 50 a	nd 51)				0	52. 00
53. 00	Total Program inpatient operating cost excluding	capital rela	ated, non-p	hysician anesth	netist, and	0	53. 00
	medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges Target amount per discharge					0	54. 00 55. 00
55. 00 56. 00	Target amount (line 54 x line 55)					0.00	56. 00
57. 00	Difference between adjusted inpatient operating	cost and tar	get amount	(line 56 minus	line 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost report	ing period e	ndi ng 1996,	updated and co	ompounded by the	0 0. 00	58. 00 59. 00
40.00	market basket	ronort und	atad by the	markat baakat		0. 00	60. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year cost If line 53/54 is less than the lower of lines 55				the amount by	0.00	61. 00
	which operating costs (line 53) are less than examount (line 56), otherwise enter zero (see insti		(lines 54	x 60), or 1% of	f the target		
62. 00	Relief payment (see instructions)	,				0	62. 00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine costs the	hrough Decemb	ber 31 of t	he cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs a</pre>	fter Decembe	r 31 of the	cost reporting	period (See	0	65. 00
	instructions) (title XVIII only)				, ,		
66. 00	Total Medicare swing-bed SNF inpatient routine co CAH (see instructions)	osts (line 64	4 plus line	: 65)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine cos((line 12 x line 19)	sts through [December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine co	sts after Dec	cember 31 o	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 rout	ina costs (li	ine 67 ± li	no 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NURSIN	NG FACILITY,	AND ICF/II	D ONLY		0	
70. 00 71. 00	Skilled nursing facility/other nursing facility/ Adjusted general inpatient routine service cost)		70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 71)	•		•			72.00
73. 00 74. 00	Medically necessary private room cost applicable Total Program general inpatient routine service		•				73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient rout			•	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 79. 00	Inpatient routine service cost (line 74 minus line Aggregate charges to beneficiaries for excess costs)		ovider reco	irds)			78. 00 79. 00
80. 00	Total Program routine service costs for compariso	on to the cos		*.	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line of						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see	instructions))				83. 00
84. 00 85. 00	Program inpatient ancillary services (see instru- Utilization review - physician compensation (see		s)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum of	lines 83 thro					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THE Total observation bed days (see instructions)	ROUGH COST				1, 091	87. 00
88. 00	Adjusted general inpatient routine cost per diem		line 2)			1, 027. 05	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see in:	structions)				1, 120, 512	89. 00

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016	Date/Time Prep 5/17/2017 9:5	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	418, 561	3, 269, 112	0. 12803	5 1, 120, 512	143, 465	90.00
91.00 Nursing School cost	0	3, 269, 112	0.00000	0 1, 120, 512	0	91.00
92.00 Allied health cost	0	3, 269, 112	0.00000	0 1, 120, 512	0	92.00
93.00 All other Medical Education	0	3, 269, 112	0. 00000	0 1, 120, 512	0	93. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-1333	Peri od: Worksheet D-3

Health Financial Systems PUTNAN	I COUNTY HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC	Provider CCN: 15-1333 P		Worksheet D-3	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre	pared:
	Title	XVIII	Hospi tal	5/17/2017 9:5 Cost	/ alli
Cost Center Description	11 21 0	Ratio of Cos		Inpati ent	
out contain bookin per an		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			3	2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			810, 164		30. 00
31.00 03100 INTENSIVE CARE UNIT			365, 495		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. 54427	· ·	192, 399	•
51. 00 05100 RECOVERY ROOM		0. 52986	•	15, 073	1
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52. 00
53. 00 05300 ANESTHESI OLOGY		1. 05815	•	13, 160	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23278	0 404, 190	94, 087	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 13702	•	5, 568	1
57. 00 05700 CT SCAN		0. 03723	9 303, 774	11, 312	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	0	0	59. 00
60. 00 06000 LABORATORY		0. 19038	2 744, 869	141, 810	60.00
60. 01 06001 BL00D LABORATORY		0.00000	0	0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	0 0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 46470	3 421, 663	195, 948	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 36566	0 177, 671	64, 967	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26175	3 51, 929	13, 593	67.00
68.00 06800 SPEECH PATHOLOGY		0. 27268	7 34, 007	9, 273	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 16764	9 31, 740	5, 321	69.00
69. 01 06901 CARDI AC REHAB		0. 74583	1 1, 738	1, 296	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.46010	4 157, 446	72, 442	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 39778	3 675, 821	268, 830	73.00
73. 01 07301 ONCOLOGY		0. 77675	1 4, 062	3, 155	73. 01
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	88. 00
88.01 08801 RURAL HEALTH CLINIC II		0.00000		0	88. 01
88.02 08802 RURAL HEALTH CLINIC III		0.00000	0	0	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
90. 00 09000 CLI NI C		3. 87252		0	90.00
91. 00 09100 EMERGENCY		0. 45518	5 42, 264	19, 238	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 55493	5 0	0	92. 00
200.00 Total (sum of lines 50-94 and 96-98)			3, 486, 189	1, 127, 472	200. 00
201.00 Less PBP Clinic Laboratory Services-Program onl	y charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			3, 486, 189		202. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 15-1333	Period: Worksheet D-3

Health Financial Systems	PUTNAM COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
	Component		From 01/01/2016 To 12/31/2016	Date/Time Pre	narod:
	Component	CCN: 15-Z333	10 12/31/2010	5/17/2017 9:5	pareu. 7 am
	Title	xVIII	Swing Beds - SNF		
Cost Center Description	· ·	Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LABORT FAIT DOUTLAS OFFILIAS OFFILIAS		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					00.00
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 INTENSIVE CARE UNIT			0		31.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43. 00
50. 00 05000 OPERATING ROOM		0. 54427	9 6, 126	3, 334	50.00
51. 00 05100 RECOVERY ROOM		0. 54427		0, 334	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		1. 05815		3	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 23278		4, 997	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 23270		4, 777	54. 01
57. 00 05700 CT SCAN		0. 03723		309	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		Ö	59.00
60. 00 06000 LABORATORY		0. 19038		17, 849	60.00
60. 01 06001 BLOOD LABORATORY		0. 00000		0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY		0. 00000		Ö	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 46470			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 36566		54, 016	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26175		22, 468	67. 00
68.00 06800 SPEECH PATHOLOGY		0. 27268		5, 932	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 16764		252	69. 00
69. 01 06901 CARDI AC REHAB		0. 74583	1 0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 46010	4 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 39778	3 202, 366	80, 498	73. 00
73. 01 07301 ONCOLOGY		0. 77675	1 350	272	73. 01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II		0.00000	0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III		0.00000		0	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	89. 00
90. 00 09000 CLI NI C		3. 87252		0	90. 00
91. 00 09100 EMERGENCY		0. 45518		904	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 55493		0	92. 00
200.00 Total (sum of lines 50-94 and 96-98)			700, 016	241, 424	
201.00 Less PBP Clinic Laboratory Services-Pro	gram only charges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)		l	700, 016		202. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	COUNTY HOSPITAL		
INDATIENT ANGLILADY SERVICE COST ADDODTIONMENT	Drovi don CCN, 1E 1222	Dori od:	Workshoot D 2	

Health Financial Systems PUTNAM CO	UNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC	Provider CCN: 15-1333		Worksheet D-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre	nared·
				5/17/2017 9:5	
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			2, 512		30.00
31. 00 03100 INTENSIVE CARE UNIT			0		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. 54427	9 4, 046	2, 202	50. 00
51.00 05100 RECOVERY ROOM		0. 52986		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		0	52. 00
53. 00 05300 ANESTHESI OLOGY		1. 05815		113	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 23278		50	1
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 13702		18	•
57. 00 05700 CT SCAN		0. 03723		58	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 00000		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	59. 00
60. 00 06000 LABORATORY		0. 19038	·	304	60.00
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 46470		26	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 36566		191	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26175		0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 27268		8	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 16764		54	69.00
69. 01 06901 CARDI AC REHAB		0. 74583		0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 00000 0. 46010		0 0	71. 00 72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 39778		470	73. 00
73. 01 07300 DROGS CHARGED TO PATTENTS		0. 34776		144	73. 00
OUTPATIENT SERVICE COST CENTERS		0.77073	103	144	73.01
88. 00 08800 RURAL HEALTH CLINIC		1. 04474	.2 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		0. 99113		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III		1. 23455		0	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000		0	89. 00
90. 00 09000 CLI NI C		3. 87252	8 0	0	90.00
91. 00 09100 EMERGENCY		0. 45518		110	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 55493	5 0	0	92. 00
200.00 Total (sum of lines 50-94 and 96-98)			10, 184	3, 748	200. 00
201.00 Less PBP Clinic Laboratory Services-Program only ch	narges (line 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)			10, 184		202. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1333	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/17/2017 9:57 am

