ioai en i i nanoi i	a. Gyoromo		1001 1 1712	111 21 00	. OI 101111 01110 E00E 10
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Fai	lure to report can r	result in all interim	FORM APPROVED
payments made	since the beginning of the co	est reporting period being	g deemed overpayments	s (42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 05-31-2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX (OST REPORT CERTIFICATION	Provider CCN: 15-133		Worksheet S
AND SETTLEMENT	SUMMARY			From 01/01/2018	
				To 12/31/2018	Date/Time Prepared:
					3/28/2019 5:42 pm
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 3/28/20	19 Time: 5:42 pm
use only	2. [] Manually submitted co	st report			
	3. [0] If this is an amended	report enter the number	of times the provide	er resubmitted this c	ost report
	4. [F] Medicare Utilization.	Enter "F" for full or "l	_" for low. '		·
Contractor	5. [1]Cost Report Status	6. Date Received:		10. NPR Date:	
use only	(1) Ås Submitted	7. Contractor No.		11. Contractor's Vendo	or Code: 4
,	(2) Settled without Audit	8. [N] Initial Report for	or this Provider CCN	12.[0]If line 5, co	lumn 1 is 4: Enter
	(3) Settled with Audit	9. [N] Final Report for	this Provider CCN		es reopened = 0-9.
	(4) Reopened				•
	(5) Amended				

PART II - CERTIFICATION

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

CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PUTNAM COUNTY HOSPITAL (15-1333) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 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.

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

(Si gned)	
	Officer or Administrator of Provider(s)
Titl∈	
-	
Date	

	Cost Center Description		Title	XVIII			
			Part A	Part B	HI T	Title XIX	
	<u> </u>	1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	250, 507	-320, 301	0	7, 438	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	17, 029	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		43, 317		0	10.00
10.01	RURAL HEALTH CLINIC II	0		16, 089		0	10. 01
10.02	RURAL HEALTH CLINIC III	0		84, 159		0	10.02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	267, 536	-176, 736	0	7, 438	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1333 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 3/28/2019 5:42 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1542 SOUTH BLOOMINGTON ST 1.00 PO Box: 1.00 Ci ty: GREENCASTLE State: IN 2.00 Zi p Code: 46135-County: PUTNAM 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, O, or N) Certi fi ed Number Number Type 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal PUTNAM COUNTY HOSPITAL 151333 26900 12/31/2005 Ν 0 0 3.00 Subprovi der - IPF 4.00 4.00 Subprovi der - IRF 5.00 5 00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 PUTNAM COUNTY HOSPITAL 15Z333 26900 12/31/2005 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospital -Based HHA 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC PPIM 15.00 158515 26900 02/23/2015 15 00 0 N N 15.01 Hospital-Based Health Clinic - RHC FMC 158513 26900 02/25/2015 Ν 0 Ν 15.01 15.02 Hospital-Based Health Clinic - RHC NPFH 158514 26900 03/17/2015 0 15.02 li i i 16.00 16.00 Hospital-Based Health Clinic - FQHC 17.00 Hospital-Based (CMHC) I 17.00 17. 10 Hospital -Based (CORF) I 17.10 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 9 21.00 1. 00 2.00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for Ν 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 | Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02

payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after

59.00

defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.

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 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 3/28/2019 5:42 pm NAHE 413.85 Worksheet A Pass-Through Qualification Y/N Line # Cri teri on Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions) 60.00 Ν Direct GME IME Y/N Direct GME 1.00 2.00 3.00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in 0 00 0. 00 61 00 column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)
61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) Enter the number of unweighted primary care/or 61.04 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Name Program Code Unwei ghted Unwei ghted IME FTE Count 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 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 61.20 0.00 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) 62 01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 'Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unwei ahted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTES FTEs in Nonprovi der Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.00 0.000000 64.00 0.00 in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care

resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)

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 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 3/28/2019 5:42 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Nonprovi der Hospi tal Si te 1.00 2. 00 3. 00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal Si te 1. 00 2.00 3. 00 4. 00 5.00 67.00 Enter in column 1, the program 0. 00 0. 00 0.000000 67.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)

	1.00	2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider?	N			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most			0	71.00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see				
42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching				
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting period.				
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	N			75.00
subprovider? Enter "Y" for yes and "N" for no.				

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	rovider CCN: 15-1333	Peri od:	Worksheet S	-2
		From 01/01/2018 To 12/31/2018		
		1.0	0 2.00 3.00	
5.00 If line 75 is yes: Column 1: Did the facility have an approved 0 recent cost reporting period ending on or before November 15, 20 no. Column 2: Did this facility train residents in a new teachir CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Col indicate which program year began during this cost reporting per	004? Enter "Y" for yes ng program in accordan umn 3: If column 2 is	n the most or "N" for ce with 42 Y,	0	76.
T. O. H. 1111 PPG			1.00	
Long Term Care Hospital PPS 1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and Is this a LTCH co-located within another hospital for part or al "Y" for yes and "N" for no.		ng period? Enter	N N	80. 81.
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEF 6.00 Did this facility establish a new Other subprovider (excluded ur §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.			N	85. 86.
7.00 Is this hospital an extended neoplastic disease care hospital cl 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	assified under section	n	N	87.
1.000(4)(1.7)(2)(1.7)(2.110)		V 1.00	XI X 2. 00	
Title V and XIX Services				
 .00 Does this facility have title V and/or XIX inpatient hospital seyes or "N" for no in the applicable column. .00 Is this hospital reimbursed for title V and/or XIX through the column. 		N N	Y	90.
full or in part? Enter "Y" for yes or "N" for no in the applicate. .00 Are title XIX NF patients occupying title XVIII SNF beds (dual of	ole column.	IN IN	N N	91.
instructions) Enter "Y" for yes or "N" for no in the applicable .00 Does this facility operate an ICF/IID facility for purposes of t	col umn.	· N	N	93.
"Y" for yes or "N" for no in the applicable column. .00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and	"N" for no in the	N	N	94.
applicable column. .00 If line 94 is "Y", enter the reduction percentage in the application books title V or XIX reduce operating cost? Enter "Y" for yes or		0. 00 N	0. 00 N	95. 96.
applicable column. On If line 96 is "Y", enter the reduction percentage in the application of the property of the intermediate of the property of the intermediate of the property of the pro	ns and residents post	0.00 Y	0. 00 Y	97. 98.
<pre>column 1 for title V, and in column 2 for title XIX. 01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.</pre>			Y	98.
.02 Does title V or XIX follow Medicare (title XVIII) for the calcul bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N for title V, and in column 2 for title XIX.		Y	Y	98
O3 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes or for title V, and in column 2 for title XIX.			N	98
O4 Does title V or XIX follow Medicare (title XVIII) for a CAH reim outpatient services cost? Enter "Y" for yes or "N" for no in col in column 2 for title XIX.		N d	N	98
O5 Does title V or XIX follow Medicare (title XVIII) and add back t Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Υ	98
O6 Does title V or XIX follow Medicare (title XVIII) when cost reim Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 f column 2 for title XIX. Rural Providers		Y	Y	98
5.00 Does this hospital qualify as a CAH? 5.00 If this facility qualifies as a CAH, has it elected the all-incl	usive method of payme	nt Y		105 106
for outpatient services? (see instructions) 7.00 If this facility qualifies as a CAH, is it eligible for cost reitraining programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25	(see instructions) If			107
reimbursed. If yes complete Wkst. D-2, Pt. II. 8.OO Is this a rural hospital qualifying for an exception to the CRNA	A fee schedule? See 4	2 N		108

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 01/01/	′2018 ′2018	Worksheet Part I Date/Time	CMS-2552-1 S-2 Prepared: 5:42 pm
	Physi cal	Occupati onal	Speed	h	Respi rat	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00 Y	2. 00 Y	3. 00 Y		4. 00 N	109.00
					1. 00	
I10.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Wolapplicable.	'Y" for yes o	or "N" for no. I	f yes,	6	N	110. 0
			1.00		2. 00	
I11.00 If this facility qualifies as a CAH, did it participate in Health Integration Project (FCHIP) demonstration for this compared for yes or "N" for no in column 1. If the response to confine in the properties of the FCHIP demo in which this CAH is participated in the properties of the FCHIP demo in which this CAH is participated in the properties of the properties of the participated in the particip	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N			111.0
Miscellaneous Cost Reporting Information				1.00	2.00 3	3. 00
I15.00 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" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 nt for long f rs) based on	2 is "E", enter term care (inclu the definition	in column des	N		0 115.00
I16.00 Is this facility classified as a referral center? Enter "Y" I17.00 Is this facility legally-required to carry malpractice insulation.			"N" for	N Y		116. 00 117. 00
118.00 s the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter			2		118.0
		Premi ums	Losse	S	Insuran	ce
		1.00	2. 00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:		183, 513		0	3.00	0118.0
Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein.			1. 00 N		2. 00	118.0
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, ' ualifies for	Y" for yes or the Outpatient	N		N	120.0
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.		· ·	Y			121.0
122.00 Does the cost report contain healthcare related taxes as det Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information			N			122.0
25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N	N" for no. If	N			125.0
126.00 If this is a Medicare certified kidney transplant center, et in column 1 and termination date, if applicable, in column 2		tification date				126.0
27.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2	2.					127.0
128.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 (129.00) If this is a Medicare certified lung transplant center, enter	2.					128. 0
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center,						130.0
date in column 1 and termination date, if applicable, in column 1	r, enter the	certi fi cati on				131. C
date in column 1 and termination date, if applicable, in col		fication date				132.0
132.00 If this is a Medicare certified islet transplant center, en				- 1		l l
	2. ter the certi 2.					133. C

lealth Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		UNTY HOSPITAL Provider CC	N: 15-1333	Peri od	d:	u of Form CMS Worksheet S-	
					01/01/2018 12/31/2018	Part I Date/Time Pr 3/28/2019 5:	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or 'are claimed, enter in column 2 the	'N" for no in column 1.	If yes, and home	office cos		1. 00 N	2.00	140.0
1.00		2. 00			3. 00		
If this facility is part of a chai			ugh 143 the	e name a	ind address	of the home	
office and enter the home office of 41.00 Name: 42.00 Street:	Contractor name and cor Contractor's Name PO Box:		Contrac	ctor's N	umber:		141. 142.
43. 00 Ci ty:	State:		Zi p Coo	le:			143.
						1.00	
44.00 Are provider based physicians' cos	ets included in Worksho	ω+ Λ2				1. 00 Y	144.
14. OUNT E PLOVI del Based physicians cos	sts Theraded TH Workshe	et A:					144.
					1. 00	2. 00	
45.00 f costs for renal services are clinpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in	'for yes or "N" for no clude Medicare utilizat for no in column 2. gy changed from the pre n column 1. (See CMS Pu	in column 1. If of ion for this cost eviously filed cos	column 1 is reporting t report?		N		145. (
yes, enter the approval date (mm/o	da/yyyy) in column 2.					1. 00	
47.00 Was there a change in the statisti	cal basis? Enter "Y" f	for yes or "N" for	no.			N N	147.
48.00 Was there a change in the order of						N	148.
49.00Was there a change to the simplifi	ed cost finding method				T: ±1 = 1/	N T: +1 - VIV	149.
		Part A 1.00	Part B 2.00		Title V 3.00	Title XIX 4.00	+
Does this facility contain a provi or charges? Enter "Y" for yes or '		an exemption fro	m the appli		of the low	er of costs	
55. 00 Hospi tal		N	N		N	N	155. (
56.00 Subprovi der - IPF		N	N		N	N	156.
57. 00 Subprovi der - I RF 58. 00 SUBPROVI DER		N	N		N	N	157. 158.
59. 00 SNF		N	N		N	N	159.
60.00 HOME HEALTH AGENCY		N	N		N	N	160. (
61. 00 CMHC			N		N	N	161.
61. 10 CORF			N		N	N	161. 1
Multicampus						1. 00	
65.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more camp	uses in dif	ferent	CBSAs?	N	165.0
	Name	County		Zip Code	_	FTE/Campus	
66.00 f line 165 is yes, for each	0	1. 00	2. 00	3. 00	4. 00	5. 00	00 166. (
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. 0	,5,100.1
						1. 00	
Health Information Technology (HI				ment Act		Υ	147
67.00 s this provider a meaningful user 68.00 f this provider is a CAH (line 10 reasonable cost incurred for the h	D5 is "Y") and is a mea	ningful user (line	e 167 is "Y	"), ent	er the	Y	167. 0168.
68.01 If this provider is a CAH and is r	not a meaningful user,	does this provide			rdshi p		168.
exception under §413.70(a)(6)(ii)?69.00 f this provider is a meaningful u	PEnter "Y" for yes or user (line 167 is "Y")	"N" for no. (see	instruction	ıs)	·	0. 0	00169.
transition factor. (see instruction	(כות			Be	egi nni ng	Endi ng	
				- 50		2. 00	
					1. 00	2.00	

Health Financial Systems PUTNAM COUNTY H	In Lie	u of Form CM	MS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Peri od:	Worksheet	S-2	
		From 01/01/2018 To 12/31/2018		
		1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have any days for indisection 1876 Medicare cost plans reported on Wkst. S-3, Pt. I "Y" for yes and "N" for no in column 1. If column 1 is yes, e 1876 Medicare days in column 2. (see instructions)	N on		0 171. 00	

	Financial Systems PUTNAM COUNT AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1333	Period:	u of Form CMS- Worksheet S-2	
,5111	THE AND HOST FALL TEACHT SAILE RET MOUNTAINE QUESTION WITH	Trovider of		From 01/01/2018 To 12/31/2018	Part II	epared:
				Y/N	Date	+z piii
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter	N for all NO re	esponses. Ente	er all dates in	the	
	mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
	Has the provider changed ownership immediately prior to th	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in	column 2. (see				
			Y/N 1,00	Date	V/I	
00	Has the provider terminated participation in the Medicare	Program2 If	1.00 N	2. 00	3. 00	2.00
00	yes, enter in column 2 the date of termination and in colu				I	2.00
	voluntary or "I" for involuntary.				I	
00	Is the provider involved in business transactions, includi		N		I	3.00
	contracts, with individuals or entities (e.g., chain home				I	
	or medical supply companies) that are related to the provi officers, medical staff, management personnel, or members				I	
	of directors through ownership, control, or family and oth				I	
	relationships? (see instructions)					
			Y/N	Туре	Date	
	Financial Data and Danasta		1.00	2. 00	3. 00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Public	l N			4.00
00	Accountant? Column 2: If yes, enter "A" for Audited, "C"	for Compiled,			I	1.00
	or "R" for Reviewed. Submit complete copy or enter date av				I	
	column 3. (see instructions) If no, see instructions.				I	
00	Are the cost report total expenses and total revenues diff those on the filed financial statements? If yes, submit re		N		I	5.00
	those on the fired financial statements? If yes, submit re	CONCITTATION.		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is t	he provider is	s N	I	6. 00
20	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see i	netructi one		N		7.00
00 00	Were nursing school and/or allied health programs approved		d during the	N N	I	8.00
	cost reporting period? If yes, see instructions.		a dairing the		I	0.00
00	Are costs claimed for Interns and Residents in an approved		cal education	N	I	9.00
00	program in the current cost report? If yes, see instruction				l	10.00
. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in	tne current	N	I	10.00
. 00	Are GME cost directly assigned to cost centers other than	I & R in an Ap	proved	N	I	11.00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
	Day Dalata				1. 00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	s saa instruc	tions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection			ost reporting	N	13.00
. 00	period? If yes, submit copy.	por roy or ange	au g till	oo t i opoi ti iig		
	If line 12 is yes, were patient deductibles and/or co-paym	ents waived? I	fyes, see ins	structi ons.	N	14.00
	Bed Complement Did total beds available change from the prior cost report	ing posted2 lf	vac coo i not	tructions	N	15 00
. 00	prid total beds available change from the prior cost report	, , , , , , , , , , , , , , , , , , , ,	_yes, see ms t A		t B	15.00
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
	PS&R Data					
.00	Was the cost report prepared using the PS&R Report only?	N		N	I	16.00
	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				I	
	instructions)				I	
		Y	12/31/2018	Υ	12/31/2018	17.00
00	Was the cost report prepared using the PS&R Report for		i	1	i	1
. 00	totals and the provider's records for allocation? If				1	
. 00	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date					
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		18 00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		18. 00
. 00	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
. 00	totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N N		N N		18.00

HOSPI T	Financial Systems PUTNAM COUNTY TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1333	Peri od:	u of Form CMS Worksheet S		
	Service of the servic			From 01/01/2018 To 12/31/2018	Part II	repared:	
		Descri	pti on	Y/N	Y/N	7. 42 piii	
		()	1.00	3. 00		
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 0	
	-	Y/N	Date	Y/N	Date		
21 00	Week the seek was at a second and a selection the second deal of	1.00	2. 00	3.00	4. 00	21.0	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.0	
					1. 00		
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS I	HOSPI TALS)	I			
	Capital Related Cost						
22. 00	Have assets been relifed for Medicare purposes? If yes, see				N	22. 0	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	• • • • • • • • • • • • • • • • • • • •			N	23.0	
	Were new leases and/or amendments to existing leases entere If yes, see instructions	· ·			Y	24.0	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period	r? If yes, see	Υ	25. 0	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during th instructions.	ne cost report	ing period?	If yes, see	N	26. 0	
27. 00	Has the provider's capitalization policy changed during the copy.	cost reporti	ng period? I	f yes, submit	N	27. 0	
8. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit en	ntered into du	ring the cos	t reporting	Y	28.0	
9. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service	Reserve Fund)	Υ	29.0	
0. 00	treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see					30.0	
1. 00	instructions. Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If ye	es, see	N	31.0	
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through c	ontractual	N	32.0	
3. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	N	33.0	
	Provi der-Based Physi ci ans						
	Are services furnished at the provider facility under an ar	rangement witl	h provider-b	ased physicians?	Υ	34.0	
5. 00		sting agreeme	nts with the	provi der-based	Υ	35.0	
	physicians during the cost reporting period? If yes, see in	structi ons.		V (0)	5 .		
				Y/N 1. 00	Date 2.00		
	Home Office Costs			1.00	2.00		
6. 00	Were home office costs claimed on the cost report?			N		36.0	
	If line 36 is yes, has a home office cost statement been pr	epared by the	home office			37.0	
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off					38.0	
	the provider? If yes, enter in column 2 the fiscal year end	of the home	offi ce.			39.0	
	see instructions. If line 36 is yes, did the provider render services to the	·	,			40.0	
	i nstructi ons.		3				
	1.00 2.0						
	Cost Report Preparer Contact Information						
1.00	held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41.0	
	respectively. Enter the employer/company name of the cost report	BLUE & CO., LL	C			42.0	
12.00	preparer.						

Heal th	Financial Systems	PUTNAM COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der		Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 3/28/2019 5:4	pared:
		-		3. 00			
	Cost Report Preparer Contact Information			3.00			
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		MANAGER				41. 00
42.00	Enter the employer/company name of the cost r	report					42.00
43. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43. 00

| Period: | Worksheet S-3 | From 01/01/2018 | Part | To | 12/31/2018 | Date/Time Prepared: Health Financial SystemsPUTNAMHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 15-1333

						То	12/31/2018	Date/Time Pre 3/28/2019 5:4	
								I/P Days /	Z piii
								0/P Visits /	
								Tri ps	
	Component	Worksheet A	No	. of Beds	Bed Days		CAH Hours	Title V	
		Line Number		0.00	Available	-	4 00	F 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1. 00 30. 00		2.00	3.00) E	4. 00 50, 376. 00	5. 00 0	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		19	0, 93	55	50, 576.00	0	1.00
	Hospice days)(see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2.00
3.00	HMO IPF Subprovider								3. 00
4.00	HMO IRF Subprovider								4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							0	
6.00	Hospital Adults & Peds. Swing Bed NF							0	
7. 00	Total Adults and Peds. (exclude observation			19	6, 93	35	50, 376. 00	0	7. 00
	beds) (see instructions)							_	
8.00	I NTENSI VE CARE UNI T	31. 00		6	2, 19	Ю	2, 304. 00	0	
9.00	CORONARY CARE UNIT								9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT								10.00 11.00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13. 00	NURSERY	43.00						0	
14. 00	Total (see instructions)	45.00		25	9, 12	25	52, 680. 00	Ö	
15. 00	CAH visits				//		02, 000. 00	0	
16.00	SUBPROVIDER - IPF							·	16.00
17.00	SUBPROVI DER - I RF	41. 00		0		0		0	17. 00
18.00	SUBPROVI DER	42.00		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	20.00							24.00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30. 00							24. 10 25. 00
25. 00	CMHC - CORF	99. 10						0	
26. 00	RURAL HEALTH CLINIC	88. 00						0	
26. 01	RURAL HEALTH CLINIC II	88. 01						Ö	
26. 02	RURAL HEALTH CLINIC III	88. 02						Ö	
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 Trips								29. 00
30.00	Employee discount days (see instruction)								30.00
31.00	Employee discount days - IRF								31.00
32.00	Labor & delivery days (see instructions)			0		0			32.00
32. 01	Total ancillary labor & delivery room								32. 01
22 00	outpatient days (see instructions)								22 00
33.00	LTCH non-covered days LTCH site neutral days and discharges								33. 00 33. 01
JJ. UI	LETON SI LE NEULT di days and discharges	ı	ı		I	- 1	ı	I	1 33.01

Provider CCN: 15-1333

Peri od: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

				'	0 12/01/2010	3/28/2019 5: 4	2 pm
	·	I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
				•		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 264	125	2, 021			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)	0	0				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	339	0	350)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	88	3		6.00
7.00	Total Adults and Peds. (exclude observation	1, 603	125	2, 459			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	174	0	174			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	C)		13.00
14.00	Total (see instructions)	1, 777	125	2, 633	0.00	274. 00	14.00
15.00	CAH visits	0	0	C)		15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF	0	0	C	0.00	0.00	17.00
18.00	SUBPROVI DER		0	C	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part))		24. 10
25.00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	O	0	(0. 00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	1, 018	0	9, 511	0. 00	3. 40	26.00
26. 01	RURAL HEALTH CLINIC II	1, 847	0	11, 215	0.00	4. 22	26. 01
26. 02	RURAL HEALTH CLINIC III	1, 218	0	5, 668	0.00	2. 20	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	283. 82	27.00
28.00	Observation Bed Days		0	1, 209			28. 00
29.00	Ambul ance Trips	o					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)	o	0	l c)		32.00
32. 01	Total ancillary labor & delivery room)		32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01
	· · · · · · · · · · · · · · · · · · ·						

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

				To	12/31/2018	Date/Time Pre 3/28/2019 5:4	
		Full Time		Di sch	arges	072072017 0. 1	2 0111
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
	I	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	436	30	771	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			o	0		2.00
3. 00	HMO IPF Subprovider				0		3.00
4. 00	HMO IRF Subprovider				Ö		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				Ğ		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	436	30	771	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - I PF	0.00	0			0	16.00
17.00	SUBPROVIDER - IRF	0. 00 0. 00	0		0	0	17. 00 18. 00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY	0.00	Ü		Ч	U	19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25.00
25. 10	CMHC - CORF	0.00					25. 10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0. 00					26. 01
26. 02	RURAL HEALTH CLINIC III	0. 00					26. 02
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						28. 00
29.00	Ambul ance Trips						29.00
30. 00 31. 00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
31.00	Labor & delivery days (see instructions)						31.00
32. 00	Total ancillary labor & delivery room						32.00
JZ. UI	outpatient days (see instructions)						JZ. U1
33. 00	LTCH non-covered days			0			33. 00
	LTCH site neutral days and discharges			l o	ļ		33. 01
	3	'			'	'	•

IOSPI :	n Financial Systems TAL-BASED RHC/FQHC STATISTICAL DATA	PUTNAM COUNT		CN: 15-1333	Peri od:	eu of Form CMS- Worksheet S-	
				CCN: 15-8515	From 01/01/2018 To 12/31/2018	3	epared
					RHC I	Cost	12 piii
	Clinic Address and Identification				1.	. 00	
. 00	Street				1542 S. BLOOMI	NGTON STREET	1.0
		1			STE 1200	1	
				ty	State	ZIP Code	-
. 00	City, State, ZIP Code, County		GREENCASTLE	00	2. 00	3. 00 46135	2.
. 00	jorty, state, zir sode, sounty		ONEENONOTEE			10100	2. \
						1. 00	
. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for		- ± A		3.
					nt Award 1.00	2. 00	
	Source of Federal Funds				1.00	2.00	
. 00	Community Health Center (Section 330(d), PHS						4.
. 00	Migrant Health Center (Section 329(d), PHS A						5.
. 00 . 00	Health Services for the Homeless (Section 34) Appalachian Regional Commission	J(d), PHS Act)					6. 7.
. 00	Look-Alikes						8.
. 00	OTHER (SPECIFY)						9.
2 00	Does this facility operate as other than a h	anital based [DUC on FOUCA F	nton "V" for	1. 00 N	2.00	10.
0. 00	yes or "N" for no in column 1. If yes, indicate 2. (Enter in subscripts of line 11 the type or	ate number of o	other operatio	ns in column			10.
	hours.)		1.	1		T I.	
		Suno from	to	from	londay to	Tuesday from	+
		1. 00	2.00	3.00	4.00	5. 00	
	Facility hours of operations (1)			I		T	
1. 00	CLINIC			08: 00	17: 00	08: 00	11.
					1. 00	2.00	
2. 00 3. 00	Is this a consolidated cost report as define	ed in CMS Pub. 100-04, chapter 9, section umn 1. If yes, enter in column 2 the			N		12. 13.
	number of providers included in this report.			ders and			
					dor name	CCN pumbos	
	number of providers included in this report.			Provi	der name	CCN number	
4. 00	number of providers included in this report.	List the names	s of all provi	Provi		2. 00	
4. 00	number of providers included in this report. numbers below.	List the names	s of all provi	Provi	1. 00 XI X	2.00 Total Visits	
4.00	number 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	List the names	s of all provi	Provi	1. 00	2. 00	
	number 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	List the names	s of all provi	Provi	1. 00 XI X	2.00 Total Visits	
	number 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.	List the names	V 2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	
5. 00	number 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)	Y/N 1.00	V 2.00	XVIII 3.00	1. 00 XI X	2.00 Total Visits	15.
5. 00	number 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.	Y/N 1.00	V 2.00 Cou	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits 5.00	15.1
5. 00	number 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)	Y/N 1.00	V 2.00 COU 4. PUTNAM Wedne	XVIII 3.00 anty 00 esday	1. 00 XI X 4. 00 Thur	2.00 Total Visits	15. (
	number 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)	Y/N 1.00 Tuesday	V 2.00 Cou	XVIII 3.00	1. 00 XI X 4. 00	2.00 Total Visits 5.00	15.

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Peri od:	Worksheet S-8	
				From 01/01/2018		
		Component	CCN: 15-8515	To 12/31/2018		
					3/28/2019 5: 4	2 pm
				RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC	08: 00	17: 00				11.00

Heal th	n Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Peri od: From 01/01/2018	Worksheet S-8	8
			Component	CCN: 15-8513	To 12/31/2018	Date/Time Pro 3/28/2019 5:4	
					RHC II	Cost	
					1	00	-
	Clinic Address and Identification				1.	00	
1. 00	Street				51 E. MARKET S		1.00
				00	State 2.00	ZIP Code 3.00	
2. 00	City, State, ZIP Code, County		CLOVERDALE 1.	00		46120	2.00
			,				
2 00	LICCOLTAL DACED FOLIO ONLY D. C. L. C. L.	II DIII C		- to a second		1.00	2 2 26
3. 00	HOSPITAL-BASED FOHCS ONLY: Designation - Ent	er "R" for rur	al or "U" for		nt Award	O Date	3.00
					1. 00	2. 00	
	Source of Federal Funds						
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4. 00 5. 00
6. 00	Health Services for the Homeless (Section 34						6.00
7. 00	Appal achi an Regi onal Commi ssi on	-(-),,					7. 00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9.00
					1. 00	2. 00	
10.00	j ,	•				0	10.00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o						
	hours.)	i otner operat	ron(s) and the	operating			
	, now or)	Sun	day	N	londay	Tuesday	
		from	to	from	to	from	
	Facility hours of operations (1)	1. 00	2.00	3. 00	4. 00	5. 00	
11. 00	CLINIC			08: 00	18: 00	08: 00	11.00
12.00	Have you received an approval for an excepti	on to the prod	ustivity stand	ard?	1. 00 N	2. 00	12.00
12. 00 13. 00						0	
	30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu	mn 2 the			
	number of providers included in this report.	List the name	s of all provi	ders and			
	numbers below.			Prov	ider name	CCN number	
	,				1. 00	2. 00	
14.00	RHC/FQHC name, CCN number) / /N		20011	V// V/	T	14.00
		Y/N 1. 00	V 2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
15. 00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	3.00	15.00
	GME cost? Enter "Y" for yes or "N" for no in						
	column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		Col	l Inty			
			4.	00			
2. 00	City, State, ZIP Code, County	T .	PUTNAM				2.00
		Tuesday		esday T +o		sday	
		to	from	to	from	to	_
		6.00	7, 00	8.00	9.00	10, 00	
	Facility hours of operations (1)	6. 00	7. 00	18: 00	9. 00	10.00	11.00

Health Financial Systems	PUTNAM COUNT	TY 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	
		Component	CCN: 15-8513	From 01/01/2018 To 12/31/2018		
				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

	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Peri od:	Worksheet S-8	·2552 3
			Component	CCN: 15-8514	From 01/01/2018 To 12/31/2018		
					RHC III	Cost	. <u> </u>
ı							
					1.	00	
00	Clinic Address and Identification				140 E DAT DAE	N/ 11/4N/	1
00	Street		Ci	ty	440 E. PAT RAD	ZIP Code	1.
				00	2.00	3. 00	1
00	City, State, ZIP Code, County		BAI NBRI DGE	00		46105	2.
					-		
						1. 00	
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for run	al or "U" for			0	3.
					t Award 1.00	Date	+
	Source of Federal Funds				1.00	2. 00	1
00	Community Health Center (Section 330(d), PHS	Act)					4.
00	Migrant Health Center (Section 329(d), PHS A						5
00	Health Services for the Homeless (Section 34	O(d), PHS Act)					6
00	Appalachian Regional Commission						7
00	Look-Alikes						8
00	OTHER (SPECIFY)						9
					1. 00	2. 00	+-
00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for	N N		10
	yes or "N" for no in column 1. If yes, indic	ate number of	other operatio	ns in column			
	2. (Enter in subscripts of line 11 the type o	f other operat	ion(s) and the	operati ng			
	hours.)		T.	1		T	
			day L +		onday	Tuesday from	+
		from 1.00	2. 00	from 3.00	4. 00	5. 00	+
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
. 00	CLINIC			08: 00	17: 00	08: 00	11
				•			
					1. 00	2.00	
					N	2.00	12
	Is this a consolidated cost report as define	d in CMS Pub.	100-04, chapte	r 9, section			12
. 00 . 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	2.00	12
	Is this a consolidated cost report as define	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N	2.00	12
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	N	2.00	12
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	N N	2.00	12
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 0 CCN number 2.00	12
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 CCN number 2.00 Total Visits	12
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN number	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 0 CCN number 2.00	12 13
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 CCN number 2.00 Total Visits	12 13
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 CCN number 2.00 Total Visits	12 13
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 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	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 CCN number 2.00 Total Visits	12 13
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC 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	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 CCN number 2.00 Total Visits	12 13
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 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. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 CCN number 2.00 Total Visits	12 13
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 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. umn 1. If yes, List the name	100-04, chapte enter in colu s of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 CCN number 2.00 Total Visits	12 13
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 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. umn 1. If yes, List the name	100-04, chapte enter in colus of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00	N N der name	2.00 CCN number 2.00 Total Visits	12 13
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 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. umn 1. If yes, List the name	100-04, chapte enter in colus of all provi	r 9, section mn 2 the ders and Provi	N N der name	2.00 CCN number 2.00 Total Visits	12 13
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. 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. umn 1. If yes, List the name Y/N 1.00	100-04, chapte enter in colus of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00	N N N N N N N N N N N N N N N N N N N	2.00 CCN number 2.00 Total Visits 5.00	12 13 13 15 15
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC 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. umn 1. If yes, List the name Y/N 1.00	100-04, chapte enter in colus of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00 unty 00 esday	N N N N N N N N N N N N N N N N N N N	2.00 CCN number 2.00 Total Visits 5.00	12 13 13 14 15
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC 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. umn 1. If yes, List the name Y/N 1.00 Tuesday to	100-04, chapte enter in colus of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00 esday to	N N N N N N N N N N N N N N N N N N N	2.00 CCN number 2.00 Total Visits 5.00	12
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. RHC/FOHC 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. umn 1. If yes, List the name Y/N 1.00	100-04, chapte enter in colus of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00 unty 00 esday	N N N N N N N N N N N N N N N N N N N	2.00 CCN number 2.00 Total Visits 5.00	12 13 13 14 14 15

Health Financial Systems	PUTNAM COUNT	ΓΥ 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	
		Component	CCN: 15-8514	From 01/01/2018 To 12/31/2018		
				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

