This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1333 Worksheet S Period: From 01/01/2020 Parts I-III AND SETTLEMENT SUMMARY 12/31/2020 Date/Time Prepared: 7/15/2021 2: 27 pm PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 7/15/2021 2:27 pm Manually prepared cost report use only ]If this is an amended report enter the number of times the provider resubmitted this cost report]Medicare Utilization. Enter "F" for full or "L" for low. 6. Date Received: 7. Contractor No. 10. NPR Date: Contractor ]Cost Report Status (1) As Submitted

7. Contractor No.

(2) Settled without Audit 8. [ N ] Initial Report for this Provider CCN 12. [ 0 ] If line 5, column 1 is 4: Enter (3) Settled with Audit

9. [ N ] Final Report for this Provider CCN | number of times reopened = 0-9. 11. Contractor's Vendor Code: use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

## PART II - CERTIFICATION

(5) Amended

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

CERTIFICATION BY 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 01/01/2020 and ending 12/31/2020 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.

[ X ]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) DENNIS WEATHERFORD
Officer or Administrator of Provider(s)

CEO Title

(Dated when report is electronically signed.)
Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	358, 354	760, 384	0	24, 768	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	33, 713	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
10.00	PUTNAM PEDIATRICS AND INTERNAL MED	0		69, 129		0	10.00
10.01	FAMILY MEDICINE OF CLOVERDALE II	0		51, 199		0	10.01
10.02	NORTH PUTNAM FAMILY HEALTHCARE III	0		92, 143		0	10.02
200.00	Total	0	392, 067	972, 855		24, 768	200.00

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

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1333 Period: Worksheet S-2

	Financial Systems	PUTNAM COUNTY								2552-10
HOSPI 1	FAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provid	der CCN: 1	5-1333	Period: From 01/01/ To 12/31/	′2020 ′2020	Workshe Part I Date/Ti	me Pre	pared:
	1.00	2. 00		3. 00			4. 00	7/15/20	21 2: 2	7 pm
	Hospital and Hospital Health Care Co									
1.00	Street: 1542 SOUTH BLOOMINGTON ST	PO Box: State: IN	7in Cod	e: 46135-	Count	EV. DUTNAM				1. 00 2. 00
2. 00	City: GREENCASTLE	Component Name	CCN	CBSA	Provi der	ty: PUTNAM Date	Pavmei	nt Syst	em (P.	2.00
		Somponone name	Number	Number	Type	Certi fi ed		0, or		
							V	XVIII		
	Hospital and Hospital-Based Componer	1.00	2. 00	3.00	4.00	5. 00	6. 00	7.00	8. 00	
3. 00	Hospi tal	PUTNAM COUNTY HOSPITAL	151333	26900	1	12/31/2005	N	0	0	3.00
4. 00	Subprovi der - IPF									4.00
5. 00	Subprovider - IRF									5.00
6. 00 7. 00	Subprovi der - (Other) Swing Beds - SNF	PUTNAM COUNTY HOSPITAL	15Z333	26900		12/31/2005	l N	0	l N	6. 00 7. 00
8. 00	Swing Beds - SNF	COUNTY HOSPITAL	102333	20900		12/31/2005	I IN	0	I IN	8.00
9. 00	Hospi tal -Based SNF									9.00
10.00	Hospital -Based NF									10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA									11. 00 12. 00
	Separately Certified ASC									13.00
14.00	Hospi tal -Based Hospi ce									14.00
15.00	Hospital -Based Health Clinic - RHC	PPIM	158515	26900		02/23/2015	N	0	N	15.00
15. 01	Hospital-Based Health Clinic - RHC	FMC	158513	26900		02/25/2015	N	0	N	15. 01
15. 02	Hospital-Based Health Clinic - RHC	NPFH	158514	26900		03/17/2015	N	0	N	15. 02
16. 00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital -Based (CMHC) I									17.00
17. 10 18. 00	Hospital-Based (CORF) I Renal Dialysis									17. 10 18. 00
	Other									19.00
			•	·	<u>'</u>	From:		То		
20.00	20.00 Cost Reporting Period (mm/dd/yyyy) 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00								20.00	
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					01/01/2	020	12/31/	2020	20. 00 21. 00
	Inpatient PPS Information				1. 00	2. 00		3. 0	00	
22. 00	Does this facility qualify and is it	currently receiving pay	vments fo	r	N					22. 00
	disproportionate share hospital adju	stment, in accordance w	ith 42 CF							
	§412.106? In column 1, enter "Y" fo									
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for		enament							
22. 01	Did this hospital receive interim ur		ts for th	is	N	N				22. 01
	cost reporting period? Enter in colu									
	the portion of the cost reporting per Enter in column 2, "Y" for yes or "N									
	reporting period occurring on or aft									
22. 02	Is this a newly merged hospital that	requires final uncompe	nsated ca	re	N	N				22. 02
	payments to be determined at cost re Enter in column 1, "Y" for yes or "N									
	cost reporting period prior to Octob									
	or "N" for no, for the portion of th									
22.02	October 1.			_	N.			N.		22.02
22. 03	Did this hospital receive a geograph rural as a result of the OMB standar				N	N		N		22. 03
	adopted by CMS in FY2015? Enter in c									
	for the portion of the cost reportir			er						
	in column 2, "Y" for yes or "N" for									
	reporting period occurring on or after October 1. (see instructions)  Does this hospital contain at least 100 but not more than 499 beds (as									
	counted in accordance with 42 CFR 41					1				
22.00	yes or "N" for no.	digald days li 04	and / 0	_						22.00
∠3.00	Which method is used to determine Me below? In column 1, enter 1 if date	3				0				23. 00
	if date of discharge. Is the method									
	reporting period different from the									
	reporting period? In column 2, ente	er y" for yes or "N" for	r no.	I		1				I

GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.

Ν

N

58.00

59.00

58.00 | If line 56 is yes, did this facility elect cost reimbursement for physicians' services as

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.

MCRI F32	-	16.	10.	172.3	;

SPI TAI	Financial Systems PUTNAN L AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provi der C	CN: 15-1333	Peri od:	u of Form CMS-2 Worksheet S-2	
0111712	E AND HOST FALL HEALTH STILL SOME LEAR FREHTH STITT ON DA		Trovider of	014. 10 1000	From 01/01/2020 To 12/31/2020	Part I Date/Time Pre 7/15/2021 2:2	pare
				NAHE 413. 8! Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1. 00	2. 00	3. 00	
aı i i	re you claiming nursing and allied health education ny programs that meet the criteria under 42 CFR 413. nstructions) Enter "Y" for yes or "N" for no in cols "Y", are you impacted by CR 11642 (or subsequent (djustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. CR) NAHE	ee If column 1	N			60
jai	ujustement: Litter i ioi yes or iv ioi no in cort	Y/N	I ME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4. 00	5. 00	
S	id your hospital receive FTE slots under ACA ection 5503? Enter "Y" for yes or "N" for no in olumn 1. (see instructions)				0.00	0. 00	61
F <sup>*</sup>	nter the average number of unweighted primary care TEs from the hospital's 3 most recent cost reports nding and submitted before March 23, 2010. (see nstructions)						61
02 Ei F ai	nter the current year total unweighted primary care TE count (excluding OB/GYN, general surgery FTEs, nd primary care FTEs added under section 5503 of CA). (see instructions)						61
03 Ei ai de	nder the base line FTE count for primary care nd/or general surgery residents, which is used for etermining compliance with the 75% test. (see nstructions)						61
04 Ei	nstructions) nter the number of unweighted primary care/or urgery allopathic and/or osteopathic FTEs in the urrent cost reporting period.(see instructions).						6
05 Ei ai pi	nter the difference between the baseline primary nd/or general surgery FTEs and the current year's rimary care and/or general surgery FTE counts (line						61
06 Ei	1.04 minus line 61.03). (see instructions) nter the amount of ACA §5503 award that is being sed for cap relief and/or FTEs that are nonprimary are or general surgery. (see instructions)						61
		Pro	gram Name	Program Cod	le Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1. 00	2. 00	3.00	4. 00	<u> </u>
SI fo co pi ui	f the FTEs in line 61.05, specify each new program pecialty, if any, and the number of FTE residents or each new program. (see instructions) Enter in olumn 1, the program name. Enter in column 2, the rogram code. Enter in column 3, the IME FTE neweighted count. Enter in column 4, the direct GME				0.00	0. 00	61
20   0 <sup>.</sup>   pi   re   i i	TE unweighted count.  If the FTEs in line 61.05, specify each expanded rogram specialty, if any, and the number of FTE esidents for each expanded program. (see nstructions) Enter in column 1, the program name.				0.00	0. 00	61
3.	nter in column 2, the program code. Enter in column, the IME FTE unweighted count. Enter in column 4, he direct GME FTE unweighted count.						
						1. 00	
	CA Provisions Affecting the Health Resources and Se					0.00	
	nter the number of FTE residents that your hospital our hospital received HRSA PCRE funding (see instruc		in this cost	reporting p	erioa for which	0. 00	62
01 Ei	nter the number of FTE residents that rotated from a uring in this cost reporting period of HRSA THC pro	a Teachi gram. (s	<u>ee instructio</u>		to your hospital	0. 00	62
00 H	eaching Hospitals that Claim Residents in Nonprovidas your facility trained residents in nonprovider so Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this o			N	63

Health Financial Systems	PUTNAN	1 COUNTY HOSPITAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				eriod: rom 01/01/2020	Worksheet S-2 Part I Date/Time Pre	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	7/15/2021 2:2 Ratio (col. 1/ (col. 1 + col. 2))	/ pm
Continue FEOM College AGA Province	ETE Deat leader to M		1.00	2. 00	3. 00	
Section 5504 of the ACA Base Yea period that begins on or after J			This base year	is your cost	reporting	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in your of (column 1 divided by (column).	s yes, or your facilit aber of unweighted nor otations occurring in a number of unweighted our hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0.00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
(5.00   5.1   1	1. 00	2. 00	3.00	4. 00	5. 00	<b>45.00</b>
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000 Ratio (col.	65. 00
			FTEs	FTEsin	1/ (col. 1 +	
			Nonprovi der Si te	Hospi tal	col. 2))	
			1.00	2. 00	3. 00	
Section 5504 of the ACA Current		n Nonprovider Setting	sEffective f	or cost report	ing periods	
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar occurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	0.00	0.00	0. 000000	66. 00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 00	3.00	4. 00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents.  Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0.000000	67. 00

From 01/01/2020 Part I Date/Time Prepared: 12/31/2020 7/15/2021 2:27 pm 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 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 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 N 75 00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00  $\S413.40(f)(1)(ii)$ ? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 N yes or "N" for no in the applicable column. is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Υ 98.00 stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and 98.04 N N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems PUTNAM COUNTY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CN: 15-1333 Pe	In Lie	worksheet S-	
HOSFITAL AND HOSFITAL HEALTH CARE CONFELX IDENTIFICATION DATA	Frovider C		om 01/01/2020	Part I	
		10		7/15/2021 2:	
			V 1. 00	2. 00	_
108.00 Is this a rural hospital qualifying for an exception to the (	CRNA fee sch	edul e? See 42	N N	2.00	108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ratory	
	1. 00	2. 00	3. 00	4.00	
109.00  f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	Y	Y	Y	N	109.00
440 00 D1	D		104	1.00	110.00
110.00 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 Workapplicable.	" for yes o	r "N" for no. I	f yes,	N	110.00
			1. 00	2. 00	
111.00   If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting umn 1 is Y, ticipating in	period? Enter enter the n column 2.	N		111.00
		1.00	2. 00	3.00	-
112.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting partier "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cease participation in the demonstration, if applicable.	oeri od? "Y", enter e	N	2. 33	5.00	112.00
Miscellaneous Cost Reporting Information  115.00 s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			 0115.00
in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (in psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) 3" percent ncludes				
116.00 ls this facility classified as a referral center? Enter "Y" 1 "N" for no.	or yes or	N			116. 00
117.00 s this facility legally-required to carry malpractice insura	ance? Enter	Y			117. 00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence poli	cv? Enter 1	2			118. 00
if the policy is claim-made. Enter 2 if the policy is occurre		D			
		Premi ums	Losses	Insurance	
		1.00	2. 00	3.00	
118.01 List amounts of malpractice premiums and paid losses:		217, 630	(	0	0118.01
			1. 00	2. 00	110.00
118.02 Are malpractice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein.			N		118. 02
119.00D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quallo	column 1, "' alifies for	Y" for yes or the Outpatient	N	N	120.00
121.00Did this facility incur and report costs for high cost implar patients? Enter "Y" for yes or "N" for no.	ntable device	es charged to	Υ		121. 00
122.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included. Transplant Center Information			N		122. 00
125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en		fication date			126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, ento	er the certi	fication date			127. 00
in column 1 and termination date, if applicable, in column 2. 128.00  f this is a Medicare certified liver transplant center, ente		fication date			128. 00
in column 1 and termination date, if applicable, in column 2. 129.00  f this is a Medicare certified lung transplant center, enter					129. 00
column 1 and termination date, if applicable, in column 2.					