		To	12/31/2016	Date/Time Pre 5/17/2017 9:5	
		Title XVIII	Hospi tal	Cost	7 diii
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			7, 120, 490	1. 00
2. 00	Medical and other services reimbursed under OPPS (see instruc-	tions)		0	2. 00
3.00	PPS payments	•		0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5. 00
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions)			0. 00 0	7. 00 8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	V col 13 line 200		0	9. 00
10. 00	Organ acqui si ti ons	17, 33.1. 13, 11.1.6 233		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			7, 120, 490	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
10.00	Reasonable charges			0	10.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	no 60)		0	12. 00 13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	ne 04)		0	
11.00	Customary charges				11.00
15.00	Aggregate amount actually collected from patients liable for patients and actually collected from patients liable for patients and actually collected from patients and actually collected from patients are particularly collected from patients and actually collected from patients are particularly collected from patients and actually collected from patients are particularly collected from patients and actually collected from patients are particularly collected from patients.	payment for services on a	charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	. 3	ı chargebasis	0	16. 00
17.00	had such payment been made in accordance with 42 CFR §413.13(e)		0.000000	17.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	vifline 18 exceeds line	11) (see	0	19. 00
	instructions)	y	, (555		17.00
20.00	Excess of reasonable cost over customary charges (complete only	y if line 11 exceeds line	18) (see	0	20. 00
21 00	instructions)			7 101 (05	21 00
21. 00 22. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	e instructions)		7, 191, 695 0	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	,		0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	0.011		40, 066	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)]		nd 221 (soo	3, 364, 252 3, 787, 377	
27.00	instructions)	or us the sum of filles 22 at	iu 23] (See	3, 707, 377	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Ii	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			3, 787, 377	
31.00	Primary payer payments			1, 763	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CFS)		3, 785, 614	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33. 00
34.00	Allowable bad debts (see instructions)			706, 524	34. 00
35. 00	Adjusted reimbursable bad debts (see instructions)			459, 241	•
36. 00	Allowable bad debts for dual eligible beneficiaries (see insti	ructions)		587, 752	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			4, 244, 855 0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	39. 50
39. 98	Partial or full credits received from manufacturers for replace		ons)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			4, 244, 855	1
40. 01	Sequestration adjustment (see instructions)			84, 897 3, 838, 795	•
41. 00 42. 00	·				1
43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 321, 163	•
44. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, cha	apter 1,	021,100	1
	§115. 2				
00.00	TO BE COMPLETED BY CONTRACTOR			^	00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money				92.00
93. 00	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems PUTANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Period: Worksheet E-1
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/17/2017 9:57 am Provider CCN: 15-1333

					5/17/2017 9: 57	<u>/ am</u>
			XVIII	Hospi tal	Cost	
		I npati en	t 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, 747, 90	8	3, 838, 795	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2. 00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3. 03
3. 04				o	l ol	3. 04
3. 05				o	0	3. 05
0.00	Provider to Program			<u> </u>		0.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				0	o	3. 51
3. 52				0	0	3. 52
3. 53				o	o	3. 53
3. 54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
0. , ,	3. 50-3. 98)					0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 747, 90	8	3, 838, 795	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVI DER			0	321, 163	6. 01
6. 02	SETTLEMENT TO PROGRAM		79, 76		0	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 668, 14		4, 159, 958	7. 00
				Contractor	NPR Date	
		,)	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor)	1. 00	2. 00	8. 00
0.00	Ivaliic of Contractor	I		1	1	0.00

Health Financial Systems PUTANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	JUN. 13-2333 1	12/31/2010	5/17/2017 9:5	
		Title	XVIII S	wing Beds - SNF		
		Inpatient Part A Part B		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		760, 491	1	0	1. 00
2.00	Interim payments payable on individual bills, either		(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)	<u> </u>				ļ
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01
3. 02			(0	3. 02
3.03			(0	3. 03
3.04			(0	3. 04
3. 05			()	0	3. 05
2 50	Provi der to Program				0	2 50
3.50	ADJUSTMENTS TO PROGRAM		(3. 50
3. 51			(0	3. 51
3. 52			(3. 52
3.53					0	3. 53 3. 54
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
3. 99	3. 50-3. 98)				U	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		760, 491		0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		700, 47	•	o o	7.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	1				ĺ
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					1
5.01	TENTATI VE TO PROVI DER		(0	5. 01
5.02			(0	5. 02
5.03			(0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51			(0	5. 51
5.52			(0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(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		(0	6. 01
6. 02	SETTLEMENT TO PROGRAM		69, 663		0	6. 02
7. 00	Total Medicare program liability (see instructions)		690, 828		0	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5. 00	maine of contractor	T.		1	I I	1 0.00

Heal th	Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of				
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1333 Period: From 01/01/2016 From 01/01/2016 To 12/31/2016 From 12/31/2016 Fro				nared:
			10 12/31/2010	Date/Time Pre 5/17/2017 9:5	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				
1. 00	Total hospital discharges as defined in AARA §4102 from Wks		e 14	719	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		1, 233	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			181	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		1, 975	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			80, 039, 567	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	line 20		724, 885	6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00	Calculation of the HIT incentive payment after sequestration	on (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
	Other Adjustment (specify)			0	31.00
32 00	Balance due provider (line 8 (or line 10) minus line 30 and	lline 31) (see instruction	18)	0	32 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

0 30.00 0 31.00 0 32.00

Health Financial Systems	PUTNAM COUNTY I	HOSPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1333	Peri od: From 01/01/2016	Worksheet E-2
		Component CCN: 15-Z333	To 12/31/2016	Date/Time Prepared: 5/17/2017 9:57 am

	Component Con. 13-2333	10 12/31/2010	5/17/2017 9:5	
	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)	471, 876	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 Part A, and sum of Wkst. D,	243, 838	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)			
4. 00	Per diem cost for interns and residents not in approved teaching program (see		0.00	4. 00
	instructions)			
5.00	Program days	456	0	
6.00	Interns and residents not in approved teaching program (see instructions)		0	1 0.00
7. 00	Utilization review - physician compensation - SNF optional method only	0		7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	715, 714	0	
9. 00	Primary payer payments (see instructions)	0	0	
10.00	Subtotal (line 8 minus line 9)	715, 714	0	1
11. 00	Deductibles billed to program patients (exclude amounts applicable to physician	0	0	11. 00
40.00	professi onal servi ces)	745 744		40.00
	Subtotal (line 10 minus line 11)	715, 714	0	
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	10, 787	0	13. 00
14 00	for physician professional services)		0	14. 00
	80% of Part B costs (line 12 x 80%)	704 027	0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	704, 927	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	
	Pioneer ACO demonstration payment adjustment (see instructions) 410A RURAL DEMONSTRATION PROJECT		U	16. 55
	Allowable bad debts (see instructions)		0	•
	Adjusted reimbursable bad debts (see instructions)		0	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	0	
	Total (see instructions)	704, 927	0	
	Sequestration adjustment (see instructions)	14, 099	0	1
	Interim payments	760, 491	0	20.00
	Tentative settlement (for contractor use only)	700, 491	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)	-69, 663	0	
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	-07, 003	0	1
23.00	chapter 1, §115.2	٩	U	23.00
	Condpto 1, 3110.2	1		ı

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1333	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E-3 Part V Date/Time Pre 5/17/2017 9:5	pared:
	Title XVIII	Hospi tal	Cost	