	Financial Systems PUTNAM COUNTY HOS FAL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN: 15	5-1333	Peri od:	u of Form CMS-2 Worksheet S-1	
03111	THE UNCOME ENSATED AND THIS DENT CARE DATA	OVI dei Con. 13		From 01/01/2018	WOLKSHEET 3-1	U
				To 12/31/2018	Date/Time Pre	pared
					3/28/2019 5: 4	2 pm
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divi	ded by line 2	02 column	า 8)	0. 331136	1.0
00	Medicaid (see instructions for each line)				225 522	, ,
. 00 . 00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				325, 533	2. 0 3. 0
.00	If line 3 is yes, does line 2 include all DSH and/or supplementa	al navments fr	om Medica	ai d2		4. (
00	If line 4 is no, then enter DSH and/or supplemental payments from		om weare	ii d :	0	5.
00	Medi cai d charges				812, 077	
00	Medicaid cost (line 1 times line 6)				268, 908	1
00	Difference between net revenue and costs for Medicaid program (I	ine 7 minus s	um of lir	nes 2 and 5; if	0	8.
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions for	each line)				
00	Net revenue from stand-alone CHIP				0	
	Stand-alone CHIP cost (Line 1 times Line 10)				0	
1.00 2.00	,	ino 11 minus	lina O·i	f < zero then	0	11. 12.
2. 00	enter zero)	THE IT IIITIUS	11116 7, 1	1 < Zero then	U	12.
	Other state or local government indigent care program (see instr	ructions for e	ach line			
3. 00	Net revenue from state or local indigent care program (Not inclu				0	13.
1. 00	Charges for patients covered under state or local indigent care				0	14.
	10)					
5. 00					0	15.
5. 00		gent care pro	gram (lir	ne 15 minus line	. 0	16.
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIF	and state/lo	cal india	nont caro progra	mc (coo	
	instructions for each line)	and State/10	cai inai (gent care progra	1113 (366	
7. 00	Private grants, donations, or endowment income restricted to fur	nding charity	care		0	17.
3. 00	Government grants, appropriations or transfers for support of ho	ospital operat	i ons		0	18.
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care	programs	s (sum of lines	0	19.
	0, 12 diu 10)	Un	i nsured	Insured	Total (col. 1	
			tients	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
	Uncompensated Care (see instructions for each line)					
0. 00		lity	695, 66	6 0	695, 666	20.
1. 00	(see instructions) Cost of patients approved for charity care and uninsured discour	nts (see	230, 36	o	230, 360	21.
1.00	instructions)	113 (366	230, 30		230, 300	21.
2. 00	Payments received from patients for amounts previously written of	off as		ol ol	0	22.
	charity care				_	
3. 00	Cost of charity care (line 21 minus line 22)		230, 36	0 0	230, 360	23.
1 00	D			. 6 . 1 1	1.00	0.4
1. 00	Does the amount on line 20 column 2, include charges for patient		a Length	of stay limit	N	24.
5. 00	imposed on patients covered by Medicaid or other indigent care partial line 24 is yes, enter the charges for patient days beyond the	-	e progran	n's Lenath of	0	25.
	stay limit	30 001	- F. 59. ui			
5. 00	Total bad debt expense for the entire hospital complex (see inst	tructions)			3, 384, 733	26.
7. 00	Medicare reimbursable bad debts for the entire hospital complex	(see instruct	i ons)		530, 487	1
7. 01	Medicare allowable bad debts for the entire hospital complex (see	ee instruction	s)		816, 135	27.
3. 00	' '				2, 568, 598	1
9. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expe	ense (see inst	ructions))	1, 136, 203	1
	Cost of uncompensated care (line 23 column 3 plus line 29)				1, 366, 563	30.
0.00	Total unreimbursed and uncompensated care cost (line 19 plus lin	20)		l l	1, 366, 563	1 ~ 4

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Cost Center Description		Financial Systems	PUTNAM COUNTY		ON 45 4000 D		u of Form CMS-2	2552-10
Cost Center Description	RECLAS	STRICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IF EXPENSES	Provider C			worksneet A	
Cost Center Description								
Company Comp		Cost Contor Doscription	Salarios	Othor	Total (col 1	Doct assi fi cat		2 pm
1.00 2.00 3.00 4.00 5.00 5.00 1.00		cost center bescription	Sai ai i es	other				
DEBUND STATES 1.00 2.00 3.00 4.00 5.00					,	7		
DEBERBAL SERVICE COST CENTERS 1.00 0.000								
1.00 001000 NEW CAP IELC COSTS-SILIC & FIXT 1.00 0.00		CENEDAL CEDILLOS COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
4.00 00-000 EMPLOYEE ERREFITS CEPTAGN 2,533,424 4,596,057 4,580,050 4,580,050 4,580,050 6,000 00-0000 CEPTAGN 1,000	1 00			2 314 496	2 314 496	310 267	2 624 763	1 00
5.00 DODOO ADMINISTRATIVE & CENERAL 2,533, 243 4,595, 245 7,128, 488 -107, 749 7,020, 739 5,00 8.00 DOSCOLLARMONY & LINEN SERVICE 26,076 154,014 181,290 181,290 181,290 8,00 8.00 DOSCOLLARMONY & LINEN SERVICE 26,076 154,014 181,290 181,290 181,290 8,00 8.00 DOSCOLLARMONY & LINEN SERVICE 26,076 154,014 181,290 7,241,190 181,290 8,00 8.00 DOSCOLLARMONY & LINEN SERVICE 26,076 154,014 181,290 7,241,190 7,241,190 8,00 8.00 DOSCOLLARMONY & LINEN SERVICE 26,076 154,041 181,290 7,241,190 7,241,190 7,245 7,241,190 7,245 7,241,190 7,245 7,241,190 7,245			50, 885					
8.00 00000 LAUNDRY & LINEN SERVICE 26, 676 154, 614 181, 200 0 181, 200 377, 612 0 177, 612 0 177, 612 10 10 10 10 10 10 10		1 1						
9.00 OSCIOL PLANSIFICH IN STRATTON 330, 245 150, 53 427, 617 594, 109 248, 078 11. 00 10100 CARELERIA 300 10100 CARELERIA 300, 201 11. 00		l I						
10.00 101000 DIETARY 330, 634 511, 552 842, 187 -594, 109 248, 078 10.00 175, 275 10.00								
11.00 01100 CAFETERIA 0 0 0 0 0 0 10.10 0594,109 10.10								
13.00 01300 MIRSING ARMIN INSTRATION			0	0 0			· ·	
17.00 10700 SOCIAL SERVICE 0			69, 839	51, 277	121, 116			
17.01 1070 UTIL IZATION REVIEW 72.095 6,099 78,796 0 78,794 17.01			310, 425	163, 449			473, 874	
IMPART ENT ROUTH NE SERVICE COST CENTERS 1,776,000 162,803 1,938,803 0 1,938,803 30.00 30.00 2000 (AUTES & PEDIA PRITIC ST 1,776,000 162,803 1,938,803 0 1,938,803 30.00 31.00			0	0				
30.00	17.01		72, 695	6, 099	/8, /94	0	78, 794	17.01
31.0 0 03100 INTENSIVE CARE UNIT	30. 00		1, 776, 060	162, 803	1, 938, 863	0	1, 938, 863	30.00
42.00 04200 SURPEROVI DER 0 0 0 0 0 42.00								
43.00 0.4300 MURSTERY 0.0 0.0 0.0 0.0 0.43.00			0	0	0	0	0	
ANCILLARY SERVICE COST CENTERS			0	0	1	0	_	
50.00	43.00		0	0	0	0	0	43.00
51.00	50.00		622, 256	901. 078	1, 523, 334	-25, 300	1, 498, 034	50.00
53.00 0.6300 AMESTHESS OLOCY 821, 684 59, 564 881, 248 50, 575 50 0. 881, 248 53, 054 0. 640, 00 640								
54.00 05400 RADIOLOGY-DIAGNOSTIC 882, 902 326, 673 1, 209, 575 54.01 4.01 05401 MUCLEAR MEDICINE-DIAGNOSTIC 0 153, 537 53.7 54.01 54.02 03480 MUCLEORY 028, 338 3, 361, 931 3, 645, 269 0 3, 645, 269 54.02 57.00 05700 05700 05700 05700 0500 0 0 0 0 0 0 58.00 08800 MAGNETIC RESONANCE IMAGING (MRI) 105, 119 254, 499 419, 612 0 0 0 0 0 0 0 59.00 05900 05900 05900 0 0 0 0 0 0 0 0 0			0	-	1		_	
54. 01 05401 NUCLEAR MEDIC INE-DI AGNOSTI C 0 153, 537 153, 537 0 3, 645, 269 54. 02 03460 2000 000 00 00 00 00 00								
54. OZ 03480 0NCOLOGY 283, 338 3, 361, 931 3, 645, 269 0 3, 645, 269 56. OZ 05. OZ								
57.00			-					1
59.00 05900 CARDIA CATHETER IZATION 0 0 0 0 59.00								
60.00 06000 LABORATORY 674, 208 1, 469, 989 2, 144, 197 0 0 2, 144, 197 60.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0	0	
60.01			٥	0	0		_	
64.00 06400 INTRAVENOUS THERAPY 346, 295 72, 331 418, 626 0 418, 626 65, 00			674, 208	1, 469, 989	2, 144, 197	0	2, 144, 197	
65.00 06500 RESPIRATORY THERRAPY 346, 295 72, 331 418, 626 0 418, 626 65.00 6600 0600 PHYSI CAT LHERAPY 0 120, 039 120, 039 0 120, 039 67.00 637, 770 60.00 67.00 67.00 06700			0	0	0	0	0	
67 00 0670			346, 295	72, 331	418, 626	0	_	
68 00 06800 SPECH PATHOLOGY 0 53,593 53,593 0 53,593 68.00	66.00		0	637, 770	637, 770	0	637, 770	66.00
99 00 06900 CADDIA CREHAB CREHAB CADDIA CREHAB CAD			- 1	·				
69-01 CARDI AC REHAB CARDIN AC REHAB		l I	-	·			· ·	
71. 00 07100 NEDICAL SUPPLIES CHARGED TO PATIENTS 0 35, 131 35, 131 -34, 709 422 71. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 0 0 60, 009 60, 009 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 184, 587 1, 203, 736 1, 388, 323 0 1, 388, 323 73. 00 07300 DRUGS CHARGED TO PATIENTS 184, 587 1, 203, 736 1, 388, 323 0 1, 388, 323 73. 00 07300 DRUGS CHARGED TO PATIENTS 184, 587 1, 203, 736 1, 388, 323 0 1, 388, 323 0 1, 388, 323 73. 00 0747 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1								
73.00 07300 DRUGS CHARGED TO PATIENTS 184, 587 1, 203, 736 1, 388, 323 0 1, 388, 323 73.00								
Name			0	0	0			
88. 00 08800 RURAL HEALTH CLINIC 903, 379 323, 001 1, 226, 380 -105, 208 1, 121, 172 88. 00 88. 01 08801 RURAL HEALTH CLINIC 11 979, 744 318, 800 1, 298, 544 -100, 629 1, 197, 915 88. 01 88. 02 08802 RURAL HEALTH CLINIC 111 485, 558 237, 769 723, 327 -83, 746 639, 581 88. 02 90. 00 9000 0 0 0 0 0 0 0	73. 00		184, 587	1, 203, 736	1, 388, 323	0	1, 388, 323	73.00
88. 01 08801 RIVRAL HEALTH CLINIC II 979, 744 318, 800 1, 298, 544 -100, 629 1, 197, 915 88, 01 88. 02 08902 RIVRAL HEALTH CLINIC III 485, 558 237, 769 723, 327 -83, 746 639, 581 88. 02 90, 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 99, 00 99, 00 99, 00 10 99, 00 10 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	88 00		903 379	323 001	1 226 380	-105 208	1 121 172	88 00
88. 02 08802 RURAL HEALTH CLINIC III 485,558 237,769 723,327 -83,746 639,581 88. 02 89. 00 08900 FEBERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 90. 00								
90. 01 09000 CLI NI C			485, 558			-83, 746		
90. 01 09001 RHEUMATOLOGY 179, 845 42, 136 221, 981 -219, 554 2, 427 90. 01 91. 00 09000 DIRERGENCY 2, 645, 262 1, 344, 186 3, 989, 448 0 3, 989, 448 91. 00 92. 00 09000 OSERVATI ON BEDS (NON-DI STI NCT PART) 09010 CORF 0 0 0 0 0 0 0 0 0			0	0	0	0		
91. 00 09100 EMERGENCY 2, 645, 262 1, 344, 186 3, 989, 448 0 3, 989, 448 91. 00 92.00 0BSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 0THER REI MBURSABLE COST CENTERS 99. 10 0 0 0 0 0 0 0 0 0			170 045	42 124	0	210 554	_	
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0								
99. 10 SPECI AL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			2,0.0,202	1,011,100	0,707,110		3,737,110	
SPECIAL PURPOSE COST CENTERS 109.00 109000 PANCREAS ACQUI SI TI ON 0 0 0 0 0 1090.00 1010.00								
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 110.00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 1110. 00 111. 00 1110 ISLET ACQUISITION 0 0 0 0 0 0 0 1111. 00 1113. 00 11300 INTEREST EXPENSE 0 0 0 0 0 0 1113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 15, 994, 442 24, 969, 446 40, 963, 888 -34, 899 40, 928, 989 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0	99. 10		0	0	0	0	0	99. 10
110.00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 110.00	100 00		0	0	1	0	0	100 00
111. 00			-	0				
114. 00	111.00	11100 I SLET ACQUISITION	0	0	0	0		
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 15, 994, 442 24, 969, 446 40, 963, 888 -34, 899 40, 928, 989 118. 00		l I		0	0	0		
NONRE MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00			15 004 443	0 0 0 11	0	0		
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 2, 494, 946 963, 405 3, 458, 351 -183, 096 3, 275, 255 192. 00 192. 01 19201 JOHNSON/NI CHOLS WI C 297, 322 52, 098 349, 420 -972 348, 448 192. 01 192. 02 19203 RHEUMATOLOGY 0 0 0 0 218, 967 218, 967 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 193. 01 19301 DME 0 0 0 0 0 0 0 0 193. 01 193. 01 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 0 0 193. 02 194. 00 195. 01 195.	118.00		15, 994, 442	24, 969, 446	40, 963, 888	-34, 899	40, 928, 989	1118.00
192. 01 19201 JOHNSON/NI CHOLS WI C 297, 322 52, 098 349, 420 -972 348, 448 192. 01 192. 02 19203 RHEUMATOLOGY 0 0 0 218, 967 218, 967 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 DME 0 0 0 0 0 0 0 193. 01 193. 01 193. 02 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 193. 02 194. 00 07950 VACANT SPACE 0 0 0 0 0 0 194. 00 194. 01 194. 01 194. 01 1975 BOARD OF HEALTH	190.00		0	0	0	0	0	190. 00
192. 02 19203 RHEUMATOLOGY 0 0 218, 967 218, 967 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 DME 0 0 0 0 0 0 0 193. 01 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 0 193. 02 193. 02 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 193. 02 194. 01 07950 VACANT SPACE 0 0 0 0 0 0 194. 00 194. 01 194. 01 07951 BOARD OF HEALTH			2, 494, 946			-183, 096	3, 275, 255	192. 00
193. 00			297, 322	52, 098				
193. 01 19301 DME			0	0	0	218, 967		
193. 02 19302 LACTATI ON CONSULTING 0 0 0 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG 0 0 0 0 0 193. 03 194. 00 07950 VACANT SPACE 0 0 0 0 0 194. 00 194. 01 07951 BOARD OF HEALTH 0 0 0 0 0 194. 01			0	0				
193. 03 19303 DI ABETI C COUNSELI NG			ol	0	0	Ö		
194. 01 07951 BOARD OF HEALTH 0 0 0 0 0 194. 01	193. 03	19303 DI ABETI C COUNSELI NG	O	0	0	0		
	194.00	07950 VACANT_SPACE	-	0				
טן ט			-	0		-		
	174.02	Jo., 702 TOTAL MATERIAL TREMATAL	<u> </u>			<u> </u>	0	11,77.02

Heal th Financi	al Systems	PUTNAM COUNTY	/ HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSI FI CATI	ON AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		Peri od:	Worksheet A	
					From 01/01/2018		
					lo 12/31/2018	Date/Time Pre	
						3/28/2019 5: 4	2 pm
Co	ost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	ions (See	Trial Balance	
					A-6)	(col. 3 +-	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
200.00 To	OTAL (SUM OF LINES 118 through 199)	18, 786, 710	25, 984, 949	44, 771, 659	9 0	44, 771, 659	200.00

 Health Financial
 Systems
 PUTNAM CO

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1333

			To 12/31/2018 Date/lime Pre 3/28/2019 5: 4	
Cost Center Description	Adjustments	Net Expenses		ļ
	(See A-8)	For		
	6. 00	Allocation 7.00		
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 NEW CAP REL COSTS-BLDG & FLXT	-94, 108	2, 530, 655		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-5, 249	4, 575, 703	•	4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	-1, 914, 124	5, 106, 615		5.00
7. 00 00700 OPERATION OF PLANT	-5, 851	1, 670, 001		7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	181, 290 477, 612	•	8. 00 9. 00
10. 00 01000 DI ETARY	0	248, 078	•	10.00
11. 00 01100 CAFETERI A	-70, 087	524, 022	•	11.00
13.00 01300 NURSING ADMINISTRATION	0	121, 116	•	13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	O	473, 874		16.00
17. 00 01700 SOCIAL SERVICE	0	0	l .	17. 00
17. 01 01701 UTI LI ZATI ON REVI EW	0	78, 794		17. 01
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS	-735, 389	1, 203, 474		30.00
31. 00 03100 NTENSI VE CARE UNI T	-735, 384	818, 466	1	31.00
41. 00 04100 SUBPROVI DER - RF	o o	0	l .	41.00
42. 00 04200 SUBPROVI DER	o	0		42.00
43. 00 04300 NURSERY	0	0		43.00
ANCILLARY SERVICE COST CENTERS		4 400 004		
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM	0	1, 498, 034 99, 809		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	99, 809	•	52.00
53. 00 05300 ANESTHESI OLOGY	-703, 481	177, 767	l .	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 209, 575	•	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	o	153, 537		54. 01
54. 02 03480 ONCOLOGY	-238	3, 645, 031		54.02
57. 00 05700 CT SCAN	0	419, 612	l .	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59. 00 05900 CARDIAC CATHETERIZATION	0	0		58. 00 59. 00
60. 00 06000 LABORATORY	0	2, 144, 197		60.00
60. 01 06001 BLOOD LABORATORY	l ő	2, 144, 177		60.01
64. 00 06400 I NTRAVENOUS THERAPY	o	0		64.00
65. 00 06500 RESPIRATORY THERAPY	0	418, 626		65.00
66. 00 06600 PHYSI CAL THERAPY	-75, 269	562, 501		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	-15, 108	104, 931	•	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	53, 593	•	68. 00 69. 00
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	165, 907 247, 968	•	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	l o	422		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	Ö	60, 009	•	72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	-88, 194	1, 300, 129		73.00
OUTPATIENT SERVICE COST CENTERS	4, 077	1 101 005		
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	-16, 277	1, 104, 895 1, 106, 464		88.00
88. 02 08802 RURAL HEALTH CLINIC III	-91, 451 -9, 165	630, 416	•	88. 01 88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0, 103	030, 410	•	89.00
90. 00 09000 CLINIC	Ö	0		90.00
90. 01 09001 RHEUMATOLOGY	-154	2, 273		90. 01
91. 00 09100 EMERGENCY	-1, 987, 193	2, 002, 255		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				92.00
99. 10 09910 CORF	O	0		99. 10
SPECIAL PURPOSE COST CENTERS	<u> </u>	<u> </u>		1 //
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110.00
111. 00 11100 SLET ACQUISITION	0	0		111.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		113. 00 114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-5, 811, 338	35, 117, 651		118.00
NONREI MBURSABLE COST CENTERS	-5, 611, 550	33, 117, 031		1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	O	3, 275, 255		192.00
192. 01 19201 JOHNSON/NI CHOLS WIC	0	348, 448	•	192. 01
192. 02 19203 RHEUMATOLOGY	0	218, 967	l .	192.02
193. 00 19300 NONPALD WORKERS	0	0		193.00
193. 01 19301 DME 193. 02 19302 LACTATION CONSULTING	0	0		193. 01 193. 02
193. 02 19302 LACTATTON CONSULTING 193. 03 19303 DI ABETI C COUNSELI NG		0		193. 02
194. 00 07950 VACANT SPACE		0		194.00
194. 01 07951 BOARD OF HEALTH	o	0		194. 01
194.02 07952 PUTNAM/HENRY PRENATAL	0	0		194. 02
200.00 TOTAL (SUM OF LINES 118 through 199)	-5, 811, 338	38, 960, 321		200.00

Health Financial Systems RECLASSIFICATIONS PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2018 Provi der CCN: 15-1333

				To 12/31/2018 Date/Time Prepared: 3/28/2019 5: 42 pm
Increas	292			3/28/2019 5: 42 piii
Cost Center Line		Sal ary	Other	
2.00 3.00		4. 00	5. 00	
A - CLINIC RECLASS				
1.00 NEW CAP REL COSTS-BLDG & FLXT	1. 00	0	166, 910	1.00
2.00 ADMINISTRATIVE & GENERAL	5.00	O	8, 580	2. 00
3.00 OPERATION OF PLANT	7. 00	0	271, 720	3.00
4. 00	0. 00	o_	0	4.00
TOTALS		0	447, 210	
B - RHEUMATOLOGY RECLASS				
1.00 RHEUMATOLOGY 1	92. 02	177, 874	41, 674	1.00
TOTALS		177, 874	41, 674	
C - CAFE RECLASS				
1. 00 CAFETERI A	11. 00	233, 241	360, 868	1.00
TOTALS		233, 241	360, 868	
D - INSURANCE RECLASS				
1.00 NEW CAP REL COSTS-BLDG &	1.00	0	133, 647	1.00
FIXT				
TOTALS		0	133, 647	
E - PPO DEPRECIATION				
1.00 NEW CAP REL COSTS-BLDG &	1. 00	0	9, 710	1.00
FIXT				
2. 00	0. 00	0	0	2.00
3. 00	0. 00	0	0	3.00
4. 00	0. 00	0	0	4.00
5. 00	0. 00	0	0	5. 00
6. 00	0.00	0	0	6.00
7. 00	0. 00	0_	0	7.00
TOTALS		0	9, 710	
F - IMPLANTABLE DEVICES				
1.00 IMPL. DEV. CHARGED TO	72. 00	0	60, 009	1.00
PAT I ENT				
TOTALS		0	60, 009	
G - MED SUPPLY COST RECLASS				
	50. 00	0_	34, 709	1.00
TOTALS		0	34, 709	
H - PHYSICIAN PRACTICE A&G				
1. 00 ADMI NI STRATI VE & GENERAL	5. 00	17, 318	0	1.00
TOTALS		17, 318		
500.00 Grand Total: Increases		428, 433	1, 087, 827	500.00

Health Financial Systems RECLASSIFICATIONS PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1333

Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

							3/28/2019 5: 42 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CLINIC RECLASS						
1.00	RURAL HEALTH CLINIC	88. 00	0	103, 012	ç		1.00
2.00	RURAL HEALTH CLINIC II	88. 01	0	98, 833	C		2.00
3.00	RURAL HEALTH CLINIC III	88. 02	0	82, 612	C		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192. 00	O	162, 753	C		4.00
	TOTALS			447, 210			
	B - RHEUMATOLOGY RECLASS						
1.00	RHEUMATOLOGY	90. 01	177, 874	41, 674	C)	1.00
	TOTALS		177, 874	41, 674			
	C - CAFE RECLASS						
1.00	DI ETARY	10. 00	233, 241	360, 868	C)	1.00
	TOTALS		233, 241	360, 868		1	
	D - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	133, 647	12	2	1.00
	TOTALS			133, 647		1	
	E - PPO DEPRECIATION						
1.00	RURAL HEALTH CLINIC	88. 00	0	2, 196	9)	1.00
2.00	RURAL HEALTH CLINIC II	88. 01	0	1, 796	C		2.00
3.00	RURAL HEALTH CLINIC III	88. 02	0	1, 134	C		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	3, 025	C		4.00
5.00	JOHNSON/NI CHOLS WIC	192. 01	0	972	C		5.00
6.00	RHEUMATOLOGY	192. 02	0	581	C		6.00
7.00	RHEUMATOLOGY	90. 01	0	6	C		7. 00
	TOTALS	T		9, 710			
	F - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50. 00	0	60, 009	C)	1.00
	TOTALS	T		60, 009			
	G - MED SUPPLY COST RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	34, 709	C)	1.00
	PATI ENTS						
	TOTALS			34, 709			
	H - PHYSICIAN PRACTICE A&G						
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	17, 318	0	C		1.00
	TOTALS		17, 318	0			
500.00	Grand Total: Decreases		428, 433	1, 087, 827]	500.00
	•				•	•	•

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS PUTNAM COUNTY HOSPITAL

Provi der CCN: 15-1333

				To	12/31/2018	Date/Time Pre 3/28/2019 5:4	
				Acqui si ti ons		3/20/2019 3.4	Z pili
		Beginning	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 ASSE	T BALANCES					
1.00	Land	159, 364	0	0	0	0	1.00
2.00	Land Improvements	329, 844	11, 980	0	11, 980	0	2.00
3.00	Buildings and Fixtures	30, 727, 017	1, 950, 561	0	1, 950, 561	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fi xed Equi pment	0	0	0	0	0	5.00
6.00	Movable Equipment	23, 096, 776	1, 202, 875	0	1, 202, 875	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	54, 313, 001	3, 165, 416	0	3, 165, 416	0	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	54, 313, 001	3, 165, 416	0	3, 165, 416	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
			Assets				
	DADT 1 4041 VOLO OF OUR 1005 AN OADLTAL 4005	6.00	7. 00				
4 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						4 00
1.00	Land	159, 364	0				1.00
2.00	Land Improvements	341, 824	0				2.00
3.00	Buildings and Fixtures	32, 677, 578	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fi xed Equipment	0	0				5.00
6.00	Movable Equipment	24, 299, 651	0				6.00
7.00	HIT designated Assets	U 57 470 417	0				7.00
8.00	Subtotal (sum of lines 1-7)	57, 478, 417	U				8.00
9.00	Reconciling Items	U 57 470 417	0				9.00
10. 00	Total (line 8 minus line 9)	57, 478, 417	0				10.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	CN: 15-1333	Peri od: From 01/01/2018 To 12/31/2018		pared:	
			Sl	JMMARY OF CAP	PLTAL			
	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 WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 314, 496	0		0 0	0	1.00	
3.00	Total (sum of lines 1-2)	2, 314, 496	0		0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2				
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	2, 314, 496				1.00	
3. 00	Total (sum of lines 1-2)	0	2, 314, 496				3.00	

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 Fo 12/31/2018	Date/Time Pre	
	,					3/28/2019 5: 4:	2 pm
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(1. 000000		1.00
3. 00	Total (sum of lines 1-2)	0	0	(1. 000000		3.00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	col s. 5			
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	0	(2, 464, 629		1. 00
3.00	Total (sum of lines 1-2)	0	0	(2, 464, 629	0	3.00
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at	(sum of cols.	
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	-67, 621			0	2, 530, 655	1.00
3.00	Total (sum of lines 1-2)	-67, 621	133, 647	(0	2, 530, 655	3.00

Expersion Charge Final Content Description Basis/Code Amount Cost Center Description Basis/Code Amount Cost Center Description Basis/Code Expersion Cost Center Description Basis/Code Expersion Cost Center Description Expersion Cost Center Description Expersion Cost Center Description Expersion Cost Center Description					From 01/01/2018 To 12/31/2018		B Date/Time Prepared: 3/28/2019 5:42 pm	
1.00				Т				
1.00		Cost Contar Description	Rasis/Code	Amount	Cost Cantar	line #	Wkst A_7	
Investment income - NEW CAP NEW CAP NEW CAP REL COSTS-BLOG & 1.00 1.00 NEW STATE NEW CAP REL COSTS-BLOG & 1.00 0 1.00		oost conter bescription	(2)				Ref.	
2	1. 00		1.00	O NI	EW CAP REL COSTS-BLDG &			1.00
COSTS-MWRIE FOULP (chapter 2) 0 0 0 0 0 0 0 0 0		2)						
Chapter 2)	2. 00			0 *	** Cost Center Deleted ***	2. 00	0	2.00
discounts (chapter 8) B 11 ADMINISTRATI VE & GENERAL 5.00 0 5.00 6.00 6.00 7.00	3. 00			0		0. 00	0	3. 00
expenses (chapter 8) 6. 00 Rental of provide for space by suppliers (chapter 8) 7. 00 Telephone services (chapter 8) 8. 00 Telephone services (chapter 9) 8. 00 Telephone services (chapter 11) 9. 00 Parking lot (chapter 21) 10. 00 Parking lot (chapter 21) 10. 00 Parking lot (chapter 21) 10. 00 Provider-based physician A-8-2 -3, 426, 063 and ustment 11. 00 Sale of scrap, waste, etc. 00 Co. 00 0.	4. 00			0		0. 00	0	4. 00
6.00 Rental of provider space by suppliers (chapter 8) 7.00 Telephone services (pay stations excluded) (chapter 2) 8.00 Telephone services (pay stations excluded) (chapter 2) 9.00 Parking lot (chapter 21) 9.00 Related organization 11.00 Sale of scrap, waste, etc. (chapter 23) 12.00 Related organization 13.00 Related organization 14.00 Carteria—supplyoes and guests 15.00 Related organization 15.00 Related organization 15.00 Related organization 16.00 Sale of medical and surgical supplies to other than partients 16.00 Sale of medical and surgical supplies to other than partients 17.00 Sale of drugs to other than partients 18.00 Sale of medical encords and substitute of the chapter of the c	5. 00		В	11 AI	DMINISTRATIVE & GENERAL	5. 00	0	5. 00
Telephone services (pay stations excluded) (chapter 21) Section Sectio	6. 00	Rental of provider space by		0		0. 00	0	6. 00
Section Television and radio service (chapter 21) 0	7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
9.00 Parking lot (chapter 21) 0 0.00 0 0.00 0 0.00 0	8. 00	Television and radio service		О		0. 00	0	8. 00
11.00 Sale of scrap, waste, etc. (Chapter 20) Related organization A-8-1 O Chapter 23) Related organization A-8-1 O Chapter 20) Chapter 21) O Laundry and linen service O O O O O O O O O		Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -3, 426, 063		0.00	0	
12.00 Related organization	11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
13.00 Laundry and I inen service 0 0.00 0.13.00 14.00 15.00 Rental of quarters to employee and others 0 0.00 0.15.00 14.00 0.00 0.15.00 14.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.15.00 0.00 0.00 0.15.00 0.00 0.00 0.15.00 0.00 0.00 0.15.00 0.00	12. 00	Related organization	A-8-1	0			0	12.00
15.00 Rental of quarters to employee and others 0 0.00 0 15.00		Laundry and linen service	D	0	AFETEDI A			
16. 00 Sale of medical and surgical supplies to other than patients 17. 00 Sale of drugs to other than patients 18. 00 Sale of drugs to other than patients 18. 00 Sale of medical records and abstracts 19. 00 Nursing and allied health education (tuition, fees, books, etc.) 19. 00 Vending machines 0 0.00		Rental of quarters to employee	Б	-70,087C/ 0	AFETERTA		O	
17.00 Sale of drugs to other than patients 0 0 0 0 0 0 0 17.00	16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
18.00 Sale of medical records and abstracts 0 0 0 0 0 0 18.00 19.00 Nursing and allied health education (tuition, fees, books, etc.) 0 0 0 0 0 0 20.00 Vending machines 0 0 0 0 0 0 21.00 Income from imposition of interest, finance or penalty charges (chapter 21) 0 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 0 0 0 0 0 0 22.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 0 0 0 0 0 24.00 1 1 1 1 1 1 1 1 1	17. 00	Sale of drugs to other than		0		0. 00	0	17. 00
19. 00 Nursing and allied health education (tuition, fees, books, etc.) 20. 00 Vending machines 21. 00 Income from imposition of interest, finance or penalty charges (chapter 21) 22. 00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments 23. 00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physical ansi compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 09 Hospice (non-distinct) (see	18. 00	Sale of medical records and		0		0.00	0	18. 00
20.00 Vending machines 0 1.000	19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
interest, finance or penal ty charges (chapter 21)		Vendi ng machi nes		0			0	20.00
overpayments and borrowings to repay Medicare overpayments Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & TIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physicians hasthetist OPHysicians' assistant 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see	21. 00	interest, finance or penalty		0		0.00	0	21.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14) Adjustment for physical therapy costs in excess of limitation (chapter 14) Algustment for physical therapy costs in excess of limitation (chapter 14) OUTILIZATION REVIEW-SNF 114.00 25.00 25.00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 O 26.00 27.00 CostS-BLDG & FIXT O *** Cost Center Deleted *** 2.00 O 27.00 28.00 Physicians assistant Algustment for occupational therapy costs in excess of limitation (chapter 14) O *** Cost Center Deleted *** O *** Cost Center D	22. 00	overpayments and borrowings to		0		0. 00	0	22. 00
24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review – physicians' compensation (chapter 21) 26. 00 Depreciation – NEW CAP REL COSTS-BLDG & 1. 00 0 26. 00 FIXT 27. 00 Depreciation – CAP REL COSTS-BLDG & 1. 00 0 27. 00 COSTS-BLDG & 1. 00 0 COSTS-BLDG & 1. 00 COSTS-BLDG & 1. 00 0 COSTS-BLDG & 1. 00 COSTS-BLDG & 1. 00 COSTS-BLDG & 1. 00 COSTS-	23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	ORI	ESPI RATORY THERAPY	65. 00		23. 00
25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - NEW CAP REL COSTS-BLDG & 1. 00 0 26. 00 COSTS-BLDG & FIXT 0 EPIXT 0 COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 0 0*** Cost Center Deleted *** 2. 00 0 27. 00 COSTS-MVBLE ians' assistant 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	24. 00	Adjustment for physical therapy costs in excess of	A-8-3	-75, 269 PI	HYSI CAL THERAPY	66. 00		24. 00
26. 00 Depreciation - NEW CAP REL COSTS-BLDG & 1.00 0 26.00 COSTS-BLDG & FIXT 0 Depreciation - CAP REL COSTS-BLDG & FIXT 0 *** Cost Center Deleted *** 2.00 0 27.00 COSTS-MVBLE EQUIP 0 *** Cost Center Deleted *** 19.00 28.00 Physicians' assistant 0.00 0 29.00 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see 0 ADULTS & PEDIATRICS 30.00 30.00 30.99	25. 00	Utilization review -		o u-	TILIZATION REVIEW-SNF	114. 00		25. 00
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 0 *** Cost Center Deleted *** 2.00 0 27.00 28. 00 Non-physician Anesthetist 0 *** Cost Center Deleted *** 19.00 28.00 29. 00 Physicians' assistant 0 0.00 0 29.00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 -15,108 OCCUPATIONAL THERAPY 67.00 30.00 30. 99 Hospice (non-distinct) (see 0 ADULTS & PEDIATRICS 30.00 30.99	26. 00	(chapter 21) Depreciation - NEW CAP REL				1. 00	0	26. 00
28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 19.00 28.00 29.00 30.00 29.00 30.99	27. 00	Depreciation - CAP REL				2. 00	0	27. 00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.00		Non-physician Anesthetist		0 *:	** Cost Center Deleted ***		0	
30. 99 Hospi ce (non-di sti nct) (see 0 ADULTS & PEDI ATRI CS 30. 00 30. 99		Adjustment for occupational therapy costs in excess of	A-8-3	-15, 108 00	CCUPATI ONAL THERAPY		0	
	30. 99	Hospice (non-distinct) (see		OAI	DULTS & PEDIATRICS	30.00		30. 99