Health Financial Systems PUTNAM COUNT HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	TY HOSPI TAL			In Lie	u of Form CMS	-2552-1
	Provider CC	N: 15-1333	Peri od:		Worksheet S	-2
				1/01/2020 2/31/2020		repared:
					7/15/2021 2:	27 pm
				1. 00	2.00	$\dashv$
130.00 If this is a Medicare certified pancreas transplant center		ti fi cati on				130.00
date in column 1 and termination date, if applicable, in c 131.00  f this is a Medicare certified intestinal transplant cent		arti fi cati o	,			131.00
date in column 1 and termination date, if applicable, in c		ertification	'			131.00
132.00 If this is a Medicare certified islet transplant center, e		ication date	e			132.00
in column 1 and termination date, if applicable, in column 133.00 Removed and reserved	1 2.					133.00
134.00 of this is an organ procurement organization (OPO), enter	the OPO number i	in column 1				134.00
and termination date, if applicable, in column 2.						_
All Providers  140.00 Are there any related organization or home office costs as	defined in CMS	Pub 15-1		N		140.00
chapter 10? Enter "Y" for yes or "N" for no in column 1. I	f yes, and home	office cost	ts			1.10.00
are claimed, enter in column 2 the home office chain numbe		tions)		2.00		
1.00 2. If this facility is part of a chain organization, enter on		uah 143 the	name an	3.00 d address	of the home	
office and enter the home office contractor name and contr						
141.00 Name: Contractor's Name:		Contrac	tor's Nu	mber:		141.00
142.00 Street: PO Box: 143.00 Ci ty: State:		Zi p Code	e:			142. 00 143. 00
		1=. p = 554				1.3.30
144 00 Are movided been disclosed about a land and in Westernet	. 42				1.00	144.00
144.00 Are provider based physicians' costs included in Worksheet	A?				Y	144.00
				1. 00	2. 00	
145.00 of costs for renal services are claimed on Wkst. A, line 7						145. 00
inpatient services only? Enter "Y" for yes or "N" for no i no, does the dialysis facility include Medicare utilizatio						
period? Enter "Y" for yes or "N" for no in column 2.		. 0				
146.00 Has the cost allocation methodology changed from the previ Enter "Y" for yes or "N" for no in column 1. (See CMS Pub.			£	N		146. 00
yes, enter the approval date (mm/dd/yyyy) in column 2.	15-2, Chapter	40, 94020) 1	'			
147.00 Was there a change in the statistical basis? Enter "Y" for	vos or "N" for	no			1. 00 N	147.00
147.00 was there a change in the statistical basis: Enter 1 Tor 148.00 was there a change in the order of allocation? Enter "Y" f					N N	148.00
149.00 Was there a change to the simplified cost finding method?	Enter "Y" for ye	es or "N" fo			N	149.00
	Part A	Part B	T	itle V 3.00	Title XIX	
Does this facility contain a provider that qualifies for a	1.00 an exemption fro	2.00 m the appli	cation o		4.00 ver of costs	
Does this facility contain a provider that qualifies for a or charges? Enter "Y" for yes or "N" for no for each compo	n exemption fro	m the appli and Part B		f the low 2 CFR §41	er of costs 3.13)	
or charges? Enter "Y" for yes or "N" for no for each compo 155.00 Hospital	n exemption fro onent for Part A N	m the appli and Part B N		f the low 2 CFR §41 N	ver of costs 3.13) N	
or charges? Enter "Y" for yes or "N" for no for each compo 155.00 Hospital 156.00 Subprovider - IPF	nn exemption fro onent for Part A N N	m the appli and Part B N N		f the low 2 CFR §41 N N	er of costs 3.13) N N	155. 00 156. 00 157. 00
or charges? Enter "Y" for yes or "N" for no for each compo 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF	n exemption fro onent for Part A N	m the appli and Part B N		f the low 2 CFR §41 N	ver of costs 3.13) N	156. 00 157. 00 158. 00
or charges? Enter "Y" for yes or "N" for no for each compo 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF	n exemption fro onent for Part A N N N	m the appli and Part B N N N		of the Low 2 CFR §41 N N N	er of costs 3.13) N N N	156. 00 157. 00 158. 00 159. 00
or charges? Enter "Y" for yes or "N" for no for each compo 155. 00 Hospi tal 156. 00 Subprovi der - I PF 157. 00 Subprovi der - I RF 158. 00 SUBPROVI DER 159. 00 SNF 160. 00 HOME HEALTH AGENCY	an exemption fro onent for Part A N N N	m the appli and Part B N N N N N		of the Low 2 CFR §41 N N N N	er of costs 3.13)  N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00
or charges? Enter "Y" for yes or "N" for no for each compo 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC	n exemption fro onent for Part A N N N	m the appli and Part B N N N		of the Low 2 CFR §41 N N N	er of costs 3.13) N N N	156. 00 157. 00 158. 00 159. 00
or charges? Enter "Y" for yes or "N" for no for each compo 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC	n exemption fro onent for Part A N N N	m the appli and Part B N N N N N N		of the low 2 CFR §41 N N N N N N	er of costs 3.13)  N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 00
or charges? Enter "Y" for yes or "N" for no for each compo 155.00 Hospi tal 156.00 Subprovi der - IPF 157.00 Subprovi der - IRF 158.00 SUBPROVI DER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC	n exemption fro onent for Part A N N N	m the appli and Part B N N N N N N		of the low 2 CFR §41 N N N N N N	er of costs 3.13)  N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 00
or charges? Enter "Y" for yes or "N" for no for each compo 155.00 Hospi tal 156.00 Subprovi der - IPF 157.00 Subprovi der - IRF 158.00 SUBPROVI DER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC	an exemption fro onent for Part A N N N N N	m the appli and Part B N N N N N N N	. (See 4	of the low 2 CFR §41 N N N N N N N	er of costs 3.13)  N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 00
or charges? Enter "Y" for yes or "N" for no for each composition of the second composition of th	an exemption fro onent for Part A N N N N N	m the appli and Part B N N N N N N N	. (See 4	of the low 2 CFR §41 N N N N N N N N N	er of costs 3.13)  N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 10
or charges? Enter "Y" for yes or "N" for no for each compound 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CMHC 161.10 CORF	an exemption from the properties of the properti	m the appliand Part B N N N N N N N N N N S N N N N N N N N	. (See 4	of the low 2 CFR §41 N N N N N N N N N N CBSAS?	er of costs 3.13)  N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 10
or charges? Enter "Y" for yes or "N" for no for each compound 155.00 Hospital 156.00 Subprovider - IPF 157.00 Subprovider - IRF 158.00 SUBPROVIDER 159.00 SNF 160.00 HOME HEALTH AGENCY 161.00 CCMHC 161.10 CORF  Multicampus 165.00 Is this hospital part of a Multicampus hospital that has o Enter "Y" for yes or "N" for no.  Name 0 166.00 If line 165 is yes, for each	an exemption fro onent for Part A N N N N N	m the appli and Part B N N N N N N N	. (See 4	of the low 2 CFR §41 N N N N N N N N N	er of costs 3.13)  N N N N N N N N N N T N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 10
or charges? Enter "Y" for yes or "N" for no for each composition of the second composition of th	an exemption from the properties of the properti	m the appliand Part B N N N N N N N N N N S N N N N N N N N	. (See 4	of the low 2 CFR §41 N N N N N N N N N N CBSAS?	er of costs 3.13)  N N N N N N N N N N T N N N N N N N N	156. 00 157. 00 158. 00 159. 00 161. 00 161. 10
or charges? Enter "Y" for yes or "N" for no for each composition of the second composition of th	an exemption from the properties of the properti	m the appliand Part B N N N N N N N N N N S N N N N N N N N	. (See 4	of the low 2 CFR §41 N N N N N N N N N N CBSAS?	er of costs 3.13)  N N N N N N N N N N T N N N N N N N N	156. 00 157. 00 158. 00 159. 00 161. 00 161. 10
or charges? Enter "Y" for yes or "N" for no for each composition of the second composition of th	an exemption from the properties of the properti	m the appliand Part B N N N N N N N N N N S N N N N N N N N	. (See 4	of the low 2 CFR §41 N N N N N N N N N N CBSAS?	er of costs 3.13)  N N N N N N N N N N T N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 10
or charges? Enter "Y" for yes or "N" for no for each composition of the second composition of th	an exemption from the properties of the properti	m the appliand Part B N N N N N N N N N N S N N N N N N N N	. (See 4	of the low 2 CFR §41 N N N N N N N N N N CBSAS?	er of costs 3.13)  N N N N N N N N N N T N N N N N N N N	156. 00 157. 00 158. 00 159. 00 161. 00 161. 10
or charges? Enter "Y" for yes or "N" for no for each composition of the second composition of th	an exemption from the properties of the properti	m the appliand Part B N N N N N N N N N N S N N N N N N N N	. (See 4	of the low 2 CFR §41 N N N N N N N N N N CBSAS?	N N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 161. 00 161. 10
or charges? Enter "Y" for yes or "N" for no for each composition of the second composition of th	an exemption fro	m the appliand Part B N N N N N N N S State Z 2.00	Ferent C ip Code 3.00	of the low 2 CFR §41 N N N N N N N N N N CBSAS?	er of costs 3.13)  N N N N N N N N N N T N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 10 165. 00
or charges? Enter "Y" for yes or "N" for no for each composition of the second composition of th	an exemption from the properties of the properti	m the appliand Part B N N N N N N N N S State Z 2.00	Ferent C ip Code 3.00	of the low 2 CFR §41 N N N N N N N N N N N N N N N N N N N	N N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 10 165. 00
or charges? Enter "Y" for yes or "N" for no for each composition of the second composition of th	can Recovery an	m the appliand Part B N N N N N N N N S State Z 2.00	Ferent C ip Code 3.00	of the low 2 CFR §41 N N N N N N N N N N N N N N N N N N N	Per of costs 3.13)  N N N N N N N N N T 1.00  N FTE/Campus 5.00 0.0	156. 00 157. 00 158. 00 159. 00 160. 00 161. 10 165. 00
or charges? Enter "Y" for yes or "N" for no for each composition 155. 00 Hospital 156. 00 Subprovider - IPF 157. 00 Subprovider - IRF 158. 00 SUBPROVIDER 159. 00 SNF 160. 00 HOME HEALTH AGENCY 161. 00 CMHC 161. 10 CORF  Multicampus  165. 00 Is this hospital part of a Multicampus hospital that has of Enter "Y" for yes or "N" for no.  Name  0  166. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	one or more camputation for part A N N N N N N N N N N N N N N N N N N	m the appliand Part B  N N N N N N N N N N N N N N N N N N	Ferent C ip Code 3.00	of the low 2 CFR §41 N N N N N N N N N N N N N N N N N N N	Per of costs 3.13)  N N N N N N N N N T 1.00  N FTE/Campus 5.00 0.0	156. 00 157. 00 158. 00 159. 00 160. 00 161. 10 165. 00
or charges? Enter "Y" for yes or "N" for no for each composition of the spirital set. 00 Subprovider - IPF 157. 00 Subprovider - IRF 158. 00 SUBPROVI DER 159. 00 SNF 160. 00 HOME HEALTH AGENCY 161. 00 CMHC 161. 10 CORF  Multicampus  165. 00 Is this hospital part of a Multicampus hospital that has one Enter "Y" for yes or "N" for no.  Name  0  166. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)  Health Information Technology (HIT) incentive in the Americation of the Hit incolumn of the sprovider is a CAH (line 105 is "Y") and is a meanical reasonable cost incurred for the HIT assets (see instructions)	can Recovery an "Y" for yes or 'ngful user (line ons) her this provide!" for no. (see internal cons)	m the appliand Part B  N N N N N N N N N N N N N N N T N	ferent C ip Code 3.00  ent Act '), ente	of the low 2 CFR §41 N N N N N N N N N N N N N N N N N N N	N N N N N N N N N N N N N N N N N N N	156. 00 157. 00 158. 00 159. 00 160. 00 161. 10 165. 00 166. 00 167. 00 168. 00

Health Financial Systems	cial Systems PUTNAM COUNTY HOSPITAL					2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	NTIFICATION DATA	Provider CCN: 15-1333	Peri		Worksheet S-	2
			From  To		Part I Date/Time Pr	anarad.
			10	12/31/2020	7/15/2021 2:	
		Begi nni ng	Endi ng			
				1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)						170. 00
				1. 00	2. 00	
171.00 If line 167 is "Y", does this provider				N		171. 00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter						
"Y" for yes and "N" for no in column 1.		nter the number of secti	on			
1876 Medicare days in column 2. (see in:	structions)					

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1333 Peri od: Worksheet S-2 From 01/01/2020 Part II Date/Time Prepared: 12/31/2020 7/15/2021 2:27 pm Date 1. 00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1 00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Y/N Date V/I 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Туре Date 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Ν 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from 5.00 N 5.00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1. 00 2.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N 7.00 Were nursing school and/or allied health programs approved and/or renewed during the 8.00 N 8.00 cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education Ν 9.00 program in the current cost report? If yes, see instructions. . Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Teaching Program on Worksheet A? If yes, see instructions Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions γ 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions. Ν 14.00 Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Ν 15.00 Part A Part B Y/N Y/N Date Date 3.00 1.00 2.00 4.00 PS&R Data Was the cost report prepared using the PS&R Report only? Ν Ν 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 instructions) 03/18/2020 17 00 Was the cost report prepared using the PS&R Report for 03/18/2020 17.00 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) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R 18.00 N Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.
19.00 If line 16 or 17 is yes, were adjustments made to PS&R Ν N 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

	Financial Systems PUTNAM COUNTY				u of Form CM	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1333	Peri od: From 01/01/2020 To 12/31/2020	Worksheet S Part II Date/Time P 7/15/2021 2	repared:
			iption	Y/N	Y/N	
20.00	LE Line 1/ and 17 in the many adjustments and to DCoD		0	1.00	3. 00	20.00
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	20.00
	report data for other: beserbe the other day astments.	Y/N	Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS	HOSPI TALS)		1.00	
	Capital Related Cost		,			
	Have assets been relifed for Medicare purposes? If yes, see				N	22.00
23. 00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made du	ring the cost	N	23.00
24. 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing leases entered	ed into during	this cost r	eporting period?	Υ	24.00
25. 00	If yes, see instructions Have there been new capitalized leases entered into during instructions.	Υ	25.00			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	If yes, see	N	26.00		
27. 00		e cost reporti	ng period? I	f yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into du	ring the cos	t reporting	Y	28.00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Υ	29.00			
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	s, see	N	30.00		
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If ye	s, see	N	31.00
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser		ed through c	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to compet	itive bidding? If	N	33.00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar	rangement wit	h provi der-b	ased physicians?	Υ	34.00
	If yes, see instructions.					
35. 00	If line 34 is yes, were there new agreements or amended exi	9 9	nts with the	provi der-based	Υ	35.00
	physicians during the cost reporting period? If yes, see in	istructions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs			00	2.00	
36. 00	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been pr	epared by the	home office			37.00
38. 00	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off	ice different	from that o	f		38.00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			S,		39.00
40. 00	j ' '	home office?	If yes, see			40.00
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information			la		
41. 00	held by the cost report preparer in columns 1, 2, and 3,	TI NA		SEVERS		41.00
	respecti vel y.		0		12.00	
42. 00	Enter the employer/company name of the cost report preparer.	BLUE & CO., LL	_C			42.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT O	UESTI ONNAI RE	Provi der		Period: From 01/01/20 To 12/31/20	Worksheet S-2 20 Part II 20 Date/Time Pro 7/15/2021 2:2	epared:	
				2.00				
	Coot Depart Dranavar Contact Information			3. 00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the tit		MANAGER				41. 00	
	held by the cost report preparer in columns	s 1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost	t report					42.00	
	preparer.							
43.00	Enter the telephone number and email address	ss of the cost					43.00	
	report preparer in columns 1 and 2, respect	ti vel y.						
		<i>y</i> 1			· ·		•	

Health Financial SystemsPUTNAMHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: Provider CCN: 15-1333