				5/17/2017 9: 5	/ am
		Title XVIII	Hospi tal	Cost	
	<u> </u>				
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	RELMBURSEMENT		
1.00	Inpatient services	17/101 77 32/101323 3331	RETINDOROEMENT	3, 067, 218	1.00
2. 00	Nursing and Allied Health Managed Care payment (see instructi	one)		3,007,210	
		uis)		0	•
3.00	Organ acqui si ti on			•	0.00
4.00	Subtotal (sum of lines 1 through 3)			3, 067, 218	
5.00	Primary payer payments			0	1 0.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 097, 890	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	1
10.00	Customary charges				10.00
11. 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge hasis	0	11. 00
12. 00	Amounts that would have been realized from patients liable fo			0	1
12.00			ii a ciiaiye basis	U	12.00
12 00	had such payment been made in accordance with 42 CFR 413.13(e)		0.000000	12.00
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 on	ly if line 14 exceeds li	ne 6) (see	0	15. 00
4, 00	instructions)		445 /		4, 00
16. 00	Excess of reasonable cost over customary charges (complete on	ly if line 6 exceeds line	e 14) (see	0	16. 00
	instructions)				
17. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18. 00	Direct graduate medical education payments (from Worksheet E-	4, line 49)			18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)			3, 097, 890	19. 00
20.00	Deductibles (exclude professional component)			401, 321	20. 00
21.00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			2, 696, 569	22. 00
23. 00	Coinsurance			0	1
24. 00	Subtotal (line 22 minus line 23)			2, 696, 569	1
25. 00	Allowable bad debts (exclude bad debts for professional servi	cos) (soo instructions)		40, 044	
26. 00	Adjusted reimbursable bad debts (see instructions)	ces) (see mistructions)		26, 029	1
		rusti spa)		·	1
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		22, 465	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			2, 722, 598	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
29. 99	Recovery of Accelerated Depreciation			0	29. 99
30.00	·				30.00
30. 01	Sequestration adjustment (see instructions)			54, 452	30. 01
31.00	Interim payments			2, 747, 908	31. 00
32. 00	Tentative settlement (for contractor use only)			0	1
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31,	and 32)		-79, 762	
34. 00	Protested amounts (nonallowable cost report items) in accorda	•	chapter 1	0	1
5 50	§115. 2			O] 55
	10		ı		'

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1333	Peri od: Worksheet E-3 From 01/01/2016 Part VII To 12/31/2016 Date/Time Prepared:

			10 12/31/2016	Date/lime Pre 5/17/2017 9:5	
		Title XIX	Hospi tal	Cost	7 dili
		2 12	Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		6, 829		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		6, 829	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)		6, 829	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		2, 512		8. 00
9.00	Ancillary service charges		10, 184	0	
10.00	Organ acquisition charges, net of revenue		0		10. 00
	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		12, 696	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
15. 00	a charge basis had such payment been made in accordance with 4 Ratio of line 13 to line 14 (not to exceed 1.000000)	12 CFR §413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		12, 696	0.000000	16.00
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	5, 867	0	
17.00	line 4) (see instructions)	y II IIIle 10 exceeds	5, 607	Ü	17.00
18. 00	Excess of reasonable cost over customary charges (complete onl	vifline 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	y IT TITLE 4 EXCECEDS TITLE		O	10.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		6, 829	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		ers.		
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0		24. 00
25.00	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27. 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)		6, 829	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6, 829	0	
	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0	0	35. 00
			6, 829	0	36.00
	, , ,		(020	0	
	Subtotal (line 36 ± line 37)		6, 829	Ü	38. 00 39. 00
	Direct graduate medical education payments (from Wkst. E-4)		6, 829	0	
	Total amount payable to the provider (sum of lines 38 and 39)			0	40. 00 41. 00
41.00	1			0	
42.00				0	
43.00	chapter 1, §115.2	ice with GW3 Fub 19-2,	0	U	43.00
	10.14p.co. 1/ 0.10.2		1		ı

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

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

Worksheet G
Date/Time Prepared:
5/17/2017 9:57 am

		General Fund	Speci fi c	Endowment Fund	Plant Fund	/ alli
			Purpose Fund			
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1. 00	Cash on hand in banks	16, 478, 891	0	ol	0	1.00
2. 00	Temporary investments	0	l o		0	2.00
3.00	Notes receivable	0	0	O	0	3. 00
4.00	Accounts receivable	9, 754, 923	0	O	0	4. 00
5.00	Other recei vable	1, 863, 847	0	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-3, 749, 686	0	0	0	
7.00	Inventory Proposite expenses	1, 014, 525	0	0	0	
8. 00 9. 00	Prepaid expenses Other current assets	295, 747	0	0	0	
10. 00	Due from other funds	0		0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	25, 658, 247	Ö	_	0	11.00
	FIXED ASSETS					
12. 00	Land	489, 208	0	0	0	12. 00
13. 00	Land improvements	0	0		0	13. 00
14.00	Accumulated depreciation	-246, 365	0	0	0	14. 00
15. 00 16. 00	Buildings Accumulated depreciation	30, 951, 035 -20, 742, 464	0	0	0	15. 00 16. 00
17. 00	Leasehold improvements	-20, 742, 404	1 0		0	17. 00
18. 00	Accumulated depreciation	0	0	0	0	18. 00
19. 00	Fi xed equipment	O	Ō	Ö	0	19. 00
20.00	Accumulated depreciation	0	0	o	0	20. 00
21. 00	Automobiles and trucks	0	0	0	0	21. 00
22. 00	Accumulated depreciation	0	0	0	0	22. 00
23. 00	Major movable equipment	21, 906, 550	0	0	0	23. 00
24. 00 25. 00	Accumulated depreciation	-17, 946, 709	0	0	0	24. 00 25. 00
26. 00	Minor equipment depreciable Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0		0	27. 00
28. 00	Accumulated depreciation	l ő	l o	o	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	O	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	14, 411, 255	0	0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	120, 049			0	31.00
32.00	Deposits on Leases	0	0		0	32.00
33. 00 34. 00	Due from owners/officers Other assets	238, 380	·		0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	358, 429			0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	40, 427, 931	Ö		0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	2, 733, 603	0	0	0	37. 00
38. 00	Salaries, wages, and fees payable	102, 636	1	0	0	
39. 00	Payroll taxes payable	96, 722	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	7, 831, 880	0	0	0	40.00
41. 00 42. 00	Deferred income Accelerated payments	0	0	U	U	41. 00 42. 00
43. 00	Due to other funds	0	0	0	0	43.00
44. 00	Other current liabilities	482, 058	Ö	o	0	1
45.00		11, 246, 899		O	0	
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	0	
47. 00	Notes payable	9, 996, 807	0		0	1
48. 00	Unsecured Loans	0	0		0	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	9, 996, 807	0		0	49. 00 50. 00
51. 00	Total liabilities (sum of lines 45 and 50)	21, 243, 706			0	51.00
01.00	CAPI TAL ACCOUNTS	21/210/700		51		0 00
52.00	General fund balance	19, 184, 225				52. 00
53.00	Specific purpose fund		0			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 58. 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	57. 00 58. 00
50.00	replacement, and expansion				U	30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	19, 184, 225	0	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	40, 427, 931	0	o	0	
	[59]					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES PUTNAM COUNTY HOSPITAL