						3/28/2019 5: 4	2 piii
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adiusted		
				l l l l l l l l l l l l l l l l l l l	to be haj astea		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	oost conten besen per on		rinoarre	oost conten	Ei iie "		
		(2)				Ref.	
		1. 00	2. 00	3. 00	4.00	5. 00	
31. 00 Ac	djustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	athology costs in excess of			. ===			
	mitation (chapter 14)						
32.00 CA	AH HIT Adjustment for		0		0. 00	0	32.00
De	epreciation and Interest						
1		D	07 255	DDUCC CHARCED TO DATLENTS	72 00	0	22 00
4	HARMACY REBATES	В		DRUGS CHARGED TO PATIENTS	73. 00	0	33.00
33. 01 MI	SC REVENUE CBO	В	-1, 130	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02 PH	HARMACY MISC REV	В	-839	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 02
4				NEW CAP REL COSTS-BLDG &	1. 00	11	33. 03
33.03	DNALLOWABLE INTEREST EXPENSE	А	-49, 929		1.00	1.1	33.03
				FIXT			
33. 04 AE	OVERTISING OFFSET	Α	-19, 557	ADMINISTRATIVE & GENERAL	5. 00	0	33.04
	OVERTI SI NG OFFSET	A		ONCOLOGY	54. 02	0	33. 05
						ŭ	
33. 06 AE	OVERTISING OFFSET	Α	-477	RURAL HEALTH CLINIC	88. 00	0	33.06
33. 07 AE	OVERTISING OFFSET	Α	-9, 165	RURAL HEALTH CLINIC III	88. 02	0	33.07
33. 08 TE	ELEPHONE WAGES	Α	_804	ADMINISTRATIVE & GENERAL	5. 00	0	33. 08
						ŭ	
4	ELEPHONE BENEFITS	Α		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 09
33. 10 TE	ELEPHONE OTHER	Α	-982	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 11 PH	HYSICIAN RECRUITMENT	Α	-6 085	ADMINISTRATIVE & GENERAL	5. 00	0	33. 11
4					88. 01	0	33. 12
	HYSICIAN RECRUITMENT	Α		RURAL HEALTH CLINIC II		ŭ	
33. 13 PH	HYSICIAN RECRUITMENT	Α	-15, 800	RURAL HEALTH CLINIC	88. 00	0	33. 13
33. 14 PH	HYSICIAN RECRUITMENT	Α	-140	RHEUMATOLOGY	90. 01	0	33. 14
4	AF EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 15
	-		·			U	
33. 16 EH	HR DEPRCIATION	А	-26, 487	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 16
				FIXT			
33. 17 07	THER MISC INCOME	В	-55 924	ADMINISTRATIVE & GENERAL	5. 00	0	33. 17
						0	33. 18
	DBBYING EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	-	
33. 19 AE	OVERTISING EXPENSE	Α		RHEUMATOLOGY	90. 01	0	33. 19
33. 20 CC	OMMUNITY RELATIONS	Α	-165, 769	ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
	DMMUNITY RELATIONS	A		EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 21
				l e		-	
33. 22 TE	ELEVISION OFFSET	Α	-5, 851	OPERATION OF PLANT	7. 00	0	33. 22
33. 23 IN	NTEREST INCOME	В	-17, 692	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 23
		_	,	FLXT			
22 24 27	FUED AD HICTMENTS (CDES) EVS		_		2 22	_	22 24
33. 24 01	THER ADJUSTMENTS (SPECIFY)		0		0. 00	0	33. 24
(3	3) l						
	THER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 25
			U		0.00	U	55. 25
(3							
50.00 TO	OTAL (sum of lines 1 thru 49)		-5, 811, 338				50.00
(1	Fransfer to Worksheet A,						
1 7	olumn 6, line 200.)						
							L
(1) Descr	ription - all chapter referen	ces in this co	Lumn pertain t	o CMS Pub 15-1			

⁽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

Peri od: Worksheet A-8-2 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

						10 12/31/2018	3/28/2019 5:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	,		Hours	
	1. 00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	91. 00	EMERGENCY	2, 339, 801	1, 987, 19	352, 608	C	0	1.00
2.00	54. 02	ONCOLOGY	169, 850		0 169, 850) c	0	2.00
3.00	60.00	LABORATORY	18, 000		0 18,000) c	0	3.00
4.00	53.00	ANESTHESI OLOGY	821, 684	703, 48	118, 203	s c	0	4.00
5.00	30.00	ADULTS & PEDIATRICS	735, 389	735, 38	39 C) c	0	5.00
6. 00	0.00		0		0 0) c	0	6.00
7. 00	0.00		0		0 0) c	0	7. 00
8. 00	0.00		0		0 0) c	0	8. 00
9. 00	0.00		0		0 0) c	0	9. 00
10.00	0.00		0		0 0	o c	0	10.00
200.00			4, 084, 724	3, 426, 06	658, 661		0	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RO	E Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1.00		EMERGENCY	0		0 0	1	1	1
2.00		ONCOLOGY	0		0 0) C	0	2.00
3.00		LABORATORY	0		0 0) C	0	0.00
4.00		ANESTHESI OLOGY	0		0 0) C	0	4. 00
5.00	30. 00	ADULTS & PEDIATRICS	0		0 0) C	0	5. 00
6.00	0. 00		0		0 0) c	0	6.00
7. 00	0. 00		0		0 0) c	0	7.00
8. 00	0. 00		0		0 0) c	0	8.00
9. 00	0. 00		0		0 0) c	0	9. 00
10.00	0. 00		0		0 0) c	0	10.00
200.00			0		0 0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE		Adjustment		
		l denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	0.00	14	1/ 00	17.00	10.00	-	
4 00	1.00	2.00	15. 00	16. 00	17. 00	18.00		1 00
1.00		EMERGENCY	0		0 0	1 ., ,	•	1.00
2.00		ONCOLOGY	0	•	0 0	C		2.00
3.00		LABORATORY	0		0	700 404)	3.00
4.00		ANESTHESI OLOGY	0		0	703, 481		4.00
5.00		ADULTS & PEDIATRICS	0		0	735, 389	(5.00
6. 00	0.00		0		0)	6.00
7. 00	0.00		0		0		<u>'</u>	7.00
8. 00	0.00		0				<u>'</u>	8.00
9. 00	0.00		0		0		<u>'</u>	9.00
10.00	0. 00		0			0 40/ 0/0	<u>'</u>	10.00
200. 00			0	I	0 0	3, 426, 063	il	200.00

REASON	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	PUTNAM COUNTY FURNI SHED BY	HOSPI TAL Provi der CC		In Lie Period: From 01/01/2018 To 12/31/2018 Physical Therapy	Date/Time Pre 3/28/2019 5:4	-3 pared:	
						1. 00		
	PART I - GENERAL INFORMATION							
1. 00 2. 00 3. 00 4. 00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	sor or therapist assistant was c	was on provi			52 780 303 229	3. 00	
5. 00 6. 00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	apy assistants (include only	visits made		0	5. 00 6. 00	
7.00	Standard travel expense rate					0. 00 0. 00		
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	Trai nees	8.00	
9. 00	Total hours worked	1.00	2. 00 3, 749. 00	3. 00 2, 119. 0	4.00	5. 00	9. 00	
10.00	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 41. 46	82. 91 41. 46	62. 1 31. 0	0.00	l	10. 00 11. 00	
	Number of travel hours (provider site)	O	0		0		12.00	
	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12. 01 13. 00	
	Number of miles driven (offsite)	O	0		0		13. 01	
						1. 00		
14.00	Part II - SALARY EQUIVALENCY COMPUTATION	1: 10)					14.00	
15. 00 16. 00	Therapists (column 2, line 9 times column 2, line 10) Assistants (column 3, line 9 times column 3, line10) Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all 310,830 19 131,759 10 131,759 10 132,759 11							
19.00	others) Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l Total allowance amount (sum of lines 17-19 f	ine 10) or respiratory t					18. 00 19. 00 20. 00	
	If the sum of columns 1 and 2 for respirator occupational therapy, line 9, is greater than	n line 2, make n						
21. 00	amount from line 20. Otherwise complete lin Weighted average rate excluding aides and tr	ainees (line 17		m of columns	1 and 2, line 9	0.00	21.00	
22 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train					0	22. 00	
	Total salary equivalency (see instructions)	· 	·			442, 589		
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance	WANCE AND TRAVEL	EXPENSE COMP	<u>UTATION - PR</u>	OVIDER SITE			
24. 00	Therapists (line 3 times column 2, line 11)					12, 562		
25. 00 26. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 24	and 25 for a	ll others)		7, 120 19, 682		
27. 00	Standard travel expense (line 7 times line 3				3 and 4 for all	0	27. 00	
28. 00	others) Total standard travel allowance and standard	travel expense	at the provid	er site (sum	of lines 26 and	19, 682	28. 00	
	27) Optional Travel Allowance and Optional Trave	I Expense						
29. 00	Therapists (column 2, line 10 times the sum	of columns 1 and	I 2, line 12)			0		
30. 00 31. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	•	and 30 for a	ll others)		0 0	30.00 31.00	
	Optional travel expense (line 8 times column				y or sum of	0	32.00	
33. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave	l expense (line	28)			19, 682	33.00	
34.00	Optional travel allowance and standard trave	l expense (sum c	of lines 27 an			0	34.00	
35. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				VICES OUTSIDE PR	OROVI DER SITE	35.00	
04 00	Standard Travel Expense						1	
36. 00 37. 00	Therapists (line 5 times column 2, line 11) 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 su Optional Travel Allowance and Optional Trave		1 6)			0	39.00	
40.00	Therapists (sum of columns 1 and 2, line 12.		2, line 10)			0	40.00	
41. 00 42. 00	Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	n 3, line 10)				0	41.00 42.00	
	Subtotal (sum of lines 40 and 41) Optional travel expense (line 8 times the su	m of columns 1-3	3, line 13.01)			0		
	Total Travel Allowance and Travel Expense -	Offsite Services	; Complete on	e of the fol	lowing three lir	nes 44, 45, or		
	46, as appropriate.						1	

44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

0 44.00 0 45.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CO		Peri od: From 01/01/2018 To 12/31/2018	3/28/2019 5:4	pared:
					Physical Therapy	Cost	
						1. 00	
6. 00	Optional travel allowance and optional trave						46.00
	•	Therapi sts 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	<u>Total</u> 5. 00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	5.00	
7. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not	0.00	0. 00	0. (0.00	0.00	47.00
	complete lines 48-55 and enter zero in each column of line 56)						
8. 00	Overtime rate (see instructions)	0.00	0. 00	0. (0. 00		48.00
9. 00	Total overtime (including base and overtime	0.00	0. 00	0. (0. 00		49.00
	allowance) (multiply line 47 times line 48)						
0. 00	CALCULATION OF LIMIT Percentage of overtime hours by category	0.00	0.00	0. (0. 00	0.00	 50. 00
). 00	(divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.1	0.00	0.00	50.00
. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0. 00	0. (0.00	0. 00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
. 00	Adjusted hourly salary equivalency amount (see instructions)	82. 91	62. 18	0. (0.00		52.0
. 00	Overtime cost limitation (line 51 times line 52)	О	0		0 0		53.0
. 00	Maximum overtime cost (enter the lesser of	О	0		0 0		54.0
5. 00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55.00
5. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 -	0	0		0 0	0	56. 0
	if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3						
	for all others.)						
						1. 00	
7 00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	AND EXCESS COST	ADJUSIMENI			442, 589	 57. 0
3. 00	Travel allowance and expense - provider site	(from lines 33	34 or 35))			19, 682	
9. 00	Travel allowance and expense - Offsite service			5)		0	59.0
0. 00	Overtime allowance (from column 5, line 56)	•		•		0	60.0
. 00	Equipment cost (see instructions)					0	61.0
2. 00	Supplies (see instructions)					0	62.0
3. 00	Total allowance (sum of lines 57-62)					462, 271	
. 00						537, 540	
5. 00	Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			75, 269	65.0
00	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of Lines 24	and 25 for a	all others		19, 682	 100_0
	Line 27 = line 7 times line 3 for respiratory				others		100.0
0. 02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	· •				19, 682	100. 0
	Line 27 = line 7 times line 3 for respirator	, , ,			others		101.0
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	Sum of lines 29	and 30 for a	all others			101. 0 101. 0
	Line 31 = line 29 for respiratory therapy or						102. 0
02.01	Line 32 = line 8 times columns 1 and 2, line	13 for respirat	ory therapy o	or sum of col	umns 1-3, line	0	102. 0°
	13 for all others						

REASON	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	PUTNAM COUNTY FURNI SHED BY	Provi der CC	N: 15-1333	Peri od: From 01/01/2018 To 12/31/2018 Occupati onal Therapy	Worksheet A-8 Parts I-VI	epared:	
						1.00		
4 00	PART I - GENERAL INFORMATION		12				1 00	
1. 00 2. 00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instruc	TI ONS)			52 780		
3. 00 4. 00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	assistant was				196	3.00	
5. 00 6. 00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	rvisors or ther apy assistants	(include only	visits made		0		
7. 00	Standard travel expense rate					0.00		
8. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8. 00	
		1. 00	2. 00	3. 00	4. 00	5. 00		
9.00	Total hours worked	0.00	1, 237. 00	0. (l .		
	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 39. 30	78. 60 39. 30	0. (0. (0.00	10.00	
12. 01	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site)	0 0	0 0 0		0 0 0		12. 00 12. 01 13. 00	
	Number of miles driven (offsite)	0	Ö		Ö		13. 01	
						1.00		
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00		
	Supervisors (column 1, line 9 times column 1					07 220		
	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					97, 228	1	
	Subtotal allowance amount (sum of lines 14 a		ratory therapy	or lines 14	-16 for all	97, 228		
18. 00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00	
	Trainees (column 5, line 9 times column 5, l					0		
	Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others) 97,228 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							
21. 00	amount from line 20. Otherwise complete lin Weighted average rate excluding aides and tr	ainees (line 17		ım of columns	1 and 2, line	0.00	21.00	
22. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and train					0	22. 00	
	Total salary equivalency (see instructions)	ccs (Triic 2 triii	C3 1111C 21)			97, 228	1	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVE	L EXPENSE COMP	PUTATION - PR	OVI DER SITE		-	
24. 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)					7, 703	24.00	
25.00	Assistants (line 4 times column 3, line 11)					0	25. 00	
	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others)				3 and 4 for all	7, 703	1	
28. 00	Total standard travel allowance and standard 27)	travel expense	at the provid	der site (sum	of lines 26 and	7, 703	28. 00	
	Optional Travel Allowance and Optional Trave	I Expense						
	Therapists (column 2, line 10 times the sum		d 2, line 12)			0	1	
30. 00 31. 00	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or		9 and 30 for a	all others)		0		
32. 00	Optional travel expense (line 8 times column				y or sum of	0	32.00	
33. 00	columns 1-3, line 13 for all others) Standard travel allowance and standard trave	l expense (line	28)			7, 703	33.00	
34. 00	Optional travel allowance and standard trave			nd 31)		7,703	1	
35. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Expense				VICES OUTSIDE PR	ROVI DER SITE	35.00	
	Therapists (line 5 times column 2, line 11)					0		
	Assistants (line 6 times column 3, line 11)					0		
	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	m of lines 5 an	d 6)			0		
	Optional Travel Allowance and Optional Trave	l Expense						
	Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times column		2, line 10)			0 0		
	Subtotal (sum of lines 40 and 41)	5, IIIIC 10 <i>)</i>				0	1	
	Optional travel expense (line 8 times the su				Landara II	0	1	
	Total Travel Allowance and Travel Expense -	uitsite Service	s; complete on	e or the fol	lowing three lir	nes 44, 45, or		
	46, as appropriate.							

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES	PUTNAM COUNTY	Y HOSPITAL Provider C	CN: 15_1333	In Lie Period:	u of Form CMS-2 Worksheet A-8	
	E SUPPLIERS	TORWI SHED DI	Trovider c		From 01/01/2018 To 12/31/2018	Parts I-VI	pared:
					Occupati onal Therapy	Cost	
						1.00	
	Optional travel allowance and standard travel Optional travel allowance and optional travel		of lines 39 a of lines 42 a		,	0	
40.00	optional travel arrowance and optional trave	Therapi sts	Assi stants	Ai des	Trai nees	Total	40.00
	PART V - OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.0	0.00	0.00	47.00
48. 00	Overtime rate (see instructions)	0. 00	0.00				48.00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0.00	0.00	0.0	0.00		49.00
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0. 00	0.0	0.00	0.00	50.00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.0	0. 00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE						
52.00	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	78. 60 0	0.00				52.00
53. 00 54. 00	Maximum overtime cost (enter the lesser of	0	0		0 0		53. 00 54. 00
55. 00	line 49 or line 53) Portion of overtime already included in	0	0		0 0		55.00
	hourly computation at the AHSEA (multiply line 47 times line 52)						
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0	0	56. 00
	respiratory therapy and columns 1 through 3 for all others.)						
						1.00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	AND EXCESS COST	ADJUSTMENT				
57. 00 58. 00 59. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servio			6)		97, 228 7, 703 0	57.00 58.00 59.00
	Overtime allowance (from column 5, line 56) Equipment cost (see instructions)					0	60.00 61.00
	Supplies (see instructions)					ő	
63.00	Total allowance (sum of lines 57-62)					104, 931	
	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65 LINE 33 CALCULATION	,				120, 039 15, 108	
100.01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27				others	0	100. 00 100. 01 100. 02
101.01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others	0	101. 00 101. 01 101. 02
	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umns 1-3. line		102. 00 102. 01
	13 for all others Line 35 = sum of lines 31 and 32		3 · · · ·	2. 20.	.,		102. 02

DE 4.000	Financial Systems	PUTNAM COUNTY		N 1E 1000		u of Form CMS-2	
	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CC	N: 15-1333	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
					Speech Pathology	3/28/2019 5: 4 Cost	2 pm
					32	1. 00	
	PART I - GENERAL INFORMATION					1.00	
1.00 2.00	Total number of weeks worked (excluding aide Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			52 780	
3. 00 1. 00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy nor therapist was on provider site (see inst	assistant was ructions)	on provider si	te but neith		141 0	3. 00 4. 00
. 00 . 00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	apy assistants	(include only	visits made		0	
. 00	Standard travel expense rate					0.00	
3. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.00
. 00	Total hours worked	1. 00	2. 00 551. 00	3.00	4. 00 00 0. 00	5. 00 0. 00	9. 00
0. 00	AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	0. 00 0. 00 37. 78	75. 55 37. 78	0. (0. 00	0.00	
2. 00	one-half of column 3, line 10) Number of travel hours (provider site)	О	0		0		12.00
	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12. 01 13. 00
	Number of miles driven (provider site)	0	0		0		13.00
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
5. 00 6. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,	line 10) line10)				0 41, 628 0	16.00
	Subtotal allowance amount (sum of lines 14 a others) Aides (column 4, line 9 times column 4, line	·	ratory therapy	or lines 14	I-16 for all	41, 628	
9. 00 0. 00	If the sum of columns 1 and 2 for respirator	or respiratory y therapy or co	lumns 1-3 for	physical the	rapy, speech pat		
	occupational therapy, line 9, is greater than amount from line 20. Otherwise complete line		no entries on	lines 21 and	i 22 and enter or	iline 23 the	
1. 00	Weighted average rate excluding aides and tr for respiratory therapy or columns 1 thru 3,			m of columns	1 and 2, line 9	75. 55	21.00
	Weighted allowance excluding aides and train					58, 929	
3. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVE	I FXPENSE COME	UTATION - PR	POVIDER SLITE	58, 929	23.00
4 0-	Standard Travel Allowance						
4. 00 5. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					5, 327 0	
6. 00	Subtotal (line 24 for respiratory therapy or				0	5, 327	26.00
7. 00	Standard travel expense (line 7 times line 3 others)	for respirator	y therapy or s	sum or rines	3 and 4 for all	0	27.00
8. 00	Total standard travel allowance and standard 27)	travel expense	at the provic	ler site (sum	n of lines 26 and	5, 327	28.00
	Optional Travel Allowance and Optional Trave						
9. 00 0. 00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		ıd 2, line 12)			0	1
1.00	Subtotal (line 29 for respiratory therapy or	sum of lines 2				0	31.00
2. 00	Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respir	atory therap	y or sum of	0	32.00
	Standard travel allowance and standard trave			1.043		5, 327	•
	Optional travel allowance and standard trave Optional travel allowance and optional trave					0	
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW				RVICES OUTSIDE PR		
5. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0] 36. 00
7. 00	Assistants (line 6 times column 3, line 11)					0	37.00
	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the su	m of lines 5 an	nd 6)			0	
	Optional Travel Allowance and Optional Trave	Expense					
0. 00 1. 00	Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum		1 2, line 10)			0	
2. 00	Subtotal (sum of lines 40 and 41)	3,				0	

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

0 44.00 0 45.00

0 43.00

Subtotal (sum of lines 40 and 41)
Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)

44.00 Standard travel allowance and standard travel expense (sum of lines 38 and 39 - see instructions)
45.00 Optional travel allowance and standard travel expense (sum of lines 39 and 42 - see instructions)

43.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CC	CN: 15-1333	Peri od: From 01/01/2018 To 12/31/2018 Speech Pathology	Date/Time Pre 3/28/2019 5:4	pared:
					speech Pathorogy	COST	
						1. 00	
6. 00	Optional travel allowance and optional travel						46.00
		Therapi sts 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	0.00	1. 00	0.00	
	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	0.00	0.00	0. (0.00	0.00	47.00
	column of line 56)						
8. 00	Overtime rate (see instructions)	0.00	0. 00	0. (0.00		48. 00
9. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48)	0. 00	0.00	0. (49. 00
	CALCULATION OF LIMIT	0.00	0.00	0.0	0.00	0.00	
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. (0.00	0.00	50.00
1. 00	Allocation of provider's standard work year for one full-time employee times the	0.00	0. 00	0. (0.00	0. 00	51.00
	percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE						
	Adjusted hourly salary equivalency amount (see instructions)	75. 55	0.00	0. (0.00		52.0
3. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53.0
4. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0		54.0
5. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	O	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 respiratory therapy and columns 1 through 3	0	0		0 0	0	56.00
	for all others.)						
		ND EVOESS SSST	AD HIGHENIT			1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	AND EXCESS COST	ADJUSIMENI			58, 929	57.0
	Travel allowance and expense - provider site	(from lines 33	34 or 35))			5, 327	58.00
	Travel allowance and expense - Offsite service			5)		0, 327	59.0
0. 00	Overtime allowance (from column 5, line 56)					0	60.0
1. 00	Equipment cost (see instructions)					0	61.0
	Supplies (see instructions)					0	62.0
3.00	Total allowance (sum of lines 57-62)					64, 256	63.0
4.00	Total cost of outside supplier services (from	m your records)				53, 443	64.0
5. 00	Excess over limitation (line 64 minus line 63		enter zero)			0	1
	LINE 33 CALCULATION Line 26 = line 24 for respiratory therapy or	sum of Lines 24	and 2E for a	all others		E 227	100 0
	Line 27 = line 7 times line 3 for respiratory				othors	5, 327	100. 0
	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	y therapy or sum		and 4 for all	Others	5, 327	
01. 00	Line 27 = line 7 times line 3 for respiratory	y therapy or sum	of lines 3 a	and 4 for all	others		101.0
	Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION	sum of lines 29	and 30 for a	all others			101. 0 101. 0
02 00	Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	all others		0	102. 0
		13 for respirat	20 .0. 0				102.0

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1333

					То	12/31/2018	Date/Time Pre 3/28/2019 5:4	
				CAPI TAL			3/20/2017 3.4	Z piii
				RELATED COSTS				
		Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI V	
			for Cost	FLXT	BENEFITS		E & GENERAL	
			Allocation (from Wkst A		DEPARTMENT			
			col. 7)					
			0	1. 00	4.00	4A	5. 00	
4 00		AL SERVICE COST CENTERS	0.500.455	0.500.455			l	
1. 00 4. 00		NEW CAP REL COSTS-BLDG & FIXT	2, 530, 655					1.00 4.00
5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4, 575, 703 5, 106, 615			6, 080, 427	6, 080, 427	5.00
7. 00		OPERATION OF PLANT	1, 670, 001	254, 876		1, 994, 766		7.00
8. 00	1	LAUNDRY & LINEN SERVICE	181, 290			204, 465	l '	8.00
9.00	00900	HOUSEKEEPI NG	477, 612	15, 571	84, 900	578, 083	106, 904	9. 00
10.00	1	DI ETARY	248, 078	86, 158		358, 041	66, 212	10.00
11.00		CAFETERI A	524, 022			620, 550	114, 757	11.00
13. 00 16. 00		NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY	121, 116 473, 874	16, 384 97, 368		154, 570 647, 117	1	13. 00 16. 00
17. 00		SOCIAL SERVICE	473, 874	77, 300		047, 117	117,070	17. 00
17. 01		UTILIZATION REVIEW	78, 794	8, 204		104, 766	19, 374	17. 01
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	1, 203, 474			1, 783, 932	329, 899	30.00
31. 00 41. 00		INTENSIVE CARE UNIT SUBPROVIDER - IRF	818, 466	69, 996 0	153, 045	1, 041, 507	192, 604	31. 00 41. 00
42. 00		SUBPROVI DER	o o	0		0	0	42.00
43.00		NURSERY	0	0	0	0	0	43.00
50.00		LARY SERVICE COST CENTERS		004 5/4	450.004	1 051 100	0.40.400	
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	1, 498, 034 99, 809			1, 851, 689 176, 358	1	50. 00 51. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	77, 607	0 0		170, 330	32,014	52.00
53. 00		ANESTHESI OLOGY	177, 767	Ö		378, 605	70, 015	
54.00	05400	RADI OLOGY-DI AGNOSTI C	1, 209, 575	74, 677	215, 802	1, 500, 054	277, 402	54.00
54. 01		NUCLEAR MEDICINE-DIAGNOSTIC	153, 537	3, 449		156, 986	l	54. 01
54. 02	1	ONCOLOGY	3, 645, 031	119, 665		3, 833, 950	l	54. 02
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	419, 612 0	32, 522 0		492, 493 0	91, 076	57. 00 58. 00
59. 00		CARDI AC CATHETERI ZATI ON	ő	0	Ö	0	Ö	59.00
60.00		LABORATORY	2, 144, 197	61, 840	164, 792	2, 370, 829	438, 433	60.00
60. 01		BLOOD LABORATORY	0	0	· ·	0	0	60. 01
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	418, 626	0 17, 246		520, 514	96, 258	64. 00 65. 00
66. 00		PHYSI CAL THERAPY	562, 501	41, 983		604, 484	111, 786	66.00
67.00		OCCUPATI ONAL THERAPY	104, 931	0	О	104, 931	19, 405	67.00
68. 00		SPEECH PATHOLOGY	53, 593	0	0	53, 593	1	•
69. 00 69. 01		ELECTROCARDI OLOGY CARDI AC REHAB	165, 907	2, 464 39, 814		186, 136	1	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	247, 968 422	39, 614		345, 428 422	63, 879 78	69. 01 71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENT	60, 009	_	· -	60, 009	l e	72.00
73. 00		DRUGS CHARGED TO PATIENTS	1, 300, 129	22, 075	45, 117	1, 367, 321	252, 856	73. 00
00.00		TIENT SERVICE COST CENTERS	1 104 005	110 140	220 007	1 111 050	2/7 102	00.00
88. 00 88. 01		RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	1, 104, 895 1, 106, 464			1, 444, 850 1, 407, 407	267, 193 260, 269	88. 00 88. 01
88. 02	1	RURAL HEALTH CLINIC III	630, 416		118, 682	888, 399	1	1
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00		CLINIC	0	3, 991	1	3, 991	738	•
90. 01 91. 00		RHEUMATOLOGY EMERGENCY	2, 273 2, 002, 255	123 143, 046		2, 878 2, 791, 872	532 516, 295	90. 01 91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART)	2,002,255	143, 040	040, 371	2, 791, 672	510, 295	91.00
		REIMBURSABLE COST CENTERS				-		
99. 10	09910		0	0	0	0	0	99. 10
100.00		AL PURPOSE COST CENTERS	0	0		0	0	109. 00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION	0	0 0		0	l e	110.00
	1	ISLET ACQUISITION	Ö	0		0		111.00
		INTEREST EXPENSE						113. 00
		UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	35, 117, 651	2, 246, 164	3, 857, 736	34, 111, 423	5, 183, 717	118.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 752	O	11, 752	2. 173	190. 00
		PHYSICIANS' PRIVATE OFFICES	3, 275, 255			4, 125, 028		•
		JOHNSON/NI CHOLS WI C	348, 448	0		421, 120		
		RHEUMATOLOGY	218, 967	11, 481	43, 476	273, 924	50, 656	
193.00		NONPALD WORKERS	0	0		0		193. 00 193. 01
		LACTATION CONSULTING	o o	o	O	0		193. 02
		DI ABETI C COUNSELING	0	0		0		193. 03

Health Financial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2018 To 12/31/2018		pared: 2 pm	
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL		
	0	1.00	4.00	4A	5. 00		
194. 00 07950 VACANT SPACE	0	0		0	0	194. 00	
194.01 07951 BOARD OF HEALTH	0	17, 074		0 17, 074	3, 157	194. 01	
194.02 07952 PUTNAM/HENRY PRENATAL	0	0		0	0	194. 02	
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0		0		201.00	
202.00 TOTAL (sum lines 118 through 201)	38, 960, 321	2, 530, 655	4, 579, 47	38, 960, 321	6, 080, 427	202. 00	