				1	0 12/31/2020	7/15/2021 2:2	
						1/P Days /	, piii
						0/P Visits /	
						Tri ps	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	·	Line Number		Avai I abl e			
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00	19	6, 954	44, 928. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)						2.00
3. 00	HMO IPF Subprovider						3.00
4. 00	HMO I RF Subprovi der					_	4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	
6.00	Hospital Adults & Peds. Swing Bed NF		40	, 054	44 000 00	0	
7. 00	Total Adults and Peds. (exclude observation		19	6, 954	44, 928. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	6	2, 196	7, 752. 00	0	8.00
9. 00	CORONARY CARE UNIT	31.00	O	2, 190	7, 752.00	U	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43.00				0	
14. 00	Total (see instructions)	10.00	25	9. 150	52, 680. 00	0	14.00
15. 00	CAH visits			1,	5=, 555: 55	0	15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGI CAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25. 00	CMHC - CMHC	00.40					25.00
25. 10	CMHC - CORF	99. 10				0	1
26. 00	PUTNAM PEDIATRICS AND INTERNAL MED	88.00				0	
26. 01 26. 02	FAMILY MEDICINE OF CLOVERDALE NORTH PUTNAM FAMILY HEALTHCARE	88. 01 88. 02				0	
26. 02	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	
27. 00	Total (sum of lines 14-26)	07.00	25			U	27.00
28. 00	Observation Bed Days		25			0	
29. 00	Ambul ance Tri ps					0	29.00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges						33. 01

Provi der CCN: 15-1333

Peri od: Worksheet S-3 From 01/01/2020 Part I To 12/31/2020 Date/Time Prepared: 7/15/2021 2:27 pm

		_				7/15/2021 2: 2	<u>7 pm</u>
		I/P Days	/ O/P Visits	/ Tri ps	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	905	42	1, 872			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	125	0	165			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	14			6.00
7.00	Total Adults and Peds. (exclude observation	1, 030	42	2, 051			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	133	0	323			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	1, 163	42	2, 374	0.00	245. 96	14.00
15.00	CAH vi si ts	0	0	0			15. 00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)			0			24. 10
25. 00	CMHC - CMHC			_			25. 00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	1
26. 00	PUTNAM PEDIATRICS AND INTERNAL MED	919	3, 088				1
26. 01	FAMILY MEDICINE OF CLOVERDALE	1, 258	3, 060		0. 00		•
26. 02	NORTH PUTNAM FAMILY HEALTHCARE	1, 290	2, 359				•
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	1,2,0	0				26. 25
27. 00	Total (sum of lines 14-26)		Ü	Ĭ	0.00		ł
28. 00	Observation Bed Days		0	634		200.00	28. 00
29. 00	Ambulance Trips	0	O	054			29.00
30.00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days (see Thisti detroit)			ĺ			31.00
32. 00	Labor & delivery days (see instructions)	0	0				32.00
32. 00	Total ancillary labor & delivery room	١	0				32.00
JZ. U1	outpatient days (see instructions)			l			32.01
33. 00	LTCH non-covered days	ما					33.00
	LTCH site neutral days and discharges						33. 01
55. 01	121011 31 to houtrai days and discharges	ı 9		I	I .	I	1 33.01

| Peri od: | Worksheet S-3 | From 01/01/2020 | Part I | Date/Time | Prepared: | Provider CCN: 15-1333

				Т	o 12/31/2020	Date/Time Pre 7/15/2021 2:2	
		Full Time		Di sch	arges	77 137 2021 2. 2	) DIII
		Equi val ents		T =			
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
1.00		11. 00	12. 00	13.00	14.00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and			0 298	7	673	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days)(see instructions for col. 2						
2 00	for the portion of LDP room available beds)						2 00
2.00	HMO and other (see instructions)			C	0		2.00 3.00
3. 00 4. 00	HMO IPF Subprovi der				0		4.00
	HMO IRF Subprovider				U		•
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5. 00 6. 00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9.00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	246. 55		0 298	7	673	•
15. 00	CAH visits	240. 33		270	Ί ΄	073	15.00
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0.00					25. 10
26.00	PUTNAM PEDIATRICS AND INTERNAL MED	13. 72					26.00
26.01	FAMILY MEDICINE OF CLOVERDALE	15. 08					26. 01
26.02	NORTH PUTNAM FAMILY HEALTHCARE	13. 21					26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	288. 56					27. 00
28. 00	Observation Bed Days						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)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days			C			33.00
33. 01	LTCH site neutral days and discharges			c	1		33. 01

	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Peri od:	eu of Form CMS- Worksheet S-8	
				CCN: 15-8515	From 01/01/2020 To 12/31/2020		
					RHC I	Cost	z / pili
	Clinic Address and Identification				1.	. 00	
00	Clinic Address and Identification Street				1542 S. BLOOMI	NGTON STREET	1.
	101.001		Ci	ty	State	ZIP Code	
	T			00	2. 00	3. 00	
00	City, State, ZIP Code, County		GREENCASTLE			46135	2.
						1. 00	
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for			0	3.
					nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	
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 Appalachian Regional Commission	O(d), PHS Act)					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 FOHC? F	nter "Y" for	1. 00 N	2. 00	10.
00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column			
	Tiour S. )	Sun	day	l N	londay	Tuesday	
		from	to	from	to	from	
	Facility bours of apprations (1)	1. 00	2. 00	3.00	4. 00	5. 00	
. 00	Facility hours of operations (1)	1. 00	2.00				11.
. 00	Facility hours of operations (1)	1.00	2.00	08: 00	17: 00	5. 00	11.
	CLINIC			08: 00	17: 00		
2. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu	o8:00 ard? r 9, section mn 2 the	17: 00 1. 00 Y	08: 00	12
2. 00	Have you received an approval for an exceptils this a consolidated cost report as define	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu	o8:00 ard? r 9, section mn 2 the ders and	17: 00 1. 00 Y N	08: 00	12.
2. 00	Have you received an approval for an excepti 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.	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu	ard? r 9, section mn 2 the ders and Provi	17:00 1.00 Y N	08: 00 2. 00 0	12.
2. 00	Have you received an approval for an excepti 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.	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu	ard? r 9, section mn 2 the ders and Provi	17: 00 1. 00 Y N	08: 00	12.
2. 00	Have you received an approval for an excepti 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.	on to the prod d in CMS Pub. umn 1. If yes,	uctivity stand 100-04, chapte enter in colu	ard? r 9, section mn 2 the ders and Provi	17:00 1.00 Y N	08: 00 2. 00 0	12.
2. 00	Have you received an approval for an excepti 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	on to the prod d in CMS Pub. umn 1. If yes, List the name	uctivity stand 100-04, chapte enter in colu s of all provi	ard? r 9, section mn 2 the ders and  Provi	17:00 1.00 Y N	08: 00 2. 00 0 CCN number 2. 00	12. 13.
2. 00 3. 00 4. 00	Have you received an approval for an excepti 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	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	ard? r 9, section mn 2 the ders and  Provi	17: 00 1. 00 Y N Ider name 1. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits	12. 13.
2. 00	Have you received an approval for an excepti 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	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	ard? r 9, section mn 2 the ders and  Provi	17: 00 1. 00 Y N Ider name 1. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits	12 13
2. 00	Have you received an approval for an excepti 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	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	ard? r 9, section mn 2 the ders and  Provi	17: 00 1. 00 Y N Ider name 1. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits	12. 13.
2. 00	Have you received an approval for an excepti 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	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	ard? r 9, section mn 2 the ders and  Provi	17: 00 1. 00 Y N Ider name 1. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits	12. 13.
2. 00	Have you received an approval for an excepti 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	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi	ard? r 9, section mn 2 the ders and  Provi	17: 00 1. 00 Y N Ider name 1. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits	12. 13.
2. 00	Have you received an approval for an excepti 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	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi V 2.00	ard? r 9, section mn 2 the ders and  Provi	17: 00 1. 00 Y N Ider name 1. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits	12. 13.
2. 00	Have you received an approval for an excepti 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.	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00	ard? r 9, section mn 2 the ders and  Provi  XVIII 3.00	17: 00 1. 00 Y N Ider name 1. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits	12. 13.
22. 00 33. 00 44. 00	Have you received an approval for an excepti 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. (see instructions)	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00	ard? r 9, section mn 2 the ders and  Provi	17: 00 1. 00 Y N Ider name 1. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits	12.
22. 00 33. 00 44. 00	Have you received an approval for an excepti 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.	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00  Cou	ard? r 9, section mn 2 the ders and  Provi  XVIII 3.00	17: 00  1. 00  Y  N  der name 1. 00  XIX  4. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits	12.
2. 00	Have you received an approval for an excepti 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. (see instructions)	on to the prod d in CMS Pub. umn 1. If yes, List the name  Y/N 1.00	uctivity stand 100-04, chapte enter in colu s of all provi  V 2.00  Cou	ard? r 9, section mn 2 the ders and  Provi  XVIII 3.00	17: 00  1. 00  Y  N  der name 1. 00  XIX  4. 00	08: 00  2. 00  0  CCN number 2. 00  Total Visits 5. 00	11. 12. 13.

Health Financial Systems	PUTNAM COUNT	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8		
		Component		From 01/01/2020 To 12/31/2020			
				RHC I	Cost	л рііі	
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12. 00	13. 00	14. 00			
Facility hours of operations (1)							
11. 00 CLINIC	08: 00	17: 00				11. 00	

Heal th	Financial Systems	PUTNAM COUNT	TY HOSPITAL		In lie	u of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA			CN: 15-1333	Peri od:	Worksheet S-8	
			Component	CCN: 15-8513	From 01/01/2020 To 12/31/2020		
					RHC II	7/15/2021 2: 2 Cost	27 pm
					KIIC II	COST	
					1.	00	
4 00	Clinic Address and Identification					TOFFT	1
1. 00	Street		) c:	+.,	51 E. MARKET S		1.00
				00	State 2.00	ZIP Code 3.00	
2. 00	City, State, ZIP Code, County		CLOVERDALE	00		46120	2.00
2.00	jointy, others, Elli sous, soulity		o Love Novice			10120	2.00
						1. 00	
3. 00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for			0	3.00
					nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	
4. 00	Community Health Center (Section 330(d), PHS	Act)					4.00
5. 00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34						6.00
7. 00	Appalachian Regional Commission						7. 00
8. 00	Look-Alikes						8.00
9. 00	OTHER (SPECIFY)						9. 00
					1. 00	2. 00	
10. 00	Does this facility operate as other than a h	ospi tal -based	RHC or FOHC? F	nter "Y" for			10.00
.0.00	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type o hours.)	ate number of	other operatio	ns in column			10.00
	, nour 9.7	Sun	nday	N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
11 00	Facility hours of operations (1)			00.00	10.00	00.00	11 00
11.00	CLINIC			08: 00	18: 00	08: 00	11.00
					1.00	2. 00	
12. 00	Have you received an approval for an excepti	on to the prod	uctivity stand	ard?	Y		12.00
13. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col	umn 1. If yes,	enter in colu	mn 2 the	N	0	13.00
	number of providers included in this report. numbers below.	List the name	s of all provi	ders and			
	Trumber 3 berow.			Prov	ider name	CCN number	
					1. 00	2. 00	
14.00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
15 00	Have you provided all or substantially all	1. 00	2. 00	3. 00	4. 00	5. 00	15.00
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider. (see instructions)						
	(See Thisti deti Olis)		Col	l inty			
				00			
2. 00	City, State, ZIP Code, County		PUTNAM				2.00
		Tuesday		esday		sday	
		to	from	to	from	to	
	Facility house of operations (1)	6. 00	7. 00	8. 00	9. 00	10.00	
11 00	Facility hours of operations (1) CLINIC	18: 00	08: 00	18: 00	08: 00	18: 00	11.00
11.00	OEI III O	1.0.00	100.00	110.00	100.00	1.0.00	1 11.00

Health Financial Systems	PUTNAM COUNT	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8		
		Component		From 01/01/2020 To 12/31/2020		pared:	
				10 12,01,2020	7/15/2021 2: 2		
				RHC II	Cost		
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12. 00	13.00	14. 00			
Facility hours of operations (1)	_						
11. 00 CLINIC	08: 00	18: 00				11. 00	

Heal th	n Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Peri od:	Worksheet S-8	3
			Component	CCN: 15-8514	From 01/01/2020 To 12/31/2020		
					RHC III	Cost	
	01:-:- Add 1 d+: £:+:				1.	00	
1. 00	Clinic Address and Identification Street				440 E. PAT RAD	V WAV	1.00
1.00	311 66,1		Ci	ty	State	ZIP Code	1.00
				00	2.00	3. 00	
2.00	City, State, ZIP Code, County		BAI NBRI DGE		IN	46105	2.00
						1 22	
2 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	or "D" for rur	al ar "II" for	urban		1.00	2 00
3. 00	HOSPITAL-BASED FUNCS UNLY: DESIGNATION - ENT	er k for rur	al of U for		nt Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds			1			
4.00	Community Health Center (Section 330(d), PHS						4.00
5. 00	Migrant Health Center (Section 329(d), PHS A						5.00
6.00	Health Services for the Homeless (Section 34	10(d), PHS Act)					6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes						7.00
9. 00	OTHER (SPECIFY)						9.00
	,			1			
					1. 00	2. 00	
10.00	j 1					0	10.00
	yes or "N" for no in column 1. If yes, indic						
	2. (Enter in subscripts of line 11 the type of hours.)	or other operat	ion(s) and the	operating			
	Tiour S. )	Sun	day	T	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2.00	3.00	4.00	5. 00	
	Facility hours of operations (1)			T	1	l	
11.00	CLINIC			08: 00	17: 00	08: 00	11.00
					1. 00	2. 00	
12. 00	Have you received an approval for an excepti	on to the prod	uctivity stand	ard?	1.00 Y	2.00	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	
				1100	1. 00	2.00	
14. 00	RHC/FQHC name, CCN number						14.00
		Y/N	V	XVIII	XIX	Total Visits	
	The state of the s	1. 00	2. 00	3. 00	4. 00	5. 00	
15. 00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)		Col	l inty			
				00			
2. 00	City, State, ZIP Code, County		PUTNAM	-			2.00
		Tuesday	Wedn	esday	Thur	sday	
		to	from	to	from	to	
	[ (1)	6. 00	7. 00	8. 00	9. 00	10.00	
11 00	Facility hours of operations (1)	17: 00	08: 00	17: 00	08: 00	17: 00	11.00
1 1. UU	I OFFI MI O	J17.00	po. 00	J17.00	No. 00	J17.00	1 11.00

Health Financial Systems	PUTNAM COUNT	PUTNAM COUNTY HOSPITAL			In Lieu 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 01/01/2020 To 12/31/2020			
				RHC III	Cost		
	Fri	day	Sa	turday			
	from	to	from	to			
	11. 00	12. 00	13.00	14. 00			
Facility hours of operations (1)	_						
11. 00 CLINIC	08: 00	17: 00				11. 00	