Provider CCN: 15-1333

					Т		Date/Time Pro 5/17/2017 9:5	
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund	
	T	1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		14, 759, 126			0		1.00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		4, 425, 099 19, 184, 225			0		2. 00 3. 00
4.00	Additions (credit adjustments) (specify)	0	19, 104, 223		0	U		1
5. 00	That it one (or our i day as imente) (opening)	o			0			
6.00		0			0		C	6. 00
7.00		0			0		C	
8.00		0			0		C	
9. 00 10. 00	Total additions (sum of line 4-9)	0	0		0	0	C	9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)		19, 184, 225			0	l	11. 00
12. 00	Deductions (debit adjustments) (specify)	0	17, 104, 223		0	0		1
13. 00		0			0		d	
14.00		0			0		C	
15. 00		0			0		C	
16.00		0			0			
17. 00 18. 00	Total deductions (sum of lines 12-17)		0		U	0	C	17. 00 18. 00
19. 00	Fund balance at end of period per balance		19, 184, 225			0	ł	19. 00
	sheet (line 11 minus line 18)							
		Endowment Fund	PI ant	Fund				
		6.00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2. 00 3. 00
4. 00	Additions (credit adjustments) (specify)	U	0		U			4. 00
5. 00	That trons (or car trady as timents) (specify)		0					5. 00
6.00			0					6. 00
7.00			0					7. 00
8. 00 9. 00			0					8. 00
10.00	Total additions (sum of line 4-9)		0		0			9. 00 10. 00
11. 00	Subtotal (line 3 plus line 10)				0			11. 00
12. 00	Deductions (debit adjustments) (specify)		0					12. 00
13.00			0					13. 00
14.00			0					14.00
15. 00 16. 00			0					15. 00 16. 00
17. 00			0					17. 00
18. 00	Total deductions (sum of lines 12-17)	o	0		0			18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	O			0			19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1333

			10	12/31/2010	5/17/2017 9:5	
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				0.00	
	General Inpatient Routine Services					
1.00	Hospi tal		1, 608, 002		1, 608, 002	1.00
2.00	SUBPROVI DER - I PF	1				2.00
3.00	SUBPROVI DER - I RF	1	0		0	3.00
4.00	SUBPROVI DER	İ	0		0	4.00
5.00	Swing bed - SNF	İ	0		0	5.00
6.00	Swing bed - NF	İ	0		0	6.00
7.00	SKILLED NURSING FACILITY	I				7.00
8.00	NURSING FACILITY	I				8.00
9.00	OTHER LONG TERM CARE	1				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	1	1, 608, 002		1, 608, 002	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		690, 751		690, 751	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 lin	nes	690, 751		690, 751	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		2, 298, 753		2, 298, 753	17.00
18.00	Ancillary services		6, 324, 993	56, 882, 381	63, 207, 374	18.00
19.00	Outpati ent servi ces		123, 628	10, 183, 539	10, 307, 167	19.00
20.00	RURAL HEALTH CLINIC		0	1, 963, 014	1, 963, 014	20.00
20. 01	RURAL HEALTH CLINIC II		0	1, 583, 747	1, 583, 747	20. 01
20. 02	RURAL HEALTH CLINIC III		0	679, 520	679, 520	20. 02
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
24. 10	CORF	1	0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	1				25.00
26. 00	HOSPI CE	1				26.00
27. 00	PRI VATE PHYSI CI AN OFFI CES		730, 248	10, 829, 948	11, 560, 196	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst.	9, 477, 622	82, 122, 149	91, 599, 771	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES		T			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		_	39, 197, 510		29. 00
30. 00	ADD (SPECIFY)		0			30. 00
31.00		1	0			31. 00
32.00		1	0			32.00
33.00		1	0			33. 00
34.00		1	0			34.00
35. 00	T	1	0			35. 00
36. 00	Total additions (sum of lines 30-35)			0		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40.00		- 1	0			40.00
41. 00			0	_		41.00
42. 00	Total deductions (sum of lines 37-41)	[0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(1	transfer		39, 197, 510		43. 00
	to Wkst. G-3, line 4)				l	

Heal th	Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	eu of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1333	Peri od:	Worksheet G-3	
			From 01/01/2016 To 12/31/2016	Doto/Time Dro	nanad.
			To 12/31/2016	Date/Time Pre 5/17/2017 9:5	
				07 177 2017 7:0	, dili
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line 28)		91, 599, 771	1. 00
2.00	Less contractual allowances and discounts on			56, 642, 845	2. 00
3.00	Net patient revenues (line 1 minus line 2)	•		34, 956, 926	3. 00
4.00	Less total operating expenses (from Wkst. G-2	, Part II, line 43)		39, 197, 510	4. 00
5.00	Net income from service to patients (line 3 m	inus line 4)		-4, 240, 584	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneo	us communication services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and gues	ts		0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical sup			0	16. 00
17. 00	Revenue from sale of drugs to other than pati	ents		0	17. 00
18. 00	Revenue from sale of medical records and abst	racts		0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, e	tc.)		0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, an	d canteen		0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
	OTHER OPER/NONOP REV			8, 665, 683	24. 00
25.00	Total other income (sum of lines 6-24)			8, 665, 683	25. 00
	Total (line 5 plus line 25)			4, 425, 099	
27. 00	OTHER EXPENSES (SPECIFY)			0	
28 00	Total other expenses (sum of line 27 and subs	crints)		1 0	28 00

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

4, 425, 099 29. 00

28. 00

	Financial Systems	PUTNAM COUNT				eu of Form CMS-	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component	CCN: 15-8515	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/17/2017 9:5	
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi fi cati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col. 4)	
		1.00	2. 00	3.00	4.00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1.00	Physi ci an	460, 554	C	460, 55	-9, 030	451, 524	1.00
2. 00	Physician Assistant	0	C		0 0	0	2.00
3.00	Nurse Practitioner	181, 855	C	181, 85	55 0	181, 855	3. 00
4.00	Visiting Nurse	0	C		0 0	0	4. 00
5.00	Other Nurse	0	C		0 0	0	5. 00
6.00	Clinical Psychologist	0	C)	0	0	6. 00
7.00	Clinical Social Worker	0	C)	0	0	7. 00
8.00	Laboratory Techni ci an	0	C		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	C)	0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	642, 409	C	642, 40	-9, 030		
11. 00 12. 00	Physician Services Under Agreement Physician Supervision Under Agreement	0			0 0	0	11. 00 12. 00
13. 00	Other Costs Under Agreement	0			0	0	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0					14. 00
15. 00	Medical Supplies	0	Č		0 0	Ö	15.00
16. 00	Transportation (Health Care Staff)	o o	Č		0 0	l ő	16. 00
17. 00	Depreciation-Medical Equipment	0	C		0 0	0	17. 00
18. 00	Professional Liability Insurance	0	C		0 0	0	18. 00
19.00	Other Health Care Costs	0	C		0 0	0	19. 00
20.00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	C		0	0	21. 00
22. 00	Total Cost of Health Care Services (sum of	642, 409	C	642, 40	-9, 030	633, 379	22. 00
	lines 10, 14, and 21)						
23. 00	COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy	0	(<u>, </u>	0 0	0	23. 00
24. 00	Dental	0		1	0 0	0	24.00
25. 00	Optometry	0				0	25. 00
25. 00	Tel eheal th	0			0 0	0	25. 00
25. 02	Chronic Care Management	0	Č		0 0	Ö	25. 02
26. 00	All other nonreimbursable costs	l o	Ċ		0 0	l o	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C		0 0	0	28. 00
	through 27)						

327, 722

327, 722

970, 131

296, 668

296, 668

296, 668

624, 390

624, 390

1, 266, 799

-113, 755

-113, 755

-122, 785

29.00

30.00

31.00

32.00

510, 635

510, 635

1, 144, 014

through 27)
FACILITY OVERHEAD
29.00 Facility Costs
30.00 Administrative Costs

and 31)

31.00

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1333 Component CCN: 15-8515	Peri od: From 01/01/2016 To 12/31/2016	Date/Time Prepared:
		DHC I	5/17/2017 9:57 am