Provider CCN: 15-1333

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared: 3/38/2019 5:42 pm

Description					7 12/31/2010	3/28/2019 5: 4	
	Cost Center Description			HOUSEKEEPI NG	DI ETARY	CAFETERI A	
SERIERAL SERVICE COST CENTERS				9.00	10. 00	11. 00	
4.00 0.0000 DATE OFFICE SERVET IS DEPARTMENT	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	111.00	
5.00 DOSOD AWAIN STRATTURE & CEMERAL 7.00 DOSOD OPERATION OF PLAN SERVICE 8.00 DOSOD DOSCRETE WITH SERVICE 9.00 DOSOD DOSCRETE WITH SERVICE 9.00 DOSOD DOSCRETE WITH SERVICE 10.00 DOSOD DELEMAN STRATTON 10.00 DOSOD DELEMAN SERVICE 11.00 DOSOD DESCRETE WITH SERVICE 11.00 DOSOD DESCRETE SER							
1.00 00000 00000 00000 00000 00000 00000 000000							
0.00 0.0000 DURSKEPF ING 19 133 1,474 706 614 10 10 10 10 10 10 10		2 2/2 /5/					
9.00 0.090			242 742				
0.000 0.000 DETARY							
11.00 01100 CAFETERIA 48, 610 0 15, 255 0 799, 172 11, 00 130, 00					564 578		
0.300 MIRSH MS ADM IN STRATION 70. 153 0 6.325 0 3.78 13.00	· · · · · · · · · · · · · · · · · · ·		·		0 1, 0, 0	799, 172	
17.00 01700 SOCIAL SERVICE 0 0 0 0 0 17.00 17.01			0		0	-	
17.0	•		0		0		
IMPART FIRT ROUTH NE SERVICE COST CENTERS 180,013 57,161 56,493 77,759 30,00 30,00 00000 QUITS & PEDI ATRICIS 180,013 57,161 56,493 77,759 30,00 31,00 01000 QUITS & PEDI ATRICIS 180,013 57,161 56,493 77,759 30,00 44,20 31,00 42,00		o	0	0	0	0	17.00
30.00 3000 ABULTS & PEDIATRICS 180,013 57,161 56,479 543,797 77,759 30,00 141,00 1010 SIBPROVIDER 18F 80,097 44,140 27,020 20,588 44,545 31,00 41,00 41,00 42,00 420,0		10, 092	0	3, 167	0	0	17. 01
31 DO 3100 INTERSIVE CARE UNIT 86,097 44,140 27,020 20,585 44,545 31,00 42.00 04200 SUBPROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				I			
14.00 04/00 (SURPROVIDER - 1 IRF 0 0 0 0 0 0 0 0 0					·		
42.00 04.00 04.00 04.00 0 0 0 0 0 0 0 42.00		86, 097	44, 140		20, 585		
43. 00 0.4000 NURSERY 0 0 0 0 0 4. 49	i i	0	0	1	0		
## MICHIL HAPY SERVICE COST CENTERS 50.00 50000 00000 0PEATH IN ROOM 247, 927 37, 244 777, 807 0 44, 283 50.00 51.00 051000 051000 051000 051000 0 0 0 0 0 0 52.00 052000 051000 051000 0 0 0 0 0 0 0 53.00 052000 051000 051000 0 0 0 0 0 0 0 53.00 053000 051000 0511000 0 0 0 0 0 0 0 53.00 053000 051000 0511000 0 0 0 0 0 0 0 53.00 053000 051000 0511000 0 0 0 0 0 54.00 05000 051000 0511000 0 0 0 0 0 54.00 05000 051000 0511000 0 0 0 0 0 54.00 05000 05000 0511000 0 0 0 0 0 0 55.00 05000 05000 05000 05000 0			0	0	0		
13.00		<u> </u>		<u> </u>			10.00
52.00 05200 DELIVERY RODIA & LABOR ROOM 0 0 0 0 0 552.00 530.00 530.00 6300 ARESTHESI OLOGY 0 0 0 0 0 0 0 0 0		247, 927	37, 244	77, 807	0	44, 283	50.00
53.00 OSSOO ANESTHESI OLOGY O O O O O O O O O	51.00 05100 RECOVERY ROOM	69, 550	4, 098	21, 827	0	4, 826	51.00
54 00 05400 RADIO LOCY-DI AGNOSTI C 91,855 19,657 28,877 0 72,484 54.00 54.01 05401 NUCLEAN MEDIC ICHE-DI AGNOSTI C 4,243 0 0 1,331 0 0 54.01 54.01 05401 NUCLEAN MEDIC ICHE-DI AGNOSTI C 4,243 0 0 1,331 0 0 54.01		0	0	0	0		
54-01		0	0	0	0		
147, 192			19, 657		0		
17.00 05700 CT SCAN			0		0	_	
SB 00 GSB00 MAGNETI C RESONANCE LIMGI NC (NR1)					0		
99.00 05900 CARDIA C CATHETERIZATION 0 0 0 0 59.00 00.00 06000 LABORATORY 76.066 0 23.872 0 72.990 0 00.01 06001 06001 06000 10780/NDIOST HERAPY 0 0 0 0 0 0 0 0 05.00 06500 07591 07590 0			0		0		
00.00 0.0000 LABORATORY 76,066 0 23,872 0 72,899 00.00			0	0	0		
0.0			0	23 872	0		
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 64.00		70,000	0	23, 072	0		
66. 00 06600 PHYSICAL THERAPY 51, 640 7, 256 16, 206 0 0 0 66, 00 67. 00 06700 0COUPATIONAL THERAPY 0 0 0 0 0 0 0 0 68. 00 06800 SEPECH PATHOLOCY 0 0 0 0 0 0 0 69. 00 06900 ELECTROCARD OLOGY 3, 031 0 951 0 5,729 69, 00 69. 01 06901 CARDI AC REHAB 48,973 0 15,369 0 14,527 69, 01 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 72. 00 72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 27, 153 0 8,522 0 15,157 73. 00 07300 DRUGS CHARGED TO PATIENTS 27, 153 0 8,522 0 15,157 73. 00 07300 DRUGS CHARGED TO PATIENTS 27, 153 0 8,522 0 15,157 73. 00 07300 MRLD EAVE (E. COST CENTERS 146,556 5,882 45,993 0 61,005 88. 01 08801 RURAL HEALTH CLINIC 11 775,611 0 0 0 0 0 0 0 88. 01 08801 RURAL HEALTH CLINIC 11 171,346 0 53,773 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC 11 171,346 0 53,773 0 0 88. 02 89. 00 08900 FEDERALLY UGALIFIED HEALTH CENTER 4,909 0 1,541 0 0 0 0 0 90. 01 09001 RIELIMATOLOGY 152 0 48 0 93,9 0 90. 01 09001 RIELIMATOLOGY 152 0 0 48 0 93,9 0 90. 01 09001 RIELIMATOLOGY 152 0 0 48 0 93,9 0 90. 01 09001 RIELIMATOLOGY 175,952 63,980 55,219 0 102,040 91,00 90. 01 09001 RIELIMATOLOGY 175,952 63,980 55,219 0 0 0 0 90. 01 09001 RIELIMATOLOGY 175,952 63,980 55,219 0 102,040 91,00 90. 01 09001 RIELIMATOLOGY 175,952 63,980 55,219 0 102,040 91,00 90. 01 09001 ORDINAL RESEAUCH 175,041 175,952		o o	0	Ö	0	_	
67. 00 06700 06700 06200 07. 00 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·	21, 214	0	6, 657	0	24, 572	65.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0	66. 00 06600 PHYSI CAL THERAPY	51, 640	7, 256	16, 206	0	0	66.00
69.00 06900		0	0	0	0	0	67. 00
69.01 06901 CARDIAC REHAB 48,973 0 15,369 0 14,527 99.01	· · · · · · · · · · · · · · · · · · ·		0		0		
71.00	· · · · · · · · · · · · · · · · · · ·		0		0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00			0	15, 369	0		
73.00 07300 DRUGS CHARGED TO PATIENTS 27, 153 0 8, 522 0 15, 157 73.00		0	0	0	0		
Second Control Contr		27 152	0	0 522	0		
88. 00 08800 RIVRAL HEALTH CLINIC 146,556 5,882 45,993 0 61,005 88. 00 88. 01 08801 RIVRAL HEALTH CLINIC 1 75,611 0 0 0 0 0 88. 01 88. 02 08802 RIVRAL HEALTH CLINIC 1 171,346 0 53,773 0 0 88. 02 89. 00 08900 FEBERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 90. 01 09000 CLINIC C 4,909 0 1,541 0 0 90. 00 90. 01 09000 RIVRAL HEALTH CENTER 175,952 63,980 55,219 0 102,040 91. 00 09100 EMERGENCY 175,952 63,980 55,219 0 102,040 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 071. 00 0910 CORE 0 0 0 0 0 0 0 08. 00 09901 CORE 0 0 0 0 0 0 09. 01 09901 CORE 0 0 0 0 0 0 0 09. 01 09901 CORE 0 0 0 0 0 0 0 0110. 00 10000 PANCREAS ACQUISITION 0 0 0 0 0 0 0 0 0110. 00 10000 INTESTINAL ACQUISITION 0 0 0 0 0 0 0 0 0 0111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 0 0 0 0		27, 155	0	0, 522	U	15, 157	73.00
88. 01 08801 RURAL HEALTH CLINIC III 75, 611 0 0 0 0 88. 01 88. 02 08802 RURAL HEALTH CLINIC III 171, 346 0 53, 773 0 0 0 88. 02 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 90. 00 09000 CLINIC 4, 909 0 1, 541 0 0 90. 00 90. 01 09001 RHEUMATOLOGY 152 0 48 0 93 90. 01 91. 00 09100 EMERGENCY 175, 952 63, 980 55, 219 0 102, 040 91. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 175, 952 63, 980 55, 219 0 102, 040 91. 00 09100 EMERGENCY 175, 952 63, 980 55, 219 0 102, 040 91. 00 09100 085ERVATI ON BEDS (NON-DISTINCT PART) 92. 00 99. 10 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 99. 10 99. 10 09910 COFF 0 0 0 0 0 0 0 110. 00 11000 INTESTI NAL ACQUISITI ON 0 0 0 0 0 0 111. 00 11100 INTESTI NAL ACQUISITI ON 0 0 0 0 0 0 111. 00 11100 INTERST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 1190. 00 19000 6HT. FLOWER, COFFEE SHOP & CANTEEN 14, 456 0 4, 537 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 300, 354 12, 334 94, 259 0 134, 970 192. 00 192. 01 19201 JOHNSON/NI CHOLS WIC 0 0 0 0 0 0 193. 01 193. 02 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 0 193. 01 193. 02 19303 LAGTATI ON CONSULTI NG 0 0 0 0 0 0 0 0 193. 01 194. 00 1975S LACATI ON CONSULTI NG 0 0 0 0 0 0 0 194. 01 194. 01 1975S BOARD OF HEALTH 21,002 0 6,591 0 0 0 194. 01 194. 02 0795S VACANT SPACE 0 0 0 0 0 0 0 0 0		146, 556	5, 882	45, 993	0	61, 005	88. 00
88 02 08802 RURAL HEALTH CLINIC III 171, 346 0 53, 773 0 0 88 02 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89 .00 09900 CLINIC 4, 909 0 1, 541 0 0 90. 00 90 .01 09001 RIEUMATOLOGY 152 0 48 0 93 90. 01 91 .00 09200 DEBERVATION BEDS (NON-DISTINCT PART) 175, 952 63, 980 55, 219 0 102, 040 91 .00 09200 DESERVATION BEDS (NON-DISTINCT PART) 92. 00 92 .00 09910 CORF 0 0 0 0 0 0 0 99 .10 SPECIAL PURPOSE COST CENTERS 99. 10 110 .00 11000 INTERTINAL ACQUISITION 0 0 0 0 0 0 110. 00 111 .00 11100 ISLET ACQUISITION 0 0 0 0 0 0 0 111. 00 113 .00 11300 INTEREST EXPENSE 113. 00 114 .00 11400 UTILIZATION REVIEW-SNF 114. 00 118 .00 SUBTOTALS (SIM OF LINES 1 through 117) 2, 013, 720 250, 428 595, 795 564, 578 628, 296 118, 00 192 .00 19200 PHYSI CLANS* PRIVATE OFFICES 300, 354 12, 334 94, 259 0 134, 970 192. 00 192 .01 19201 JOHNSON/NI CHOLS WIC 0 0 0 0 0 0 0 0 193 .01 19301 MORKERS 0 0 0 0 0 0 0 0 193 .02 19302 LACTATION CONSULTING 0 0 0 0 0 0 0 194 .00 07950 VACANT SPACE 0 0 0 0 0 0 0 194 .01 07951 BOARD OF HEALTH 21, 002 0 6, 591 0 0 0 194 .01 07951 BOARD OF HEALTH 21, 002 0 6, 591 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 0 194 .02 07950 VACANT SPACE 0 0 0 0 0 0 195 .00 0 0 0 0 0 0 0 0					0		
90. 00 09000 CLINIC			0	53, 773	0	0	88. 02
90. 01 09001 RHEUMATOLOGY 152 0 48 0 93 90. 01 91. 00 09100 EMERGENCY 175, 952 63, 980 55, 219 0 102, 040 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 07HER REI MBURSABLE COST CENTERS 99. 10 0 0 0 0 0 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 99. 10 09910 CORF 0 0 0 0 0 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 110. 00 111. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 2, 013, 720 250, 428 595, 795 564, 578 628, 296 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 14, 456 0 4, 537 0 0 190. 00 191. 00 19200 PAYSIC I ANS' PRI VATE OFFI CES 300, 354 12, 334 94, 259 0 134, 970 192. 01 192. 01 19201 JOHNSON/NI CHOLS WIC 0 0 0 0 0 193. 00 193. 01 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 01 19301 DME 0 0 0 0 0 0 194. 01 07951 BOARD OF HEALTH 21, 002 0 6, 591 0 0 194. 01 194. 01 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194. 01 194. 01 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 0 194. 02 07950 Cross Foot Adjustments 200. 00 0 0 0 194. 02 07950 Cross Foot Adjustments 200. 00 0 0 0 194. 02 07950 Cross Foot Adjustments 200. 00 0 0 0 194. 01 07951 BOARD OF HEALTH 21, 002 0 6, 591 0 0 0 194. 02 07950 Cross Foot Adjustments 200. 00 0 0 0 194. 02 07950 Cross Foot Adjustments 200. 00 0 0 0 194. 02 07950 Cross Foot Adjustments 200. 00 0 0 0 194. 02 07950 Cross Foot Adjustments 200. 00 0 0 0 195. 00 00 00 00 0 0 0 195. 00 00 00 00 0 0 0 195. 00 00 00 00 0 0 0 195. 00 00 00 00 0 0 0 195. 00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0	0	0	0	89. 00
91. 00 09100 EMERGENCY 175, 952 63, 980 55, 219 0 102, 040 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 99. 10 OTHER REIMBURSABLE COST CENTERS 99. 10 OPTION CONTROL O		4, 909	0	1, 541	0	_	
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0			0		_		
OTHER REIMBURSABLE COST CENTERS O O O O O O O O O		175, 952	63, 980	55, 219	0	102, 040	
99. 10 O9910 CORF SPECIAL PURPOSE COST CENTERS O O O O O O O O O	, ,						92.00
SPECIAL PURPOSE COST CENTERS 109.00 109000 PANCREAS ACQUI SITION 0 0 0 0 0 0 1010.00 10000 1010.00 1010.00 1010.00 1010.00 1010.00 1010.00 1010.00 1010.00 1011.00			0		0	0	00 10
109. 00 109.00 109.00 109.00 109.00 100.00		<u> </u>		<u> </u>	U	U	99. 10
110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 110.00 111.00 11100 INTESTINAL ACQUISITION 0 0 0 0 0 0 111.00 11300 11300 INTEREST EXPENSE 111.00 113.00 11400 UTILIZATION REVIEW-SNF 114.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2,013,720 250,428 595,795 564,578 628,296 118.00 NONREI MBURSABLE COST CENTERS 14,456 0 4,537 0 0 190.00 190.00 19200 PHYSI CIANS' PRI VATE OFFICES 300,354 12,334 94,259 0 134,970 192.00 192.01 19201 JOHNSON/NI CHOLS WI C 0 0 0 0 27,488 192.01 192.02 19203 RHEUMATOLOGY 14,122 0 4,432 0 8,418 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 193.01 19301 DME 0 0 0 0 0 0 193.02 19302 LACTATION CONSULTING 0 0 0 0 0 194.00 07950 VACANT SPACE 0 0 0 0 0 194.00 07950 VACANT SPACE 0 0 0 0 0 194.00 07950 PUTNAM/HENRY PRENATAL 0 0 0 0 0 200.00 Cross Foot Adj ustments 200.00		ام	0	0	0	0	109 00
111.00		- 1	-	_	_		
113. 00 11300 11300 1 NTEREST EXPENSE		l ol	0	Ö	0		
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 013, 720 250, 428 595, 795 564, 578 628, 296 118. 00							
NONRE MBURSABLE COST CENTERS 190.00 19000 GI FT FLOWER, COFFEE SHOP & CANTEEN 14,456 0 4,537 0 190.00 190.00 192.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 300,354 12,334 94,259 0 134,970 192.00 192.01 19201 JOHNSON/NI CHOLS WI C 0 0 0 0 27,488 192.01 192.02 19203 RHEUMATOLOGY 14,122 0 4,432 0 8,418 192.02 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 193.01 19301 DME 0 0 0 0 0 193.01 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 193.02 193.03 19303 DI ABETI C COUNSELI NG 0 0 0 0 0 193.03 194.00 19750 BOARD OF HEALTH 21,002 0 6,591 0 0 194.00 19	114.00 11400 UTILIZATION REVIEW-SNF						114.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 14, 456 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 300, 354 12, 334 94, 259 0 134, 970 192. 00 192. 01 19201 JOHNSON/NI CHOLS WI C 0 0 0 0 27, 488 192. 01 192. 02 19203 RHEUMATOLOGY 144, 122 0 4, 432 0 8, 418 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 01 19301 DME 0 0 0 0 0 0 193. 01 193. 02 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 193. 01 193. 03 19303 DI ABETI C COUNSELI NG 0 0 0 0 0 193. 03 194. 00 107951 BOARD AT SPACE 0 0 0 0 0 0 194. 01 194. 01 194. 01 194. 01 1975 BOARD OF HEALTH 21, 002 207952 PUTNAM/HENRY PRENATAL 0 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments		2, 013, 720	250, 428	595, 795	564, 578	628, 296	118. 00
192. 00 19200 19200 19200 19201 19201 19201 19201 19201 19201 19201 19201 19201 19201 19201 19202 19203 19203 19202 19202 1920							
192. 01 19201 JOHNSON/NI CHOLS WI C			0		0		
192. 02 19203 RHEUMATOLOGY 14, 122 0 4, 432 0 8, 418 192. 02 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 DME 0 0 0 0 0 0 193. 01 193. 02 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG 0 0 0 0 0 0 194. 03 194. 00 07950 VACANT SPACE 0 0 0 0 0 0 194. 03 194. 01 07951 BOARD OF HEALTH 21, 002 0 6, 591 0 0 194. 02 194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 200. 00		300, 354	12, 334		0		
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 193. 00 193. 01 19301 DME 0 0 0 0 0 0 0 193. 01 193. 02 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG 0 0 0 0 0 193. 03 194. 00 07950 VACANT SPACE 0 0 0 0 0 0 194. 00 194. 01 194. 0		14 100	0	-	0		
193. 01 19301 DME		14, 122	0	4, 432	0		
193. 02 19302 LACTATION CONSULTING 0 0 0 0 193. 02 193.03 19303 DI ABETI C COUNSELI NG 0 0 0 0 193. 03 194. 00 07950 VACANT SPACE 0 0 0 0 0 194. 00 194. 01 07951 BOARD OF HEALTH 21, 002 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments			0		0		
193. 03 19303 DI ABETI C COUNSELI NG 0 0 0 0 193. 03 194. 00 194. 00 194. 01 194. 01 194. 02			0		n		
194. 00 07950 VACANT SPACE 0 0 0 0 0 194. 00 194. 01 194. 02 07951 BOARD OF HEALTH 21,002 0 0 6,591 0 0 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments		l ő	0	ا	0		
194. 01 07951 BOARD OF HEALTH 21, 002 0 6, 591 0 0 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 21, 002 0 0 0 0 0 194. 02 200. 00		ol	0		0		
194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194. 02 200. 00 Cross Foot Adjustments 200. 00		21, 002	0	6, 591	0	0	194. 01
		1	0	0	0	0	
201.00 Negative Cost Centers 0 0 0 0 0 201.00							
	201.00 Negative Cost Centers	0	0	0	0	0	201.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co	CN: 15-1333	Peri od:	Worksheet B	
				From 01/01/2018		
				To 12/31/2018	Date/Time Pre	
					3/28/2019 5: 4	2 pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11. 00	
202.00 TOTAL (sum lines 118 through 201)	2, 363, 654	262, 762	705, 61	4 564, 578	799, 172	202.00

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

				7	To 12/31/2018	Date/Time Pre 3/28/2019 5:4	
	Cost Center Description	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	UTI LI ZATI ON REVI EW	Subtotal	piii
		13. 00	16. 00	17. 00	17. 01	24.00	
1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	215, 810 0 0	958, 487 0				1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00
17. 01	01701 UTI LI ZATI ON REVI EW	0	0	(137, 399		17. 01
30. 00 31. 00 41. 00 42. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	74, 801 42, 850 0 0	510, 470 0 0 0 0	(5, 010 0 0	3, 746, 910 1, 504, 358 0 0	31.00 41.00 42.00
50. 00	05000 OPERATING ROOM	0	188, 287	(0	2, 789, 666	50.00
51. 00 52. 00 53. 00 54. 01 54. 02 57. 00 58. 00 59. 00 60. 01 64. 00 65. 00 66. 00 67. 00 68. 00 69. 01 71. 00 72. 00 73. 00 88. 01 88. 01 88. 02 89. 00 90. 00 90. 01	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05200 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 NUCLEAR MEDI CINE-DI AGNOSTI C 03480 ONCOLOGY 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 001TPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLI NI C I I 08801 RURAL HEALTH CLI NI C I I 08900 FEDERALLY QUALI FI ED HEALTH CENTER 09000 CLI NI C 09001 RHEUMATOLOGY 09100 EMERGENCY	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	188, 287 0 0 0 0 21, 939 0 0 0 0 0 0 0 0 0 0 0 0 0			2, 789, 666 309, 273 0 460, 675 1, 990, 279 191, 591 4, 789, 811 648, 846 0 2, 982, 090 0 669, 215 791, 372 124, 336 63, 504 230, 269 488, 176 500 71, 106 1, 671, 009	51. 00 52. 00 53. 00 54. 00 54. 01 54. 02 57. 00 58. 00 60. 00 60. 01 64. 00 65. 00 66. 00 67. 00 68. 00 69. 01 71. 00 72. 00 73. 00 88. 01 88. 01 88. 02 89. 00 90. 00 90. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					· · ·	92.00
	OTHER REIMBURSABLE COST CENTERS 09910 CORF SPECIAL PURPOSE COST CENTERS	0	0		0	0	
110. 00 111. 00 113. 00	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117)	0 0 0 215, 810	0 0 0 958, 487	(0	0	109. 00 110. 00 111. 00 113. 00 114. 00 118. 00
100.00	NONREI MBURSABLE COST CENTERS			,			
192. 00 192. 01 192. 02 193. 00 193. 01 193. 02 193. 03 194. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 JOHNSON/NICHOLS WIC 19203 RHEUMATOLOGY 19300 NONPAID WORKERS 19301 DME 19302 LACTATION CONSULTING 19303 DI ABETIC COUNSELING 07950 VACANT SPACE 07951 BOARD OF HEALTH 07952 PUTNAM/HENRY PRENATAL Cross Foot Adjustments	0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		0 0 0 0 0	5, 429, 792 526, 485 351, 552 0 0 0 0 47, 824	192. 01

Heal th Fina	ncial Systems	PUTNAM COUNT	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCA	ATION - GENERAL SERVICE COSTS		Provider Co	CN: 15-1333	Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre 3/28/2019 5:4			
	Cost Center Description	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	UTI LI ZATI ON REVI EW	Subtotal			
		13. 00	16. 00	17. 00	17. 01	24. 00			
201. 00 202. 00	Negative Cost Centers TOTAL (sum Lines 118 through 201)	0 215, 810	958, 487		0 0 0 137, 399		201.00		

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

 COST ALLOCATION - GENERAL SERVICE COSTS
 Provider CCN: 15-1333
 Period: Worksheet B

From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 3/28/2019 5:42 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 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 16.00 01600 MEDICAL RECORDS & LIBRARY 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, 746, 910 30.00 03100 INTENSIVE CARE UNIT 0 31.00 1,504,358 31.00 04100 SUBPROVI DER - I RF 41 00 0 41 00 C 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 0 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 2, 789, 666 50.00 51.00 05100 RECOVERY ROOM 0 309, 273 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 460, 675 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 990, 279 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 191, 591 54.01 54.01 54.02 03480 ONCOLOGY 000000000000000 4, 789, 811 54.02 05700 CT SCAN 57 00 648, 846 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 60.00 06000 LABORATORY 2, 982, 090 60.00 60.01 06001 BLOOD LABORATORY 60 01 0 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 669, 215 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 791, 372 66,00 06700 OCCUPATIONAL THERAPY 67 00 67.00 124, 336 68.00 06800 SPEECH PATHOLOGY 63, 504 68.00 69 00 06900 ELECTROCARDI OLOGY 230, 269 69.00 06901 CARDI AC REHAB 69.01 69.01 488, 176 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 500 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 71, 106 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 1, 671, 009 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 1, 971, 479 88.00 08801 RURAL HEALTH CLINIC II 0 1, 743, 287 88.01 0 08802 RURAL HEALTH CLINIC III 88.02 88.02 1, 277, 808 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 r 89 00 90.00 09000 CLI NI C 0 11, 179 90.00 0 90. 01 09001 RHEUMATOLOGY 3, 703 90.01 0 09100 EMERGENCY 4, 041, 308 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 0 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 111.00 113. 00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 0 32, 571, 750 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 32, 918 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 5, 429, 792 192.00 192. 01 19201 JOHNSON/NI CHOLS WIC 0 0 526, 485 192.01 192. 02 19203 RHEUMATOLOGY 351, 552 192 02 193. 00 19300 NONPALD WORKERS C 193.00 193. 01 19301 DME 0 0 0 193.01 193. 02 19302 LACTATION CONSULTING 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG C 193.03 194.00 07950 VACANT SPACE 194.00 194. 01 07951 BOARD OF HEALTH 47,824 194.01

Health Financial Sys	tems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GE	NERAL SERVICE COSTS		Provi der C	CN: 15-1333	Peri od:	Worksheet B		
					From 01/01/2018 To 12/31/2018	Part Date/Time Pro	oparod:	
					10 12/31/2018	3/28/2019 5:		
Cost Cer	nter Description	Intern &	Total					
		Resi dents						
		Cost & Post						
		Stepdown						
		Adjustments						
		25. 00	26. 00					
194. 02 07952 PUTNAM/F	IENRY PRENATAL	0	0				194. 02	
200.00 Cross Fo	oot Adjustments	0	0				200.00	
201.00 Negati ve	e Cost Centers	0	0				201.00	
202.00 TOTAL (s	sum lines 118 through 201)	o	38, 960, 321				202. 00	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | Part Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-1333

				10	5 12/31/2018	3/28/2019 5:4	
	Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	<u> </u>
		0	1. 00	2A	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0 0 0 0 0 0	3, 770 350, 396 254, 876 16, 655 15, 571 86, 158 39, 519 16, 384 97, 368	350, 396 254, 876 16, 655 15, 571 86, 158 39, 519 16, 384 97, 368	3, 770 513 57 5 70 20 47 14 62	350, 909 21, 288 2, 182 6, 169 3, 821 6, 623 1, 650 6, 906	1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 16.00 17.00
17. 01	01701 UTI LI ZATI ON REVI EW	0	8, 204	8, 204	15	1, 118	17. 01
30. 00 31. 00 41. 00 42. 00 43. 00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER 04300 NURSERY	0 0 0 0	146, 348 69, 996 0 0	69, 996 0 0	357 126 0 0 0	0	30. 00 31. 00 41. 00 42. 00 43. 00
50. 00 51. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM	0	201, 561 56, 543	56, 543	125 16	1, 882	50. 00 51. 00
52. 00 53. 00 54. 00 54. 01 54. 02 57. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY O5400 RADI OLOGY-DI AGNOSTI C O5401 NUCLEAR MEDI CI NE-DI AGNOSTI C O3480 ONCOLOGY O5700 CT SCAN	0 0 0	0 74, 677 3, 449 119, 665 32, 522	0 74, 677 3, 449 119, 665 32, 522	0 165 177 0 57	4, 040 16, 009 1, 675 40, 916 5, 256	52. 00 53. 00 54. 00 54. 01 54. 02 57. 00
58. 00 59. 00 60. 00 60. 01	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06400 INTRAVENOUS THERAPY	0	0 0 61, 840 0	0 0 61,840 0	0 0 136 0 0	0 25, 301 0	58. 00 59. 00 60. 00 60. 01
64. 00 65. 00 66. 00 67. 00	06500 RESPIRATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0 0	17, 246 41, 983 0	17, 246 41, 983	70 0 0	5, 555 6, 451	64. 00 65. 00 66. 00 67. 00
68. 00 69. 00 69. 01 71. 00 72. 00 73. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	0 0 0 0 0	0 2, 464 39, 814 0 0 22, 075	39, 814 0 0	0 15 47 0 0 37	572 1, 986 3, 686 5 640 14, 592	68. 00 69. 00 69. 01 71. 00 72. 00 73. 00
88 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	O	119, 148	119, 148	182	15, 419	88. 00
88. 01 88. 02 89. 00 90. 00 90. 01	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 RHEUMATOLOGY 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0 0	61, 471 139, 301 0 3, 991 123 143, 046	61, 471 139, 301 0 3, 991 123	197 98 0 0 0 535	15, 020 9, 481 0 43 31	88. 01 88. 02 89. 00 90. 00 90. 01
00 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	O	0	0	0	0	99. 10
//. 10	SPECIAL PURPOSE COST CENTERS	, o		·			77.10
110. 00 111. 00 113. 00	0 10900 PANCREAS ACQUISITION 0 11000 INTESTINAL ACQUISITION 0 11100 ISLET ACQUISITION 0 11300 INTEREST EXPENSE 0 11400 UTILIZATION REVIEW-SNF 0 SUBTOTALS (SUM OF LINES 1 through 117)	0 0	0 0 0 2, 246, 164	0	0 0 0 3, 176	0	109. 00 110. 00 111. 00 113. 00 114. 00 118. 00
192. 0 192. 0 192. 0 193. 0 193. 0 193. 0	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CI ANS' PRI VATE OFFI CES 1 19201 JOHNSON/NI CHOLS WI C 2 19203 RHEUMATOLOGY 0 19300 NONPAI D WORKERS 1 19301 DME 2 19302 LACTATI ON CONSULTI NG 3 19303 DI ABETI C COUNSELI NG 0 07950 VACANT SPACE	0 0 0 0 0 0 0	11, 752 244, 184 0 11, 481 0 0 0 0	244, 184 0 11, 481 0 0 0 0	0 498 60 36 0 0 0	44, 039 4, 494 2, 923 0 0 0	190. 00 192. 00 192. 01 192. 02 193. 00 193. 01 193. 02 193. 03 194. 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 01/01/2018 To 12/31/2018		nared.	
				12,01,2010	3/28/2019 5: 4		
		CAPI TAL					
		RELATED COSTS					
Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V		
	Assigned New	FLXT		BENEFITS	E & GENERAL		
	Capi tal			DEPARTMENT			
	Related Costs						
	0	1. 00	2A	4. 00	5. 00		
194. 01 07951 BOARD OF HEALTH	0	17, 074	17, 07	4 0	182	194. 01	
194.02 07952 PUTNAM/HENRY PRENATAL	0	0		0 0	0	194. 02	
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0		0	0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	0	2, 530, 655	2, 530, 65	5 3, 770	350, 909	202. 00	

Provider CCN: 15-1333

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2018 | Part II |
| To | 12/31/2018 | Date/Time | Prepared: | 3/28/2019 | 5:42 pm |

				12/31/2018	3/28/2019 5: 4	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT 7. 00	LINEN SERVICE 8.00	9.00	10.00	11. 00	
GENERAL SERVICE COST CENTERS	7.00	8.00	7.00	10.00	11.00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 OPERATION OF PLANT	276, 221					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	2, 394	21, 236				8. 00
9. 00 00900 HOUSEKEEPI NG	2, 238	119		400 (44		9.00
10. 00 01000 DI ETARY	12, 385	88 0		103, 611	E2 202	10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	5, 681 2, 355	0	522 217	0	52, 392 405	11. 00 13. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	13, 996	0	1, 287	0	2, 252	16.00
17. 00 01700 SOCI AL SERVI CE	13, 770	0	1, 207	0	0	17. 00
17. 01 01701 UTILIZATION REVIEW	1, 179	Ö	-	0	Ö	17. 01
INPATIENT ROUTINE SERVICE COST CENTERS	·		·			
30. 00 03000 ADULTS & PEDIATRICS	21, 037	4, 620	1, 935	99, 833	5, 098	30.00
31.00 03100 INTENSIVE CARE UNIT	10, 061	3, 567	925	3, 778		31.00
41. 00 04100 SUBPROVI DER - I RF	0	0	0	0	0	41.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 O5000 OPERATING ROOM	28, 973	3, 010	2 445	0	2, 903	50.00
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM	8, 128	3,010	2, 665 748	0		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0, 120	331	740	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	ő	Ö	0	0	790	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 734	1, 589	987	0	4, 752	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	496	0	46	0	0	54. 01
54. 02 03480 ONCOLOGY	17, 201	683	1, 582	0	1, 513	54.02
57. 00 05700 CT SCAN	4, 675	0	430	0	834	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY	8, 889	0	818	0	4, 778	60.00
60. 01 06001 BL00D LABORATORY	0	0	0	0	0	60.01
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	2, 479	0	0 228	0	1, 611	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	6, 035	586		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0, 033	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0	0	0	Ö	68. 00
69. 00 06900 ELECTROCARDI OLOGY	354	0	33	0	376	69.00
69. 01 06901 CARDI AC REHAB	5, 723	0	526	0	952	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 173	0	292	0	994	73. 00
OUTPATIENT SERVICE COST CENTERS		.==	1			
88. 00 08800 RURAL HEALTH CLINIC	17, 127	475		0	-,	88.00
88. 01 08801 RURAL HEALTH CLINIC II 88. 02 08802 RURAL HEALTH CLINIC III	8, 836	0	0	0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	20, 024 0	0	1, 842 0	0	0	88. 02 89. 00
90. 00 09000 CLI NI C	574	0	53	0	0	90.00
90. 01 09001 RHEUMATOLOGY	18	0	2	0	6	90. 01
91. 00 09100 EMERGENCY	20, 562	5, 171	1, 891	0	6, 690	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	,		, ,	-		92.00
OTHER REIMBURSABLE COST CENTERS			•			
99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0	1	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUI SITI ON	0	0	0	0	0	111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	235, 327	20, 239	20, 406	103, 611	41, 189	114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	233, 327	20, 239	20, 400	103, 011	41, 107	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 689	0	155	0	0	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	35, 101	997		0		192.00
192. 01 19201 JOHNSON/NI CHOLS WI C	0	0	0	0	· ·	192. 01
192. 02 19203 RHEUMATOLOGY	1, 650	Ö	152	0		192. 02
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01 19301 DME	o	0	0	0		193. 01
193. 02 19302 LACTATION CONSULTING	0	0	0	0		193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	0	0	0		193. 03
194. 00 07950 VACANT SPACE	0	0	0	0		194.00
194. 01 07951 BOARD OF HEALTH	2, 454	0	226	0		194. 01
194. 02 07952 PUTNAM/HENRY PRENATAL	0	0	0	0		194. 02
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0	0	0	0		200. 00 201. 00
201. 00 megati ve cost centers	ا ا	0	1 0	U	ı <u> </u>	<u> </u> 201.00

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu				u of Form CMS-2	2552-10		
ALLOCATION OF CAPITAL RELATED COSTS			Provi der CO		Peri od:	Worksheet B	
					From 01/01/2018		
					To 12/31/2018	Date/Time Pre	
						3/28/2019 5: 4	2 pm
Cost Center Description	OPE	ERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
		PLANT L	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
202.00 TOTAL (sum lines 118 throu	gh 201)	276, 221	21, 236	24, 16	7 103, 611	52, 392	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1333

				Т	o 12/31/2018	Date/Time Pre 3/28/2019 5:4	
	Cost Center Description	NURSI NG ADMI NI STRATI O	MEDI CAL RECORDS &	SOCI AL SERVI CE	UTI LI ZATI ON REVI EW	Subtotal	_ p
		N 13. 00	16. 00	17. 00	17. 01	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
4. 00 5. 00	00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	21, 025					11. 00 13. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	21,025	121, 871	•			16.00
17. 00	01700 SOCI AL SERVI CE	l o	0	c			17. 00
17. 01	01701 UTI LI ZATI ON REVI EW	0	0) c	10, 624		17. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	7 007		1	10.007	200 (05	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	7, 287 4, 175	64, 905		· ·	380, 695 107, 050	1
41. 00	04100 SUBPROVI DER – I RF	4, 175	0			107,030	41.00
42. 00	04200 SUBPROVI DER		0		-	0	42.00
43.00	04300 NURSERY	O	0	d c	0	0	43.00
F0 00	ANCILLARY SERVICE COST CENTERS		00.044	1	u al	202 222	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	23, 941	C	-	282, 939 67, 964	50.00 51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		-	07, 904	52.00
53. 00	05300 ANESTHESI OLOGY	l o	0	d	ol ol	4, 995	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	c	o	108, 925	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	C	0	5, 666	
54. 02	03480 ONCOLOGY	0	2, 790			184, 407	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)		0			43, 750 0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0		-	0	59.00
60.00	06000 LABORATORY	O	0	d	o	101, 762	
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	07.100	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0			27, 189 55, 610	
67. 00	06700 OCCUPATI ONAL THERAPY		0			1, 120	1
68. 00	06800 SPEECH PATHOLOGY	l o	0	d	ol ol	572	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	o	5, 228	
69. 01	06901 CARDI AC REHAB	0	0	C	0	50, 748	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		0			5 640	71.00 72.00
73. 00	07300 DRUGS CHARGED TO PATTENTS		0			41, 163	1
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1	,	117 100	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	C	0	157, 925	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	1	-	85, 524	
88. 02 89. 00	08802 RURAL HEALTH CLINIC III	0	0			170, 746	
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0			0 4, 661	1
90. 01	09001 RHEUMATOLOGY		0		ól ől	180	
91.00	09100 EMERGENCY	9, 563	30, 235	d	o	247, 488	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
00.10	OTHER REIMBURSABLE COST CENTERS				y al	-	00 10
99. 10	O9910 CORF SPECI AL PURPOSE COST CENTERS	0	0		0	0	99. 10
109.00	10900 PANCREAS ACQUISITION	l ol	0		ol ol	0	109. 00
	11000 INTESTINAL ACQUISITION	O	0	d	o		110.00
	11100 ISLET ACQUISITION	0	0	C	0	0	111. 00
	11300 I NTEREST EXPENSE						113.00
114.00	11400 UTI LI ZATI ON REVI EW-SNF	21, 025	121, 871		10, 624	2, 136, 952	114.00
110.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	21,025	121,0/1	1	10, 624	2, 130, 932	1116.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	13, 721	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	0	C	0	336, 896	
	19201 JOHNSON/NI CHOLS WI C	0	0	C	0	6, 356	192. 01
	19203 RHEUMATOLOGY	0	0			16, 794	
	19300		0				193. 00 193. 01
	19302 LACTATION CONSULTING		0				193.01
	19303 DI ABETI C COUNSELI NG		0		ol ol		193. 03
	07950 VACANT SPACE		0	(o		194. 00
	07951 BOARD OF HEALTH	0	0	<u> </u>	0	19, 936	
194. 02 200. 00	PO7952 PUTNAM/HENRY PRENATAL Cross Foot Adjustments	0	0	' C	ار ا		194. 02 200. 00
200.00	1 or oss root haj astillerits	1		1	<u> </u>	0	1=00.00