Heal th	Financial Systems PUTNAM COUNTY HO	OSPI TAL		In Lie	u of Form CMS-2	<u> 2552-10</u>
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC	CN: 15-1333	Period: From 01/01/2020 To 12/31/2020	Worksheet S-1 Date/Time Pre 7/15/2021 2:2	pared:
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vided by li	ne 202 collui	nn 8)	0. 403569	1.00
2.00	Net revenue from Medicaid				2, 510, 232	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	tal naumant	s from Modia	ani dO		3.00
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplemen If line 4 is no, then enter DSH and/or supplemental payments f	cai u ?	0	4. 00 5. 00		
6.00	Medi cai d charges		15, 560, 821	6.00		
7. 00 8. 00	Medicaid cost (line 1 times line 6)	noo O and E. if	6, 279, 865			
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(Title / IIII)	ius suili oi Ti	nes 2 and 5; 11	3, 769, 633	8.00
	Children's Health Insurance Program (CHIP) (see instructions f	or each lin	ne)			
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges		0			
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	1
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9;	if < zero then	0	12.00
	enter zero) Other state or local government indigent care program (see ins	tructions f	or each line	2)		-
13. 00	Net revenue from state or local indigent care program (Not inc				0	13.00
14. 00	Charges for patients covered under state or local indigent car	e program (	(Not included	d in lines 6 or	0	14.00
15. 00	10)  State or local indigent care program cost (line 1 times line 1	4)			0	15.00
16.00	Difference between net revenue and costs for state or local in		e program (Li	ne 15 minus line	0	16. 00
	13; if < zero then enter zero)  Grants, donations and total unreimbursed cost for Medicaid, CH instructions for each line)	IIP and stat	e/Local indi	gent care progra	nms (see	
17. 00	Private grants, donations, or endowment income restricted to f				0	
18. 00 19. 00	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16)			ns (sum of lines	0 3, 769, 633	
	[0, 12 did 10)		Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	Uncompensated Care (see instructions for each line)		1.00	2. 00	3. 00	
20. 00	Charity care charges and uninsured discounts for the entire fa (see instructions)	ncility	9, 354, 9	04 0	9, 354, 904	20.00
21. 00	Cost of patients approved for charity care and uninsured discoinstructions)	ounts (see	3, 775, 3	49 0	3, 775, 349	21.00
22. 00	Payments received from patients for amounts previously written charity care	off as		0 0	0	22. 00
23.00	Cost of charity care (line 21 minus line 22)		3, 775, 3	49 0	3, 775, 349	23. 00
					1. 00	
24. 00	Does the amount on line 20 column 2, include charges for patie		ond a Lengtl	n of stay limit	N	24.00
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t stay limit		care progra	am's length of	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see in	structions)			6, 950, 707	26. 00
27. 00	Medicare reimbursable bad debts for the entire hospital comple	•	,		457, 114	1
27. 01 28. 00	Medicare allowable bad debts for the entire hospital complex (Non-Medicare bad debt expense (see instructions)	see instruc	ctions)		703, 252 6, 247, 455	1
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (see	instructions	5)	2, 767, 417	1
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	! 20)			6, 542, 766	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			10, 312, 399	31.00

Control   Cont	Heal th	Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-	2552-10
Cost Center Description	RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		From 01/01/2020	Date/Time Pre	
CHERNEL STRVICE COST CENTERS   1.00   DOTOLOG DEPLOYEE SERVET S DEPLOYMENT STATE   1.00   DOTOLOG DEPLOYEE SERVET S DEPLOYMENT STATE   2.729, 157   2.729, 157   437, 871   2.667, 078   1.00		Cost Center Description	Sal ari es	Other		ions (See	Reclassified Trial Balance (col. 3 +-	
DITION   MIN CAP PIT CONTS-RIDGE A FIXT			1. 00	2. 00	3. 00	4. 00	5. 00	
4.00   00.000   EMPLOYEE BEREFITS DEPARTWENT   68, 728   5, 561, 397   5, 522, 125   0   5, 623, 125   4, 00   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.0000   00.00000   00.00000   00.00000   00.00000   00.00000   00.00000   00.000000   00.00000000	1 00			2 220 457	2 220 45	7 427 071	2 //7 020	1 00
5.00   GOSCOL ARMIN INSTRATIVE & GENERAL   2.977, 796   5.437, 809   8, 366, 606   -94, 786   1, 372, 383   7.00   0.0000   CORRESTION OF PLANT   344, 451   995, 788   1,340, 209   32, 253   33, 326   0.00000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000			60 720					1
7.00 0 00000 DERATION OF PLANT         344, 451         995, 758         1, 340, 209         32, 529         1, 372, 738         7, 00           9.00 1 00000 LUSISKEEPING         447, 938         83, 632         513, 157         0         233, 267         10, 70         10, 70         00         00         233, 267         10, 70         10, 70         00         00         20, 28, 28         28, 28, 20         10, 70         10, 70         0         0         232, 28, 20         10, 70         11, 70         10, 70         10, 70         10, 70         10, 70         10, 70         10, 70         10, 70         10, 70         10, 70         10, 70         10, 70 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
9.00   0.0900  PUUSEKEEPING								
10.00   01000   DETARY	8.00	00800 LAUNDRY & LINEN SERVICE	30, 820	182, 543			213, 363	8. 00
11.00   01100   CAFETERIA   0   0   0-93, 268   6.92, 268   11.00   11.00   13.00   1300   MISSIN KAD MINISTRATION   1110, 531   39, 818   150, 349   13.00   388, 841   16.00   0   388, 841   16.00   17.00								1
13.00   01300   MURSING ADMINISTRATION   110, 531   39, 818   150, 349   0   150, 349   13.00   17.0			407, 006		1			1
16.00   01000   IEDICAL RECORDS & LIBRARY   20.0 842   127, 999   388, 841   0   0   388, 841   17.00   1700   01701   01711   1211   0   1700   1710   01701   01711   1211   0   1700   1710   01701   01711   1211   0   1700   1710   01701   01711   1211   0   10   17.01   17		1	110 531	O			1	1
17.00   01700   SOCIAL SERVICE   0   0   0   0   0   0   0   0   0								1
IMPATIE NIT BOUTINE SERVICE COST CENTERS   2, 140, 333   283, 243   2, 443, 576   -6, 643   2, 436, 933   30. 00   300   0010   NUTESN EV CARE UNIT   721, 930   232, 981   994, 911   -38, 376   916, 535   31. 00   31. 00   0010   NUTESN EV CARE UNIT   721, 930   232, 981   994, 911   -38, 376   916, 535   31. 00   31. 00   0010   NUTESN EV CARE UNIT   721, 930   232, 981   994, 911   -38, 376   916, 535   31. 00   0010   NUTESN EV CARE UNIT   721, 930   232, 981   791, 612   1, 527, 455   -129, 207   1, 398, 248   50. 00   50. 00   0010   OPERATI NG ROOM   47, 129   232, 983   791, 132   791, 112   51. 00   791, 112	17. 00			0	1		0	17. 00
30.00   3000   ADULT'S & PEDIATRICS   2.160, 333   283, 248   2.443, 576   -6.643   2.436, 933   30.00   30.00   (1) INENSIVE CASE UNIT   721, 930   232, 981   954, 911   954, 911   343, 00   43.0	17. 01		100, 923	7, 193	108, 11	6 0	108, 116	17. 01
31.00   03100   INTERSIYE CARE UNIT   721, 920   232, 981   946, 911   -38, 376   916, 535   31, 00   0500   NINSERY   070   031, 00   0500   NINSERY   070   050	20.00		2 1/0 222	202 242	2 442 57	4 442	2 424 022	20.00
0   0   0   0   0   0   0   0   0   0						·		
ANCILLARY SERVICE COST CENTERS   50.00   GROOD (PERATING ROM)   735, 843   791, 612   1,527, 455   -129, 207   1,398, 248   50.00   510.00   6100 (PERATING ROM)   47, 129   23, 983   71, 112   0   77, 112   51.00   752, 00   52.00   05200 (DELIVERY ROMA & LABOR ROW)   0   0   0   0   0   0   52.00   0520 (DELIVERY ROM & LABOR ROW)   1,475, 342   0   862, 784   53.00   63500 (ANESTHESS) OLOGY   1,908, 985   336, 397   1,435, 382   0   1,435, 382   54.00   6		1	· · ·		1		l '	1
51.00   05100   RECOVERY ROOM   A LABOR ROOM   0   0   0   0   0   0   0   0   0			-					
52 OD   05200D   DELIVERY ROOM & LABOR ROOM   0   0   0   0   0   52 OD		1						1
53.00   05300   ANESTHESIOLOGY   819, 435   43, 349   862, 784   50   862, 784   53.00   4.453, 382   54.00   05401   NUCLEAR MEDICINE-DIAGNOSTIC   1,098, 55   336, 397   1,435, 382   54.00   1,435, 382   54.01   54.00   3400   NUCLEAR MEDICINE-DIAGNOSTIC   20   137, 322   137, 322   0   137, 322   54.01   54.00   3419, 208   57.00   05700   CT SCAN   178, 892   240, 316   419, 208   0   419, 208   57.00   05700   CT SCAN   178, 892   240, 316   419, 208   0   419, 208   57.00   05900   05900   CARDIAC CATHETERIZATION   0   0   0   0   0   0   0   0   0							1	
54. 00   05400  RADIOLOGY-DIACNOSTIC   1,098,985   336,997   1,435,382   0   1,455,382   54. 00   10   40. 00   10   10   10   10   10   10   10			٩	•		٥	•	
54. 01 06401   MUCLEAR MEDICINE-DIAGNOSTIC 0 137, 322 0 137, 322 0 137, 322 54, 54 02 03480   MOCLOGY 320, 298 3, 725, 596 0 0 3, 725, 596 54 0. 0 570 0 6700   CT SCAN 178, 892 240, 316 419, 208 0 419, 208 57. 00 0 6500   MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 0 0 0 59. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1					•	
57.00   GS700   CT SCAN   178.892   240, 316   419, 208   0   419, 208   55.00   59.00   0.5900   0.6900   0.5900   0.			0					1
58. 00   05800   MARCHTIC RESONANCE IMAGINS (MRI)   0   0   0   0   0   0   59. 00	54. 02	03480 ONCOLOGY		3, 405, 298	3, 725, 59	6 0	3, 725, 596	54.02
59.00   OS900   CARDIA C CATHETERIZATION   0   0   0   0   59.00				240, 316	419, 20	8 0		
0.00   0.0000   LABORATORY   791, 681   1, 728, 259   2, 519, 940   0   2, 519, 940   60. 00   0.0			-	0		0	· -	1
0.00   0.00			٥,	1 728 259	2 519 94			
64 00   06400   INTRAVENOUS THERAPY   426, 448   148, 519   574, 967   0   574, 967   0   66 00   0600   06000   06000   0700   074, 967   06 070   06700   06800   SPEECH PATHOLOGY   60, 733   89, 182   149, 915   0   149, 915   69, 00   06900   LECTROCARDI OLDGY   60, 733   89, 182   149, 915   0   149, 915   69, 00   0710   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   24, 917   11, 480   35, 951   -35, 951   0, 71, 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   24, 471   11, 480   35, 951   -35, 951   0, 71, 0187   72, 00   73, 00   07300   DRUGS CHARGED TO PATIENTS   326, 055   1, 023, 890   1, 349, 945   0   1, 349, 945   73, 00   73, 01   039950   ONCOLOGY   0   0   0   0   0   0   0   0   0				1, 720, 237	2,517,74			
66 00   06600   PHYSI CAL THERAPY   0   492, 028   492, 028   0   492, 028   66, 00   67, 00   67, 00   67, 00   67, 00   67, 00   67, 00   67, 00   67, 00   67, 00   67, 00   67, 00   67, 00   68, 00   68, 00   68, 00   68, 00   68, 00   68, 00   68, 00   68, 00   68, 00   69, 0			0	0		0	0	1
67.00   06700   06700   06200   06800   06800   06800   06800   06900   06900   06800   06900   06900   06800   0690			426, 448					1
68. 00   06900   DEFECH PATHOLOGY   0   45, 480   45, 480   0   45, 480   68. 00			0					1
69. 00   06900   CARDI ACREADI OLOGY   60, 733   89, 182   149, 915   0   149, 915   69, 00			0				1	1
69-01			60. 733					
72.00   07200   IMPL DEV. CHARGED TO PATIENT   0 0 0 0   210, 187   210, 187   72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   326, 055   1, 023, 890   1, 349, 945   0 0 1, 349, 945   73.00   03950   ONCOLOGY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			249, 825	6, 852				1
73.00   07300   DRUGS CHARGED TO PATIENTS   326,055   1,023,890   1,349,945   0   1,349,945   73.00     73.01   03950   ONCOLOGY   0   0   0   0   0   0     73.01   OUTPATTENT SERVICE COST CENTERS			24, 471	11, 480	35, 95			
0   0   0   0   0   0   0   0   0   0			0	1 000 000	1 240 04			1
OUTPATIENT SERVICE COST CENTERS			· · ·	1, 023, 890	1, 349, 94			
88. 00   08800   PUTNAM PEDI ATRI CS AND INTERNAL MED   1, 433, 736   342, 679   1, 776, 415   -96, 246   1, 680, 169   88. 00   08801   FAMI LY MEDI CI NE OF CLOVERDALE   1, 166, 918   395, 559   1, 564, 577   -96, 651   1, 467, 926   88. 01   88. 02   08802   NORTH PUTNAM FAMI LY HEALTHCARE   1, 156, 295   367, 315   1, 523, 610   -85, 964   1, 437, 646   88. 02   09000   CLI NI C   0   0   0   0   0   0   0   0   0	73.01		o <sub>l</sub>			01 0		73.01
88.02   08802   NORTH PUTNAM FAMILY HEALTHCARE   1, 156, 295   367, 315   1, 523, 610   -85, 964   1, 437, 646   88.02   90.00   0   0   0   0   0   0   0   0   0	88.00		1, 433, 736	342, 679	1, 776, 41	5 -96, 246		
90. 00   09000   CLINIC   0   0   0   0   0   0   0   0   0								
90. 01   09001   RHEUMATOLOGY   402,908   53,838   456,746   -1,174   455,572   90. 01   91.00   09100   EMERGENCY   3,160,248   1,605,096   4,765,344   -10   4,765,334   91. 00   00   00   00   00   00   00   00			1, 156, 295				, ,	1
91. 00			402 908	O				
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   92. 00   OTHER REI MBURSABLE COST CENTERS   99. 10   O9910   CORF   0   0   0   0   0   0   0   0   0								
99. 10   09910   CORF   0   0   0   0   0   0   0   0   0								
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   SUBTOTALS (SUM OF LINES 1 through 117)   19,983,298   27,140,685   47,123,983   105,579   47,229,562   118.00   NONREI MBURSABLE COST CENTERS			-				_	
113.00	99. 10		0	0		0 0	0	99. 10
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   19, 983, 298   27, 140, 685   47, 123, 983   105, 579   47, 229, 562   118. 00	113 00			0		0	0	113 00
NONRE   MBURSABLE   COST   CENTERS   C			19, 983, 298				1	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3, 344, 375 1, 104, 123 4, 448, 498 -96, 161 4, 352, 337 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 265, 989 48, 872 314, 861 -9, 418 305, 443 192. 01 192. 02 19203 RHEUMATOLOGY 0 0 0 0 0 0 192. 02 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 1930 DME 0 0 0 0 0 0 0 193. 01 19301 DME 0 0 0 0 0 0 0 193. 01 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 0 193. 02 194. 00 07950 VACANT SPACE 0 0 0 0 0 0 0 194. 01 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL								1
192. 01 19201 JOHNSON/NI CHOLS WI C 265, 989 48, 872 314, 861 -9, 418 305, 443 192. 01 192. 02 19203 RHEUMATOLOGY 0 0 0 0 0 192. 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 19302 LACTATI ON CONSULTI NG 0 0 0 0 0 193. 02 193. 02 193. 02 193. 02 193. 02 10 ABETI C COUNSELI NG 0 0 0 0 0 0 193. 03 194. 00 07950 VACANT SPACE 0 0 0 0 0 0 194. 00 194. 01 07951 BOARD OF HEALTH 0 0 0 0 0 0 0 194. 02 194. 02 07952 PUTNAM/HENRY PRENATAL			- 1					
192. 02 19203 RHEUMATOLOGY 0 0 0 0 192. 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 0 193. 02 193.02 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 0 194. 00 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 0 0 194. 02		1						
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. 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 0 194. 03 194. 00 07950 VACANT SPACE 0 0 0 0 0 0 194. 00 194. 01 07951 BOARD OF HEALTH 0 0 0 0 0 0 194. 00 194. 02 07952 PUTNAM/HENRY PRENATAL			205, 989	48, 872 0	314,80			1
193. 01   19301   DME			ő	0				
193. 03   19303   DI ABETI C COUNSELI NG			0	0		0 0		
194. 00 07950 VACANT SPACE 0 0 0 0 194. 00 194. 01 07951 BOARD OF HEALTH 0 0 0 0 0 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 0 194. 02			O	0	1		<b>l</b>	
194. 01 07951 BOARD OF HEALTH 0 0 0 0 194. 01 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194. 02			0	0		0		
194.02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 0 194.02				0		0		
			0	0		o o		
			23, 593, 662	28, 293, 680	51, 887, 34			
			·					