			Component	CCN: 15-8515	То	12/31/2016	Date/Time Pre 5/17/2017 9:5	
						RHC I	Cost	, u
		Adjustments	Net Expenses					
			for Allocation					
			(col. 5 + col.					
		6. 00	6) 7. 00	+				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00					
1.00	Physi ci an	ol	451, 524	1				1.00
2. 00	Physician Assistant	o	.0.,02					2.00
3. 00	Nurse Practitioner	o	181, 85	5				3. 00
4.00	Visiting Nurse	o	(4.00
5.00	Other Nurse	o	(5. 00
6.00	Clinical Psychologist	o	(6.00
7.00	Clinical Social Worker	o	(o				7. 00
8.00	Laboratory Techni ci an	o	(o				8. 00
9.00	Other Facility Health Care Staff Costs	o	(0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	633, 379	9				10.00
11.00	Physician Services Under Agreement	0	(0				11. 00
12.00	Physician Supervision Under Agreement	0	(0				12.00
13.00	Other Costs Under Agreement	0	(0				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	(0				14. 00
15. 00	Medical Supplies	0	(0				15. 00
16. 00	Transportation (Health Care Staff)	0	(O				16. 00
17. 00	Depreciation-Medical Equipment	0	(0				17. 00
18. 00	Professional Liability Insurance	0	(0				18. 00
19. 00	Other Health Care Costs	0	(O				19. 00
20. 00	Allowable GME Costs	_		_				20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	()				21. 00
22. 00	Total Cost of Health Care Services (sum of	0	633, 379	7				22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES							-
23. 00	Pharmacy	ol						23. 00
24. 00	Dental	0						24. 00
25. 00	Optometry	0						25. 00
25. 01	Tel eheal th	0	(25. 00
25. 02	Chronic Care Management	o	Ċ					25. 02
26. 00	All other nonreimbursable costs	o	Ċ					26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	О	(28. 00
	through 27)							
	FACILITY OVERHEAD							
	Facility Costs	0	(-				29. 00
30.00	Administrative Costs	0	510, 63	5				30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	510, 63	5				31.00
	30)							
32. 00	Total facility costs (sum of lines 22, 28	0	1, 144, 014	4				32. 00
	and 31)	l l		I				1

Heal th	Financial Systems	PUTNAM COUNT				eu of Form CMS-	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 01/01/2016 To 12/31/2016		nared:
			Component	JCN. 13-0313	10 12/31/2010	5/17/2017 9:5	
					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Recl assi fi ed	
		·		+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						1
1. 00	Physi ci an	264, 139	0	264, 13			1
2.00	Physici an Assistant	203, 801	0	203, 80	1	203, 801	2. 00
3.00	Nurse Practitioner	0	0		0	0	
4.00	Visiting Nurse	0	0		0	0	
5.00	Other Nurse	65, 639	0	65, 63	9 0	65, 639	1
6.00	Clinical Psychologist	0	0		0	0	
7. 00	Clinical Social Worker	0	0		0	0	1.00
8.00	Laboratory Techni ci an	0	0		0	0	0.00
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	/ // 00
10.00	Subtotal (sum of lines 1 through 9)	533, 579	0	533, 57	-8, 474	1	1
11.00	Physician Services Under Agreement	0	0		0	0	
12. 00 13. 00	Physician Supervision Under Agreement	0	0		0	0	1.2.00
14. 00	Other Costs Under Agreement Subtotal (sum of lines 11 through 13)	0	0		0	0	13. 00
15. 00	Medical Supplies	0	0		0	0	
16. 00	Transportation (Health Care Staff)	0	0		0	0	
17. 00		0			0	0	1
18. 00	Professional Liability Insurance	0			0 0	0	18. 00
19. 00		0			0 0	0	1
20. 00	Allowable GME Costs		Ĭ			Ĭ	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0	0	
22. 00	Total Cost of Health Care Services (sum of	533, 579	0	533, 57	9 -8, 474	_	
22.00	lines 10, 14, and 21)	000,077	Ĭ	000,07	0, 1, 1	020, 100	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	l	ļ.		<u>'</u>		1
23.00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0 0	0	24. 00
25. 00	Optometry	0	0		0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27)		l	I	1	1	1

300, 284

300, 284

833, 863

271, 744

271, 744

271, 744

572, 028

572, 028

1, 105, 607

-93, 257

-93, 257

-101, 731

29.00

30.00

31.00

32.00

478, 771

478, 771

1, 003, 876

through 27)
FACILITY OVERHEAD
29.00 Facility Costs
30.00 Administrative Costs

and 31)

31.00

32.00

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FOHC COSTS		Peri od: Worksheet M-1 From 01/01/2016
	Component CCN: 15-8513	To 12/31/2016 Date/Time Prepared:

			Component	JON. 13-0313	12/31/2010	5/17/2017 9:5	
					RHC II	Cost	
	·	Adjustments	Net Expenses				
		•	for Allocation				
			(col. 5 + col.				
			6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	255, 665				1.00
2.00	Physician Assistant	0	203, 801				2. 00
3.00	Nurse Practitioner	0	0				3. 00
4.00	Visiting Nurse	0	0				4. 00
5.00	Other Nurse	0	65, 639				5. 00
6.00	Clinical Psychologist	0	0				6. 00
7.00	Clinical Social Worker	0	0				7. 00
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	525, 105				10.00
11.00	Physician Services Under Agreement	0	0				11. 00
12.00	Physician Supervision Under Agreement	0	0				12. 00
13.00	Other Costs Under Agreement	0	0				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14. 00
15.00	Medical Supplies	0	0				15. 00
16.00	Transportation (Health Care Staff)	0	0				16. 00
17.00	Depreciation-Medical Equipment	0	0				17. 00
18. 00	Professional Liability Insurance	0	0				18. 00
19. 00	Other Health Care Costs	0	0				19. 00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0				21. 00
22.00	Total Cost of Health Care Services (sum of	0	525, 105				22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0	0	•			23. 00
24. 00	Dental	0	0				24. 00
25. 00	Optometry	0	0				25. 00
25. 01	Tel eheal th	0	0				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28. 00
	through 27)						1
	FACILITY OVERHEAD						1
29. 00	Facility Costs	0	0	1			29. 00
30. 00	Administrative Costs	-100		•			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-100	478, 671				31. 00
00.05	30)	ا = = د	4 000 ==:				00.00
32. 00	Total facility costs (sum of lines 22, 28	-100	1, 003, 776				32. 00
	and 31)			I			I

	Financial Systems	PUTNAM COUNT		011 45 4000		u of Form CMS-	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1333	Peri od: From 01/01/2016	Worksheet M-1	
			Component	CCN: 15-8514	To 12/31/2016	Date/Time Pre	
						5/17/2017 9:5	7 am
				T	RHC III	Cost	
		Compensation	Other Costs		1 Reclassi fi cati	Reclassified	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	3.00	
1.00	Physi ci an	0	()	0 28, 119	28, 119	1.00
2.00	Physician Assistant	0		1	0 20,117	0	
3.00	Nurse Practitioner	253, 345	Č	253, 34	-	253, 345	3. 00
4. 00	Visiting Nurse	0	Č	200,0	0 0	0	1
5. 00	Other Nurse	0	Ċ		0 0	0	
6. 00	Clinical Psychologist	0	Ċ		o o	Ō	1
7.00	Clinical Social Worker	0	Ċ		0 0	0	7. 00
8.00	Laboratory Techni ci an	0	Ċ		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	C		0 0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	253, 345	C	253, 34	5 28, 119	281, 464	10.00
11. 00	Physician Services Under Agreement	0	C		0 0	0	11. 00
12.00	Physician Supervision Under Agreement	0	C		0 0	0	12. 00
13.00	Other Costs Under Agreement	0	C		0 0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	C		0 0	0	14. 00
15.00	Medical Supplies	0	C		0 0	0	15. 00
16.00	Transportation (Health Care Staff)	0	C		0 0	0	16. 00
17.00	Depreciation-Medical Equipment	0	C		0 0	0	17. 00
18.00	Professional Liability Insurance	0	C		0	0	18. 00
19. 00	Other Health Care Costs	0	C		0	0	19. 00
20.00	Allowable GME Costs						20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	C)	0	0	
22. 00	Total Cost of Health Care Services (sum of	253, 345	C	253, 34	5 28, 119	281, 464	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES					Г	
23. 00	Pharmacy	0	C)	0		
24. 00	Dental	0	()	0	· -	24. 00
25. 00	Optometry	0	(2	0	ľ	25. 00
25. 01	Tel eheal th	0	(2	0	0	25. 01
25. 02	Chronic Care Management	0			0	0	25. 02
26. 00	All other nonreimbursable costs	0	('	0	0	
27. 00 28. 00	Nonallowable GME costs Total Nonreimbursable Costs (sum of lines 23		,	J	0	0	27. 00 28. 00
∠ŏ. UU	through 27)			ή		l ⁰	∠8. UU