Heal th Fina	ancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-		
		Provider Co		Peri od: From 01/01/2018			
	Cost Center Description	NURSI NG ADMI NI STRATI O N	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	UTI LI ZATI ON REVI EW	Subtotal	
		13. 00	16. 00	17. 00	17. 01	24.00	
201. 00 202. 00	Negative Cost Centers TOTAL (sum Lines 118 through 201)	0 21, 025	0 121, 871		0 0		201.00

Health FinancialSystemsPUTNAM COUNTY HOSPITALIn Lieu of Form CMS-2552-10ALLOCATION OF CAPITALRELATED COSTSProvider CCN: 15-1333Period:Worksheet B

From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 3/28/2019 5:42 pm Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 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 16.00 01600 MEDICAL RECORDS & LIBRARY 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 0 380, 695 30.00 03100 INTENSIVE CARE UNIT 0 31.00 107, 050 31.00 04100 SUBPROVI DER - I RF 0 41 00 41 00 C 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 0 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 282, 939 50.00 51.00 05100 RECOVERY ROOM 0 67, 964 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 4, 995 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 108, 925 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 5, 666 54.01 54.01 54.02 03480 ONCOLOGY 00000000 184, 407 54.02 05700 CT SCAN 57 00 43, 750 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 59.00 C 60.00 06000 LABORATORY 101, 762 60.00 60.01 06001 BLOOD LABORATORY 60 01 0 64.00 06400 I NTRAVENOUS THERAPY 64.00 06500 RESPIRATORY THERAPY 65.00 27, 189 65.00 66.00 06600 PHYSI CAL THERAPY 00000 55, 610 66,00 06700 OCCUPATIONAL THERAPY 67.00 67.00 1, 120 68.00 06800 SPEECH PATHOLOGY 572 68.00 69 00 06900 ELECTROCARDI OLOGY 5, 228 69.00 06901 CARDI AC REHAB 69.01 50, 748 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 640 72.00 07300 DRUGS CHARGED TO PATIENTS 0 41, 163 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 157, 925 88.00 88 01 08801 RURAL HEALTH CLINIC II 0 85, 524 88.01 0 08802 RURAL HEALTH CLINIC III 88.02 88.02 170, 746 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 r 89 00 90.00 09000 CLI NI C 0 90.00 4,661 0 90. 01 09001 RHEUMATOLOGY 180 90.01 0 09100 EMERGENCY 91.00 247, 488 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 0 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 111.00 113. 00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 0 2, 136, 952 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 13, 721 190.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 336, 896 192.00 192. 01 19201 JOHNSON/NI CHOLS WIC 00000 6, 356 192.01 192. 02 19203 RHEUMATOLOGY 16, 794 192 02 193. 00 19300 NONPALD WORKERS 0 193.00 193. 01 19301 DME 0 193.01 193. 02 19302 LACTATION CONSULTING 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG C 193.03 194.00 07950 VACANT SPACE 194.00 194. 01 07951 BOARD OF HEALTH 19, 936 194.01

Health Financial Systems	PUTNAM COUNTY HOSPITAL			In Lieu	In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CCN: 15-1333		Peri od: From 01/01/2018 To 12/31/2018			
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total					
194. 02 07952 PUTNAM/HENRY PRENATAL	25. 00	26. 00				194. 02	
200.00 Cross Foot Adjustments	o	0				200.00	
201.00 Negative Cost Centers	O	0				201.00	
202.00 TOTAL (sum lines 118 through 201)	0	2, 530, 655				202.00	

	Financial Systems	PUTNAM COUNTY		011 45 4000 5		u or form CMS-2	2552-10
COST A	ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2018	Worksheet B-1	
				Т	o 12/31/2018	Date/Time Pre 3/28/2019 5:4	
		CAPI TAL				3/20/2019 5.4	Z pili
		RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE		ADMI NI STRATI V	OPERATION OF	
		FIXT (SQUARE	BENEFITS DEPARTMENT	n	E & GENERAL	PLANT	
		FEET)	(GROSS		(ACCUM. COST)	(SQUARE FEET)	
		,	SALARI ES)		3331)		
	January 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1	1. 00	4. 00	5A	5. 00	7. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT	102, 715		1			1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	153	18, 735, 825				4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	14, 222	2, 550, 561		32, 879, 894		5. 00
7. 00	00700 OPERATION OF PLANT	10, 345	285, 934	1	1, ., ,	77, 995	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	676	26, 676			676	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	632 3, 497	347, 349 97, 393	1		632 3, 497	9. 00 10. 00
11. 00	01100 CAFETERI A	1, 604	233, 241	1		1, 604	11.00
13.00	01300 NURSING ADMINISTRATION	665	69, 839	1		665	13.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 952	310, 425	l .		3, 952	16.00
17.00	01700 SOCIAL SERVICE	0	72.405			0	17.00
17. 01	01701 UTILIZATION REVIEW INPATIENT ROUTINE SERVICE COST CENTERS	333	72, 695	(104, 766	333	17. 01
30.00	03000 ADULTS & PEDIATRICS	5, 940	1, 776, 060	C	1, 783, 932	5, 940	30.00
31. 00	03100 INTENSIVE CARE UNIT	2, 841	626, 149	1	, ,	2, 841	31.00
41.00	04100 SUBPROVI DER – I RF	0	0			0	41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0	0			0	42. 00 43. 00
	ANCILLARY SERVICE COST CENTERS	9			,		10100
50.00	05000 OPERATING ROOM	8, 181	622, 256	1	, ,	8, 181	50.00
51.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	2, 295	81, 848			2, 295	51.00
52. 00 53. 00	05300 ANESTHESI OLOGY	0	821, 684	1	1	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 031	882, 902			3, 031	
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	140	0	C		140	
54. 02 57. 00	03480 ONCOLOGY	4, 857	283, 338	1	.,	4, 857	
58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 320	165, 119 0	1	1,	1, 320 0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	d		0	59.00
60.00	06000 LABORATORY	2, 510	674, 208	1		2, 510	60.00
60. 01 64. 00	06001 BLOOD LABORATORY 06400 I NTRAVENOUS THERAPY	0	0			0	60. 01 64. 00
65. 00	06500 RESPIRATORY THERAPY	700	346, 295			700	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 704	0	d		1, 704	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C		0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	100	72, 683			0 100	68. 00 69. 00
69. 01	06901 CARDI AC REHAB	1, 616	235, 845			1, 616	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1		0	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	C			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	896	184, 587	<u> </u>	1, 367, 321	896	73. 00
88. 00	08800 RURAL HEALTH CLINIC	4, 836	903, 379		1, 444, 850	4, 836	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	2, 495	979, 744	1		2, 495	
88. 02	08802 RURAL HEALTH CLINIC III	5, 654	485, 558	1		5, 654	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 162	0			0 162	89. 00 90. 00
	09001 RHEUMATOLOGY	5	1, 971			5	90.00
91.00	09100 EMERGENCY	5, 806	2, 645, 262	1		5, 806	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
00 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0		0	0	99. 10
99. 10	SPECIAL PURPOSE COST CENTERS	ı o	0) 0	0	77. 10
	10900 PANCREAS ACQUISITION	0	0	1			109. 00
	11000 NTESTINAL ACQUISITION	0	0				110.00
) 11100 SLET ACQUISITION) 11300 NTEREST EXPENSE	0	U	C	0		111. 00 113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
118.00		91, 168	15, 783, 001	-6, 080, 427	28, 030, 996	66, 448	118. 00
100 00	NONREI MBURSABLE COST CENTERS	177		1 0	11 752	177	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	477 9, 911	0 2, 477, 628				190. 00 192. 00
192. 01	19201 JOHNSON/NI CHOLS WIC	0	297, 322	c	421, 120	0	192. 01
	2 19203 RHEUMATOLOGY	466	177, 874	l .			192.02
	0 19300 NONPALD WORKERS 1 19301 DME	0	0		1		193. 00 193. 01
193. 02	19302 LACTATION CONSULTING	0	0		1		193. 01
193. 03	19303 DI ABETI C COUNSELI NG	0	0	1			193. 03

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
				From 01/01/2018 To 12/31/2018		
	CAPI TAL					
	RELATED COSTS					
Cost Center Description	NEW BLDG &	EMPLOYEE	Reconciliation	ADMI NI STRATI V		
	FLXT	BENEFITS	n	E & GENERAL	PLANT	
	(SQUARE	DEPARTMENT		(ACCUM.	(SQUARE FEET)	
	FEET)	(GROSS		COST)		
		SALARI ES)				
	1. 00	4. 00	5A	5. 00	7. 00	
194. 00 07950 VACANT SPACE	0	0	1	0	0	194. 00
194. 01 07951 BOARD OF HEALTH	693	0		0 17, 074	693	194. 01
194.02 07952 PUTNAM/HENRY PRENATAL	0	0		0	0	194. 02
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 530, 655	4, 579, 473		6, 080, 427	2, 363, 654	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	24. 637638	0. 244423		0. 184928	30. 305199	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)		3, 770		350, 909	276, 221	204. 00
205.00 Unit cost multiplier (Wkst. B, Part		0. 000201		0. 010672	3. 541522	205. 00
	1		I		i .	00100

206. 00

207. 00

NAHE adjustment amount to be allocated (per Wkst. B-2)
NAHE unit cost multiplier (Wkst. D, Parts III and IV)

206.00

207.00

	ILLOCATION - STATISTICAL BASIS	TOTIVAM COUNT	Provi der Co	CN: 15-1333 P	eri od:	Worksheet B-1	
				F	rom 01/01/2018	Date/Time Pre	
					0 12/31/2016	3/28/2019 5: 4	2 pm
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(PATI ENT DAYS)	(MANHOURS)	ADMINISTRATIO N	
		LAUNDRY)		57.1.0)		(DI RECT	
						NRSI NG HRS)	
	GENERAL SERVICE COST CENTERS	8. 00	9. 00	10. 00	11. 00	13. 00	
1. 00	00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	178, 565					7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	1, 002					9.00
10.00	01000 DI ETARY	740					10.00
11.00	01100 CAFETERI A	0	1,001	0	370, 248		11.00
13. 00 16. 00	01300 NURSI NG ADMI NI STRATI ON 01600 MEDI CAL RECORDS & LI BRARY	0	665 3, 952	0	2, 862 15, 913	l .	
17. 00	01700 SOCIAL SERVICE	0	0	0	13, 713	0	1
	01701 UTILIZATION REVIEW	0	333	0	0	0	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20.045	F 040	2 527	2/ 025	27, 025	20.00
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	38, 845 29, 996		2, 537 96	36, 025 20, 637		
	04100 SUBPROVI DER – I RF	0	0	0	0	0	1
42.00	04200 SUBPROVI DER	0	_	0	0	l	
43. 00	04300 NURSERY	0	0	0	0	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	25, 310	8, 181	0	20, 516	0	50.00
51. 00	05100 RECOVERY ROOM	2, 785	1	Ö	2, 236	l	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	05300 ANESTHESI OLOGY	12 250	0	0	5, 585	0	53.00
54. 00 54. 01	05400 RADI OLOGY-DI AGNOSTI C 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	13, 358	3, 031 140	0	33, 581 0	1	54. 00 54. 01
54. 02	03480 ONCOLOGY	5, 740		Ö	10, 695	-	54. 02
57. 00	05700 CT SCAN	0	.,	0	5, 893		57.00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	58. 00 59. 00
60.00	06000 LABORATORY		2, 510	0	33, 769	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 931	700 1, 704	0	11, 384	0	65. 00 66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	1, 704	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	100	0	2, 654		69.00
69. 01 71. 00	06901 CARDI AC REHAB 07100 MEDI CAL SUPPLI ES CHARGED TO PATIENTS	0	1, 616	0	6, 730 0	0	69. 01 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	Ö	ō	0	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	896	0	7, 022	0	73.00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	3, 997	4, 836	0	28, 263	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	3, 447	4, 630	0		0	1
88. 02	08802 RURAL HEALTH CLINIC III	0	5, 654	0	0	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	
90. 00 90. 01	09000 CLI NI C 09001 RHEUMATOLOGY	0	162	0	43	0	90.00
91. 00	09100 EMERGENCY	43, 479	5, 806	0	47, 274	-	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
00 10	OTHER REIMBURSABLE COST CENTERS	1 0	ıl o		0		00 10
99. 10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
	11000 INTESTINAL ACQUISITION	0	0	0			110.00
	11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111.00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
118.00		170, 183	62, 645	2, 633	291, 082	103, 936	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0 8, 382		0		l	190. 00 192. 00
	19201 JOHNSON/NI CHOLS WI C	0, 302	9, 911	0	62, 531 12, 735	0	192.00
	19203 RHEUMATOLOGY	Ö	466	ő	3, 900		192.02
	19300 NONPAI D WORKERS	0	0	0	0		193. 00
	19301 DME 19302 LACTATION CONSULTING	0		0	0		193. 01 193. 02
193. 02	19302 DI ABETI C COUNSELI NG	0		0	0		193. 02
194.00	07950 VACANT SPACE	0	o o	o o	0	0	194. 00
194. 01	07951 BOARD OF HEALTH	0	693	0	0	0	194. 01

Health Financial Systems PUT	NAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-1333	Peri od: From 01/01/2018	Worksheet B-1 Date/Time Prepared:

				10	0 12/31/2018	3/28/2019 5: 4	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(SQUARE FEET)	(PATI ENT	(MANHOURS)	ADMI NI STRATI O	
		(POUNDS OF		DAYS)		N	
		LAUNDRY)				(DI RECT	
						NRSING HRS)	
		8. 00	9. 00	10. 00	11. 00	13. 00	
194. 02	07952 PUTNAM/HENRY PRENATAL	0	0	0	0	0	194. 02
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	i i	262, 762	705, 614	564, 578	799, 172	215, 810	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 471520	9. 510648	214. 423851	2. 158478	2. 076374	203. 00
204.00		21, 236	24, 167	103, 611	52, 392	21, 025	204. 00
	Part II)						
205.00	· · · · · · · · · · · · · · · · · · ·	0. 118926	0. 325736	39. 350930	0. 141505	0. 202288	205. 00
206.00	, , , , , , , , , , , , , , , , , , ,						206. 00
007.0	(per Wkst. B-2)						
207.00							207. 00
	Parts III and IV)						1

Health Financial Systems

In Lieu of Form CMS-2552-10 PUTNAM COUNTY HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1333 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 3/28/2019 5:42 pm Cost Center Description MEDI CAL SOCI AL UTI LI ZATI ON RECORDS & SERVI CE **REVIEW** LI BRARY (PATI ENT (PATI ENT (TIME SPENT) DAYS) DAYS 16.00 17.00 17.01 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 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 119, 094 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 17.01 01701 UTILIZATION REVIEW 0 2,633 17.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 63, 427 0 2,537 30.00 31.00 03100 INTENSIVE CARE UNIT 0 96 31.00 04100 SUBPROVI DER - I RF 41.00 0 0 0 41.00 04200 SUBPROVI DER 0 0 42.00 42.00 0 43.00 04300 NURSERY 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 23, 395 0 50.00 0 05100 RECOVERY ROOM 51.00 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 52.00 05300 ANESTHESI OLOGY 0 53.00 0 0 53.00 0 54 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54 00 0 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 0 C 54.01 54.02 03480 ONCOLOGY 0 54.02 2,726 0 57.00 05700 CT SCAN 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 58.00 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 59.00 06000 LABORATORY 0 60.00 0000000000 0 60.00 60 01 06001 BLOOD LABORATORY 0 0 60 01 0 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67 00 67 00 Ω 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 69.01 06901 CARDI AC REHAB 0 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 Ω 71 00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT C 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88 00 88.01 08801 RURAL HEALTH CLINIC II 0 0 0 88.01 88 02 08802 RURAL HEALTH CLINIC III 0 0 88 02 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 89.00 0 0 90 00 09000 CLI NI C 0 C 90 00 09001 RHEUMATOLOGY 0 90.01 90.01 09100 EMERGENCY 0 91.00 29, 546 C 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF 0 0 0 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 0 Ω 0 110.00 11000 INTESTINAL ACQUISITION 0 0 C 111.00 11100 I SLET ACQUISITION 0 C 0 113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 119,094 0 2,633 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN C C 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 01 19201 JOHNSON/NI CHOLS WIC 0 0 192. 02 19203 RHEUMATOLOGY 0 0

Health Financial Syste	ems	PUTNAM COUNTY HO	OSPI TAL		In Lie	eu of Form CMS-2552-10
COST ALLOCATION - STA	TISTICAL BASIS		Provider C	CN: 15-1333	From 01/01/2018	Worksheet B-1 B Date/Time Prepared:

					3/28/2019 5: 42	pm
	Cost Center Description	MEDI CAL	SOCI AL	UTI LI ZATI ON		
		RECORDS &	SERVI CE	REVI EW		
		LI BRARY	(PATI ENT	(PATI ENT		
		(TIME SPENT)	DAYS)	DAYS)		
		16. 00	17. 00	17. 01		
200.00	Cross Foot Adjustments				20	00.00
201.00	Negative Cost Centers				20	1.00
202.00	Cost to be allocated (per Wkst. B,	958, 487	0	137, 399	20	2.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	8. 048155	0.000000	52. 183441	20	3.00
204.00	Cost to be allocated (per Wkst. B,	121, 871	0	10, 624	20	4.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	1. 023318	0. 000000	4. 034941	20	5.00
	11)					
206.00	NAHE adjustment amount to be allocated				20	6. 00
	(per Wkst. B-2)					
207.00	NAHE unit cost multiplier (Wkst. D,				20	7.00
	Parts III and IV)					

Date/Time Prepared: 12/31/2018 3/28/2019 5: 42 pm Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 746, 910 3, 746, 910 0 0 30.00 03100 INTENSIVE CARE UNIT 1,504,358 1, 504, 358 0 0 31.00 31.00 0 41.00 04100 SUBPROVI DER - I RF 0 0 0 41.00 04200 SUBPROVI DER 0 0 0 42.00 42.00 0 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 2, 789, 666 2, 789, 666 0 0 50.00 0 05100 RECOVERY ROOM 51.00 309, 273 309, 273 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53.00 05300 ANESTHESI OLOGY 460, 675 460, 675 0 53.00 1, 990, 279 05400 RADI OLOGY-DI AGNOSTI C 1, 990, 279 54.00 0 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 191, 591 191, 591 0 54.01 03480 ONCOLOGY 4, 789, 811 4, 789, 811 0 54.02 54.02 57.00 05700 CT SCAN 648, 846 648, 846 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 58 00 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 2, 982, 090 2, 982, 090 60.00 60.00 0 06001 BLOOD LABORATORY 60.01 0 60.01 0 06400 INTRAVENOUS THERAPY 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 669, 215 669, 215 0 65.00 06600 PHYSI CAL THERAPY 66.00 791, 372 791, 372 0 66.00 67 00 06700 OCCUPATIONAL THERAPY 124 336 124 336 Ω 67 00 06800 SPEECH PATHOLOGY 68.00 63, 504 63, 504 0 68.00 69.00 06900 ELECTROCARDI OLOGY 230, 269 230, 269 0 69.00 0 69.01 06901 CARDI AC REHAB 488. 176 488. 176 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 500 500 0 71.00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENT 71, 106 71, 106 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 671, 009 1, 671, 009 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 1, 971, 479 1, 971, 479 0 0 88.01 08801 RURAL HEALTH CLINIC II 1, 743, 287 1, 743, 287 0 0 88.01 08802 RURAL HEALTH CLINIC III 0 88.02 1, 277, 808 1, 277, 808 0 88.02 o 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 Ω 0 0 11, 179 0 90.00 09000 CLI NI C 11, 179 0 90.00 09001 RHEUMATOLOGY 3, 703 3, 703 0 0 90.01 90.01 91.00 09100 EMERGENCY 4,041,308 4,041,308 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 265, 364 92.00 92.00 1, 265, 364 0 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109, 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 200.00 Subtotal (see instructions) 33, 837, 114 33, 837, 114 0 200.00 201.00 Less Observation Beds 1, 265, 364 1, 265, 364 0 201.00

32, 571, 750

0

32, 571, 750

0 202.00

202.00

Total (see instructions)

From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 3/28/2019 5:42 pm Title XVIII Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3 233 333 3, 233, 333 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 249, 541 1, 249, 541 31.00 04100 SUBPROVI DER - I RF 41.00 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 0 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 905, 968 3, 925, 988 4 831 956 0.577337 0.000000 50.00 05100 RECOVERY ROOM 0.547301 565, 088 0.000000 51.00 51.00 70, 339 494, 749 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52 00 52 00 53.00 05300 ANESTHESI OLOGY 30, 723 412,079 442, 802 1.040363 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 824, 015 8,073,628 8, 897, 643 0. 223686 0.000000 54.00 1, 259, 482 1, 291, 313 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 31, 831 0.000000 0.148369 54 01 54.02 03480 ONCOLOGY 12, 799 6, 146, 326 6, 159, 125 0.777677 0.000000 54.02 05700 CT SCAN 18, 540, 320 19, 327, 789 57 00 57 00 787, 469 0.033571 0.000000 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 0.000000 58.00 0 0 05900 CARDIAC CATHETERIZATION 59 00 0.000000 0.000000 59 00 06000 LABORATORY 1, 565, 006 15, 636, 631 17, 201, 637 0.173361 0.000000 60.00 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0.000000 60.01 06400 I NTRAVENOUS THERAPY 64.00 0 0.000000 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 1, 538, 915 848, 953 2, 387, 868 0. 280256 0.000000 65.00 66, 00 06600 PHYSI CAL THERAPY 498, 164 2, 467, 740 2, 965, 904 0.266823 0.000000 66,00 06700 OCCUPATI ONAL THERAPY 74, 104 534, 980 609, 084 0. 204136 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 56, 049 161, 962 218.011 0.291288 0.000000 68 00 69.00 06900 ELECTROCARDI OLOGY 49, 489 1, 305, 401 1, 354, 890 0.169954 0.000000 69.00 06901 CARDI AC REHAB 0.698271 69.01 980 698, 141 699, 121 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.000000 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 515, 779 72.00 133, 380 382, 399 0.137861 0.000000 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1,506,486 2, 662, 089 4, 168, 575 0.400859 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 2, 025, 520 88 00 08800 RURAL HEALTH CLINIC 2 025 520 88 00 08801 RURAL HEALTH CLINIC II 0 88.01 2,043,009 2,043,009 88.01 08802 RURAL HEALTH CLINIC III 0 699, 738 699, 738 88.02 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 09000 CLI NI C 0 0.000000 90 00 90 00 3, 651 3,651 3 061901 90.01 09001 RHEUMATOLOGY 0 1, 304 1, 304 2.839724 0.000000 90.01 253, 649 15, 335, 183 15, 588, 832 0. 259244 0.000000 91.00 09100 EMERGENCY 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1<u>, 882, 138</u> <u>1, 882, 13</u>8 0. 672301 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 109 00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00

0

85, 541, 411

85. 541. 411

12, 822, 240

12, 822, 240

0

98, 363, 651

98. 363. 651

111.00

113.00

1114 00

200.00

201.00

202.00

111.00 11100 I SLET ACQUISITION

114. 00 11400 UTILIZATION REVIEW-SNF

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

113.00 11300 INTEREST EXPENSE

200.00

201.00

202.00

Health 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 01/01/2018 To 12/31/2018 Date/Time Prepared:

			10 12/31/2018	3/28/2019 5:4	
		Title XVIII	Hospi tal	Cost	rz piii
Cost Center Description	PPS Inpatient		1100pi tui	0001	
oost contor boson per on	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
41. 00 04100 SUBPROVI DER - RF					41.00
42. 00 04200 SUBPROVI DER					42.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS	<u> </u>				
50. 00 05000 OPERATI NG ROOM	0. 000000				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000				54. 01
54. 02 03480 ONCOLOGY	0. 000000				54.02
57. 00 05700 CT SCAN	0. 000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
69. 01 06901 CARDI AC REHAB	0. 000000				69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					1
88. 00 08800 RURAL HEALTH CLINIC					88. 00
88. 01 08801 RURAL HEALTH CLINIC II					88. 01
88.02 08802 RURAL HEALTH CLINIC III					88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89.00
90. 00 09000 CLI NI C	0. 000000				90.00
90. 01 09001 RHEUMATOLOGY	0. 000000				90.01
91. 00 09100 EMERGENCY	0. 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
OTHER REIMBURSABLE COST CENTERS					
99. 10 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 I SLET ACQUI SI TI ON					111.00
113. 00 11300 NTEREST 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 Total (see instructions)					202.00
•					•

					0 12/31/2018	Date/Time Pre 3/28/2019 5:4	
			Ti tl	e XIX	Hospi tal	Cost	2 piii
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col . 26)	2.00	2.00	4.00	Г 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	3, 746, 910		3, 746, 910	0	3, 746, 910	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 504, 358		1, 504, 358	0	1, 504, 358	
41. 00	04100 SUBPROVI DER – I RF	1, 304, 330		1, 304, 330	0	1, 304, 330	41.00
42. 00	04200 SUBPROVI DER	0		0	o	0	1
43. 00	04300 NURSERY			0	0	0	43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	l o		0	U U	U	43.00
50.00	05000 OPERATING ROOM	2, 789, 666		2, 789, 666	O	2, 789, 666	50.00
51. 00	05100 RECOVERY ROOM	309, 273		309, 273	o	309, 273	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		307, 279	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	460, 675		460, 675	o	460, 675	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 990, 279		1, 990, 279	o	1, 990, 279	54.00
54. 01	05401 NUCLEAR MEDICINE-DI AGNOSTI C	191, 591		191, 591	o	191, 591	54. 01
54. 02	03480 ONCOLOGY	4, 789, 811		4, 789, 811	0	4, 789, 811	54.01
57. 00	05700 CT SCAN	648, 846		648, 846	_	648, 846	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	040, 040		040, 040	0	040, 040	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON			0	0	0	59.00
60.00	06000 LABORATORY	2, 982, 090		2, 982, 090	-	2, 982, 090	
60. 00	06001 BLOOD LABORATORY	2, 982, 090		2, 902, 090	0	2, 982, 090	60.00
64. 00	06400 I NTRAVENOUS THERAPY			0	0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	669, 215	0	669, 215	0	669, 215	65.00
66. 00	06600 PHYSI CAL THERAPY	791, 372	0	791, 372	0	791, 372	
67. 00	06700 OCCUPATI ONAL THERAPY	124, 336	0	124, 336	0	124, 336	1
68. 00	06800 SPEECH PATHOLOGY	63, 504	0	63, 504	0	63, 504	
69.00	06900 ELECTROCARDI OLOGY	230, 269	O	230, 269	0	230, 269	
69. 01	06901 CARDI AC REHAB	488, 176		488, 176	o	488, 176	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	500		500	0	500	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	71, 106		71, 106	o	71, 106	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 671, 009		1, 671, 009	o	1, 671, 009	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	1,071,007		1,071,007	<u> </u>	1,071,007	73.00
88. 00	08800 RURAL HEALTH CLINIC	1, 971, 479		1, 971, 479	0	1, 971, 479	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	1, 743, 287		1, 743, 287	0	1, 743, 287	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	1, 277, 808		1, 277, 808	0	1, 277, 808	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	1,277,000		1,277,000	0	1,277,000	89.00
90.00	09000 CLINIC	11, 179		11, 179	0	11, 179	
90. 01	09001 RHEUMATOLOGY	3, 703		3, 703	0	3, 703	
91. 00	09100 EMERGENCY	4, 041, 308		4, 041, 308	o	4, 041, 308	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 265, 364		1, 265, 364	Ŭ	1, 265, 364	
72.00	OTHER REIMBURSABLE COST CENTERS	1, 200, 304		1, 203, 304		1, 203, 304	72.00
99 10	09910 CORF	O		0		0	99. 10
,,,,,	SPECIAL PURPOSE COST CENTERS	<u> </u>					77
109. 00	10900 PANCREAS ACQUISITION	O		0		0	109. 00
	11000 INTESTINAL ACQUISITION	o		0			110.00
	11100 SLET ACQUISITION	l o		ő			111.00
	11300 NTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
200.00		33, 837, 114	0	33, 837, 114	0	33, 837, 114	
201.00	· · · · · · · · · · · · · · · · · · ·	1, 265, 364		1, 265, 364		1, 265, 364	
202.00		32, 571, 750	0				

Health Financial Systems

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

			Title XIX		Hospi tal	Cost	
	·		Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	'	+ col . 7)	Rati o	Inpatient	
				_		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
-	INPATIENT ROUTINE SERVICE COST CENTERS			•			
	03000 ADULTS & PEDIATRICS	3, 233, 333		3, 233, 333	3		30.00
	03100 INTENSIVE CARE UNIT	1, 249, 541		1, 249, 54			31.00
	04100 SUBPROVI DER - I RF	0					41.00
	04200 SUBPROVI DER	o o					42.00
	04300 NURSERY	o					43.00
	ANCILLARY SERVICE COST CENTERS	-1					1
	05000 OPERATING ROOM	905, 968	3, 925, 988	4, 831, 956	0. 577337	0.000000	50.00
51. 00	05100 RECOVERY ROOM	70, 339	494, 749			0. 000000	51.00
	05200 DELIVERY ROOM & LABOR ROOM	l ol	. 0			0. 000000	
	05300 ANESTHESI OLOGY	30, 723	412, 079	442, 802		0. 000000	1
	05400 RADI OLOGY-DI AGNOSTI C	824, 015	8, 073, 628			0. 000000	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	31, 831	1, 259, 482			0. 000000	1
	03480 ONCOLOGY	12, 799	6, 146, 326			0. 000000	
	05700 CT SCAN	787, 469	18, 540, 320			0. 000000	
	05800 MAGNETIC RESONANCE IMAGING (MRI)	707, 407	10, 540, 520			0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0			0. 000000	
	06000 LABORATORY	1, 565, 006	15, 636, 631	1		0. 000000	
	06001 BLOOD LABORATORY	1, 303, 000	15, 030, 031	1		0.000000	
	06400 I NTRAVENOUS THERAPY	0	0	1		0.000000	
65. 00	06500 RESPIRATORY THERAPY	1, 538, 915				0.000000	
	06600 PHYSI CAL THERAPY		848, 953				
		498, 164	2, 467, 740			0.000000	
67. 00	06700 OCCUPATI ONAL THERAPY	74, 104	534, 980			0.000000	
	06800 SPEECH PATHOLOGY	56, 049	161, 962			0.000000	1
	06900 ELECTROCARDI OLOGY	49, 489	1, 305, 401			0.000000	
	06901 CARDI AC REHAB	980	698, 141	1		0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0. 000000	
	07200 I MPL. DEV. CHARGED TO PATIENT	133, 380	382, 399			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 506, 486	2, 662, 089	4, 168, 575	0. 400859	0. 000000	73.00
	OUTPATIENT SERVICE COST CENTERS			T			
	08800 RURAL HEALTH CLINIC	0	2, 025, 520				1
	08801 RURAL HEALTH CLINIC II	0	2, 043, 009			0. 000000	
	08802 RURAL HEALTH CLINIC III	0	699, 738	1			1
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0. 000000	
	09000 CLI NI C	0	3, 651			0. 000000	
	09001 RHEUMATOLOGY	0	1, 304			0. 000000	
	09100 EMERGENCY	253, 649	15, 335, 183			0. 000000	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 882, 138	1, 882, 138	0. 672301	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	()		99. 10
	SPECIAL PURPOSE COST CENTERS						
	10900 PANCREAS ACQUISITION	0	0				109. 00
	11000 INTESTINAL ACQUISITION	0	0	1			110.00
	11100 I SLET ACQUISITION	0	0	()		111.00
	11300 I NTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114. 00
200.00	Subtotal (see instructions)	12, 822, 240	85, 541, 411	98, 363, 651			200.00
201.00	Less Observation Beds						201.00
202. 00	Total (see instructions)	12, 822, 240	85, 541, 411	98, 363, 651			202.00

Health 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 01/01/2018 To 12/31/2018 Date/Time Prepared:

			10 12/31/2018	3/28/2019 5:42	
		Title XIX	Hospi tal	Cost	. piii
Cost Center Description	PPS Inpatient	THE ALX	1100pi tui	3331	
555 5511 55551 Pt 1 511	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
41. 00 04100 SUBPROVI DER - I RF					41.00
42. 00 04200 SUBPROVI DER					42.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM	0. 000000				50.00
51.00 05100 RECOVERY ROOM	0. 000000				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000				54. 01
54. 02 03480 ONCOLOGY	0. 000000				54. 02
57. 00 05700 CT SCAN	0. 000000				57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
60. 00 06000 LABORATORY	0. 000000				60.00
60. 01 06001 BLOOD LABORATORY	0. 000000				60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000				64.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
69. 01 06901 CARDI AC REHAB					69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000 0. 000000			•	71.00
73. 00 07300 DRUGS CHARGED TO PATIENT	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS	0.000000				73.00
88. 00 08800 RURAL HEALTH CLINIC	0. 000000				88. 00
88. 01 08801 RURAL HEALTH CLINIC I	0. 000000				88. 01
88. 02 08802 RURAL HEALTH CLINIC III	0. 000000				88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			+	89. 00
90. 00 009000 CLINIC	1				
	0.000000				90.00
90. 01 09001 RHEUMATOLOGY 91. 00 09100 EMERGENCY	0. 000000 0. 000000				90. 01 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				91.00
OTHER REIMBURSABLE COST CENTERS	0.000000				92.00
					00 10
99. 10 09910 CORF					99. 10
SPECI AL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUI SI TI ON				1	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				1	110.00
111. 00 11100 SLET ACQUI SI TI ON					111.00
113. 00 11300 I NTEREST EXPENSE				I	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				I	114.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201.00
202.00 Total (see instructions)	1			2	202. 00