Provider CCN: 15-1333

Period: Worksheet A From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 2:27 pm

			7/15/2021 2: 2	<u>7 pm</u>
Cost Center Description	Adjustments	Net Expenses		
	(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	-150, 502	2, 516, 526		1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	-5, 942			4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL	-2, 175, 442			5.00
7. 00   00700   OPERATION OF PLANT	-8, 678			7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG	0			8. 00 9. 00
10. 00   01000 DI ETARY		1		10.00
11. 00 01100 CAFETERI A	-44, 507			11.00
13. 00 01300 NURSING ADMINISTRATION	0			13.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-264	388, 577		16.00
17. 00 01700 SOCIAL SERVICE	0	0		17. 00
17. 01 01701 UTI LI ZATI ON REVI EW	0	108, 116		17. 01
INPATIENT ROUTINE SERVICE COST CENTERS	1 100 100	1 22/ 450		20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	-1, 100, 483 0			30. 00 31. 00
43. 00   04300   NURSERY	0			43.00
ANCI LLARY SERVI CE COST CENTERS		<u> </u>		10.00
50. 00 05000 OPERATING ROOM	0	1, 398, 248		50.00
51.00   05100   RECOVERY ROOM	0			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1 -1		52.00
53. 00 05300 ANESTHESI OLOGY	-712, 916			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C	-1, 440 0			54. 00 54. 01
54. 01   05401   NUCLEAR MEDICINE-DI AGNOSTIC 54. 02   03480   ONCOLOGY				54.01
57. 00 05700 CT SCAN	0			57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	o		59.00
60. 00   06000   LABORATORY	0	2, 519, 940		60.00
60. 01   06001   BL00D   LABORATORY	0	0		60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0	1		64.00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	0			65. 00 66. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY				67.00
68. 00 06800 SPEECH PATHOLOGY				68.00
69. 00 06900 ELECTROCARDI OLOGY	0			69.00
69. 01   06901   CARDI AC   REHAB	-208			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	210, 187		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	-28, 417	1, 321, 528		73.00
73. 01 O3950 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	0	0		73. 01
88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	-255	1, 679, 914		88. 00
88. 01 08801 FAMILY MEDICINE OF CLOVERDALE	-75, 000			88. 01
88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE	-19, 992	1, 417, 654		88. 02
90. 00 09000 CLINIC	0	1 -1		90.00
90. 01   09001   RHEUMATOLOGY	-249, 985			90. 01
91. 00 09100 EMERGENCY	-2, 421, 270	2, 344, 064		91.00
92. 00   O9200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS				92.00
99. 10 09910 CORF	0	0		99. 10
SPECIAL PURPOSE COST CENTERS		<u> </u>		,,,,,
113. 00 11300   NTEREST EXPENSE	0			113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-6, 995, 301	40, 234, 261		118. 00
NONREI MBURSABLE COST CENTERS	T	1 -1		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4 252 227		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 JOHNSON/NI CHOLS WI C	0			192. 00 192. 01
192. 01 19201 JOHNSON/NI CHOLS WIC 192. 02 19203  RHEUMATOLOGY	0			192.01
193. 00 19300 NONPALD WORKERS	0			193.00
193. 01 19301 DME	0	l o		193. 01
193. 02 19302 LACTATION CONSULTING	0	o		193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	0		193. 03
194. 00 07950 VACANT SPACE	0			194.00
194. 01 07951 BOARD OF HEALTH	0	0		194. 01
194.02 07952 PUTNAM/HENRY PRENATAL 200.00  TOTAL (SUM OF LINES 118 through 199)	-6, 995, 301	44, 892, 041		194. 02 200. 00
200.00   TOTAL (50m of LINES 110 till ough 177)	0, 775, 301	1 77,072,041	I	<sub>1</sub> 200.00

Heal th Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATIONS Provider CCN: 15-1333 Period: From 01/01/2020 From 01/01/2020 Period: Telephone Proposed Provider CCN: 15-1333 Period: From 01/01/2020 Period: Telephone Proposed Provider CCN: 13-13/2020 Period: Telephone Proposed Provider CCN: 13-13/2020 Period: Telephone Proposed Provider CCN: 15-1333 Period: Telephone Proposed Provider CCN: 15-1333 Period: Telephone Provider CCN: 15-1333 Period: Teleph

					To 12/31/2020 Date/Time Prep	ared:
		Increases			7/15/2021 2: 27	pm
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - CLINIC RECLASS	3.00	4.00	5.00		
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	340, 637		1.00
1.00	FIXT	1.00	٥	340, 037		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	4, 398		2.00
3. 00	OPERATION OF PLANT	7. 00	0	32, 529	l l	3.00
4. 00	OF ERATION OF FEATURE	0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
0.00			— — <del>j</del>	377, 564		0.00
	C - CAFE RECLASS	I	<u> </u>	377, 304		
1. 00	CAFETERI A	11. 00	289, 062	404, 206		1.00
1.00	0		289, 062	404, 206		1.00
	D - INSURANCE RECLASS		207, 002	101, 200		
1. 00	NEW CAP REL COSTS-BLDG &	1.00	0	82, 194		1.00
	FIXT			02, . , .		00
	0			82, 194		
	E - PPO DEPRECIATION			<u> </u>		
1.00	NEW CAP REL COSTS-BLDG &	1, 00	0	15, 040		1.00
	FLXT			.,		
2.00		0.00	o	0		2.00
3.00		0.00	o	0		3.00
4.00		0.00	o	0		4.00
5.00		0.00	o	0		5.00
6.00		0.00	o	0		6.00
				15, 040		
	F - IMPLANTABLES	·				
1.00	IMPL. DEV. CHARGED TO	72. 00	0	210, 187		1.00
	PATI ENT					
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0_	0		4.00
	0		0	210, 187		
	G - MED SUPPLY COST RECLASS					
1.00	OPERATING ROOM	50. 00	24, 471	11, 480		1.00
	0		24, 471	11, 480		
500.00	Grand Total: Increases		313, 533	1, 100, 671	5	00.00

			'	o 12/31/2020 Date/Time Pr   7/15/2021 2:	
Decreases				77 137 2021 2.	Z / piii
Cost Center Line #	Sal ary	Other	Wkst. A-7 Ref.		
6.00 7.00	8. 00	9. 00	10.00		
A - CLINIC RECLASS					
1.00 ADMINISTRATIVE & GENERAL 5.0		6, 990			1.00
2.00 PUTNAM PEDIATRICS AND 88.0	00	93, 483	0		2. 00
INTERNAL MED					
3. 00 FAMILY MEDICINE OF 88. 0	0	92, 595	0		3. 00
CLOVERDALE		04 774			4.00
4.00 NORTH PUTNAM FAMILY 88.0	0	84, 771	0		4. 00
5. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 0		92, 779			5.00
6. 00 JOHNSON/NI CHOLS WIC 192. 0		92, 779 6, 946			6.00
0.00	· #	377, 564			0.00
C - CAFE RECLASS	<u> </u>	377, 304			
1. 00 DI ETARY 10. 0	289, 062	404, 206	0		1.00
0	289, 062	404, 206			1.00
D - INSURANCE RECLASS		, ====	l l		
1. 00 ADMI NI STRATI VE & GENERAL 5. 0	00	82, 194	13		1.00
	+ $ 0$	82, 194			1
E - PPO DEPRECIATION					
1.00 PUTNAM PEDIATRICS AND 88.0	00 0	2, 763	9		1.00
INTERNAL MED					
2. 00 FAMILY MEDICINE OF 88. 0	0	4, 056	0		2.00
CLOVERDALE			_		
3. 00 NORTH PUTNAM FAMILY 88. 0	0	1, 193	0		3. 00
HEALTHCARE 4. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 0		3, 382			4.00
5. 00 JOHNSON/NI CHOLS WI C 192. 0		3, 382 2, 472			5.00
6. 00 RHEUMATOLOGY 90. 0		2, 472 1, 174			6.00
0.00 KILOWATOLOGI	TH — — #	15, 040			0.00
F - IMPLANTABLES	<u> </u>	15, 040			
1. 00 ADULTS & PEDI ATRI CS 30. 0	00 0	6, 643	0		1.00
2. 00 INTENSIVE CARE UNIT 31. 0		38, 376			2.00
3. OO OPERATING ROOM 50. C		165, 158			3.00
4. 00 EMERGENCY 91. 0	ool ol	10	o		4.00
	+	210, 187			
G - MED SUPPLY COST RECLASS					1
1.00 MEDICAL SUPPLIES CHARGED TO 71.0	24, 471	11, 480	0		1.00
PATI ENTS	$\perp$ $  \downarrow$		L		
0	24, 471	11, 480			
500.00 Grand Total: Decreases	313, 533	1, 100, 671			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS PUTNAM COUNTY HOSPITAL Provider CCN: 15-1333

				10	12/31/2020	7/15/2021 2:2	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2.00	3.00	4. 00	5. 00	
	ALYSIS OF CHANGES IN CAPITAL ASSE						
1. 00 Land		182, 502	0	0	0	0	1.00
2.00 Land Improve		369, 154	35, 741	0	35, 741	0	2.00
3.00 Buildings a		33, 176, 888	1, 833, 672	0	1, 833, 672	01	3.00
4.00 Building Imp		0	0	0	0	01	4. 00
5.00 Fixed Equip		0	0	0	0	01	5.00
6.00 Movable Equi		24, 590, 930	317, 580	0	317, 580	01	6. 00
7.00 HIT desi gna		0	0	0	0	01	7. 00
	um of lines 1-7)	58, 319, 474	2, 186, 993	0	2, 186, 993	01	8. 00
9.00 Reconciling		0	0	0	0	0	,,,,,
10.00 Total (line	8 minus line 9)	58, 319, 474	2, 186, 993	0	2, 186, 993	0	10.00
		Endi ng	Fully				
		Bal ance	Depreciated				
		4.00	Assets				
DADT I ANA	ALVOLO OF CHANCES IN CARLEAL ACCE	6.00	7. 00				
	ALYSIS OF CHANGES IN CAPITAL ASSE		0				1 00
1. 00 Land		182, 502	0			ļ	1.00
2.00 Land Improve		404, 895	0			l	2.00
3. 00 Buildings at		35, 010, 560	0			l	3.00
4.00 Building Imp		0	0			l	4.00
5. 00 Fi xed Equi pr		24, 908, 510	0			ļ	5. 00 6. 00
6.00 Movable Equi		24, 908, 510	0			l	7.00
3		(0.50/.4/7	0			l	
8.00 Subtotal (so	um of lines 1-7)	60, 506, 467	0			ļ	8. 00 9. 00
		40 504 447	0			ļ	10.00
10.00   Total (Tine	8 minus line 9)	60, 506, 467	U	l		l	10.00

Heal th	n Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Peri od: From 01/01/2020		
					To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see instructions)	instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	1, 827, 305	0	401, 85		0	1.00
3.00	Total (sum of lines 1-2)	1, 827, 305		401, 85	52 0	0	3. 00
		SUMMARY 0	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	and 2			
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	2, 229, 157			ļ	1. 00
3.00	Total (sum of lines 1-2)	0	2, 229, 157			ļ	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		Peri od:	Worksheet A-7	
					From 01/01/2020 To 12/31/2020		narod:
					10 12/31/2020	7/15/2021 2: 2	7 pm
	·	COMF	PUTATION OF RAT	TI 0S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 -			
		1, 00	2.00	col. 2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	3.00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	60, 506, 467	0	60, 506, 46	7 1. 000000	0	1.00
3. 00	Total (sum of lines 1-2)	60, 506, 467	l .	60, 506, 46			3. 00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
		/ 00	ed Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	NEW CAP REL COSTS-BLDG & FIXT	ENTERS			2, 182, 982	0	1. 00
3. 00	Total (sum of lines 1-2)	0	0		2, 182, 982	l .	3. 00
3.00	Total (Sum of Tries 1 2)		SI.	JMMARY OF CAPI			3.00
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see	9 through 14)	
		11.00	10.00	10.00	instructions)	15.00	
	DART III DECONOLILATION OF CARLTAL COCTO	11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS C			02.10	4	2 514 524	1 00
1. 00 3. 00	NEW CAP REL COSTS-BLDG & FIXT Total (sum of lines 1-2)	251, 350 251, 350	l e	82, 19 82, 19		2, 516, 526 2, 516, 526	1. 00 3. 00
3.00	Total (Suil Of Filles 1-2)	251, 350	l O	[ 82, 19·	4  U	∠, ɔ10, ɔ20	3.00