165, 832

165, 832

419, 177

130, 074

130, 074

130, 074

29.00

30.00

31.00

32.00

256, 757

256, 757

538, 221

295, 906

295, 906

549, 251

-39, 149

-39, 149

-11, 030

through 27)
FACILITY OVERHEAD
29.00 Facility Costs
30.00 Administrative Costs

and 31)

31.00

32.00

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 01/01/2016	Worksheet M-1
	Component CCN: 15-8514	To 12/31/2016	Date/Time Prepared: 5/17/2017 9:57 am
		RHC III	Cost

			Compo	onent CCN	l: 15-8514	То	12/31/2016	Date/Time Pre 5/17/2017 9:5	
							RHC III	Cost	7 4111
		Adjustments	Net Exp	enses					
			for Allo	cati on					
			(col. 5	+ col.					
			6)						
	54044574 454454 0405 05455 00050	6. 00	7. 00)					
	FACILITY HEALTH CARE STAFF COSTS	ام		00.440					
1.00	Physi ci an	0	1	28, 119					1.00
2.00	Physician Assistant	0	l	0					2.00
3.00	Nurse Practitioner	U O	2:	53, 345					3.00
4.00	Visiting Nurse	U O		0					4. 00 5. 00
5. 00 6. 00	Other Nurse Clinical Psychologist	U O		0					6.00
7. 00	Clinical Social Worker	O O		0					7.00
8. 00	Laboratory Techni ci an	0		0					8.00
9. 00	Other Facility Health Care Staff Costs	0		0					9.00
10. 00	Subtotal (sum of lines 1 through 9)	0	29	31, 464					10.00
11. 00	Physician Services Under Agreement	0		0					11.00
12. 00	Physician Supervision Under Agreement	0		o					12. 00
13. 00	Other Costs Under Agreement	o O		o					13. 00
14. 00	Subtotal (sum of lines 11 through 13)	Ö		0					14. 00
15. 00	Medical Supplies	Ö		o					15. 00
16. 00	Transportation (Health Care Staff)	ol		0					16. 00
17. 00	Depreciation-Medical Equipment	ol		ol					17. 00
18. 00	Professional Liability Insurance	ol		o					18.00
19. 00	Other Health Care Costs	o		O					19. 00
20.00	Allowable GME Costs								20.00
21.00	Subtotal (sum of lines 15 through 20)	o		o					21. 00
22.00	Total Cost of Health Care Services (sum of	o	28	81, 464					22. 00
	lines 10, 14, and 21)								
	COSTS OTHER THAN RHC/FQHC SERVICES								
23. 00	Pharmacy	0		0					23. 00
24. 00	Dental	0		0					24. 00
25. 00	Optometry	0		0					25. 00
25. 01	Tel eheal th	0		0					25. 01
25. 02	Chronic Care Management	0		0					25. 02
26. 00	All other nonreimbursable costs	0		0					26. 00
27. 00	Nonallowable GME costs								27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		0					28. 00
	through 27)								
20.00	FACILITY OVERHEAD	ما		٥					20.00
29. 00	Facility Costs	0	l .	0 56, 757					29. 00
30. 00 31. 00	Administrative Costs Total Facility Overhead (sum of lines 29 and	U O	ŀ	56, 757 56, 757					30.00
31.00	30)	٩	2	30, /3/					31.00
32. 00	Total facility costs (sum of lines 22, 28	0	5.	38, 221					32. 00
JZ. 00	and 31)	ď]	30, 22 1					32.00
	1	1	1	1					1

	Financial Systems	PUTNAM COUNT				u of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der Co		Peri od:	Worksheet M-2	
			Component		From 01/01/2016 To 12/31/2016	Date/Time Pre 5/17/2017 9:5	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.		
					3)	4	
		1.00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	1. 96					1. 00
2.00	Physician Assistant	0.00		_,			2. 00
3.00	Nurse Practitioner	1. 87					3. 00
4.00	Subtotal (sum of lines 1 through 3)	3. 83			12, 159	-	
5.00	Visiting Nurse	0. 00				0	
6.00	Clinical Psychologist	0. 00				0	6. 00
7.00	Clinical Social Worker	0. 00	l e			0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00	l e			0	7. 01
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
8.00	Total FTEs and Visits (sum of lines 4 through 7)	3. 83	9, 031			12, 159	8. 00
9.00	Physician Services Under Agreements		0			0	9. 00
	<u>,, , , , , , , , , , , , , , , , , , ,</u>	L	-	I.	L		
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O HOSPI TAL-BASE	D RHC/FQHC SER	VI CES			
10.00	Total costs of health care services (from Wks	st. M-1, col. 7	7, line 22)			633, 379	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11. 00
12.00	Cost of all services (excluding overhead) (si	um of lines 10	and 11)			633, 379	12. 00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (from	om Worksheet. M	1-1, col. 7, li	ne 31)		510, 635	14. 00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			906, 829	15. 00
16.00	Total overhead (sum of lines 14 and 15)					1, 417, 464	16. 00
17.00	Allowable GME overhead (see instructions)					0	17. 00
18.00	Enter the amount from line 16					1, 417, 464	18. 00
19.00	Overhead applicable to hospital-based RHC/FQ	HC services (li	ne 13 x line 1	8)		1, 417, 464	19. 00
20 00	Total allowable cost of hospital-based RHC/F	OHC services (s	um of lines 10	and 19)		2, 050, 843	20 00

	Financial Systems	PUTNAM COUNT				eu of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provi der C		Period: From 01/01/2016	Worksheet M-2	
			Component		To 12/31/2016	Date/Time Pre 5/17/2017 9:5	
					RHC II	Cost	
		Number of FTE	Total Visits		Minimum Visits		
		Personnel		Standard (1)			
					3)	4	
	hu ou to take propulativii ti	1.00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						1
4 00	Posi ti ons	0.04	4 055	1 00	4 000	<u> </u>	4 00
1.00	Physi ci an	0. 96				l .	1.00
2.00	Physician Assistant	2. 54					2.00
3.00	Nurse Practitioner	0.00				0.2//	3.00
4. 00 5. 00	Subtotal (sum of lines 1 through 3)	3. 50 0. 00			9, 366		
6.00	Visiting Nurse Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				0	7. 00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.00
7. 01	Diabetes Self Management Training (FQHC	0.00				0	7. 01
7.02	only)	0.00		1			7.02
8.00	Total FTEs and Visits (sum of lines 4	3. 50	7, 610			9, 366	8. 00
0.00	through 7)	0.00	,,,,,,			,,,,,,	0.00
9.00	Physician Services Under Agreements		l c			0	9. 00
	· · · · · · · · · · · · · · · · · · ·	•		1			
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	HOSPITAL-BASE	D RHC/FQHC SER	RVICES			
10.00	Total costs of health care services (from Wk	st. M-1, col. 7	7, line 22)			525, 105	10.00
11. 00						0	
12.00	Cost of all services (excluding overhead) (s					525, 105	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14. 00	Total hospital-based RHC/FQHC overhead - (fr			ne 31)		478, 671	
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			565, 936	
16. 00	Total overhead (sum of lines 14 and 15)					1, 044, 607	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16		40 11 4	.0)		1, 044, 607	
	Overhead applicable to hospital-based RHC/FQ					1, 044, 607	
20. 00	Total allowable cost of hospital-based RHC/F	uht services (s	sum of lines 10	and 19)		1, 569, 712	20.00