Health Financial Systems	PUTNAM COUNT	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 3/28/2019 5:4	pared: 2 pm
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	282, 939	4, 831, 956	0. 05855	6 423, 132	24, 777	50.00
51.00 05100 RECOVERY ROOM	67, 964	565, 088	0. 12027	2 35, 115	4, 223	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	4, 995	442, 802	0. 01128	0 18, 385	207	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	108, 925	8, 897, 643	0. 01224	2 448, 893	5, 495	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	5, 666	1, 291, 313	0.00438	8 18, 773	82	54. 01
54. 02 03480 ONCOLOGY	184, 407	6, 159, 125	0. 02994	0 1, 156	35	54. 02
57. 00 05700 CT SCAN	43, 750	19, 327, 789	0.00226	441, 077	999	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0. 00000	0 0	0	59.00
60. 00 06000 LABORATORY	101, 762	17, 201, 637	0. 00591	6 912, 801	5, 400	60.00
60. 01 06001 BL00D LABORATORY	0	0	0. 00000	0 0	0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000	0 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	27, 189	2, 387, 868			10, 012	65.00
66. 00 06600 PHYSI CAL THERAPY	55, 610				3, 665	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 120				47	
68.00 06800 SPEECH PATHOLOGY	572		0. 00262		89	68.00
69. 00 06900 ELECTROCARDI OLOGY	5, 228				125	
69. 01 06901 CARDI AC REHAB	50, 748				71	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5	0	0. 00000		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	640	515, 779			166	
73. 00 07300 DRUGS CHARGED TO PATIENTS	41, 163	1	•		5. 447	
OUTPATIENT SERVICE COST CENTERS	117 100	1, 100, 070	0.00707	00.7007	0, 11.	70.00
88. 00 08800 RURAL HEALTH CLINIC	157, 925	2, 025, 520	0. 07796	8 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	85, 524				0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	170, 746				0	88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	170,710	1	•		Ö	89.00
90. 00 09000 CLI NI C	4, 661	1	1. 27663		0	90.00
90. 01 09001 RHEUMATOLOGY	180	1	•		0	90.01
91. 00 09100 EMERGENCY	247, 488				110	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	128, 564				0	92.00
200.00 Total (lines 50 through 199)	1, 777, 771			4, 158, 871	60, 950	
200.00 10tal (11100 00 thi oagh 177)	1 1,7,7,7,7	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I	1, 155, 671	00, 700	_55.50

Health Financial Systems	PUTNAM COUNTY HOSE	PITAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Pr			Worksheet D
TUDOUCU COCTO			From 01/01/2018	Dart IV

THROUGH COSTS To 12/31/2018 Date/Time Prepared: 3/28/2019 5: 42 pm Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursi ng Nursi ng Allied Health Allied Health Anestheti st School Post-Stepdown School Post-Stepdown Cost Adjustments Adjustments 1. 00 2.00 ЗА 3. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 0 0000000000000000000000000 0 05100 RECOVERY ROOM 0 51.00 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 0 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 0 54.01 54.02 03480 ONCOLOGY 0 0 0 54.02 05700 CT SCAN 0 0 57.00 57.00 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 0 0 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 60.00 06000 LABORATORY 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 0 06400 I NTRAVENOUS THERAPY 0 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 0 0 69.01 06901 CARDI AC REHAB 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 0 0 0 0 0 88. 01 08801 RURAL HEALTH CLINIC II 0 0 88.01 08802 RURAL HEALTH CLINIC III 0 0 88.02 0 0 0 0 0 0 0 0 88.02 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 89.00 0 90.00 09000 CLI NI C 0 0 90.00 0 09001 RHEUMATOLOGY 0 0 90.01 90.01 0 0 91. 00 09100 EMERGENCY 0 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0

0

0 200.00

200.00

Total (lines 50 through 199)

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: Worksheet D
TUDOUCH COCTS		From 01/01/2018 Part IV

THROUGH COSTS To 12/31/2018 Date/Time Prepared: 3/28/2019 5: 42 pm Title XVIII Hospi tal Cost All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) 4. 00 5.00 7. 00 8.00 6.00 ANCILLARY SERVICE COST CENTERS 50 00 4, 831, 956 0.000000 50 00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 565, 088 0.000000 51.00 00000000000000000000 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 0 0 442, 802 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 8, 897, 643 54.00 0.000000 54.00 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 1, 291, 313 0.000000 54.01 54.02 03480 ONCOLOGY 0 6, 159, 125 0.000000 54.02 0 57 00 05700 CT SCAN 0 19, 327, 789 0.000000 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 0 60.00 06000 LABORATORY 0 17, 201, 637 0.000000 60.00 0 06001 BLOOD LABORATORY 0 0.000000 60.01 60.01 64.00 06400 I NTRAVENOUS THERAPY 0 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 2, 387, 868 0.000000 65.00 06600 PHYSI CAL THERAPY 0 0 2, 965, 904 0.000000 66.00 66,00 67.00 06700 OCCUPATI ONAL THERAPY 0 609, 084 0.000000 67.00 06800 SPEECH PATHOLOGY 0 218, 011 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0 0 1, 354, 890 0.000000 69.00 69.00 06901 CARDI AC REHAB 0 69. 01 0 699, 121 0.000000 69.01 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 515, 779 72.00 0 0 0.000000 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 4, 168, 575 0.000000 73 00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 2, 025, 520 0.000000 88.00 08801 RURAL HEALTH CLINIC II 0 0 2,043,009 88.01 0000000 0.000000 88.01 08802 RURAL HEALTH CLINIC III 0 88 02 0 699, 738 0.000000 88 02 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0.000000 89.00 90.00 09000 CLI NI C 0 0 3, 651 0.000000 90.00 09001 RHEUMATOLOGY 0 90.01 0 1, 304 0.000000 90.01 0 91. 00 09100 EMERGENCY 0 0.000000 91.00 15, 588, 832 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 1, 882, 138 0.000000 92.00

93, 880, 777

200.00

Total (lines 50 through 199)

Health Financial Systems		PUTNAM COUNTY F	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERV	/ICE OTHER PASS	Provider CCN: 15-1333		Worksheet D
TURQUIQUE GOOTO				Erom 01/01/2010	Dort IV

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provi der CCN: 15-1333					
		Title	XVIII	Hospi tal	Cost	Ζ μιιι	
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent		
, , , , , , , , , , , , , , , , , , ,	Ratio of Cost	Program	Program	Program	Program		
	to Charges	Charges	Pass-Through		Pass-Through		
	(col. 6 ÷	ŭ	Costs (col.	8	Costs (col. 9		
	col. 7)		x col. 10)		x col. 12)		
	9. 00	10. 00	11.00	12.00	13. 00		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0. 000000	423, 132		0 0	0	50.00	
51.00 05100 RECOVERY ROOM	0. 000000	35, 115		0 0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00	
53. 00 05300 ANESTHESI OLOGY	0. 000000	18, 385		0 0	0	53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	448, 893		0 0	0	54.00	
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	18, 773		0 0	0	54.01	
54. 02 03480 ONCOLOGY	0. 000000	1, 156		o o	0	54.02	
57.00 05700 CT SCAN	0. 000000	441, 077		o o	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		o o	0	58.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00	
60. 00 06000 LABORATORY	0. 000000	912, 801		0 0	0	60.00	
60. 01 06001 BLOOD LABORATORY	0. 000000	. 0		o o	0	60. 01	
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		o o	0	64.00	
65. 00 06500 RESPIRATORY THERAPY	0. 000000	879, 347		ol ol	0	65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	195, 450		o o	0	66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	25, 553	l .	0	0	67.00	
68. 00 06800 SPEECH PATHOLOGY	0. 000000	33, 762	l .	0	0	68.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	32, 518		o o	0	69.00	
69. 01 06901 CARDI AC REHAB	0. 000000	977		0	0	69. 01	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		o o	0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	133, 376		o o	0	72.00	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	551, 639		0	0	73.00	
OUTPATIENT SERVICE COST CENTERS							
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00	
88. 01 08801 RURAL HEALTH CLINIC II	0. 000000	0		o o	0	88. 01	
88. 02 08802 RURAL HEALTH CLINIC III	0. 000000	0		o o	0	88. 02	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		o o	0	89.00	
90. 00 09000 CLI NI C	0. 000000	0		0	0	90.00	
90. 01 09001 RHEUMATOLOGY	0. 000000	0		o o	0	90. 01	
91. 00 09100 EMERGENCY	0. 000000	6, 917		ol ol	0	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		ol ol	0	92.00	
200.00 Total (lines 50 through 199)		4, 158, 871		0 0		200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-1333 Peri od: Worksheet D From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 3/28/2019 5: 42 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 629, 259 0. 577337 50.00 05100 RECOVERY ROOM 0 0.547301 132, 109 51.00 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 0 0 52.00 53.00 05300 ANESTHESI OLOGY 1.040363 110,603 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 223686 2, 143, 357 0 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 0.148369 387. 935 0 54.01 54.02 03480 ONCOLOGY 0.777677 3, 200, 629 0 54.02 57.00 05700 CT SCAN 0.033571 5, 383, 084 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0.000000 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 59.00 59 00 \cap 0 60.00 06000 LABORATORY 0.173361 5, 594, 354 0 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 0 60.01 06400 INTRAVENOUS THERAPY 0.000000 64 00 0 0 64 00 65.00 06500 RESPIRATORY THERAPY 0.280256 324, 403 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 266823 772,009 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0. 204136 77, 436 0 67.00 06800 SPEECH PATHOLOGY 0 20, 917 68 00 0 291288 Ω 68 00 69.00 06900 ELECTROCARDI OLOGY 0.169954 0 332, 437 0 69.00 06901 CARDI AC REHAB 0.698271 191, 528 0 69.01 69.01 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 71.00 65, 987 07200 IMPL. DEV. CHARGED TO PATIENT 0.137861 Ω 72.00 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0.400859 349,660 0 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 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 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 0 89.00 90.00 09000 CLI NI C 3.061901 547 0 90.00 0 0 0 0 90.01 09001 RHEUMATOLOGY 2.839724 0 90.01 09100 EMERGENCY 0. 259244 3, 275, 392 0 91.00 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.672301 0 699, 690 0 92.00 0 200.00 Subtotal (see instructions) 24, 691, 336 200.00 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

24, 691, 336

0 202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-1333		Worksheet D
			From 01/01/2018	Part V

					From 01/01/2018 To 12/31/2018	Part V Date/Time Pro 3/28/2019 5:4	epared: 42 pm
				XVIII	Hospi tal	Cost	
			sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00		<u> </u>		
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	940, 632	0				50.00
	05100 RECOVERY ROOM	72, 303	0	1			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESI OLOGY	115, 067	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	479, 439	0				54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	57, 558	0				54.01
54.02	03480 ONCOLOGY	2, 489, 056	0				54.02
57.00	05700 CT SCAN	180, 716	0				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	969, 843	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60. 01
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00	06500 RESPIRATORY THERAPY	90, 916	0				65.00
66.00	06600 PHYSI CAL THERAPY	205, 990	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	15, 807	0				67.00
	06800 SPEECH PATHOLOGY	6, 093	Ö				68. 00
	06900 ELECTROCARDI OLOGY	56, 499	Ö	1			69.00
	06901 CARDI AC REHAB	133, 738	Ö	1			69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	1			71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	9, 097	Ö				72.00
	07300 DRUGS CHARGED TO PATIENTS	140, 164	l ő				73.00
70.00	OUTPATIENT SERVICE COST CENTERS	110,101					70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0				88.00
	08801 RURAL HEALTH CLINIC II	0	0				88. 01
	08802 RURAL HEALTH CLINIC III	0	l ő	1			88. 02
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1			89.00
	09000 CLINIC	1, 675		1			90.00
	09001 RHEUMATOLOGY	1,075	0	1			90.00
91. 00	09100 EMERGENCY	849, 126	0	1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	470, 402		1			92.00
200.00	,	1	0	-			200.00
200.00		7, 284, 121 0					200.00
201.00	Only Charges						201.00
202. 00		7, 284, 121	0	1			202. 00
202.00	[1,204,121	1	I			J202.00

		Component	CCN: 15-Z333 T	o 12/31/2018	Date/Time Pre 3/28/2019 5:4	
		Title	XVIII S	wing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 577337	0	1	1	0	50.00
51.00 05100 RECOVERY ROOM	0. 547301	0	C	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	C	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	1. 040363	0	-	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 223686	0	-	0	0	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 148369	0	C	0	0	54. 01
54. 02 03480 ONCOLOGY	0. 777677	0	C	0	0	54. 02
57.00 05700 CT SCAN	0. 033571	0	C	0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0	C	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	C	0	0	59.00
60. 00 06000 LABORATORY	0. 173361	0	C	0	0	60.00
60. 01 06001 BL00D LABORATORY	0. 000000	0	C	0	0	60. 01
64.00 06400 I NTRAVENOUS THERAPY	0. 000000	0	C	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 280256	0	C	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 266823	0	C	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 204136	0	C	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 291288	0	C	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 169954	0	C	0	0	69. 00
69. 01 06901 CARDI AC REHAB	0. 698271	0	C	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	C	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 137861	0	C	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 400859	0	C	0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	l .			0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0. 000000	l .			0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	l .			0	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00 09000 CLI NI C	3. 061901	0	C	0	0	90.00
90. 01 09001 RHEUMATOLOGY	2. 839724	0	C	0	0	90. 01
91. 00 09100 EMERGENCY	0. 259244	0	C	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 672301	0	C	0	0	92.00
200.00 Subtotal (see instructions)		0	C	0		200. 00
201.00 Less PBP Clinic Lab. Services-Program			C	0		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	(C	0	0	202. 00

Health Financial Systems	PUTNAM COUNTY H	In Lieu	u of Form CMS-2552-10	
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1333 Component CCN: 15-Z333	From 01/01/2018 To 12/31/2018	

			Component	CCN: 15-Z333	То	12/31/2	018	Date/Time Pro 3/28/2019 5:4	
			Title	XVIII	Swi no	Beds -	SNF	Cost	·- p···
		Cos				,			
	Cost Center Description	Cost	Cost	1					
	·	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	0	0						50.00
51.00	05100 RECOVERY ROOM	0	0						51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0						52.00
53.00	05300 ANESTHESI OLOGY	0	0						53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	0						54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	O	0						54. 01
54.02	03480 ONCOLOGY	o	0						54. 02
57.00	05700 CT SCAN	O	0	ol					57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0)					58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0	ol					59.00
60.00	06000 LABORATORY	o	0	o					60.00
60. 01	06001 BLOOD LABORATORY	o	0)					60. 01
64.00	06400 I NTRAVENOUS THERAPY	ol	0	o l					64.00
65.00	06500 RESPI RATORY THERAPY	ol	0	o l					65.00
	06600 PHYSI CAL THERAPY	ol	0						66. 00
	06700 OCCUPATI ONAL THERAPY	l ol	0	ol .					67.00
68. 00	06800 SPEECH PATHOLOGY	ol	0						68. 00
69. 00	06900 ELECTROCARDI OLOGY	ol	0						69. 00
	06901 CARDI AC REHAB	o	0						69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0						71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	o	0						72.00
	07300 DRUGS CHARGED TO PATIENTS	o	0						73.00
	OUTPATIENT SERVICE COST CENTERS								
88. 00	08800 RURAL HEALTH CLINIC	0	0						88. 00
88. 01	08801 RURAL HEALTH CLINIC II	o	0						88. 01
	08802 RURAL HEALTH CLINIC III	o	0						88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	ol	0						89.00
	09000 CLI NI C	0	0						90.00
90. 01	09001 RHEUMATOLOGY	0	0						90. 01
91. 00	09100 EMERGENCY	0	0						91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0	1					92.00
200. 00			0	1					200.00
201.00	1 1	ام	O						201.00
2000	Only Charges								
202.00		o	0	o					202.00

n Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
TATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1333	Peri od:	Worksheet D-1	
			Date/Time Pre 3/28/2019 5:4	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				
			1.00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				
Inpatient days (including private room days	and swing-bed days, excluding newborn)		3, 668	1.00
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3,23				
Private room days (excluding swing-bed and do not complete this line.	observation bed days). If you have only p	orivate room days,	0	3. 00
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS Inpatient days (including private room days Inpatient days (including private room days Private room days (excluding swing-bed and	TATION OF INPATIENT OPERATING COST Provider CCN: 15-1333 Title XVIII Cost Center Description PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days (excluding swing-bed and observation bed days).	TATION OF INPATIENT OPERATING COST Provider CCN: 15-1333 Period: From 01/01/2018 To 12/31/2018 Title XVIII Hospital Cost Center Description PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	TATION OF INPATIENT OPERATING COST Provider CCN: 15-1333 Period: From 01/01/2018 To 12/31/2018 Date/Time Preside System 12/31/2018 Date/Tim

	oest center sessify to a	1. 00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 668	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3, 230	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed days)	2, 021	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	350	5.00
5.00	reporting period	330	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	_	
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	88	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 264	9. 00
10.00	newborn days)	222	40.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	339	10.00
11. 00	through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
.2.00	through December 31 of the cost reporting period	J.	.2.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
10.00	reporting period		10 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
17.00	reporting period	0.00	17.00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	3, 746, 910	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22.00
	5 x line 17)		
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
24.00	x line 18)	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
23.00	Is line 20)	O	25.00
26. 00	Total swing-bed cost (see instructions)	366, 317	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 380, 593	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)	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	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35. 00 36. 00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line	0 3, 380, 593	36.00
37.00	27 minus line 36)	3, 300, 393	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 046. 62	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 322, 928	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 322, 928	41.00

7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	88	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 264	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	339	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
15.00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	14. 00 15. 00 16. 00
16.00	SWING BED ADJUSTMENT	0	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18. 00
19. 00	Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	3, 746, 910 0	21. 00 22. 00
23. 00		0	23. 00
24. 00	,	0	24. 00
25. 00	x line 20)	0	25. 00
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	366, 317 3, 380, 593	26. 00 27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00 29. 00
	Pri vate room charges (excluding swing-bed charges) Semi-pri vate room charges (excluding swing-bed charges)	0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	0. 00	
	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3, 380, 593	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 046. 62	
	Program general inpatient routine service cost (line 9 x line 38)	1, 322, 928	39. 00 40. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 1, 322, 928	

Heal th	Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre	
			Title	XVIII	Hospi tal	3/28/2019 5: 4 Cost	2 piii
	Cost Center Description	Total Inpati ent	Total Inpatient	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x	
		Cost	Days	÷ col . 2)		col . 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>	- O	0.0	5 0		42.00
43. 00 44. 00	INTENSIVE CARE UNIT	1, 504, 358	174	8, 645. 7	174	1, 504, 359	43. 00 44. 00
	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wks	+ D 2 col 2	lino 200)			1. 00 1, 120, 942	48. 00
	Total Program inpatient costs (sum of lines 4			ns)		3, 948, 229	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	tiont routing	corvices (from	Wkst D sum	of Parts Land	0	50. 00
30.00			·				30.00
51. 00	Pass through costs applicable to Program inpa and IV)	tient ancillary	y services (fr	om Wkst. D, s	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines 5					0	52.00
53. 00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5		lated, non-phy	sician anesth	netist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56.00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and tai	rget amount (I	ine 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period (endi ng 1996, u	pdated and co	ompounded by the	-	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year c	ost report und	dated by the m	arket hasket		0.00	60. 00
61. 00	If line 53/54 is less than the lower of lines	55, 59 or 60 e	enter the Less	er of 50% of		0	61.00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target		
62.00	Relief payment (see instructions)	ŕ				0	62.00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	nt (see instru	ctions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cost	s through Decer	mber 31 of the	cost reporti	ng period (See	354, 804	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost</pre>	s after Decembe	er 31 of the c	ost reportino	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	e costs (line d	64 plus line 6	5)(title XVII	I only). For	354, 804	66. 00
	CAH (see instructions)	•	•	, ,	3,		
67. 00	(line 12 x line 19)	costs through	December 31 0	i the cost re	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70. 00
71.00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica	•	(line 14 x li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine servi	ce costs (line	72 + line 73)				74.00
75. 00	Capital-related cost allocated to inpatient r 26, line 45)	outine service	costs (from w	юrкsneet в, н	art II, column		75. 00
76.00	Per diem capital related costs (line 75 ÷ lin						76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79.00	33 3				nus Lino 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		JSE TIMELALION	1 (11118 78 HILL)	ius IIIle /9)		80. 00 81. 00
82. 00 83. 00	Inpatient routine service cost limitation (li						82. 00 83. 00
84.00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		3)				83.00
85. 00 86. 00	Utilization review - physician compensation (85. 00 86. 00
00.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough obj				00.00
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per d	iem (line 27 ±	line 2)			1, 209 1, 046. 62	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	2)			1, 265, 364	

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 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	380, 695	3, 746, 910	0. 10160	2 1, 265, 364	128, 564	90.00
91.00 Nursing School cost	0	3, 746, 910	0.00000	0 1, 265, 364	0	91.00
92.00 Allied health cost	0	3, 746, 910	0.00000	0 1, 265, 364	0	92.00
93.00 All other Medical Education	0	3, 746, 910	0. 00000	0 1, 265, 364	0	93. 00

Heal th	Financial Systems	PUTNAM COUNTY F	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15-1333	Peri od:	Worksheet D-1	
				From 01/01/2018	D . (T) D	
				To 12/31/2018	Date/Time Pre 3/28/2019 5:4	parea: 2 nm
			Title XIX	Hospi tal	Cost	
	Cost Center Description					
	DART I ALL DROVERED COMPONENTS				1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1. 00	Inpatient days (including private room days	and swing had day	s oveluding newborn)		3, 668	1.00
2. 00	Inpatient days (including private room days,				3, 230	
3. 00	Private room days (excluding swing-bed and o			rivato room days	3, 230	
3.00	do not complete this line.	bbservation bed da	ys). If you have only p	i i vate i ooni days,	U	3.00
4. 00	Semi-private room days (excluding swing-bed	and observation b	ed days)		2, 021	4.00
5. 00	Total swing-bed SNF type inpatient days (inc			er 31 of the cost		5.00
	reporting period					
6.00	Total swing-bed SNF type inpatient days (inc	cluding private ro	om days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0	on this line)	•			
7.00	Total swing-bed NF type inpatient days (incl	uding private roo	m days) through Decembe	r 31 of the cost	88	7. 00
	reporting period					
8. 00	Total swing-bed NF type inpatient days (incl		m days) after December :	31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0		- the Discourse (and odin		105	0.00
9. 00	Total inpatient days including private room newborn days)	days applicable t	o the Program (excluding	g swing-bed and	125	9. 00
10. 00	Swing-bed SNF type inpatient days applicable	e to title XVIII o	nlv (including private	room days)	0	10.00
10.00	through December 31 of the cost reporting pe			days)	Ü	10.00
11.00	Swing-bed SNF type inpatient days applicable	e to title XVIII o	nly (including private	room days) after	0	11.00
	December 31 of the cost reporting period (if	f calendar year, e	nter 0 on this line)	,		
12.00	Swing-bed NF type inpatient days applicable	to titles V or XI	X only (including priva	te room days)	0	12.00
	through December 31 of the cost reporting pe					
13.00	Swing-bed NF type inpatient days applicable				0	13.00
	after December 31 of the cost reporting peri	od (if calendar y	ear, enter 0 on this li	ne)	_	
	Medically necessary private room days applic	cable to the Progr	am (excluding swing-bed	days)		14.00
15.00						15.00
16.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT				0	16. 00
17 00	Medicare rate for swing-bed SNF services app	alicable to service	os through Docombor 21	of the cost		17. 00
17.00	reporting period	officable to service	es thi ough becember 31 t	of the cost		17.00
18 00	Medicare rate for swing-bed SNF services app	olicable to servic	es after December 31 of	the cost		18.00
	reporting period	01.104.0.0 10 0011.0		1110 0001		10.00
19.00	Medicaid rate for swing-bed NF services appl	icable to service	s through December 31 o	f the cost	0.00	19.00
	reporting period		-			
20.00	Medicaid rate for swing-bed NF services appl	icable to service	s after December 31 of	the cost	0.00	20.00
	reporting period					
	Total general inpatient routine service cost				3, 746, 910	
22.00	Swing-bed cost applicable to SNF type service	ces through Decemb	er 31 of the cost repor	ung period (line	. 0	22. 00
22.00	5 x line 17)		24 . 6 . 1		0	22.00

	Cost Center Description	1.00	
	DADT I ALL DROW DED COMPONENTS	1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS		
1. 00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 668	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3, 230	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0 0	3.00
	do not complete this line.	-	
4.00	Semi-private room days (excluding swing-bed and observation bed days)	2, 021	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	339	5.00
	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		7 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	88	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	٥	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	125	9.00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	o	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	ő	15. 00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
10 00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00		0. 00	20. 00
20.00	reporting period	0.00	20.00
21.00		3, 746, 910	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
	5 x line 17)		
23.00	1 31 1 1	0	23.00
	x line 18)		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
25 00	7 x line 19)	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	٥	25. 00
26. 00	,	355, 899	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	3, 391, 011	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	373717311	27.00
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Pri vate room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	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 minus line 33) (see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35) Conoral impatient routing sorving cost not of swing bod cost and private room cost differential (line	2 201 011	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	3, 391, 011	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 049. 85	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	131, 231	39. 00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	131, 231	41.00

Heal th	Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der 0	CCN: 15-1333	Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018		
			Ti ti	le XIX	Hospi tal	3/28/2019 5: 4 Cost	2 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x	
		Inpatient Cost	Inpatient Days	Di em (col. 1 + col. 2)		col . 4)	
42.00	NUDSERV (+i +l o V & VIV only)	1. 00	2.00	3.00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	U _I		о, с	0	U	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 504, 358	174	8, 645. 7	0	0	43.00 44.00
	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
40.00	Drogram i proti ent anci llary comi co cost (Wko	+ D 2 col 2	line 200)			1. 00 201, 740	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4			ons)		332, 971	
	PASS THROUGH COST ADJUSTMENTS				C. Davida I		FO 00
50. 00	Pass through costs applicable to Program inpa	tient routine s	services (Tro	om wkst. D, Su	m or Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpa	tient ancillary	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines 5	0 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclud		ated, non-ph	nysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	2)					
	Program di scharges					0 0. 00	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	56.00
57.00	Difference between adjusted inpatient operati	ng 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 rep	orting period e	ending 1996,	updated and c	ompounded by the	0.00	58. 00 59. 00
(0.00	market basket	0.	<u> </u>				(0.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year c If line 53/54 is less than the lower of lines					0. 00 0	60. 00 61. 00
	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						
62. 00	, , , , , , , , , , , , , , , , , , ,						62.00
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	nt (see instruc	ctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cost	s through Decer	mber 31 of th	ne cost report	ing period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after Decembe	er 31 of the	cost reportin	a period (See	0	65. 00
	instructions)(title XVIII only)			·			
66. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	e costs (line 6	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
	(line 13 x line 20)			·	3 1		
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	,		•)		70. 00 71. 00
72.00	Program routine service cost (line 9 x line 7		ne /o - i i ne	; 2)			72.00
73. 00 74. 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73. 00 74. 00
75.00	Capital -related cost allocated to inpatient r	•		,	Part II, column		75.00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	۵ 2)					76. 00
77. 00	Program capital related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der recor	rde)			78. 00 79. 00
80.00	Total Program routine service costs for compa	rison to the co			nus line 79)		80. 00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (s	ee instructions					83. 00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation (ns)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 thr					86.00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)	THROUGH COST				1, 209	87. 00
88. 00	Adjusted general inpatient routine cost per d	•	line 2)			1, 049. 85	88. 00
89.00	Observation bed cost (line 87 x line 88) (see	ınstructions)				1, 269, 269	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 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	380, 695	3, 746, 910	0. 10160	2 1, 269, 269	128, 960	90.00
91.00 Nursing School cost	0	3, 746, 910	0.00000	0 1, 269, 269	0	91.00
92.00 Allied health cost	0	3, 746, 910	0.00000	0 1, 269, 269	0	92.00
93.00 All other Medical Education	o	3, 746, 910	0. 00000	0 1, 269, 269	0	93. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co		Period: From 01/01/2018 To 12/31/2018	Worksheet D-3	pared:
	Title	XVIII	Hospi tal	Cost	z piii
Cost Center Description	11110	Ratio of Cos		Inpati ent	
cost conto. Soco., pt. a		To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 833, 627		30.00
31.00 03100 INTENSIVE CARE UNIT			645, 977		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		0 57700	7 400 100	244 200	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM		0. 57733 0. 54730		244, 290 19, 218	
52. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 00000		19, 218	52.00
53. 00 05200 DELI VERT ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		1. 04036		19, 127	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 22368		100, 411	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 14836		2, 785	
54. 02 03480 0NCOLOGY		0. 77767		899	54. 02
57. 00 05700 CT SCAN		0. 03357		14, 807	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000	0	0	59.00
60. 00 06000 LABORATORY		0. 17336	1 912, 801	158, 244	60.00
60. 01 06001 BL00D LABORATORY		0.00000	0 0	0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 28025		246, 442	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 26682		52, 151	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 20413		5, 216	
68. 00 06800 SPEECH PATHOLOGY		0. 29128	· ·	9, 834	
69. 00 06900 ELECTROCARDI OLOGY		0. 16995		5, 527	
69. 01 06901 CARDI AC REHAB		0. 69827		682	69. 01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 13786	·	18, 387	72.00
73. 00 O7300 DRUGS CHARGED TO PATI ENTS OUTPATI ENT SERVI CE COST CENTERS		0. 40085	9 551, 639	221, 129	73.00
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 DIDNI HENTTH CLINIC III		0.00000		0	

0.000000

0.000000

3. 061901

2.839724

0. 259244

0.672301

4, 158, 871

89.00

90.00

90.01

91.00

92.00

201.00

202.00

0 88.02

0

0

0

1, 120, 942 200. 00

1, 793

08802 RURAL HEALTH CLINIC III

08900 FEDERALLY QUALIFIED HEALTH CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

88.02

89.00

90. 01

201.00

202.00

90. 00 09000 CLI NI C

91. 00 09100 EMERGENCY

09001 RHEUMATOLOGY

Health Financial Systems	PUTNAM COUNTY H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-1333	Peri od:	Worksheet D-3	
		Component	CCN: 15-Z333	From 01/01/2018 To 12/31/2018		pared: 2 pm
		Ti tl e	: XVIII	Swing Beds - SNF	Cost	
Cost Center Description			Ratio of Cos To Charges		Inpatient Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30 00 03000 ADULTS & PEDLATRICS				0		30 00

	cost center bescription	To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	0.00	col . 2)	
	INDATIENT POUTINE CERVICE COCT CENTERC	1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		0		30.00
30.00	03100 INTENSIVE CARE UNIT		0		31.00
	04100 SUBPROVI DER – I RF		0		41.00
41.00	04200 SUBPROVI DER		0		42.00
42.00	04300 NURSERY		U		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS			L	43.00
50.00	05000 OPERATI NG ROOM	0. 577337	66, 920	38, 635	50.00
	05100 RECOVERY ROOM	0. 547301	725		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0		52.00
53.00	05300 ANESTHESI OLOGY	1. 040363	530	551	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 223686	17, 697	3, 959	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 148369	0	0	54. 01
54.02	03480 ONCOLOGY	0. 777677	0	0	54. 02
57.00	05700 CT SCAN	0. 033571	17, 942	602	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000	0	0	59.00
60.00	06000 LABORATORY	0. 173361	79, 449	13, 773	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 280256	156, 734	43, 926	65.00
66.00	06600 PHYSI CAL THERAPY	0. 266823	123, 326	32, 906	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 204136	24, 034	4, 906	67.00
68.00	06800 SPEECH PATHOLOGY	0. 291288	9, 717	2, 830	68.00
	06900 ELECTROCARDI OLOGY	0. 169954	3, 159	537	69.00
69. 01	06901 CARDI AC REHAB	0. 698271	0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0. 137861	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 400859	103, 561	41, 513	73.00
	OUTPATIENT SERVICE COST CENTERS				
	08800 RURAL HEALTH CLINIC	0. 000000		0	
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. 061901	0	1	90.00
90. 01	09001 RHEUMATOLOGY	2. 839724	0	0	90. 01
91.00	09100 EMERGENCY	0. 259244	9, 834	2, 549	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 672301	0	0	92.00
200.00			613, 628		
201.00			(40.100		201.00
202. 00	Net charges (line 200 minus line 201)		613, 628	I	202. 00

Health Financial Systems	PUTNAM COUNTY H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-1333	Peri od: From 01/01/2018	Worksheet D-3	
				To 12/31/2018	Date/Time Pre 3/28/2019 5:4	pared: 2 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x	
				,	col. 2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				147, 719		30.00
21 00 02100 INTENCLIVE CARE UNIT				/ / -		21 00

	Cost Center Description	Ratio of Cost	Inpatient	Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2. 00	col. 2) 3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	
30.00	03000 ADULTS & PEDIATRICS		147, 719		30. 00
31. 00	03100 I NTENSI VE CARE UNI T	•	65, 536		31.00
41. 00	04100 SUBPROVI DER - I RF		03, 330 N		41.00
42. 00	04200 SUBPROVI DER		0		42.00
43. 00	04300 NURSERY		0		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS				43.00
50.00	05000 OPERATI NG ROOM	0. 577337	163, 803	94, 570	50.00
51. 00	05100 RECOVERY ROOM	0. 547301	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	1. 040363	2, 708	2, 817	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 223686	27, 312	6, 109	54.00
54.01	05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0. 148369	1, 910	283	54. 01
54.02	03480 ONCOLOGY	0. 777677	11, 639	9, 051	54.02
57.00	05700 CT SCAN	0. 033571	68, 368	2, 295	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0.000000	0	0	59.00
60.00	06000 LABORATORY	0. 173361	116, 998	20, 283	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 280256	36, 786	10, 309	65.00
66.00	06600 PHYSI CAL THERAPY	0. 266823	20, 959	5, 592	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 204136	1, 389	284	67.00
68.00	06800 SPEECH PATHOLOGY	0. 291288	1, 270	370	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 169954	13, 811	2, 347	69.00
69. 01	06901 CARDI AC REHAB	0. 698271	0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 137861	0	0	72.00
73.00		0. 400859	93, 516	37, 487	73.00
	OUTPAȚI ENT SERVI CE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0. 973320	0	0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0. 853294	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	1. 826123	0	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	0	89.00
90.00	09000 CLI NI C	3. 061901	0	0	90.00
90. 01	09001 RHEUMATOLOGY	2. 839724	0	0	90. 01
91. 00	09100 EMERGENCY	0. 259244	38, 354	9, 943	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 672301	0	0	92.00
200.00			598, 823	201, 740	
201.00			0		201. 00
202.00	Net charges (line 200 minus line 201)		598, 823		202. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1333	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 3/28/2019 5:42 pm
	T: +1 - \0.0111	Hanni Ani	C+

			, 12,01,2010	3/28/2019 5: 4	2 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			7, 284, 121	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		0	2.00
3.00	OPPS payments			0	3.00
4.00	Outlier payment (see instructions)			0	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
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	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9.00
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7, 284, 121	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for	payment for services on a	charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable fo	r payment for services on	a chargebasis	0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)			
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18.00	Total customary charges (see instructions)			0	18.00
19.00	Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds line	11) (see	0	19.00
	instructions)	•			
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds line	18) (see	0	20.00
	instructions)				
21.00	Lesser of cost or charges (see instructions)			7, 356, 962	21.00
22.00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		48, 707	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	e 24 (for CAH, see instruc	tions)	3, 845, 295	26. 00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22 a	nd 23] (see	3, 462, 960	27.00
	instructions)				
28.00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			3, 462, 960	30.00
31.00	Primary payer payments			2, 880	31.00
32.00	Subtotal (line 30 minus line 31)			3, 460, 080	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			793, 019	
35. 00	Adjusted reimbursable bad debts (see instructions)			515, 462	
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		736, 354	
	Subtotal (see instructions)			3, 975, 542	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for repla	ced devices (see instructi	ons)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00	Subtotal (see instructions)			3, 975, 542	
40. 01	Sequestration adjustment (see instructions)			79, 511	
40. 02	Demonstration payment adjustment amount after sequestration			0	
41. 00	Interim payments			4, 216, 332	
42. 00	Tentative settlement (for contractors use only)			0	42. 00
43.00	Balance due provider/program (see instructions)			-320, 301	
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2, ch	apter 1,	0	44. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
	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 PUT
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 3/28/2019 5: 42 pm Provi der CCN: 15-1333

				3/28/2019 5: 42	<u> 2 pm</u>
	Title	XVIII	Hospi tal	Cost	
	Inpatien	t Part A	Par	rt B	
	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	1.00	2.00	3.00	4. 00	
.00 Total interim payments paid to provider	1.00	3, 206, 989			1. (
				4, 216, 332	
.00 Interim payments payable on individual bills, either		0		0	2. (
submitted or to be submitted to the contractor for					
services rendered in the cost reporting period. If none,					
write "NONE" or enter a zero					
.00 List separately each retroactive lump sum adjustment					3. (
amount based on subsequent revision of the interim rate					
for the cost reporting period. Also show date of each					
payment. If none, write "NONE" or enter a zero. (1)					
Program to Provider	_				
. 01 ADJUSTMENTS TO PROVI DER	08/15/2018	66, 700		0	3.
. 02	007 137 2010	00, 700			3.
03					3.
. 04		0		0	3.
. 05		0		0	3.
Provider to Program					
.50 ADJUSTMENTS TO PROGRAM		0		0	3.
. 51		0		0	3.
52		0		0	3.
53		l o		l ol	3.
54		0		0	3.
.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines		66, 700		0	3.
3. 50-3. 98)		00, 700		Ĭ	Ο.
.00 Total interim payments (sum of lines 1, 2, and 3.99)		3, 273, 689		4, 216, 332	4.
(transfer to Wkst. E or Wkst. E-3, line and column as		3, 273, 007		4, 210, 332	7.
appropriate)					
TO BE COMPLETED BY CONTRACTOR					
.00 List separately each tentative settlement payment after					5.
					٥.
desk review. Also show date of each payment. If none,					
write "NONE" or enter a zero. (1)					
Program to Provider		_		_	_
01 TENTATI VE TO PROVI DER		0		0	5.
. 02		0		0	5.
03		0		0	5.
Provider to Program					
50 TENTATIVE TO PROGRAM		0		0	5.
. 51		0		l ol	5.
52		l o		l ol	5.
.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		ام	5.
5. 50-5. 98)		Ĭ		Ĭ	٥.
OD Determined net settlement amount (balance due) based on					6.
the cost report. (1)					Ο.
		250 507		0	6.
.01 SETTLEMENT TO PROVIDER		250, 507		_	
.02 SETTLEMENT TO PROGRAM		0 ==		320, 301	6.
.00 Total Medicare program liability (see instructions)		3, 524, 196		3, 896, 031	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
)	1.00	2. 00	
.00 Name of Contractor					8.