From 01/01/2020 12/31/2020 Date/Time Prepared: 7/15/2021 2:27 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5.00 1.00 Investment income - NEW CAP ONEW CAP REL COSTS-BLDG & 1.00 1.00 REL COSTS-BLDG & FIXT (chapter FLXT Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2) 0 \*\*\* Cost Center Deleted \*\*\* 2.00 2.00 2.00 Investment income - other 3.00 0.00 3.00 (chapter 2) Trade, quantity, and time 4.00 0.00 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by suppliers (chapter 8) 6.00 0.00 6.00 7 00 7.00 Tel ephone services (pay 0.00 stations excluded) (chapter 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) 9 00 Parking Lot (chapter 21) 9 00 0.00 10.00 Provi der-based physici an A-8-2 -4, 452, 893 10.00 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 0 (chapter 23) Related organization 12.00 12.00 A - 8 - 10 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 14.00 Cafeteria-employees and guests В -44, 507 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15 00 0 00 and others 16.00 Sale of medical and surgical 0 0.00 16.00 supplies to other than pati ents Sale of drugs to other than 17.00 17.00 0.00 O pati ents 18.00 Sale of medical records and 0.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 0.00 22.00 22.00 overpayments and borrowings to repay Medicare overpayments ORESPIRATORY THERAPY 23.00 Adjustment for respiratory A-8-3 65.00 23.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 24.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review -0 \*\*\* Cost Center Deleted \*\*\* 114.00 25.00 physicians' compensation (chapter 21) 26.00 Depreciation - NEW CAP REL ONEW CAP REL COSTS-BLDG & 1.00 26.00 FIXT 0 \*\*\* Cost Center Deleted \*\*\* COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL 2.00 27.00 COSTS-MVBLE EQUIP 0 \*\*\* Cost Center Deleted \*\*\* 28.00 19 00 28 00 Non-physician Anesthetist 29.00 Physicians' assistant 29.00 0.00 Adjustment for occupational 30.00 A-8-3 O OCCUPATIONAL THERAPY 67.00 30.00 therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30.00 30.99 instructions)

-255 PUTNAM PEDIATRICS AND

-144, 873 ADMINISTRATIVE & GENERAL

-5, 705 EMPLOYEE BENEFITS DEPARTMENT

-237 EMPLOYEE BENEFITS DEPARTMENT

-985 ADMINISTRATIVE & GENERAL

-1, 082 ADMINISTRATIVE & GENERAL

INTERNAL MED

HEALTHCARE

-8,678 OPERATION OF PLANT

-12,000 ADULTS & PEDIATRICS

-12,000 NORTH PUTNAM FAMILY

-1, 955, 266 ADMI NI STRATI VE & GENERAL

-110, 093 NEW CAP REL COSTS-BLDG &

-75,000 FAMILY MEDICINE OF

CLOVERDALE

HEALTHCARE -19, 761 EMERGENCY

FLXT

-6, 995, 301

-7, 992 NORTH PUTNAM FAMILY

88.00

88. 02

5.00

4.00

5.00

4 00

5.00

7.00

30.00

88.01

88. 02

91.00

5.00

1.00

33.10

33.11

33.13

33.14

33 15

33.16

33.17

33.21

0 33.22

33.25

50.00

0 33.12

0 33.19

0 33.20

0 33.24

11

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В

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A, column 6, line 200.)

33.10

33. 11

33.12

33. 13

33.14

33 15

33. 16

33. 17

33.19

33.20

33. 21

33. 22

33. 24

33. 25

50.00

ADVERTISING OFFSET

ADVERTISING OFFSET

TELEPHONE WAGES

TELEPHONE OTHER

HAF EXPENSE

INTEREST INCOME

TELEVISION OFFSET

PHYSICIAN RECRUITMENT

PHYSICIAN RECRUITMENT

PHYSICIAN RECRUITMENT

PHYSICIAN RECRUITMENT

TELEPHONE BENEFITS

COMMUNITY RELATIONS OFFSET

COMMUNITY RELATIONS OFFSET

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.

<sup>(2)</sup> Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

<sup>(3)</sup> 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

					'	12/31/2020	7/15/2021 2: 2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				·	•		Hours	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00	91. 00	EMERGENCY	2, 948, 333	2, 401, 509	546, 824	0	0	1.00
2.00	73. 01	ONCOLOGY	122, 125	0	122, 125	0	0	2. 00
3.00	60.00	LABORATORY	36, 000	0	36, 000	0	0	3. 00
4.00	30.00	ADULTS & PEDIATRICS	1, 088, 483	1, 088, 483	0	0	o	4.00
5.00	53.00	ANESTHESI OLOGY	819, 435	712, 916	106, 519	0	o	5. 00
6.00	90. 01	RHEUMATOLOGY	249, 985	249, 985	0	0	o	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	O	o	8. 00
9. 00	0.00		0	0	0	O	o	9. 00
10.00	0.00		0	0	0	O	0	10.00
200.00			5, 264, 361	4, 452, 893	811, 468		0	1
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er		Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2. 00	8. 00	9. 00	12.00	13. 00	14.00	
1. 00	91. 00	EMERGENCY	0	0	0	0	0	1.00
2.00	73. 01	ONCOLOGY	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	4. 00
5.00	53. 00	ANESTHESI OLOGY	0	0	0	0	0	5. 00
6.00	90. 01	RHEUMATOLOGY	0	0	0	0	o	6. 00
7.00	0.00		0	0	0	0	o	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	o	9. 00
10.00	0.00		0	0	0	0	o	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00		
1. 00		EMERGENCY	0	0	0	2, 401, 509		1.00
2. 00		ONCOLOGY	0	0	0	0	)	2. 00
3.00		LABORATORY	0	0	0	0	)	3.00
4.00		ADULTS & PEDIATRICS	0	0	0	1, 088, 483		4. 00
5.00		ANESTHESI OLOGY	0	0	0	712, 916		5. 00
6.00	90. 01	RHEUMATOLOGY	0	0	0	249, 985		6. 00
7.00	0.00		0	0	0	0		7. 00
8.00	0.00		0	0	0	0		8. 00
9. 00	0.00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0	)	10.00
200.00			0	0	0	4, 452, 893		200.00

JE 4 0 0	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	Peri od: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
					Physi cal Therapy	7/15/2021 2: 2 <sup>s</sup> Cost	7 pm
						1. 00	
	PART I - GENERAL INFORMATION					1.00	
. 00	Total number of weeks worked (excluding aide: Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			52 780	1.00 2.00
. 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	· /	307 187	3. 00 4. 00
. 00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - there assistant and on which supervisor and/or the instructions)	apy assistants	(include only	visits made		0	5. 00 6. 00
. 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
00	Total hours worked	1. 00	2. 00	3. 00	4. 00	5. 00	0.00
	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	0. 00 0. 00 42. 70	4, 897. 00 85. 39 42. 70	1, 547. ( 64. ( 32. (	0.00	0. 00 0. 00	9.00 10.00 11.00
2. 00	one-half of column 3, line 10) Number of travel hours (provider site)	0	О		О		12.00
2. 01	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0	ļ	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	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a	line 10) line10)	ratory therapy	or lines 14	I-16 for all	0 418, 155 99, 070 517, 225	16.00
	sistants (column 3, line 9 times column 3, line10)  btotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all 517, 225 hers)  des (column 4, line 9 times column 4, line 10)  alinees (column 5, line 9 times column 5, line 10)  tal allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)  the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech pathology or					18.00 19.00 20.00	
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than amount from line 20. Otherwise complete line	y therapy or co n line 2, make	lumns 1-3 for	physical the	rapy, speech pat		
1. 00	Weighted average rate excluding aides and traffer respiratory therapy or columns 1 thru 3,	ainees (line 17	,	m of columns	1 and 2, line 9	0.00	21.00
	Weighted allowance excluding aides and train Total salary equivalency (see instructions)					0 517, 225	
55	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	WANCE AND TRAVE	L EXPENSE COMP	UTATION - PR	OVIDER SITE	517,225	
4. 00	Therapists (line 3 times column 2, line 11)					13, 109	24.00
	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	ll others)		5, 988 19, 097	
	Standard travel expense (line 7 times line 3				3 and 4 for all	0	27.00
3. 00	others) Total standard travel allowance and standard 27)	travel expense	at the provid	ler site (sum	n of lines 26 and	19, 097	28. 00
9. 00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum		d 2 line 12 \			0	29.00
0. 00	Assistants (column 3, line 10 times column 3	, line 12)	,			0	30.00
	Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times column:				ov or sum of	0	31.00 32.00
	columns 1-3, line 13 for all others)		•	_ co. y chorap	., S. Sam 01		
3. 00 1. 00	Standard travel allowance and standard trave Optional travel allowance and standard trave			id 31)		19, 097 0	33.00 34.00
	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	l expense (sum	of lines 31 an	ıd 32)	PVICES OUTSIDE DD	0	
	Standard Travel Expense	THE PROPERTY OF THE PROPERTY O	LAI LASE COMPO	TATION - SEP			
6. 00 7. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)					0	36. 00 37. 00
3. 00	Subtotal (sum of lines 36 and 37)					0	38.00
). 00	Standard travel expense (line 7 times the sw Optional Travel Allowance and Optional Travel		d 6)			0	39.00
0. 00	Therapists (sum of columns 1 and 2, line 12.	01 times column	2, line 10)			0	
1 00	Assistants (column 3, line 12.01 times colum	n 3, line 10)				0	
2. 00	Subtotal (sum of lines 40 and 41)				I	Ol	42.0

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

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)

ealth Financial Systems	PUTNAM COUNTY		ON 15 1000		u of Form CMS-2	
EASONABLE COST DETERMINATION FOR THERAPY SERVICES UTSIDE SUPPLIERS	FURNI SHED BY	Provi der CO	JN: 15-1333	Peri od: From 01/01/2020 To 12/31/2020	Worksheet A-8 Parts I-VI Date/Time Pre 7/15/2021 2:2	pared:
				Physical Therapy		
					1. 00	
6.00 Optional travel allowance and optional trave	expense (sum o	of Lines 42 ar	nd 43 - see i	nstructions)		46.00
	Therapists	Assi stants	Ai des	Trainees	Total	
	1. 00	2. 00	3. 00	4.00	5. 00	
PART V - OVERTIME COMPUTATION						
7.00 Overtime hours worked during reporting	0. 00	0. 00	0. (	0. 00	0. 00	47.00
period (if column 5, line 47, is zero or						
equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each						
column of line 56)						
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				49.00
allowance) (multiply line 47 times line 48)						
CALCULATION OF LIMIT						
0.00 Percentage of overtime hours by category	0. 00	0. 00	0. (	0.00	0. 00	50.00
(divide the hours in each column on line 47						
by the total overtime worked - column 5, line 47)						
1.00 Allocation of provider's standard work year	0.00	0. 00	0. (	0.00	0.00	51.00
for one full-time employee times the						
percentages on line 50) (see instructions)						]
DETERMINATION OF OVERTIME ALLOWANCE						
2.00 Adjusted hourly salary equivalency amount	85. 39	64. 04	0. 0	0.00		52.00
(see instructions) 3.00 Overtime cost limitation (line 51 times line	0	0		0 0		53.00
52)	۷	U				33.00
4.00 Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
line 49 or line 53)						
5.00 Portion of overtime already included in	0	0		0 0		55.00
hourly computation at the AHSEA (multiply						
line 47 times line 52)	0	0			0	F, 0
6.00 Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	٩	U		0 0	U	56.00
the sum of columns 1, 3, and 4 for						
respiratory therapy and columns 1 through 3						
for all others.)						
					1 00	
Part VI - COMPUTATION OF THERAPY LIMITATION A	IND EVCESS COST	AD ILICTMENT			1. 00	
7.00 Salary equivalency amount (from line 23)	IND EXCESS COST	ADSOSTMENT			517, 225	57.00
8.00 Travel allowance and expense - provider site	(from lines 33,	34, or 35))			19, 097	58.00
9.00 Travel allowance and expense - Offsite servi	ces (from lines	44, 45, or 46	5)		0	59.0
0.00 Overtime allowance (from column 5, line 56)					0	60.0
1.00 Equipment cost (see instructions)					0	61.0
2.00 Supplies (see instructions)					0	
3.00 Total allowance (sum of lines 57-62)	, ,,,,,,,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,				536, 322	
4.00  Total cost of outside supplier services (from 5.00  Excess over limitation (line 64 minus line 6.		enter zero)			419, 883	65.0
LINE 33 CALCULATION	s - II negative,	enter zero)			0	05.0
00.00 Line 26 = line 24 for respiratory therapy or	sum of lines 24	4 and 25 for a	all others		19, 097	100.0
00.01 Line 27 = line 7 times line 3 for respirator				others	0	100. 0°
00.02 <u>Line 33 = line 28 = sum of lines 26 and 27</u>					19, 097	100. 02
LINE 34 CALCULATION						
01.00 Line 27 = line 7 times line 3 for respirator				others		101.00
01.01 Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	all others			101.0
01.02 Line 34 = sum of lines 27 and 31					0	101. 0
LINE 35 CALCULATION	sum of lines 20	and 30 for a	all others		0	102. 0
			arr conters			1102.0
02.00 Line 31 = line 29 for respiratory therapy or				umns 1-3 line		102 n
D2.00 Line 31 = line 29 for respiratory therapy or 02.01 Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line		102. 0