	Financial Systems	PUTNAM COUNT				eu of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	ERVI CES	Provider C		Peri od:	Worksheet M-2	
			Component		From 01/01/2016 To 12/31/2016	Date/Time Pre 5/17/2017 9:5	pared: 7 am
					RHC III	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
1.00	Physi ci an	0. 13					1.00
2.00	Physician Assistant	0. 00		-/		l	2.00
3.00	Nurse Practitioner	2. 13					3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 26			5, 019	5, 019	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC only)	0.00	(0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	2. 26	3, 220			5, 019	8. 00
0 00	through 7)						0.00
9. 00	Physician Services Under Agreements		(<u>/ </u>		0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	HOSPI TAL-BASE	D RHC/FQHC SEF	RVICES			
10.00	Total costs of health care services (from Wks	st. M-1, col. 7	7, line 22)			281, 464	10.00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11.00
12. 00	Cost of all services (excluding overhead) (si					281, 464	12.00
13. 00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13.00
14. 00	Total hospital-based RHC/FQHC overhead - (from	om Worksheet. N	N-1, col. 7, li	ne 31)		256, 757	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			300, 683	15. 00
16. 00	Total overhead (sum of lines 14 and 15)					557, 440	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					557, 440	
	Overhead applicable to hospital-based RHC/FQ					557, 440	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (s	sum of lines 10	and 19)		838, 904	20.00

Heal th	Financial Systems PUTNAM COUNTY H	IOSPI TAI	Inlie	u of Form CMS-2	2552_10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1333	Peri od:	Worksheet M-3	
SERVI (Component CCN: 15-8515	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/17/2017 9:5	pared:
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			0.050.040	
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (from			2, 050, 843	1.00
2.00	Cost of vaccines and their administration (from Wkst. M-4, lin	ne 15)		184, 282	2.00
3. 00 4. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			1, 866, 561 12, 159	3. 00 4. 00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 0)		12, 139	5.00
6.00	Total adjusted visits (line 4 plus line 5)	1116 7)		12. 159	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)			153. 51	7. 00
7.00	This district cost per visit (Time o di vided by Time o)		Cal cul ati on		7.00
				(-)	
			Prior to	On or After	
			January 1	January 1	
			1. 00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	81. 32	8. 00
9. 00	Rate for Program covered visits (see instructions)		153. 51	153. 51	9. 00
10.00	CALCULATION OF SETTLEMENT			1 10/	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line		0	1, 196 183, 598	
12. 00	Program covered visits for mental health services (from contra	,	0	183, 598	12.00
13. 00	Program covered cost from mental health services (line 9 x line)	•	0	0	13. 00
14. 00	Limit adjustment for mental health services (see instructions)	,	0	0	14. 00
15. 00	Graduate Medical Education Pass Through Cost (see instructions			O	15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	183, 598	
16. 01	Total program charges (see instructions)(from contractor's rec			227, 096	
16. 02	Total program preventive charges (see instructions)(from provi			4, 482	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	line 16)		3, 623	16. 03
16.04	Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		129, 614	16. 04
	(Titles V and XIX see instructions.)				
16. 05	Total program cost (see instructions)		0	133, 237	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(Trom contractor		17, 958	18. 00
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		40, 931	19. 00
20. 00	Net Medicare cost excluding vaccines (see instructions)			133, 237	20. 00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		19, 900	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		153, 137	22. 00
23.00	Allowable bad debts (see instructions)			0	23. 00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00	,	ructions)		0	24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25. 00
25. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	25. 50
26. 00	Net reimbursable amount (see instructions)			153, 137	
26. 01	Sequestration adjustment (see instructions)			3, 063	
27. 00 28. 00	Interim payments Tentative settlement (for contractor use only)			115, 712 0	27. 00 28. 00
28.00	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		34, 362	
30.00	Protested amounts (nonallowable cost report items) in accordan			34, 302	30.00
55. 55	chapter I, §115.2	.55 (11 55 1 45. 15-11,		O	00.00
			1		•

	Financial Systems PUTNAM COUNTY HATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provi der CCN: 15-1333	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CE		Component CCN: 15-8513	From 01/01/2016 To 12/31/2016	Date/Time Prep 5/17/2017 9:5	pared:
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
	Total Allowable Cost of hospital-based RHC/FQHC Services (from			1, 569, 712	1
	Cost of vaccines and their administration (from Wkst. M-4, lin	ne 15)		81, 088	
. 00	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			1, 488, 624 9, 366	
	Physicians visits under agreement (from Wkst. M-2, column 5, I	line 9)		9, 300	
	Total adjusted visits (line 4 plus line 5)			9, 366	
. 00	Adjusted cost per visit (line 3 divided by line 6)			158. 94	7. (
			Cal cul ati on	of Limit (1)	
			Prior to	On or After	
			January 1	January 1	
			1. 00	2. 00	
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	.6 or your contractor)	0.00	81. 32	
	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		158. 94	158. 94	9.
	Program covered visits excluding mental health services (from	contractor records)	0	1, 630	10.
	Program cost excluding costs for mental health services (line		0	259, 072	11.
	Program covered visits for mental health services (from contra		0	0	
	Program covered cost from mental health services (line 9 x line)		0	0	
	Limit adjustment for mental health services (see instructions) Graduate Medical Education Pass Through Cost (see instructions		0	0	14. 15.
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	259, 072	
	Total program charges (see instructions)(from contractor's red	,		304, 453	
	Total program preventive charges (see instructions) (from provi	•		2, 758	
	Total program preventive costs ((line 16.02/line 16.01) times			2, 347	16.
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0% (Titles V and XIX see instructions.)	3 and 18) times .80)		174, 205	16.
6. 05	Total program cost (see instructions)		o	176, 552	16.
	Primary payer amounts			0	17.
8. 00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		38, 969	18.
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		52, 545	19.
0. 00	Net Medicare cost excluding vaccines (see instructions)			176, 552	20.
	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		29, 421	21.
	Total reimbursable Program cost (line 20 plus line 21)			205, 973	
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	e)		0	
	Net reimbursable amount (see instructions)	3)		205, 973	
	Sequestration adjustment (see instructions)			4, 119	
7. 00	Interim payments			168, 962	
	Tentative settlement (for contractor use only)			0	
	Balance due component/program (line 26 minus lines 26.01, 27,			32, 892	
	Protested amounts (nonallowable cost report items) in accordar chapter I, §115.2	nce with CMS Pub. 15-II,		0	30.

	Financial Systems PUTNAM COUNTY H .TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1333	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CE	S	Component CCN: 15-8514	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/17/2017 9:5	
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
	Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2. line 20)		838, 904	1.0
	Cost of vaccines and their administration (from Wkst. M-4, li			34, 431	2. (
00	Total allowable cost excluding vaccine (line 1 minus line 2)			804, 473	3.
	Total Visits (from Wkst. M-2, column 5, line 8)			5, 019	
	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
	Total adjusted visits (line 4 plus line 5)			5, 019	
. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	160. 29	7.
			Carcuration	DI LIIII (I)	
			Prior to	On or After	
			January 1	January 1	
			1. 00	2. 00	
1	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	.6 or your contractor)	0.00	81. 32	1
	Rate for Program covered visits (see instructions)		160. 29	160. 29	9.
	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	ol	430	10.
	Program cost excluding costs for mental health services (line			68, 925	
	Program covered visits for mental health services (from contra		Ö	00, 729	
	Program covered cost from mental health services (line 9 x lin		o	0	
	Limit adjustment for mental health services (see instructions)		o	0	14.
5. 00	Graduate Medical Education Pass Through Cost (see instructions	s)			15.
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	68, 925	
	Total program charges (see instructions)(from contractor's red	•		84, 809	
	Total program preventive charges (see instructions)(from provi			4, 682	1
	Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0)			3, 805 45, 416	
3. 04	(Titles V and XIX see instructions.)	s and 16) trilles .60)		43, 410	10.
6. 05	Total program cost (see instructions)		o	49, 221	16.
	Primary payer amounts			0	17.
3. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		8, 350	18.
	records)				
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	ns) (from contractor		14, 355	19.
0. 00	Net Medicare cost excluding vaccines (see instructions)			49, 221	20.
	Program cost of vaccines and their administration (from Wkst.	M-4. Line 16)		2, 899	
	Total reimbursable Program cost (line 20 plus line 21)	,		52, 120	
3. 00	Allowable bad debts (see instructions)			0	23.
3. 01	Adjusted reimbursable bad debts (see instructions)			0	23.
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction: Net reimbursable amount (see instructions)	S)		0 52. 120	
	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			52, 120 1, 042	
	Interim payments			39, 282	1
	Tentative settlement (for contractor use only)			0	28.
	Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		11, 796	
	Protested amounts (nonallowable cost report items) in accordan			0	1