Provider CCN: 15-1333 | Period: | Worksheet E-1 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | 3/28/2019 5: 42 pm Provi der CCN: 15-1333

					3/28/2019 5: 4	2 pm
		Title	XVIII S	wing Beds - SNF		
		Inpati en	it 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		508, 333	3	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)					
	Program to Provider			_		
3. 01	ADJUSTMENTS TO PROVI DER		(0	
3. 02			(0	
3. 03			(0	
3.04			(0	
3.05			(0	3.05
	Provider to Program					ļ
3. 50	ADJUSTMENTS TO PROGRAM		(0	
3. 51			(0	
3. 52			(0	
3. 53			(1	0	0.00
3. 54			(0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		508, 333	3	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					1
5. 00	List separately each tentative settlement payment after		I		I	5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					1
5. 01	TENTATI VE TO PROVI DER				0	5. 01
5. 02	TEMMINE TO THOMBEN				0	
5. 03					0	
	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		17, 029	9	0	
6. 02	SETTLEMENT TO PROGRAM		(0	
7. 00	Total Medicare program liability (see instructions)		525, 362		0	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	No. 10 Contractor	()	1.00	2. 00	0.65
8.00	Name of Contractor	l		1	1	8.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Worksheet E-1			
		From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	pared:
			3/28/2019 5: 4	
	Title XVIII	Hospi tal	Cost	
TO DE COMPLETED BY CONTRACTOR FOR MONOTANDA	ACCT DEPOSTS		1. 00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDA				-
HEALTH INFORMATION TECHNOLOGY DATA COLLECTI		14		1 00
1.00 Total hospital discharges as defined in AAR		ne 14		1.00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				2.00 3.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, co 4.00 Total inpatient days from S-3, Pt. I col. 8				4.00
5.00 Total hospital charges from Wkst C, Pt. I,	·			5.00
6.00 Total hospital charity care charges from Wk				6.00
7.00 CAH only - The reasonable cost incurred for		w Wkst S 2 Dt I		7.00
line 168	ie purchase or certiffed fill technolog	y WKSL. 3-2, FL. I		7.00
8.00 Calculation of the HIT incentive payment (s	instructions)			8.00
9.00 Sequestration adjustment amount (see instru				9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				
INPATIENT HOSPITAL SERVICES UNDER THE IPPS	AH			
30.00 Initial/interim HIT payment adjustment (see	nstructions)			30.00
31.00 Other Adjustment (specify)				31.00
32.00 Balance due provider (line 8 (or line 10) m	us line 30 and line 31) (see instructi	ons)		32.00

Health Financial Systems	PUTNAM COUNTY H	IOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1333		Worksheet E-2
			From 01/01/2018	
		Component CCN: 15-Z333	To 12/31/2018	Date/Time Prepared:
		·		3/28/2019 5: 42 pm
		T' 11 . \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	C ' . D. L. CNE	0

		-		3/28/2019 5: 4	2 pm
		Title XVIII S	wing Beds - SNF		
			Part A	Part B	
	[1.00	2. 00	
4 00	COMPUTATION OF NET COST OF COVERED SERVICES		250 250		1 00
1.00	Inpatient routine services - swing bed-SNF (see instructions)		358, 352	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)		100.055	0	2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,		188, 955	0	3. 00
4 00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru	•		0.00	4.00
4. 00	Per diem cost for interns and residents not in approved teaching instructions)	program (see		0.00	4.00
5. 00	Program days		339	0	5. 00
6. 00	Interns and residents not in approved teaching program (see instr	uctions)	337	0	•
7. 00	Utilization review - physician compensation - SNF optional method		0	O	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	om y	547, 307	0	•
9. 00	Primary payer payments (see instructions)		0 17, 007	0	•
10. 00	Subtotal (line 8 minus line 9)		547, 307	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applicable	e to physician	0	0	11.00
00	professional services)	o to pilyororan		ŭ	
12.00	Subtotal (line 10 minus line 11)		547, 307	0	12.00
	Coinsurance billed to program patients (from provider records) (e	xcl ude coi nsurance	11, 223	0	13.00
	for physician professional services)		·		
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		536, 084	0	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstrati	on) payment	0		16. 55
	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruct	i ons)	0	0	
	Total (see instructions)		536, 084	0	
	Sequestration adjustment (see instructions)		10, 722	0	19. 01
	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
	Interim payments		508, 333	0	20.00
	Tentative settlement (for contractor use only)	21)	17 020	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, and	•	17, 029	0	22.00
23. 00	Protested amounts (nonallowable cost report items) in accordance	WITH CMS PUB. 15-2,	U	0	23. 00
	chapter 1, §115.2 Rural Community Hospital Demonstration Project (§410A Demonstrati	on) Adiustment			
200 00	Is this the first year of the current 5-year demonstration period				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	under the 213t			200.00
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from Wkst	. D-1. Pt. II. line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from Wk	st. D-3, col. 3, line			202.00
	200 (title XVIII swing-bed SNF))				
203.00	Total (sum of lines 201 and 202)				203.00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in fir	st year of the curren	t 5-year demons	trati on	
	peri od)				
	Medicare swing-bed SNF target amount				205. 00
206. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times				206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburseme				
	Program reimbursement under the §410A Demonstration (see instruct				207. 00
208. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, c	ol. 1, sum of lines 1			208. 00
000 00	and 3)				000 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	ns)			209.00
210.00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement	nlue lino 210) (ccc			215 00
∠15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 209	prus fille 210) (see			215. 00
	instructions)		1		I

	Financial Systems PUTNAM COUNTY	HOSPI TAL	In Lie	u of Form CMS-:	2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-1333 Period: From 01/01/2018 To 12/31/2018					
		Title XVIII	Hospi tal	Cost		
				1. 00		
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARI	F PART A SERVICES - COS	T RELMBURSEMENT	1.00		
1.00	Inpatient services	= 171K1 7K SEKVI SES - 505	T RETINDORGEMENT	3, 948, 229	1.00	
2. 00	Nursing and Allied Health Managed Care payment (see instruct	ions)		0, 710, 227	1	
3. 00	Organ acquisition	10113)		0	3.00	
4. 00	Subtotal (sum of lines 1 through 3)			3, 948, 229	4.00	
5. 00	Primary payer payments			0, 740, 227		
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			3, 987, 711		
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			3, 707, 711	0.00	
	Reasonable charges					
7. 00	Routine service charges			0	7.00	
8. 00	Ancillary service charges			0		
9. 00	Organ acquisition charges, net of revenue			0	ı	
	00 Total reasonable charges					
10.00	Customary charges			0	10.00	
11 00	Aggregate amount actually collected from patients liable for	navment for services on	a charge basis	0	11.00	
	Amounts that would have been realized from patients liable for			-		
12.00	had such payment been made in accordance with 42 CFR 413.13(on a charge basis	0	12.00	
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	c)		0. 000000	13 00	
	Total customary charges (see instructions)			0.000000	1	
15. 00	Excess of customary charges over reasonable cost (complete or	nlv if line 14 exceeds L	ine 6) (see	0		
10.00	instructions)	my in time in exceeds i	1110 0) (300	Ü	10.00	
16. 00	Excess of reasonable cost over customary charges (complete or	nlv if line 6 exceeds li	ne 14) (see	0	16. 00	
	instructions)	ye e enecede		· ·	10.00	
17. 00	Cost of physicians' services in a teaching hospital (see ins	tructions)		0	17. 00	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1	
18. 00	Direct graduate medical education payments (from Worksheet E	-4. line 49)		0	18.00	
	Cost of covered services (sum of lines 6, 17 and 18)	,		3, 987, 711		
	Deductibles (exclude professional component)			404, 608	1	
	Excess reasonable cost (from line 16)			0	21. 00	
	Subtotal (line 19 minus line 20 and 21)			3, 583, 103		
	Coinsurance			2, 010	1	
	Subtotal (line 22 minus line 23)			3, 581, 093		
	Allowable bad debts (exclude bad debts for professional serv	ices) (see instructions)		23, 116		
	Adjusted reimbursable bad debts (see instructions)	, (111		15, 025		
	Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		14, 927		
	Subtatal (sum of Lines 24 and 25 an Line 24)	,		2 FO/ 110		

28.00

29.00

29. 50

29.99

30.00

30.01

30.02

31.00

32.00

33.00 34.00

3, 596, 118

0

0 3, 596, 118

0

0

0

71, 922

3, 273, 689

250, 507

Pioneer ACO demonstration payment adjustment (see instructions)

33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)

34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,

Demonstration payment adjustment amount after sequestration

29.99 Demonstration payment adjustment amount before sequestration

Subtotal (sum of lines 24 and 25, or line 26)

Sequestration adjustment (see instructions)

Tentative settlement (for contractor use only)

29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

30.00 Subtotal (see instructions)

31.00 | Interim payments

§115. 2

28.00

29. 50

30.01

30. 02

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 01/01/2018 Part VII To 12/31/2018 Date/Time Prepared: 3/28/2019 5:42 pm

			10 12/31/2018	Date/lime Pre 3/28/2019 5:4	
		Title XIX	Hospi tal	Cost	2 piii
		THO MIN	Inpatient	Outpati ent	
			1. 00	2. 00	
F	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	tireze ren irreze r en m	X 02.XV. 02.0		1
	Inpatient hospital/SNF/NF services		332, 971		1.00
	Medical and other services			0	
	Organ acquisition (certified transplant centers only)		o		3.00
	Subtotal (sum of lines 1, 2 and 3)		332, 971	0	
	Inpatient primary payer payments		o		5.00
	Outpatient primary payer payments			0	
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		332, 971	0	7.00
(COMPUTATION OF LESSER OF COST OR CHARGES				
F	Reasonable Charges				
8. 00	Routine service charges		213, 255		8.00
9. 00	Ancillary service charges		598, 823	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		812, 078	0	12.00
_	CUSTOMARY CHARGES				
	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
	basi s				
	Amounts that would have been realized from patients liable for		0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			45.00
	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	
	Total customary charges (see instructions)	! 6 ! 1/	812, 078	0	16.00
	Excess of customary charges over reasonable cost (complete on line 4) (see instructions)	ry it time to exceeds	479, 107	0	17. 00
	Excess of reasonable cost over customary charges (complete on	Ly if line 4 exceeds line	. 0	0	18. 00
	16) (see instructions)	Ty IT TITLE 4 exceeds Title	il i	U	10.00
	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line		332, 971	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be				200
	Other than outlier payments	compressed for the province	T 0	0	22.00
	Outlier payments		o	0	23.00
	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
26. 00	Routine and Ancillary service other pass through costs		O	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
	Titles V or XIX (sum of lines 21 and 27)		332, 971	0	29. 00
(COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	332, 971	0	31.00
32. 00	Deducti bl es		0	0	
	Coi nsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34.00
	Utilization review		0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	332, 971	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Subtotal (line 36 ± line 37)		332, 971	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
	Total amount payable to the provider (sum of lines 38 and 39)		332, 971	0	
	Interim payments		325, 533	0	
	Balance due provider/program (line 40 minus line 41)	noo with CMC Dut 15 0	7, 438	0	
	Protested amounts (nonallowable cost report items) in accordal chapter 1, §115.2	TICE WITH CWS PUB 15-2,	0	0	43.00
1'	Chapter 1, 3113.2		1		I

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

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

Provi der CCN: 15-1333

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 3/28/2019 5:42 pm

——————————————————————————————————————					3/28/2019 5: 4	2 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	18, 079, 707	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts recei vable	18, 014, 345	0	0	0	4.00
5.00	Other receivable	3, 031, 476		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	1 '	1	0	0	6.00
7.00	Inventory	629, 365	1	0	0	7.00
8. 00	Prepai d expenses	354, 899	0	0	0	8.00
9. 00 10. 00	Other current assets	0		0	0	9.00
11. 00	Due from other funds Total current assets (sum of lines 1-10)	34, 127, 599	0	0	l	10.00 11.00
11.00	FIXED ASSETS	34, 127, 377	0	0		11.00
12. 00	Land	159, 364	0	0	0	12.00
13. 00	Land improvements	341, 824	0	0	1	13.00
14. 00	Accumulated depreciation	-259, 359		0	1	14.00
15. 00	Bui I di ngs	33, 745, 977		0	l	15.00
16.00	Accumulated depreciation	-22, 755, 442	1	0	0	16.00
17.00	Leasehold improvements	0	o	0	0	17.00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
19.00	Fi xed equi pment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	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	24, 299, 651	0	0	0	23. 00
24.00	Accumulated depreciation	-19, 789, 456	0	0	0	24.00
25. 00	Mi nor equi pment depreciable	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27.00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	15, 742, 559	0	0	0	30.00
31. 00	OTHER ASSETS Investments	182, 573	l ol	0	0	31.00
32.00	Deposits on Leases	102, 3/3		0	0	32.00
33. 00	Due from owners/officers			0	0	33.00
34. 00	Other assets	244, 689	_	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	427, 262	1	0	Ö	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	50, 297, 420		0	1	36.00
	CURRENT LIABILITIES			-		
37.00	Accounts payable	4, 465, 203	0	0	0	37.00
38.00	Salaries, wages, and fees payable	111, 467	0	0	0	38.00
39.00	Payrol I taxes payable	118, 424	0	0	0	39.00
40.00	Notes and Loans payable (short term)	5, 137, 876	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44. 00	Other current liabilities	545, 198	·	0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	10, 378, 168	0	0	0	45. 00
	LONG TERM LIABILITIES	_			_	
46. 00	Mortgage payable	0	0	0		46.00
47. 00	Notes payable	9, 297, 142		0		47.00
48. 00	Unsecured Loans	0	0	0		48.00
49.00	Other long term liabilities	0 207 142	0	0		49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9, 297, 142	1	0		50.00
51. 00	Total liabilities (sum of lines 45 and 50) CAPITAL ACCOUNTS	19, 675, 310	0	0	0	51.00
52. 00	General fund balance	30, 622, 110				52.00
53. 00	Specific purpose fund	30,022,110				53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant			· ·	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				Ö	58.00
	replacement, and expansion				l	
59.00	Total fund balances (sum of lines 52 thru 58)	30, 622, 110	o	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and	50, 297, 420	1	0	0	60.00
	59)					

PUTNAM COUNTY HOSPITAL

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Period: Worksheet G-1
From 01/01/2018 Provi der CCN: 15-1333

					From 01/01/201 To 12/31/201		
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0	25, 753, 590 4, 868, 520 30, 622, 110			0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00
9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0 0 0 0 0	0 30, 622, 110 0		0 0 0 0 0	0	9. 00 10. 00 11. 00 12. 00 0 13. 00 0 14. 00 0 15. 00 0 16. 00 17. 00 18. 00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	Endowment	30, 622, 110 Pl ant			0	19. 00
		Fund	Prant	runa			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0	0.00	0		1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0		0		8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0		0		17. 00 18. 00 19. 00

| Peri od: | Worksheet G-2 | From 01/01/2018 | Parts | & II | To | 12/31/2018 | Date/Time | Prepared: Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-1333

PART I - PATIENT REVENUES 1.00 2.00 3.00				То	12/31/2018	Date/Time Pre 3/28/2019 5:4	
PART L - PATTENT REVENUES		Cost Center Description	I nnati ent		Outpati ent		Z piii
PART - PATI ENT REVENUES		0031 0011101 203011 [211011					
Simple Simple Services		PART I - PATIENT REVENUES	1.00		2.00	0.00	
Hospital							
SubPROVIDER IPF	1.00		3, 233, 3	333		3, 233, 333	1. 00
3.00 SUBPROVIDER 1RF 5.00 Swing bed - SNF 6.00 Swing bed - SNF 7.00 SILLED NURSING FACILITY 8.00 O'HER LOW, TERM CAMP 9.00			, , , , ,			-,,	
5.00 Swing bed - SNF				0		0	
Swing bed - NF Skille DNRSING FACILITY Swing bed - NF Swing bed -	4.00	SUBPROVI DER		0		0	4.00
SKILLED NURSING FACILITY	5.00	Swing bed - SNF		0		0	5.00
NURSING FACILITY	6.00	Swing bed - NF		0		0	6.00
OTHER LONG TERM CARE	7.00	SKILLED NURSING FACILITY					7.00
10. 00 Total general Inpatient care services (sum of lines 1-9) 3, 233, 333 3, 233, 23	8.00	NURSING FACILITY					8.00
Intensive Care Type Inpatient Hospital Services	9.00	OTHER LONG TERM CARE					9.00
11.00 INTENSIVE CARE UNIT 1, 249, 541 1, 249, 541 1, 200 13.	10.00		3, 233, 3	333		3, 233, 333	10.00
12.00 CORONARY CARE UNIT							
13.00 BURN INTENSIVE CARE UNIT			1, 249, 5	541		1, 249, 541	
14. 00 SURGICAL INTENSIVE CARE UNIT							
15.00 OTHER SPECIAL CARE (SPECIFY) 1.249,541 1.500 1.249,541 1.500 1.249,541 1.500 1.249,541 1.500 1.249,541 1.500 1.249,541 1.500 1.249,541 1.500 1.249,541 1.500 1.249,541 1.249,541 1.500 1.249,541 1							
1. 249, 541 1. 249, 541, 541 1. 249, 541, 541 1. 249, 541, 541, 541, 541, 541, 541, 541, 541							
11-15 Total inpatient routine care services (sum of lines 10 and 16) 4, 482, 874 4, 482, 874 17, 00 18, 00 19, 00 19, 00 0, 00 17, 22, 276 17, 475, 925 19, 00 19, 00 0, 00 17, 22, 276 17, 475, 925 19, 00 17, 22, 276 17, 475, 925 17, 475, 925 17, 475, 925 17, 475, 925 17, 475, 925 17, 475, 925 17, 475, 925 17, 475, 925 17, 475, 925 17, 475, 925 17, 475		, ,					
17. 00	16. 00		1, 249, 5	541		1, 249, 541	16. 00
18. 00	47.00						47.00
19, 00 0							
20. 00 RURAL HEALTH CLINIC 0 2.025, 520 2.025, 520 2.025, 520 2.025, 520 RURAL HEALTH CLINIC 11 0 2.043, 009 2.044, 009 2.							
20. 01 RURAL HEALTH CLINIC I			253, 6				
20. 02 RURAL HEALTH CLINIC III 0 699, 738 699, 738 20. 02 21. 00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 21. 00 0 22. 00 22. 00 23. 00 24. 00 2							
21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 21.00 22.00 HOWE HEALTH AGENCY 22.00 22.00 HOWE HEALTH AGENCY 22.00 22							
22.00 HOME HEALTH AGENCY 23.00 AMBULANCE SERVICES 24.00 24				-			
23.00 AMBULANCE SERVICES 23.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 24.00 25.00				U	U	U	
24.00 CMHC CORF							
24. 10 CORF							
25. 00 AMBULATORY SURGICAL CENTER (D. P.) 25. 00 26. 00 HOSPICE 25. 00 26. 00 26. 00 26. 00 27. 00 2				0	0	0	
26. 00 HOSPICE 27. 00 PHYSICIAN PRIVATE OFFICE 27. 01 JOHNSON NI CHOLS WIC 418, 405 4118, 4018				U	o o	U	
27. 00 PHYSICIAN PRIVATE OFFICE 893, 668 12, 404, 223 13, 297, 891 27. 00 27. 01 27. 01 27. 01 27. 02 28. 00 6.3, line 1) PART II - OPERATING EXPENSES 29. 00 31. 00 32. 00 33. 00 33. 00 34. 00 35. 00 35. 00 36. 00 37. 00 38. 00 39.							
27. 01			893 /	568	12 404 223	13 207 801	
27. 02 RHEUMATOLOGY Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 13, 612, 167 98, 585, 436 112, 197, 603 28.00 6-3, line 1) PART II - OPERATING EXPENSES Operating expenses (per Wkst. A, column 3, line 200) ADD (SPECIFY) ADD (SPECIFY) O Total additions (sum of lines 30-35) DEDUCT (SPECIFY) Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42) (transfer 42) (transfer 42) (transfer 42) (transfer 42) (transfer 42) (transfer 44, 771, 659 43.00			073, 0				
28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 13,612,167 98,585,436 112,197,603 28.00							
G-3, line 1) PART II - OPERATING EXPENSES 29.00			st 13 612 1	-			
PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 44,771,659 29.00 30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 33.00 33.00 0 0 33.00 34.00 0 0 34.00 35.00 36.00 Total additions (sum of lines 30-35) 0 36.00 37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 0 0 38.00 39.00 40.00 0 0 40.00 40.00 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)(transfer 44,771,659 43.00	20.00		10,012,		70,000,100		20.00
30.00 ADD (SPECIFY) 0 30.00 31.00 32.00 32.00 32.00 33.00 34.00 35.00 35.00 35.00 35.00 36.00 35.00 36.00 37.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 44,771,659 43.00			'		<u>'</u>		
31.00 32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 36.00 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 10 31.00 32.00 31.00 32.00 33.00 33.00 33.00 33.00 33.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 39.00 40.00 41.00 42.00 43.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 44,771,659	29.00	Operating expenses (per Wkst. A, column 3, line 200)			44, 771, 659		29. 00
32.00 33.00 33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 32.00 32.00 33.00 33.00 34.00 35.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 44,771,659	30.00			0			30.00
33.00 34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00 44,771,659	31.00			0			31.00
34.00 35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 0 34.00 0 35.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00			0			32.00
35.00 36.00 Total additions (sum of lines 30-35) DEDUCT (SPECIFY) 0 37.00 38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer) 0 35.00 36.00 37.00 36.00 37.00 37.00 37.00 38.00 0 0 0 40.00 41.00 42.00 44.771,659	33.00			0			33.00
36.00 Total additions (sum of lines 30-35)	34.00			0			
37.00 DEDUCT (SPECIFY) 0 37.00 38.00 39.00 0 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 44,771,659 43.00	35.00			0			35.00
38.00 39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer					0		
39.00 40.00 41.00 42.00 Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 39.00 0 40.00 41.00 42.00 44,771,659		DEDUCT (SPECIFY)					37.00
40.00 41.00 42.00 Total deductions (sum of lines 37-41) 7 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 44,771,659 43.00				- 1			
41.00 42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 44,771,659 43.00							
42.00 Total deductions (sum of lines 37-41) 43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 44,771,659 43.00							
43.00 Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer 44,771,659 43.00		T		0	_		
		, ,	. 6.		0		
TO WKST. G-3, TIME 4)	43.00		isrer		44, //1, 659		43.00
		ן נט אואסנ. ט-ס, דווש 4)	I		I		

Heal th	Financial Systems PUTNAM COUNTY I	HOSPI TAL	In Lie	u of Form CMS-2	2552-10		
	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1333 Period: W						
	From 01/01/2018 To 12/31/2018						
				1.00			
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir			112, 197, 603	1.00		
2.00	Less contractual allowances and discounts on patients' accour	its		71, 027, 476	2.00		
3.00	Net patient revenues (line 1 minus line 2)	10)		41, 170, 127	3.00		
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		44, 771, 659	4.00		
5. 00	Net income from service to patients (line 3 minus line 4)			-3, 601, 532	5.00		
6. 00	OTHER INCOME Contributions, donations, bequests, etc			0	6. 00		
7. 00	Income from investments			0	7. 00		
8. 00	Revenues from telephone and other miscellaneous communication	e corvi cos		0	8. 00		
9. 00	Revenue from television and radio service	i sei vi ces		0	9. 00		
10.00	Purchase di scounts			0	10.00		
11. 00	Rebates and refunds of expenses			0	11. 00		
12. 00	· ·			0	12. 00		
13. 00				0	13. 00		
	Revenue from meals sold to employees and guests			0	14. 00		
	Revenue from rental of living quarters			ő	15.00		
	Revenue from sale of medical and surgical supplies to other t	han natients		ő	16.00		
	Revenue from sale of drugs to other than patients	man patronts		ő	17. 00		
18. 00				0	18. 00		
	Tuition (fees, sale of textbooks, uniforms, etc.)			o l	19. 00		
20.00				0	20.00		
21. 00	Rental of vending machines			ol	21. 00		
22. 00	Rental of hospital space			0	22.00		
23. 00	Governmental appropriations			o	23. 00		
24.00	OTHER OPERATING AND NON-OPERATING IN			8, 470, 052	24.00		
25. 00	Total other income (sum of lines 6-24)			8, 470, 052	25. 00		
26. 00	,			4, 868, 520	26.00		
27. 00				0	27.00		
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28.00		
29. 00	Net income (or loss) for the period (line 26 minus line 28)			4, 868, 520	29.00		

Haal th	Financial Systems	PUTNAM COUNT	V HOSDITAI		In lie	u of Form CMS-:	2552_10
	SIS OF HOSPITAL-BASED RHC/FOHC COSTS	TOTIVAM COUNT	Provi der C	CN: 15-1333	Peri od:	Worksheet M-1	
				CCN: 15-8515	From 01/01/2018 To 12/31/2018		pared:
					RHC I	Cost	2 piii
		Compensation	Other Costs	Total (col.	1 Reclassificat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
				,		(col. 3 +	
						col. 4)	
		1. 00	2.00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	345, 429	0	345, 42	29 0	345, 429	1.00
2.00	Physi ci an Assi stant	0	0		0	0	
3.00	Nurse Practitioner	204, 827	0	204, 83	27 0	204, 827	3.00
4.00	Visiting Nurse	0	0		0	0	
5. 00	Other Nurse	0	0		0	0	
6.00	Clinical Psychologist	0	0		0	0	
7. 00	Clinical Social Worker	0	0		0	0	
8. 00	Laboratory Techni ci an	0	0		0	0	
9.00	Other Facility Health Care Staff Costs	0	0	550.0	0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	550, 256	0	550, 2		550, 256	
11.00	Physician Services Under Agreement	0	0		0 0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
13.00	Other Costs Under Agreement	0	0		0 0	0	
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	
15.00	Medical Supplies	0	0		0 0	0	
16. 00 17. 00	Transportation (Health Care Staff) Depreciation-Medical Equipment	O O	0		0	0	
18. 00	Professional Liability Insurance	O O	0		0 0	0	18.00
	Other Health Care Costs	0	0		0 0	0	
20.00	Allowable GME Costs	٩	0			0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0 0	0	
22. 00	Total Cost of Health Care Services (sum of	550, 256	0	550, 2!	٥		1
22.00	lines 10, 14, and 21)	330, 230	O	330, 2	50	330, 230	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES					L	
23. 00	Pharmacy	O	0		0 0	0	23. 00
24.00	Dental	o	0		0 0	0	24.00
25.00	Optometry	o	0		0 0	0	25. 00
25. 01	Tel eheal th	o	0		0 0	0	25. 01
25.02	Chronic Care Management	o	0		0 0	0	25. 02
26.00	All other nonreimbursable costs	o	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	0		0 0	1	
30.00	Administrative Costs	353, 123	323, 001	676, 12	· ·	·	
31.00	Total Facility Overhead (sum of lines 29 and	353, 123	323, 001	676, 13	-105, 208	570, 916	31.00
	(30)			I		I	I

903, 379

323, 001

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

-105, 208

1, 121, 172

32.00

1, 226, 380

lealth Financial Systems	PUTNAM COUNT	Y HOSPITAL			In Lieu	of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1333	Period From C	1/01/2018	Worksheet M-1	
		Component	CCN: 15-8515	To 1	2/31/2018	Date/Time Pre 3/28/2019 5:4	pared: 2 pm
				F	RHC I	Cost	
·	Adjustments	Net Expenses					
		for					
		Allocation					
		(col. 5 +					
		col. 6)					
	6. 00	7. 00					
FACILITY HEALTH CARE STAFF COSTS							

		Adjustments	Net Expenses		
			for		
			Allocation		
			(col. 5 +		
			col. 6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				
1. 00	Physi ci an	0			1.00
2.00	Physician Assistant	0			2.00
3.00	Nurse Practitioner	0	204, 827		3.00
4.00	Visiting Nurse	0	0		4.00
5.00	Other Nurse	0	l ol		5.00
6.00	Clinical Psychologist	0	l ol		6.00
7. 00	Clinical Social Worker	0	o		7.00
8.00	Laboratory Techni ci an	0	o		8.00
9. 00	Other Facility Health Care Staff Costs	0	0		9.00
10.00	Subtotal (sum of lines 1 through 9)	0	-		10.00
11. 00	Physician Services Under Agreement	0	000, 200		11.00
12. 00	Physician Supervision Under Agreement	0	0		12.00
13. 00	Other Costs Under Agreement	0	0		13.00
		0	0		14.00
14. 00	Subtotal (sum of lines 11 through 13)	Ü			
15.00	Medical Supplies	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			21.00
22. 00	Total Cost of Health Care Services (sum of	0	550, 256		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	o		25. 02
26.00	All other nonreimbursable costs	0	l o		26.00
27. 00	Nonallowable GME costs				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	o		28.00
	through 27)	_			
	FACILITY OVERHEAD				1
29. 00	Facility Costs	0	0		29. 00
30.00	Administrative Costs	-16, 277			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-16, 277	554, 639		31.00
51.50	30)	10, 211	331,037		31.00
32. 00	Total facility costs (sum of lines 22, 28	-16, 277	1, 104, 895		32.00
52.00	and 31)	10, 277	1, 104, 073		32.00
	lana 01)		l l	I	1

∐oal ±h	Financial Systems	PUTNAM COUNT	V HOSDITAI			In Lie	u of Form CMS-2	0552 10
	IS OF HOSPITAL-BASED RHC/FOHC COSTS	FUTNAM COUNT	Provi der Co	CN: 15-1333	Per	ri od:	Worksheet M-1	
				CCN: 15-8513		om 01/01/2018	Date/Time Pre	pared:
						RHC II	3/28/2019 5: 4 Cost	2 pm
		Compensation	Other Costs	Total (col.	1 R	Reclassi fi cat	Reclassi fi ed	
				+ col . 2)		ions	Trial Balance	
				,			(col. 3 +	
							col . 4)	
		1. 00	2. 00	3. 00		4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS		_					
1.00	Physi ci an	260, 763	0			0	260, 763	1.00
2.00	Physician Assistant	329, 563	0			0	329, 563	2.00
3. 00 4. 00	Nurse Practitioner Visiting Nurse	12, 500 0	0	12, 5	00	0	12, 500 0	3. 00 4. 00
5. 00	Other Nurse	0	0		0	0	0	5.00
6. 00	Clinical Psychologist	0	0		0	0	0	6.00
7. 00	Clinical Social Worker	0	0		0	0	0	7.00
8. 00	Laboratory Techni ci an	Ö	0		0	Ö	0	ł
9. 00	Other Facility Health Care Staff Costs	o	0		0	o	0	
10.00	Subtotal (sum of lines 1 through 9)	602, 826	0	602, 8	26	0	602, 826	•
11.00	Physician Services Under Agreement	0	0		0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14.00
15. 00	Medical Supplies	0	0		0	0	0	15. 00
16. 00	Transportation (Health Care Staff)	0	0		0	0	0	16.00
17. 00	Depreciation-Medical Equipment	0	0		0	0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	0	18.00
20.00	Other Health Care Costs Allowable GME Costs	U	U		U	U	0	19. 00 20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	0		0	0	0	
22. 00	Total Cost of Health Care Services (sum of	602, 826	0		26	0	602, 826	
22.00	lines 10, 14, and 21)	002, 020	J	002, 0		Ö	002, 020	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES	,				,		
23.00	Pharmacy	0	0		0	0	0	23. 00
24.00	Dental	0	0		0	0	0	24. 00
25.00	Optometry	0	0		0	0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	0	26.00
27. 00	Nonallowable GME costs							27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28. 00
	through 27) FACILITY OVERHEAD							
29. 00	Facility Costs	0	0		0	O	0	29. 00
30.00	Admi ni strati ve Costs	376, 918	318, 800		-	-100, 629	595, 089	30.00
31. 00	Total Facility Overhead (sum of lines 29 and		318, 800		-	-100, 629	595, 089	
	30)	,	,			,		