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provi der CCN: 15-1333	Peri od: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:	
				Occupati onal Therapy	7/15/2021 2:2 Cost	27 pm	
					1. 00		
	PART I - GENERAL INFORMATION						
. 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	sor or therapist assistant was c	was on provider site	` /	52 780 257 0	2. 0 3. 0	
5. 00 5. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	rvisors or thera apy assistants (	include only visits mad	de by therapy	0	5. ( 6. (	
7. 00 8. 00	Standard travel expense rate				0. 00 0. 00		
5. 00	Optional travel expense rate per mile	Supervi sors	Therapists Assistan	ts Ai des	Trai nees	0.0	
	Total Language and a language	1.00	2.00 3.00	4.00	5. 00		
0. 00 0. 00 1. 00	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0. 00 0. 00 40. 48	80. 95	0. 00 0. 00 0. 00 0. 00	0. 00 0. 00		
2. 00 2. 01 3. 00	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. 0 12. 0 13. 0	
3. 01	Number of miles driven (offsite)	0	0	0		13. 0	
					1. 00		
	Part II - SALARY EQUIVALENCY COMPUTATION						
4. 00 5. 00	Supervisors (column 1, line 9 times column 1 Therapists (column 2, line 9 times column 2,				0 126, 525		
6. 00	Assistants (column 3, line 9 times column 3,				0	1	
7. 00	Subtotal allowance amount (sum of lines 14 a	nd 15 for respir	ratory therapy or lines	14-16 for all	126, 525	17.0	
8. 00	others) Aides (column 4, line 9 times column 4, line	10)			0	18.0	
9. 00	Trainees (column 5, line 9 times column 5, line 10)						
20.00	Trainees (column 5, line 9 times column 5, line 10)  Total allowance amount (sum of lines 17-19 for respiratory therapy or lines 17 and 18 for all others)  126,525  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						
1.00	amount from line 20. Otherwise complete lin Weighted average rate excluding aides and tr		divided by sum of colu	mns 1 and 2. line 9	0.00	21. (	
2 00	for respiratory therapy or columns 1 thru 3,					22.6	
2. 00 2. 00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (Tine 2 time	es ime 21)		0 126, 525		
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVEL	EXPENSE COMPUTATION -	PROVI DER SITE	·		
4 00	Standard Travel Allowance Therapists (line 3 times column 2, line 11)				10, 403	24. (	
25. 00	Assistants (line 4 times column 3, line 11)				0	1	
26. 00 27. 00	Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3				10, 403 0		
28. 00	others) Total standard travel allowance and standard						
.5. 50	27)	·	at the provider site (	Jam Of FITTES 20 dile	10, 403		
9. 00	Optional Travel Allowance and Optional Trave Therapists (column 2, line 10 times the sum		1 2 line 12 )		0	29.0	
0.00	Assistants (column 3, line 10 times column 3		1 2, 11110 12 )		0	1	
1.00	Subtotal (line 29 for respiratory therapy or				0		
32. 00	Optional travel expense (line 8 times column columns 1-3, line 13 for all others)	s 1 and 2, line	13 for respiratory the	rapy or sum of	0	32.0	
3. 00	Standard travel allowance and standard trave				10, 403	33.0	
34.00	Optional travel allowance and standard trave				0	1	
5. 00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW			SERVICES OUTSIDE PR	OVIDER SITE	] 35. C	
	Standard Travel Expense					]	
6. 00 7. 00	Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)				0	1	
88.00	Subtotal (sum of lines 36 and 37)				0	1	
9. 00	Standard travel expense (line 7 times the su		1 6)		0	39.0	
0 00	Optional Travel Allowance and Optional Trave		2 line 10)		0	40.0	
1.00	Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum		z, 11110 10)		0		
2.00	Subtotal (sum of lines 40 and 41)	2,			Ö	1	
3.00	Optional travel expense (line 8 times the su				0	43.0	
0.00						II.	
0.00	Total Travel Allowance and Travel Expense - 46, as appropriate.	urrsite services	; complete one of the	rollowing three lin	es 44, 45, or		

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	PUTNAM COUNTY FURNI SHED BY	Provi der C		Peri od: From 01/01/2020 To 12/31/2020	Worksheet A-8 Parts I-VI	pared:
					Occupational Therapy	Cost	
						1. 00	
	Optional travel allowance and standard travel					0	
46. 00	Optional travel allowance and optional travel	expense (sum Therapists	of lines 42 au Assistants	nd 43 - see i Ai des	nstructions) Trainees	0 Total	46.00
		1. 00	2. 00	3.00	4. 00	5. 00	
	PART V - OVERTIME COMPUTATION  Overtime hours worked during reporting period (if column 5, line 47, is zero or	0.00	0.00	O. C	0.00	0.00	47.00
	equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						
	Overtime rate (see instructions) Total overtime (including base and overtime	0. 00 0. 00	0. 00 0. 00				48. 00 49. 00
	allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT						
50. 00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0. C	0.00	0.00	50.00
	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0. 00	O. C	0.00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE  Adjusted hourly salary equivalency amount	80. 95	0.00	0.0	0.00		52.00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0. 95	0.00		0 0		53.00
54. 00	52) Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54.00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	O	0		0 0		55.00
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0 0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				
	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 22	) 24 or 2E))			126, 525 10, 403	
59.00	Travel allowance and expense - Offsite service			6)		10, 403	1
	Overtime allowance (from column 5, line 56)					0	
	Equipment cost (see instructions) Supplies (see instructions)					0	
	Total allowance (sum of lines 57-62)					136, 928	
	Total cost of outside supplier services (from					108, 286	1
	Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	3 - if negative	e, enter zero)			0	65.00
	Line 26 = line 24 for respiratory therapy or	sum of lines 2	24 and 25 for a	all others		10, 403	100.00
	Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	/ therapy or su	um of lines 3 a	and 4 for all	others	0 10, 403	100. 01 100. 02
101. 01	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						1
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line						102. 00 102. 01

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES	PUTNAM COUNTY	HOSPI TAL Provi der CO	N. 15 1222	In Lie	u of Form CMS-2 Worksheet A-8	
	E SUPPLIERS	FORMI SHED BY	Provider Co	JN: 15-1333	From 01/01/2020 To 12/31/2020	Parts I-VI	pared:
					Speech Pathology		7 piii
						1 00	
	PART I - GENERAL INFORMATION					1. 00	
. 00 . 00 . 00	Total number of weeks worked (excluding aider Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervisions. Number of unduplicated days in which therapy	sor or therapis	t was on provi			52 780 141 0	1.00 2.00 3.00 4.00
00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe	ructions) rvisors or thera	apists (see in	nstructions)		0	5. 00
. 00	Number of unduplicated offsite visits - there assistant and on which supervisor and/or the instructions)					0	6.00
. 00 . 00	Standard travel expense rate Optional travel expense rate per mile					0. 00 0. 00	7. 00 8. 00
. 55	operation expense rate per illine	Supervi sors	Therapi sts	Assi stants		Trai nees	0.00
	Total Language Lad	1. 00	2. 00	3. 00	4.00	5. 00	0.00
. 00 0. 00	Total hours worked AHSEA (see instructions)	0. 00 0. 00	716. 00 77. 80				9. 00 10. 00
	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	38. 90	38. 90				11.00
	Number of travel hours (provider site)	0	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)	ō	0		0		13. 01
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
	Supervisors (column 1, line 9 times column 1					0	
5. 00 6. 00	Therapists (column 2, line 9 times column 2, Assistants (column 3, line 9 times column 3,					55, 705 0	15. 00 16. 00
7. 00	Subtotal allowance amount (sum of lines 14 au others)	nd 15 for respi	ratory therapy	y or lines 14	1-16 for all	55, 705	
	Aides (column 4, line 9 times column 4, line Trainees (column 5, line 9 times column 5, l					0	18.00 19.00
0.00	Total allowance amount (sum of lines 17-19 for	or respiratory	therapy or lir	nes 17 and 18	3 for all others)	55, 705	
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater than amount from line 20. Otherwise complete line	n line 2, make m		1 2	13. 1	55	
1. 00	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,			um of columns	s 1 and 2, line 9	77. 80	21.00
2. 00	Weighted allowance excluding aides and train					60, 684	22.00
3. 00	Total salary equivalency (see instructions)	MANOE AND TRAVE	EVDENCE COM	DUTATION D	ON II DED. CLITE	60, 684	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	WANCE AND TRAVE	_ EXPENSE COME	PUTATION - PE	ROVIDER SITE		
	Therapists (line 3 times column 2, line 11)					5, 485	
	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 2	1 and 25 for a	all others)		0 5, 485	25. 00 26. 00
	Standard travel expense (line 7 times line 3				3 and 4 for all	0	27.00
3. 00	others) Total standard travel allowance and standard 27)	travel expense	at the provid	der site (sur	n of lines 26 and	5, 485	28. 00
	Optional Travel Allowance and Optional Travel	Expense					
	Therapists (column 2, line 10 times the sum		d 2, line 12)	)		0	29.00
	Assistants (column 3, line 10 times column 3 Subtotal (line 29 for respiratory therapy or	•	9 and 30 for a	all others)		0	30. 00 31. 00
	Optional travel expense (line 8 times column:				y or sum of	0	32.00
	columns 1-3, line 13 for all others)	l ovnonce (line	20)			E 40E	22.00
	Standard travel allowance and standard trave Optional travel allowance and standard trave			nd 31)		5, 485 0	33. 00 34. 00
	Optional travel allowance and optional trave	l expense (sum	of lines 31 ar	nd 32)		0	35. 00
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	ANCE AND TRAVEL	EXPENSE COMPL	JTATION - SEF	RVICES OUTSIDE PR	ROVI DER SITE	
5. 00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					n	36.00
	1 1 2 2 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3 3						37.00

Subtotal (line 24 for respiratory therapy or sum of lines 24 and 25 for all others)	5, 485	26. 00
Standard travel expense (line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all	0	27.00
others)		
Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and	5, 485	28. 00
27)		
Optional Travel Allowance and Optional Travel Expense		
	0	29. 00
Assistants (column 3, line 10 times column 3, line 12)	0	30.00
Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)	0	31.00
Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of	0	32.00
columns 1-3, line 13 for all others)		
Standard travel allowance and standard travel expense (line 28)	5, 485	33.00
Optional travel allowance and standard travel expense (sum of lines 27 and 31)	0	34.00
Optional travel allowance and optional travel expense (sum of lines 31 and 32)	0	35.00
Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PRO	OVIDER SITE	
Standard Travel Expense		
Therapists (line 5 times column 2, line 11)	0	36.00
Assistants (line 6 times column 3, line 11)	0	37.00
Subtotal (sum of lines 36 and 37)	0	38.00
Standard travel expense (line 7 times the sum of lines 5 and 6)	0	39.00
Optional Travel Allowance and Optional Travel Expense		
Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)	0	40.00
Assistants (column 3, line 12.01 times column 3, line 10)	0	41.00
Subtotal (sum of lines 40 and 41)	0	42.00
Optional travel expense (line 8 times the sum of columns 1-3, line 13.01)	0	43.00
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line	es 44, 45, or I	
Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three line 46, as appropriate.	es 44, 45, or	
		44. 00
	Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 27)  Optional Travel Allowance and Optional Travel Expense  Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12)  Assistants (column 3, line 10 times column 3, line 12)  Subtotal (line 29 for respiratory therapy or sum of lines 29 and 30 for all others)  Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others)  Standard travel allowance and standard travel expense (line 28)  Optional travel allowance and standard travel expense (sum of lines 27 and 31)  Optional travel allowance and optional travel expense (sum of lines 31 and 32)  Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PRESTANDARD (line 5 times column 2, line 11)  Assistants (line 5 times column 3, line 11)  Subtotal (sum of lines 36 and 37)  Standard travel expense (line 7 times the sum of lines 5 and 6)  Optional Travel Allowance and Optional Travel Expense  Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)  Assistants (column 3, line 12.01 times column 3, line 10)  Subtotal (sum of lines 40 and 41)	others) Total standard travel allowance and standard travel expense at the provider site (sum of lines 26 and 5, 485 27) Optional Travel Allowance and Optional Travel Expense Therapists (column 2, line 10 times the sum of columns 1 and 2, line 12) Assistants (column 3, line 10 times column 3, line 12) Optional travel expense (line 29 for respiratory therapy or sum of lines 29 and 30 for all others) Optional travel expense (line 8 times columns 1 and 2, line 13 for respiratory therapy or sum of columns 1-3, line 13 for all others) Standard travel allowance and standard travel expense (line 28) Optional travel allowance and standard travel expense (sum of lines 27 and 31) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel allowance and optional travel expense (sum of lines 31 and 32) Optional travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 5 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum of lines 5 and 6) Optional Travel Allowance and Optional Travel Expense Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10) Assistants (column 3, line 12.01 times column 3, line 10) Subtotal (sum of lines 40 and 41)

Health Fir	nancial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	E COST DETERMINATION FOR THERAPY SERVICES		Provi der CO	CN: 15-1333	Peri od: From 01/01/2020 To 12/31/2020		pared:
					Speech Pathology	Cost	
						1. 00	
46. 00   0p <sup>-1</sup>	tional travel allowance and optional trave						46. 00
		Therapi sts 1.00	Assi stants 2.00	Ai des 3. 00	Trai nees 4.00	Total 5. 00	
	RT V - OVERTIME COMPUTATION						
per equ cor	ertime hours worked during reporting riod (if column 5, line 47, is zero or ual to or greater than 2,080, do not mplete lines 48-55 and enter zero in each lumn of line 56)	0.00	0.00	0. (	0.00	0.00	47.00
48. 00 Ove	ertime rate (see instructions)	0.00	0. 00	0. (	0.00		48. 00
al I	tal overtime (including base and overtime lowance) (multiply line 47 times line 48)  LCULATION OF LIMIT	0.00	0. 00	0. (	0.00		49. 00
50. 00 Per (di by	rcentage of overtime hours by category ivide the hours in each column on line 47 the total overtime worked - column 5, ne 47)	0.00	0.00	0. (	0. 00	0.00	50.00
51.00 All for per	location of provider's standard work year r one full-time employee times the rcentages on line 50) (see instructions)	0.00	0. 00	0. (	0.00	0.00	51.00
	TERMINATION OF OVERTIME ALLOWANCE	77. 80	0.00	0.0	0.00		52.00
(50	justed hourly salary equivalency amount ee instructions) ertime cost limitation (line 51 times line		0.00	0.1	0 0		53.00
	) ximum overtime cost (enter the lesser of ne 49 or line 53)	0	0		0 0		54.00
55. 00 Por	rtion of overtime already included in urly computation at the AHSEA (multiply	0	0		0 0		55.00
56.00 Ove if the	ne 47 times line 52) ertime allowance (line 54 minus line 55 - negative enter zero) (Enter in column 5 e sum of columns 1, 3, and 4 for spiratory therapy and columns 1 through 3 r all others.)	0	0		0 0	0	56.00
						1. 00	
	rt VI - COMPUTATION OF THERAPY LIMITATION	AND EXCESS COST	ADJUSTMENT			60, 684	
58. 00 Tra 59. 00 Tra 60. 00 Ove 61. 00 Equ 62. 00 Sup 63. 00 To 64. 00 To 65. 00 Exc	57.00 Salary equivalency amount (from line 23) 58.00 Travel allowance and expense - provider site (from lines 33, 34, or 35)) 59.00 Travel allowance and expense - Offsite services (from lines 44, 45, or 46) 60.00 Overtime allowance (from column 5, line 56) 61.00 Equipment cost (see instructions) 62.00 Supplies (see instructions) 63.00 Total allowance (sum of lines 57-62) 64.00 Total cost of outside supplier services (from your records) 65.00 Excess over limitation (line 64 minus line 63 - if negative, enter zero)						57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 65. 00
100.00 Li r	NE 33 CALCULATION ne 26 = line 24 for respiratory therapy or ne 27 = line 7 times line 3 for respirator				others	0	100. 00 100. 01
LIN	ne 33 = line 28 = sum of lines 26 and 27 NE 34 CALCULATION						100. 02
101. 01 Li r 101. 02 Li r	ne 27 = line 7 times line 3 for respirator ne 31 = line 29 for respiratory therapy or ne 34 = sum of lines 27 and 31 NE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
102.00 Lir 102.01 Lir	ne 31 = line 29 for respiratory therapy or ne 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01
1	for all others ne 35 = sum of lines 31 and 32					0	102. 02