Health Financial Systems	PUTNAM COUNTY H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1333	Peri od: From 01/01/2016	Worksheet M-4	
WHOOFINE GOOT		Component CCN: 15-8515	To 12/31/2016	Date/Time Pre 5/17/2017 9:5	
		Title XVIII	RHC I	Cost	
			Pneumococcal	Influenza	

		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		633, 379	633, 379	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 011266	0. 020053	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	ne 1 x line 2)	7, 136	12, 701	3. 00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	27, 191	9, 885	4. 00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	34, 327	22, 586	5. 00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	633, 379	633, 379	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 417, 464	1, 417, 464	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 054197	0. 035660	8. 00
	divided by line 6)				
9. 00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l		76, 822		
10. 00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	111, 149	73, 133	10. 00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		359	•	11. 00
12. 00	Cost per pneumococcal and influenza vaccine injection (line 10	•	309. 61	•	
13. 00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	14	136	13. 00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (the	neir) administration	4, 335	15, 565	14. 00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (thei			184, 282	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				
16. 00	Total Program cost of pneumococcal and influenza vaccine and i			19, 900	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	PUTNAM COUNTY F	IOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1333	Peri od: From 01/01/2016	Worksheet M-4
VACCINE COST		Component CCN: 15-8513	To 12/31/2016	Date/Time Prepared: 5/17/2017 9:57 am
		Title XVIII	RHC LT	Cost

				3/1//2017 7.3	<i>i</i> aiii
		Title XVIII	RHC II	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		525, 105	525, 105	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 004155	0. 016174	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	2, 182	8, 493	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	9, 165	7, 286	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	11, 347	15, 779	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	525, 105	525, 105	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 044, 607	1, 044, 607	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 021609	0. 030049	8. 00
	divided by line 6)				
9. 00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	•	22, 573		
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	33, 920	47, 168	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		121		11. 00
12. 00	Cost per pneumococcal and influenza vaccine injection (line 10		280. 33		
13. 00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	11	263	13. 00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (t	neir) administration	3, 084	26, 337	14. 00
45.00	(line 12 x line 13)			04 000	45.00
15. 00	Total cost of pneumococcal and influenza vaccine and its (the			81, 088	15. 00
4, 00	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			00.404	4, 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	` ,		29, 421	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to WKST. M-3,			
	line 21)				

Health Financial Systems	PUTNAM COUNTY F	IOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1333	Peri od: From 01/01/2016	Worksheet M-4
VACCINE GOST		Component CCN: 15-8514		Date/Time Prepared: 5/17/2017 9:57 am
		Title XVIII	RHC LLL	Cost

				3/1//2017 9.3	i alli
		Title XVIII	RHC III	Cost	
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		281, 464	281, 464	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 003989	0. 008296	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lin	ne 1 x line 2)	1, 123	2, 335	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fi	rom your records)	5, 681	2, 413	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	6, 804	4, 748	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	281, 464	281, 464	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		557, 440	557, 440	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 024174	0. 016869	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l		13, 476	9, 403	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	20, 280	14, 151	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		75		11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10		270. 40		12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	2	26	13. 00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (the	neir) administration	541	2, 358	14.00
	(line 12 x line 13)				
15. 00				34, 431	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,	•			
16. 00	Total Program cost of pneumococcal and influenza vaccine and i	,		2, 899	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	PUTNAM COUNTY F	IOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1333 Component CCN: 15-8515	Peri od: From 01/01/2016 To 12/31/2016	Worksheet M-5 Date/Time Prepared: 5/17/2017 9:57 am

				5/17/2017 9:5	7 am
			RHC I	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			115, 712	1. C
2.00	Interim payments payable on individual bills, either submit			0	2.0
	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 amount				3.0
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider			1	
3. 01				0	3. 0
3. 02				0	3. (
. 03				0	
3. 04				0	3. (
3. 05				0	3. (
	Provider to Program				1
. 50				0	3.
. 51				0	
. 52				0	3.
. 53				0	3.
3. 54 3. 99	 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9	00)		0	3. 3.
i. 99 I. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			115, 712	4.
1. 00	27)	Tel to worksheet M-3, Title		113, /12	4. (
	TO BE COMPLETED BY CONTRACTOR				
5. 00	List separately each tentative settlement payment after desi	k review. Also show date of	,		5.0
00	each payment. If none, write "NONE" or enter a zero. (1)	it review in se enew date of			0
	Program to Provider		· ·		
. 01				0	5. (
. 02				0	5.
. 03				0	5.
	Provider to Program				
. 50				0	5.
. 51				0	5.
. 52				0	5.
. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
. 00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
. 01	SETTLEMENT TO PROVIDER			34, 362	6.
. 02	SETTLEMENT TO PROGRAM			0	6.
. 00	Total Medicare program liability (see instructions)			150, 074	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
2.00		0	1. 00	2. 00	
3. 00	Name of Contractor				8. 0

Health Financial Systems	PUTNAM COUNTY H	OSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provider CCN: 15-1333 Component CCN: 15-8513	From 01/01/2016 To 12/31/2016	

		Component CCN: 15-8513	10 12/31/2016	5/17/2017 9:57	
			RHC II	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			168, 962	1.
00	Interim payments payable on individual bills, either submitt the contractor for services rendered in the cost reporting p "NONE" or enter a zero	period. If none, write		0	2.
0	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3.
_	Program to Provider			_	
)1				0	3.
)2				0	3
)3				0	3
14				0	3
15				0	3
^	Provider to Program			0	,
0					3
1 2				1	3
				0	
3				0	3
4	Cultural (20)		0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.9			0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transf 27)	er to worksheet M-3, line		168, 962	4
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after desk	roviow Also show data o	f		5
U	each payment. If none, write "NONE" or enter a zero. (1)	review. Also show date o	1		`
	Program to Provider				_
11				0	5
2				0	5
3				0	5
_	Provider to Program				١.
0				0	5
1				0	5
2	Subtatal (our of lines E 01 E 40 minus our of lines E 50 E 0	20)		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9			0	5
0	Determined net settlement amount (balance due) based on the SETTLEMENT TO PROVIDER	cost report. (1)		22 002	6
1	SETTLEMENT TO PROGRAM			32, 892 0	6
0	Total Medicare program liability (see instructions)			201, 854	7
·U	Total wedicale program frability (see fistructions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems PUTNAM COUNTY	HOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1333	Peri od:	Worksheet M-5
SERVICES RENDERED TO PROGRAM BENEFICIARIES	C	From 01/01/2016	
	Component CCN: 15-8514	10 12/31/2016	5/17/2017 9:57 am

		Component Con. 13-8314	10 12/31/2010	5/17/2017 9: 57	
			RHC III	Cost	
				rt B	
			mm/dd/yyyy	Amount	
			1, 00	2, 00	
1. 00	Total interim payments paid to hospital-based RHC/FQHC			39, 282	1. 00
2. 00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2. 00
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero	, , , , , , , , , , , , , , , , , , , ,			
3. 00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3.00
	revision of the interim rate for the cost reporting period.				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3. 0
3. 02				0	3. 02
3. 03				0	3. 03
3. 04				0	3.0
3. 05				0	3. 05
	Provider to Program				
3. 50				0	3. 50
3. 51				0	3. 5
3. 52				0	3. 5
3. 53				0	3. 5
3.54				o	3. 5
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		0	3. 9
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line		39, 282	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after des	sk review. Also show date of	f		5. 0
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
5. 01				0	5. 0
5. 02				0	5. 02
5. 03				0	5. 03
	Provider to Program				
5. 50				0	5. 50
5. 51				0	5. 5
5. 52				0	5. 5.
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	*		0	5. 9
6. 00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6. 0
6. 01	SETTLEMENT TO PROVIDER			11, 796	6. 0
6. 02	SETTLEMENT TO PROGRAM			0	6. 0
7. 00	Total Medicare program liability (see instructions)			51, 078	7. 0
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
8. 00	Name of Contractor				8. 00