979, 744

318, 800

1, 298, 544

-100, 629

1, 197, 915

32.00

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

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lieu	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der (CCN: 15-1333	Peri od: From 01/01/2018	Worksheet M-1	
		Component	CCN: 15-8513			
				RHC II	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				

Net Expenses						RHC II	Cost	
Allocation (col. 5 + col. 6)			Adjustments	Net Expenses				
FACILITY HEALTH CARE STAFF COSTS				for				
FACILITY HEALTH CARE STAFF COSTS				Allocation				
FACILITY HEALTH CARE STAFF COSTS				(col. 5 +				
FACILITY HEALTH CARE STAFF COSTS				col. 6)				
1.00			6. 00	7. 00				
2.00		FACILITY HEALTH CARE STAFF COSTS						
3.00	1.00	Physi ci an	0	260, 763				1.00
4.00	2.00	Physician Assistant	0	329, 563				2. 00
5.00	3.00	Nurse Practitioner	0	12, 500				3.00
6.00 Clinical Social Worker 0 0 0 0 0 0 0 0 0	4.00	Visiting Nurse	0	0				4.00
7.00	5.00	Other Nurse	0	0				5.00
7.00	6.00	Clinical Psychologist	0	0				6.00
9.00 Other Facility Health Care Staff Costs 0 0 0 0 0 0 0 0 0	7.00		0	0				7.00
9.00 Other Facility Health Care Staff Costs 0 0 0 0 0 0 0 0 0	8.00	Laboratory Techni ci an	0	0				8.00
10.00 Subtotal (sum of lines 1 through 9) 0 602,826 10.00 11.00 Physician Services Under Agreement 0 0 0 0 12.00 12.00 13.00 0 0 0 0 0 0 0 13.00 0 0 0 0 0 13.00 0 0 0 0 0 0 0 0 0			0	0				9.00
11.00 Physician Services Under Agreement 0 0 0 12.00 Physician Supervision Under Agreement 0 0 0 0 12.00 13.00 14.00 14.00 15.00 14.00 15.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 17.00 17.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 10.00 10.00 19.00 10.			0		1			1
12.00			0					
13.00 Other Costs Under Agreement			0	_				
14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 18. 00 19			0	_				
15.00 Medical Supplies			0	_	ł			1
16.00 Transportation (Heal th Care Staff) 0 0 0 0 17.00 17.00 19.00 17.00 19.00			0		•			
17. 00 Depreciation-Medical Equipment 0 0 0 0 18. 00 19. 00 19. 00 0 19. 00 0 19. 00 0 0 19. 00 0 0 19. 00 0 0 0 0 0 0 0 0 0		, ''	0	_	1			
18.00 Professional Liability Insurance 0 0 0 0 18.00 19.00 19.00 19.00 19.00 20.00 2			0	_	1			
19.00 Other Heal th Care Costs 0 0 0 20.00 20.00 21.00 22.00 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES 23.00 Pharmacy 0 0 0 24.00 25.00 0 25.00 0 0 25.00 25.00 25.00 25.00 25.00 26.		1	0	_	1			
20.00 21.00 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy Dental Optometry Optometry Optomic Care Management Corronic Care Management All other nonreimbursable costs Nonallowable GME Costs 20.00 20.00 20.00 21.00 22.00 22.00 23.00 24.00 25.00 26.00 27.00 28.00 29.00 20.			0	_	1			
21.00 Subtotal (sum of lines 15 through 20) 0 0 0		4	U	U				
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy			0	0				
Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES 23.00 Pharmacy 0 0 0 24.00 24.00 25.00 Optometry 0 0 0 0 25.00 25.00 Optometry 0 0 0 0 25.00 25.00 Chronic Care Management 0 0 0 25.00 25.00 Chronic Care Management 0 0 0 25.00 26.00 All other nonreimbursable costs 0 0 0 26.00 27.00 Nonallowable GME costs 0 0 0 0 28.00 Costs 0 0 0 0 0 0 0 0 0			0	_	1			
COSTS OTHER THAN RHC/FQHC SERVICES 23.00 24.00 25.00 26.00	22.00		U	002, 820				22.00
Pharmacy								
24.00 Dental 0 0 0 24.00 25.00 Optometry 0 0 0 25.01 Tel eheal th 0 0 0 25.02 Chronic Care Management 0 0 0 26.00 All other nonreimbursable costs 0 0 27.00 Nonal I owable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 27.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00 Total VoyerHEAD 28.00 29.00 Facility Costs 0 0 30.00 Administrative Costs -91, 451 503, 638 30.00	22 00		0	0				22 00
25. 00			0		1			
Tel eheal th 0 0 0 25.01		4	0	_	1			
25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 through 27) FACILITY OVERHEAD 29. 00 Facility Costs 0 0 0 30. 00 Administrative Costs 0 0 0 0 30. 00 Administrative Costs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 .	0		1			
26. 00		4	0	_	1			
27. 00 Nonallowable GME costs 27. 00 28. 00 10 10 10 10 10 10 1			0	_				
28. 00		4	0	0				
through 27) FACILITY OVERHEAD 29. 00 Facility Costs Facility Cost		4						1
FACILITY OVERHEAD 29. 00 Facility Costs 0 0 29. 00 30. 00 Administrative Costs -91, 451 503, 638 30. 00	28.00		0	0				28.00
29. 00 Facility Costs 0 0 29. 00 30. 00 Administrative Costs -91, 451 503, 638 30. 00								1
30. 00 Administrative Costs -91, 451 503, 638 30. 00	00.00		<u></u>		I			00.00
			-		1			
	31. 00	Total Facility Overhead (sum of lines 29 and	-91, 451	503, 638				31.00
30)		1 '		4 404				
32.00 Total facility costs (sum of lines 22, 28 -91, 451 1, 106, 464 32.00	32.00		-91, 451	1, 106, 464				32.00
and 31)		and 31)			I			I

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPLTAL		In Lie	eu of Form CMS-:	2552-10
	IS OF HOSPITAL-BASED RHC/FOHC COSTS	TOTIVAWI COOKT	Provi der C	CN: 15-1333	Peri od:	Worksheet M-1	
				CCN: 15-8514	From 01/01/2018 To 12/31/2018	3	pared:
					RHC III	Cost	2 piii
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	+	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	64, 399	0				1.00
2. 00	Physician Assistant	0	0		0 (1	
3. 00	Nurse Practitioner	180, 947	0	180, 9	47 (3.00
4. 00	Visiting Nurse	0	0		0	0	
5.00	Other Nurse	0	0		0	0	
6.00	Clinical Psychologist	0	0			0	
7.00	Clinical Social Worker	U	0		0	0	
8. 00 9. 00	Laboratory Technician	0	0		0 0	0 0	
10.00	Other Facility Health Care Staff Costs Subtotal (sum of lines 1 through 9)	245, 346	0	245, 3	١		
11. 00	Physician Services Under Agreement	245, 346	0	240, 34	0 (245, 346	1
12.00	Physician Supervision Under Agreement	0	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		0		14.00
15. 00	Medical Supplies	0	0		0	ol ö	
16. 00	Transportation (Health Care Staff)	o	0		0	ol o	
17. 00	Depreciation-Medical Equipment	o	0		0	ol o	
18.00	Professional Liability Insurance	o	0		0	o o	18.00
19.00		О	0		0	ol o	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	0		0	0	21.00
22.00	Total Cost of Health Care Services (sum of	245, 346	0	245, 3	46 (245, 346	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	_1		Г		.1	
23. 00	Pharmacy	0	0		0		1
24. 00	Dental	0	0		0	1 °	
25. 00	Optometry	0	0			0	25. 00
25. 01 25. 02	Tel eheal th	0	0		0	0 0	
26. 00	Chronic Care Management All other nonreimbursable costs	0	0				1
27.00	Nonallowable GME costs	U	U) 0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	o l	1
20.00	through 27)	o o	O)	20.00
	FACILITY OVERHEAD				<u> </u>	<u> </u>	1
29. 00	Facility Costs	0	0		0 (0	29. 00
30.00	Admi ni strati ve Costs	240, 212	237, 769			1	
31.00	Total Facility Overhead (sum of lines 29 and	·	237, 769				
	30)	,		· ·			

485, 558

237, 769

723, 327

-83, 746

639, 581

32.00

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

lealth Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu	of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1333	Peri od: From 01/01/2018	Worksheet M-1	
	Component CCN: 15-8514		To 12/31/2018	Date/Time Pre 3/28/2019 5:4	pared: 2 pm	
				RHC III	Cost	
	Adjustments	Net Expenses				
		for				
		Allocation				
		(col. 5 +				
		col. 6)				
	6. 00	7. 00				

			for	
			Allocation	
			(col. 5 +	
			col. 6)	
		6. 00	7.00	
	FACILITY HEALTH CARE STAFF COSTS			
1.00	Physi ci an	0	64, 399	1.00
2.00	Physician Assistant	0	0	2.00
3.00	Nurse Practitioner	0	180, 947	3. 00
4.00	Visiting Nurse	0	0	4. 00
5.00	Other Nurse	0	0	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	245, 346	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	Medi cal Supplies	0	0	15.00
16.00	Transportation (Health Care Staff)	O	0	16.00
	Depreciation-Medical Equipment	0	0	17.00
18.00		o	0	18.00
19.00	Other Health Care Costs	o	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	245, 346	22.00
	lines 10, 14, and 21)			
	COSTS OTHER THAN RHC/FQHC SERVICES			
23.00		0	0	23. 00
24.00	1 7 7 7	0	0	24.00
25.00	Optometry	0	0	25.00
25. 01	4	0	0	25. 01
25. 02	Chronic Care Management	0	0	25. 02
26. 00		0	0	26.00
27. 00	4			27.00
28. 00	`	0	0	28. 00
	through 27)			
	FACILITY OVERHEAD			4
	Facility Costs	0	0	29. 00
30.00		-9, 165	385, 070	30.00
31. 00		-9, 165	385, 070	31.00
00.5-	30)			
32. 00	,	-9, 165	630, 416	32.00
	and 31)	l		I

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			C		From 01/01/2018		
			Component	CCN: 15-8515	To 12/31/2018	3/28/2019 5: 4	
					RHC I	Cost	<u> </u>
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions		1	1			
1. 00	Physi ci an	1. 38					1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	2. 02				10.000	3.00
4. 00	Subtotal (sum of lines 1 through 3)	3. 40		1	10, 038	· ·	
5.00	Visiting Nurse	0.00				0	
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0. 00 0. 00				0	6. 00 7. 00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7.00
7. 01	Diabetes Self Management Training (FQHC	0.00	_	1		0	7.01
7.02	only)	0.00		1		U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	3. 40	9, 511			10, 038	8.00
0.00	through 7)	0.10	,, 511			10,000	0.00
9. 00	Physician Services Under Agreements		0			0	9.00
	<u> </u>			'			
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					550, 256	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	
12.00	Cost of all services (excluding overhead) (s					550, 256	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		554, 639	
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			866, 584	
16.00	Total overhead (sum of lines 14 and 15)					1, 421, 223	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	NIC comi cos (1	ino 12 v li	10)		1, 421, 223	
	Overhead applicable to hospital-based RHC/FC Total allowable cost of hospital-based RHC/F					1, 421, 223	
∠∪. ∪∪	Tiotal allowable cost of Hospital-Dased RHC/F	unc services (Sum Of Fiftes I	o anu 19)	ļ	1, 971, 479	20.00

	Financial Systems	PUTNAM COUNT				u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2018 To 12/31/2018	Date/Time Pre	nared:
			Component	0011. 13 0313	10 12/31/2010	3/28/2019 5: 4	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2.00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Positions	1	I				
1.00	Physi ci an	1.00					1.00
2.00	Physician Assistant	3.00					2.00
3.00	Nurse Practitioner	0. 22				44 045	3.00
4.00	Subtotal (sum of lines 1 through 3)	4. 22		1	10, 962	11, 215	
5.00	Visiting Nurse	0.00		(0	5.00
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0. 00 0. 00				0	6. 00 7. 00
7. 00	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7.00
7. 01	Diabetes Self Management Training (FQHC	0.00	l .			0	7.01
7.02	only)	0.00	_	'		U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	4. 22	11, 215			11, 215	8.00
0. 00	through 7)	1. 22	11,210	1		11, 210	0.00
9. 00	Physician Services Under Agreements		l c			0	9.00
	,			1			
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	ED RHC/FQHC SE	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			602, 826	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			602, 826	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 - (fr	om Worksheet. I	M-1, col. 7, I	ine 31)		503, 638	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			636, 823	15.00
16.00	Total overhead (sum of lines 14 and 15)					1, 140, 461	
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					1, 140, 461	
	Overhead applicable to hospital-based RHC/FC					1, 140, 461	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (:	sum of lines 1	0 and 19)		1, 743, 287	20.00

Number of FTE Personnel Total Visits Productivity Standard (1) Nisits (col. 2 or col. 4 1.00 2.00 3.00 4.00 5.00		Financial Systems	PUTNAM COUNT				u of Form CMS-2	2552-10
Number of FTE Personnel Number of FTE Standard (1) Number of FTE Number of FTE Number of FTE Number of Policy Indianard (1) Number of FTE Number of FTE Number of FTE Number of Policy Indianard (1) Number of FTE Number of FTE Number of Policy Indianard (1) Number of FTE Number of FTE Number of FTE Number of Policy Indianard (1) Number of FTE Num	ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C			Worksheet M-2	
Number of FTE Personnel				Component				
Personnel Standard (1) Visits (col. col. 2 or col. 4						RHC III	Cost	
Note				Total Visits	Producti vi ty		Greater of	
NISITS AND PRODUCTIVITY			Personnel		Standard (1)			
VISITS AND PRODUCTIVITY								
Positions			1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00 Physician								
2.00 Physician Assistant								
3.00 Nurse Practitioner 2.00 3,599 2,100 4,200 5,668 4.00 5,040 5,668 4.00 5,040 5,668 4.00 5,040 5,668 4.00 5,040 5,668 4.00 5,000 10 5,000 0 5,000 0 5,000 0 5,000 0 5,000 0 6,000 0		1 3						
4.00 Subtotal (sum of lines 1 through 3) 2.20 5,668 5,040 5,668 4.00								
5.00 Visiting Nurse								
6.00 Clinical Psychologist 0.00 0 0 0 0 0 0 7.00 7.00 7.00 7.00 0 7.00 7.00 7.00 0 7.00 7.00 0 7.00					1	5, 040	·	
7. 00 Clinical Social Worker 0.00 0 0 7. 00 7. 00 7. 01 Medical Nutrition Therapist (FQHC only) 0.00 0 0 7. 01 0.00 0 0 0 0 0 0 0 0					1			
7. 01 Medical Nutrition Therapist (FQHC only)			1		1		_	
7. 02 Di abetes Sel f Management Training (FQHC 0.00 only) 8. 00 Total FTEs and Visits (sum of lines 4 2. 20 5, 668 through 7) 9. 00 Physician Services Under Agreements 0 0 5, 668 10 9, 00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES			1		1		_	
only) 8. 00 Total FTEs and Visits (sum of lines 4 2. 20 5, 668 through 7) 9. 00 Physician Services Under Agreements 0 0 9. 00 DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10. 00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 11. 00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 22) 12. 00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13. 00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 14. 00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 15. 00 Parent provider overhead allocated to facility (see instructions) 16. 00 Total overhead (sum of lines 14 and 15) 17. 00 Allowable GME overhead (see instructions) 18. 00 Enter the amount from line 16 19. 00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 19. 00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18)			1		1		_	
### Through 7) Physician Services Under Agreements 0 9.00	7. 02		0.00	O			0	7. 02
9. 00 Physician Services Under Agreements 0 1.00 DETERMI NATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FQHC SERVICES	8. 00		2. 20	5, 668			5, 668	8. 00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES Total costs of health care services (from Wkst. M-1, col. 7, line 22) 245, 346 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 245, 346 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 385, 070 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 647, 392 15.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,032,462 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 1,032,462 19.00 19	9 00						0	9 00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 245, 346 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 245, 346 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 385,070 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 647,392 15.00 16.00 Total overhead (sum of lines 14 and 15) 1,032,462 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,032,462 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 1,032,462 19.00	7.00	Triffs of all ber vices offact rigit coments			1			7.00
DETERMINATION OF ALLOWABLE COST APPLICABLE TO HOSPITAL-BASED RHC/FOHC SERVICES 10.00 Total costs of health care services (from Wkst. M-1, col. 7, line 22) 245, 346 10.00 11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 245, 346 12.00 13.00 Ratio of hospital-based RHC/FOHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FOHC overhead - (from Worksheet. M-1, col. 7, line 31) 385,070 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 647,392 15.00 16.00 Total overhead (sum of lines 14 and 15) 1,032,462 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,032,462 18.00 19.00 Overhead applicable to hospital-based RHC/FOHC services (line 13 x line 18) 1,032,462 19.00							1. 00	
11.00 Total nonreimbursable costs (from Wkst. M-1, col. 7, line 28) 0 11.00 12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 245, 346 12.00 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 1.000000 13.00 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 385,070 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 647,392 15.00 16.00 Total overhead (sum of lines 14 and 15) 1,032,462 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,032,462 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,032,462 19.00		DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES			
12.00 Cost of all services (excluding overhead) (sum of lines 10 and 11) 13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 245, 346 12.00 1.000000 13.00 1.0000000 13.00 1.000000 13.00 1.000000 13.00	10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			245, 346	10.00
13.00 Ratio of hospital-based RHC/FQHC services (line 10 divided by line 12) 14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 15.00 Parent provider overhead allocated to facility (see instructions) 16.00 Total overhead (sum of lines 14 and 15) 17.00 Allowable GME overhead (see instructions) 18.00 Enter the amount from line 16 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1.000000 13.00 14.00 15.00 16.70 Overhead (see instructions) 1.000000 13.00 14.00 15.00 17.00 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18)	11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31) 385,070 14.00 15.00 Parent provider overhead allocated to facility (see instructions) 647,392 15.00 16.00 Total overhead (sum of lines 14 and 15) 1,032,462 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,032,462 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,032,462 19.00	12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			245, 346	12.00
Parent provider overhead allocated to facility (see instructions) 15. 00 16. 00 Total overhead (sum of lines 14 and 15) 17. 00 Allowable GME overhead (see instructions) 18. 00 Enter the amount from line 16 19. 00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 647, 392 15. 00 1, 032, 462 16. 00 1, 032, 462 18. 00 1, 032, 462 19. 00	13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13.00
Parent provider overhead allocated to facility (see instructions) 15. 00 16. 00 17. 00 18. 00 18. 00 19. 0	14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet.	M-1, col. 7, l	ine 31)		385, 070	14.00
16.00 Total overhead (sum of lines 14 and 15) 1,032,462 16.00 17.00 Allowable GME overhead (see instructions) 0 17.00 18.00 Enter the amount from line 16 1,032,462 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,032,462 19.00	15.00				•		647, 392	15.00
18.00 Enter the amount from line 16 1,032,462 18.00 19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,032,462 19.00	16.00	Total overhead (sum of lines 14 and 15)	•	,			1, 032, 462	16.00
19.00 Overhead applicable to hospital-based RHC/FQHC services (line 13 x line 18) 1,032,462 19.00	17.00	Allowable GME overhead (see instructions)					0	17. 00
	18.00	Enter the amount from line 16					1, 032, 462	18.00
20.00 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19) 1,277,808 20.00	19.00	Overhead applicable to hospital-based RHC/FC	MC services (I	ine 13 x line	18)		1, 032, 462	19.00
	20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		1, 277, 808	20.00

	Financial Systems PUTNAM COUNTY F			u of Form CMS-2	
	LATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	Provi der CCN: 15-1333	Peri od: From 01/01/2018	Worksheet M-3	
SERVI (YE2	Component CCN: 15-8515	To 12/31/2018	Date/Time Pre 3/28/2019 5:4	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 971, 479	
2. 00 3. 00	Cost of vaccines and their administration (from Wkst. M-4, li Total allowable cost excluding vaccine (line 1 minus line 2)	ne 15)		210, 195 1, 761, 284	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			10, 038	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5. 00
6. 00	Total adjusted visits (line 4 plus line 5)			10, 038	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	175.46	7.00
			carcuration	OI LIMIT (1)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	82. 30	83. 45	8. 00
9. 00	Rate for Program covered visits (see instructions)		175. 46	175. 46	9.00
10 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	0	1, 018	10.00
10. 00 11. 00	Program cost excluding costs for mental health services (line	-	0	178, 618	
12.00	Program covered visits for mental health services (from contr		0	0	
13.00	Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions	•	0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	178, 618	15. 00 16. 00
16. 00	Total program charges (see instructions) (from contractor's re	-	J	170, 618	
16. 02	Total program preventive charges (see instructions) (from prov			20, 610	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		21, 441	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		108, 784	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	130, 225	16. 05
17. 00	Primary payer amounts			0	17. 00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		21, 197	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		30, 100	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			130, 225	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		32, 576	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		162, 801	
23.00	Allowable bad debts (see instructions)			0	23.00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions)	rueti ene)		0	23. 01
25. 00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	24. 00 25. 00
25. 50	1 ' ' ' ' '	s)		0	
25. 99	Demonstration payment adjustment amount before sequestration			0	25. 99
26.00	Net reimbursable amount (see instructions)			162, 801	
26. 01 26. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			3, 256 0	
	Interim payments			116, 228	
28. 00	1			0	28.00
	Balance due component/program (line 26 minus lines 26.01, 26.	•		43, 317	
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II	,	0	30.00

	Financial Systems PUTNAM COUNTY F			u of Form CMS-2	
CALCUI SERVI (LATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1333	Peri od: From 01/01/2018	Worksheet M-3	
SERVI	JES .	Component CCN: 15-8513	To 12/31/2018	Date/Time Pre 3/28/2019 5:4	
		Title XVIII	RHC II	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 743, 287	1
2. 00 3. 00	Cost of vaccines and their administration (from Wkst. M-4, li Total allowable cost excluding vaccine (line 1 minus line 2)	ne 15)		122, 803 1, 620, 484	1
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			11, 215	1
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			11, 215	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	144.49 of limit (1)	7.00
			car car a troir	01 211111 (1)	
			Pri or to Jan.	On or After	
			1 (Rate Period 1)	Jan. 1 (Rate Period 2)	
			1.00	2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	82. 30	83. 45	8. 00
9. 00	Rate for Program covered visits (see instructions)		144. 49	144. 49	9.00
10. 00	CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from	contractor records)	0	1, 847	10.00
11. 00	Program cost excluding costs for mental health services (line	-	0	266, 873	1
12. 00	Program covered visits for mental health services (from contr		0	0	1
13.00	Program covered cost from mental health services (line 9 x li	•	0	0	1
14.00	Limit adjustment for mental health services (see instructions		0	0	
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	266, 873	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's re	-		334, 915	1
16. 02	Total program preventive charges (see instructions) (from prov			15, 720	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		12, 526	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		168, 171	16. 04
16. 05	Total program cost (see instructions)		0	180, 697	16. 05
17.00	Pri mary payer amounts			0	I
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		44, 133	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		56, 656	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			180, 697	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		39, 434	1
22. 00	Total reimbursable Program cost (line 20 plus line 21)	,		220, 131	
23. 00	Allowable bad debts (see instructions)			0	
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00 25. 00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	
25. 50		s)		0	
	Demonstration payment adjustment amount before sequestration	•		0	l
26.00	Net reimbursable amount (see instructions)			220, 131	1
26. 01	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			4, 403	1
26. 02 27. 00	Interim payments			0 199, 639	
28. 00	1			0	28.00
	Balance due component/program (line 26 minus lines 26.01, 26.			16, 089	1
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II		0	30.00

	Financial Systems PUTNAM COUNTY F			u of Form CMS-2	
CALCUI SERVI (ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1333	Peri od: From 01/01/2018	Worksheet M-3	
SERVI	.E.S	Component CCN: 15-8514	To 12/31/2018	Date/Time Pre 3/28/2019 5:4	
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			1, 277, 808	
2. 00 3. 00	Cost of vaccines and their administration (from Wkst. M-4, li Total allowable cost excluding vaccine (line 1 minus line 2)	ne 15)		92, 013 1, 185, 795	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			5, 668	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.00
6.00	Total adjusted visits (line 4 plus line 5)			5, 668	6. 00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Calculation	209. 21	7.00
			Cal cul ati on	OI LIMIT (I)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	82. 30	83. 45	8.00
9. 00	Rate for Program covered visits (see instructions)		209. 21	209. 21	9. 00
10 00	CALCULATION OF SETTLEMENT			1 210	10.00
10.00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	-	0	1, 218 254, 818	
12.00	Program covered visits for mental health services (from contr		0	254, 010	1
13.00	Program covered cost from mental health services (line 9 x li	ne 12)	0	0	13.00
14.00	Limit adjustment for mental health services (see instructions		0	0	14.00
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction	,	0	2E4 010	15. 00 16. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's re	-	0	254, 818 172, 333	
16. 02	Total program preventive charges (see instructions) (from prov			29, 330	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		43, 368	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		152, 710	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	196, 078	16. 05
17. 00	Pri mary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		20, 563	18.00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		29, 454	19.00
	records)			40/ 070	
20.00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M 4 line 16)		196, 078 29, 751	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	W-4, TTHE 10)		225, 829	
23. 00	Allowable bad debts (see instructions)			0	23.00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24.00	3	ructions)		0	24.00
25. 00 25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	e)		0	
	Demonstration payment adjustment amount before sequestration	٠,		0	
26.00	Net reimbursable amount (see instructions)			225, 829	26.00
26. 01	Sequestration adjustment (see instructions)			4, 517	
26. 02	Demonstration payment adjustment amount after sequestration Interim payments			0 137, 153	
28. 00	Tentative settlement (for contractor use only)			137, 153	28.00
	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		84, 159	
	Protested amounts (nonallowable cost report items) in accorda		1	0	

Health Financial Systems	PUTNAM COUNTY F	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 01/01/2018	Worksheet M-4	
Widding 3331		Component CCN: 15-8515	To 12/31/2018	Date/Time Pre 3/28/2019 5:4	
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	

Title XVIII RHC I Cos	
Dnoumagagaad Influenza	
Pneumococcal Influenza	
1.00 2.00	
1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 550,256 550,2	56 1.00
2.00 Ratio of pneumococcal and influenza vaccine staff time to total health care staff time 0.008131 0.0193	72 2.00
3.00 Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) 4,474 10,6	3.00
4.00 Medical supplies cost - pneumococcal and influenza vaccine (from your records) 28,463 15,0	70 4.00
5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) 32,937 25,7	5.00
6.00 Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) 550,256 550,2	6.00
7.00 Total overhead (from Wkst. M-2, line 19) 1,421,223 1,421,2	23 7.00
8.00 Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 0.059858 0.0467	8.00
divided by line 6)	
9.00 Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) 85,072 66,4	56 9.00
10.00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of 118,009 92,1	36 10.00
lines 5 and 9)	
11.00 Total number of pneumococcal and influenza vaccine injections (from your records) 230 5	48 11.00
12.00 Cost per pneumococcal and influenza vaccine injection (line 10/line 11) 513.08 168.	22 12.00
13.00 Number of pneumococcal and influenza vaccine injections administered to Program 33	93 13.00
beneficiaries	
	14. 00
(line 12 x line 13)	
	95 15.00
of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)	
	76 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	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provi der CCN: 15-1333	Peri od: From 01/01/2018	Worksheet M-4	
VIOSTINE GOST		Component CCN: 15-8513	To 12/31/2018	Date/Time Pre 3/28/2019 5:4	
		Title XVIII	RHC II	Cost	
			Pneumococcal	Influenza	

				0/20/201/ 0. 1	2 0111
		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)		602, 826	602, 826	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0. 003987	0. 014497	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	2, 403	8, 739	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	17, 325	13, 998	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	19, 728	22, 737	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	602, 826	602, 826	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 140, 461	1, 140, 461	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 032726	0. 037717	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	37, 323	43, 015	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	57, 051	65, 752	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	140	509	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	407. 51	129. 18	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	47	157	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	19, 153	20, 281	14.00
	(line 12 x line 13)				
15.00	Total cost of pneumococcal and influenza vaccine and its (the			122, 803	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			39, 434	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	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1333	Peri od: From 01/01/2018	Worksheet M-4	
VACCINE COST		Component CCN: 15-8514	To 12/31/2018	Date/Time Pre 3/28/2019 5:4	
		Title XVIII	RHC III	Cost	
			Pneumococcal	I nfl uenza	

				3/20/2019 3.4.	z piii
		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)		245, 346	245, 346	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	al health care staff time	0. 002458	0. 015352	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	ne 1 x line 2)	603	3, 767	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	rom your records)	5, 569	7, 728	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	6, 172	11, 495	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksho	eet M-1, col. 7, line 22)	245, 346	245, 346	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 032, 462	1, 032, 462	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 025156	0. 046852	8. 00
	divided by line 6)				l
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	25, 973	48, 373	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	32, 145	59, 868	10.00
	lines 5 and 9)				l
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	45	281	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10)/line 11)	714. 33	213. 05	12.00
13.00	Number of pneumococcal and influenza vaccine injections admini	stered to Program	16	86	13.00
	benefi ci ari es				l
14.00	Program cost of pneumococcal and influenza vaccine and its (the	neir) administration	11, 429	18, 322	14.00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (thei			92, 013	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	,		29, 751	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				ı

Health Financial Systems	PUTNAM COUNTY F	IOSPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-13	33 Period: From 01/01/2018	Worksheet M-5
SERVISES REMERED TO TROOM III BENEFITOTAL		Component CCN: 15-8	515 To 12/31/2018	Date/Time Prepared: 3/28/2019 5:42 pm
			RHC I	Cost

		Component CCN. 13-0313	10 12/31/2010	3/28/2019 5: 4	
			RHC I	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			116, 228	1.00
2.00	Interim payments payable on individual bills, either submit			0	2.00
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3.0
3. 02				0	3.02
3. 03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program				
3.50				0	3.50
3. 51				0	3. 5
3. 52				0	3.52
3. 53				0	3.5
3.54				0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	:	116, 228	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR		_1	1	
5. 00	List separately each tentative settlement payment after des	sk review. Also show date c	of		5.00
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider		<u> </u>		
5. 01				0	5.01
5. 02				0	5. 02
5. 03	Dec. 1 Lea La Borraga			0	5. 03
F F0	Provider to Program				
5. 50				0	5. 50
5. 51				0	5.5
5. 52	C.ht-t-1 (f F 01 F 40 - F 1 F 50 F	00)		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)		40 017	6.00
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM			43, 317	6. 0°
					7.00
7. 00	Total Medicare program liability (see instructions)		Contractor	159, 545 NPR Date	7.00
		0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor	U	1.00	2.00	8.00
0.00	INAME OF CONTRACTOR			1	1 0.00

Health Financial Systems	PUTNAM COUNTY HOS	SPI TAL	In Lieu	of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI	ES		From 01/01/2018 To 12/31/2018	
			DUC II	C+

				3/28/2019 5: 42	2 pm
			RHC II	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			199, 639	1.
00	Interim payments payable on individual bills, either submit	ted or to be submitted to		0	2.
	the contractor for services rendered in the cost reporting				
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
21				0	3.
02				0	3.
03				0	3
)4				0	3
)5				0	3
	Provider to Program		'		
0				0	3
51					3
2				0	3
3				0	3
54				l ol	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)			3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			199, 639	4
50	27)	Ter to workshoot in o, Title		177,007	
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	k review Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)	me revieur 7m ee enem date e	•		Ŭ
	Program to Provider				
01	i rogi am to rrovi do.			0	5
)2				l ol	5
)3					5
	Provider to Program				Ŭ
0	1 to tradit to trog, am			0	5
1					5
52				l ol	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)			5
00	Determined net settlement amount (balance due) based on the				6
)1	SETTLEMENT TO PROVIDER	. 3331 . opol t. (1)		16, 089	6
)2	SETTLEMENT TO PROGRAM			10,007	6
00	Total Medicare program liability (see instructions)			215, 728	7
,,,	Total medicale program trabitity (see instructions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
			Nullibel		
		0	1. 00	2.00	

Health Financial Systems	PUTNAM COUNTY F	HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASE SERVICES RENDERED TO PROGRAM BENEFICI		Provi der CCN: 15-1333 Component CCN: 15-8514	From 01/01/2018 To 12/31/2018	Worksheet M-5 Date/Time Prepared: 3/28/2019 5:42 pm

		Component CCN: 15-8514	10 12/31/2018	3/28/2019 5: 42	
			RHC III	Cost	
			Par	t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
. 00	Total interim payments paid to hospital-based RHC/FQHC			137, 153	1. 0
. 00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero	period. If none, write		0	2. 0
.00	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) Program to Provider				3.0
. 01	11 ogram to 11 ovrao.			0	3. 0
. 02				o o	3.0
. 03				o o	3.0
. 04				o o	3. 0
05				0	3. (
. 03	Provider to Program			0	5. (
50	11 ovi dei 10 11 ogi dili			0	3. !
51				ő	3.
52				o o	3.
53				0	3.
54				0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	00)		0	3.
. 99	Total interim payments (sum of lines 1, 2, and 3.99) (trans				4. (
00		Ter to worksheet M-3, Tine	=	137, 153	4. (
	TO BE COMPLETED BY CONTRACTOR				
. 00	List separately each tentative settlement payment after des	k raviow. Also show data s	s€		5. (
00	each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date (וכ		5.
	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.			0	5.
00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.
01	SETTLEMENT TO PROVIDER			84, 159	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			221, 312	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	