| Period: | Worksheet B | From 01/01/2020 | Part | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1333

				o 12/31/2020	Date/Time Pre	
		CAPI TAL			7/15/2021 2:2	/ pm
		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	
GENERAL SERVICE COST CENTERS						
1.00   00100   NEW CAP REL COSTS-BLDG & FIXT	2, 516, 526					1.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL	5, 617, 183				7, 135, 078	4. 00 5. 00
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	6, 105, 377 1, 364, 060	330, 171 240, 163	699, 530 82, 299		318, 709	7.00
8. 00   00800   LAUNDRY & LINEN SERVICE	213, 363	l '			44, 677	8.00
9. 00   00900   HOUSEKEEPI NG	531, 570	l '	•			9.00
10. 00   01000   DI ETARY	282, 870			392, 234	74, 122	10.00
11. 00   01100   CAFETERI A	648, 761	37, 237			142, 687	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	150, 349					
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	388, 577	91, 747	62, 322		102, 546 0	16. 00 17. 00
17. 00   01700   SOCIAL SERVICE 17. 01   01701   UTI LI ZATI ON REVI EW	108, 116	7, 731	24, 113	-	26, 449	17.00
INPATIENT ROUTINE SERVICE COST CENTERS	100, 110	,,,,,,	21,110	, 107, 700	20, 117	17.01
30. 00 03000 ADULTS & PEDIATRICS	1, 336, 450	137, 899	516, 162	1, 990, 511	376, 155	30.00
31.00 03100 INTENSIVE CARE UNIT	916, 535				218, 261	
43. 00 O4300 NURSERY	0	0	C	)  0	0	43.00
ANCILLARY SERVICE COST CENTERS  50.00 OPERATING ROOM	1, 398, 248	189, 925	181, 660	1, 769, 833	334, 452	50.00
51. 00   05100   RECOVERY ROOM	71, 112	53, 279			25, 635	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53. 00   05300   ANESTHESI OLOGY	149, 868	l e	195, 785		65, 319	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 433, 942	70, 366			333, 895	1
54. 01   05401   NUCLEAR MEDICINE-DI AGNOSTI C	137, 322	l '			26, 564	
54. 02   03480   ONCOLOGY 57. 00   05700   CT   SCAN	3, 725, 596 419, 208	l '			739, 811 93, 087	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	117, 200	0 0	12,772		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	d	0	0	59.00
60. 00   06000   LABORATORY	2, 519, 940	58, 271	189, 154	2, 767, 365	522, 960	
60. 01   06001   BLOOD   LABORATORY	0	0	C	0	0	
64. 00 06400 I NTRAVENOUS THERAPY	F74 047	14 251	101 000	0	120.070	64.00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	574, 967 492, 028	16, 251 39, 559	101, 890		130, 979 100, 456	1
67. 00 06700 OCCUPATI ONAL THERAPY	108, 569	37, 337		108, 569	20, 517	67.00
68. 00 06800 SPEECH PATHOLOGY	45, 480	Ö				1
69. 00 06900 ELECTROCARDI OLOGY	149, 915	2, 322	14, 511			69.00
69. 01   06901   CARDI AC REHAB	256, 469	37, 516	59, 690	353, 675		1
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		-	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENT 73.00   07300   DRUGS CHARGED TO PATIENTS	210, 187	0	77.003	210, 107	39, 720 268, 387	72. 00 73. 00
73. 00 07300 DR0G3 CHARGED TO PATTENTS  73. 01 03950 ONCOLOGY	1, 321, 528	l	77, 903	1, 420, 232	200, 307	73.00
OUTPATIENT SERVICE COST CENTERS				,		70.01
88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	1, 679, 914	112, 270	342, 558	2, 134, 742	403, 411	88. 00
88. 01 08801 FAMILY MEDICINE OF CLOVERDALE	1, 392, 926					
88. 02   08802   NORTH PUTNAM FAMILY HEALTHCARE	1, 417, 654				348, 624	1
90. 00   09000   CLI NI C 90. 01   09001   RHEUMATOLOGY	205, 587	3, 761 10, 934		-,	711 59, 109	
91. 00 09100 EMERGENCY	2, 344, 064				611, 127	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,011,001	101,707	, 55, 55,	0	011,127	92.00
OTHER REIMBURSABLE COST CENTERS			1			
99. 10   09910   CORF	0	0	(	0	0	99. 10
SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE			1			113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	40, 234, 261	2, 239, 938	4, 758, 130	39, 095, 068	6, 039, 606	
NONREI MBURSABLE COST CENTERS	1 197 = 9 17 = 9 1		., ., ., ., .,		3/ 33./ 333	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	,	•	,	2, 093	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	4, 352, 337	249, 426		-,, -		
192. 01 19201 JOHNSON/NI CHOLS WI C	305, 443	0	63, 552	368, 995		192. 01 192. 02
192. 02 19203 RHEUMATOLOGY 193. 00 19300 NONPAI D WORKERS	0	0				192.02
193. 01 19301 DME	0			0		193.00
193. 02 19302 LACTATI ON CONSULTI NG	0	0		o o		193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	0	C	0		193. 03
194. 00 07950 VACANT SPACE	0	0	C	-		194. 00
194. 01 07951 BOARD OF HEALTH	0	16, 088		16, 088		194. 01
194.02 07952 PUTNAM/HENRY PRENATAL 200.00  Cross Foot Adjustments	0	0	۱	ر	0	194. 02 200. 00
201.00 Regative Cost Centers		_			n	200.00
202.00 TOTAL (sum lines 118 through 201)	44, 892, 041	2, 516, 526	5, 620, 735	44, 892, 041	7, 135, 078	
		•				·

Provider CCN: 15-1333 Peri od: Worksheet B From 01/01/2020 Part I To 12/31/2020 Date/Ti me Prepared: 7/15/2021 2:27 pm

					12/31/2020	7/15/2021 2: 2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
-		7. 00	8. 00	9. 00	10. 00	11. 00	
	ENERAL SERVICE COST CENTERS	1		1			
1	0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
1	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
1	0500 ADMINISTRATIVE & GENERAL	2 005 221					5.00
1	0700 OPERATION OF PLANT	2, 005, 231	207 207				7. 00 8. 00
	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	16, 199 15, 145	297, 297 1, 668	1			9.00
	1000 DI ETARY	83, 800	1, 232		591, 876		10.00
1	1100 CAFETERI A	38, 437	1, 232	1	371, 070	954, 758	11.00
	1300 NURSI NG ADMI NI STRATI ON	15, 936	0	7, 699	0	4, 000	13.00
	1600 MEDI CAL RECORDS & LI BRARY	94, 703	0	45, 756	0	46, 850	16. 00
	1700 SOCIAL SERVICE	0	0	0	o	0	17. 00
	1701 UTILIZATION REVIEW	7, 980	0	3, 855	O	8, 917	17. 01
	NPATIENT ROUTINE SERVICE COST CENTERS	· · ·					
30.00 0	3000 ADULTS & PEDIATRICS	142, 342	64, 674	68, 773	504, 780	113, 365	30. 00
31. 00 0	3100 INTENSIVE CARE UNIT	68, 080	49, 941	32, 893	87, 096	64, 290	31.00
43.00 0	4300 NURSERY	0	0	0	0	0	43.00
	NCILLARY SERVICE COST CENTERS	,					
	5000 OPERATING ROOM	196, 044	42, 203		0	60, 187	50.00
	5100 RECOVERY ROOM	54, 996	4, 572		0	2, 787	51.00
	5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
	5300 ANESTHESI OLOGY	0	0	0	0	19, 857	53.00
	5400 RADI OLOGY-DI AGNOSTI C	72, 633	22, 240		0	119, 573	54.00
	5401 NUCLEAR MEDICINE-DIAGNOSTIC	3, 355	0 9. 557	.,	U	0	54.01
1	3480 ONCOLOGY	116, 390	9, 557		0	36, 180	54.02
1	5700 CT SCAN 5800 MAGNETIC RESONANCE IMAGING (MRI)	31, 632 0	0	15, 283 0	0	21, 599	57. 00 58. 00
1	5900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
1	6000 LABORATORY	60, 148	0	29, 061	0	118, 158	60.00
1	6001 BLOOD LABORATORY	00, 140	0	27,001	0	0	60. 01
	6400 I NTRAVENOUS THERAPY	0	0	0	0	Ö	64.00
	6500 RESPI RATORY THERAPY	16, 774	0	8, 105	0	40, 870	65. 00
1	6600 PHYSI CAL THERAPY	40, 834	8, 210		Ö	0	66.00
1	6700 OCCUPATI ONAL THERAPY	0	0	O	0	0	67.00
68.00 0	6800 SPEECH PATHOLOGY	0	0	О	0	0	68. 00
69.00 0	6900 ELECTROCARDI OLOGY	2, 396	0	1, 158	0	7, 164	69. 00
69. 01 0	6901 CARDI AC REHAB	38, 725	0	18, 710	0	20, 458	69. 01
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	21, 471	0	10, 374	0	30, 701	73.00
	3950 ONCOLOGY	0	0	0	0	0	73. 01
	UTPATIENT SERVICE COST CENTERS	445 007	, ,,,,	FF 004	ما		00.00
	8800 PUTNAM PEDIATRICS AND INTERNAL MED 8801 FAMILY MEDICINE OF CLOVERDALE	115, 887	6, 655	55, 991 0	0	0	88.00
	8802 NORTH PUTNAM FAMILY HEALTHCARE	155, 762 155, 762	0	0	0	0	88. 01 88. 02
	9000 CLINIC	3, 882	0	1, 876	0	0	90.00
	9001 RHEUMATOLOGY	11, 287	0		0	33, 094	
	9100 EMERGENCY	139, 131	72, 390		0	164, 562	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	107, 101	72,070	07,222	Ŭ	101,002	92.00
	THER REIMBURSABLE COST CENTERS						
	9910 CORF	0	0	0	0	0	99. 10
	PECIAL PURPOSE COST CENTERS				-"		
113. 00 1	1300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 719, 731	283, 342	665, 235	591, 876	912, 612	118.00
	ONREI MBURSABLE COST CENTERS						
190. 00 1	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 431	0		0		190. 00
	9200 PHYSICIANS' PRIVATE OFFICES	257, 462	13, 955	114, 747	0		192. 00
	9201 JOHNSON/NI CHOLS WI C	0	0	0	0	42, 146	
	9203 RHEUMATOLOGY	0	0	0	0		192. 02
	9300 NONPALD WORKERS	0	0	0	0		193.00
193. 01 1		0	0	0	0		193. 01
	9302 LACTATION CONSULTING	0	0	0	U		193. 02
1	9303 DI ABETI C COUNSELI NG 7950 VACANT SPACE	0	0		0		193. 03 194. 00
	7950 VACANT SPACE 7951 BOARD OF HEALTH	16, 607	0	8, 024	٥		194.00
	7952 PUTNAM/HENRY PRENATAL	10,007	0	0, 024	o n		194. 01
200.00	Cross Foot Adjustments		0		Ĭ		200. 00
201.00	Negative Cost Centers	o	0	o	o	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2, 005, 231	297, 297	793, 529	591, 876		
'	, , , , , , , , , , , , , , , , , , , ,	,	•				•

| Period: | Worksheet B | From 01/01/2020 | Part | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 15-1333

				To 12/31/2020		
Cost Center Description	NURSI NG	MEDI CAL	SOCI AL	UTI LI ZATI ON	7/15/2021 2: 2 Subtotal	:/ pm
3337 33.113.1 2333.1 \$2.1 3.1	ADMI NI STRATI O N	RECORDS & LI BRARY	SERVI CE	REVI EW	<b>345</b> (3 (4)	
OFFICE OFFICE COOK OFFICE	13. 00	16. 00	17. 00	17. 01	24. 00	
GENERAL SERVICE COST CENTERS  1.00   OO100   NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7.00
8.00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A						10.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	256, 151					13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	832, 501				16.00
17. 00 01700 SOCIAL SERVICE	o	0		0		17. 00
17. 01 01701 UTILIZATION REVIEW	0	0		0 187, 161		17. 01
INPATIENT ROUTINE SERVICE COST CENTERS	04.055	252 470		150 (00	0.055.554	00.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	84, 855 48, 121	350, 479 0		0 159, 620 0 27, 541	3, 855, 554 1, 751, 202	1
43. 00 04300 NURSERY	40, 121	0		0 27, 341	1, 731, 202	1
ANCILLARY SERVICE COST CENTERS	-1	-,		-, -,		1
50. 00 05000 OPERATING ROOM	0	272, 419		0 0	2, 769, 857	
51. 00   05100   RECOVERY ROOM	0	0		0 0	250, 212	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	1
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		0 0	430, 829 2, 350, 319	1
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0			172, 112	1
54. 02   03480   0NCOLOGY	o o	o		o o	4, 873, 053	
57.00 05700 CT SCAN	o	o		0 0	654, 195	
58.00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0	0		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	0	259		0 0	3, 497, 951 0	1
64. 00 06400 I NTRAVENOUS THERAPY		ő			0	1
65. 00 06500 RESPIRATORY THERAPY	o	o		0 0	889, 836	1
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	700, 816	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	129, 086	
68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY	0	0		0 0	54, 075 208, 977	1
69. 01   06901   CARDI AC   REHAB		Ö			498, 403	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	O	o		0 0	0	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	249, 907	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	1, 751, 165	1
73. 01 03950 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	73. 01
88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	O	ol		0 0	2, 716, 686	88. 00
88.01 08801 FAMILY MEDICINE OF CLOVERDALE	o	O		0 0	2, 323, 423	1
88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE	0	0		0 0	2, 349, 210	1
90. 00   09000   CLI NI C	0	0		0 0	10, 230	1
90. 01   09001   RHEUMATOLOGY 91. 00   09100   EMERGENCY	123, 175	209, 344		0 0	421, 730 4, 620, 873	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	123, 175	209, 344			4, 020, 073	92.00
OTHER REIMBURSABLE COST CENTERS						]
99. 10 09910 CORF	0	0		0 0	0	99. 10
SPECIAL PURPOSE COST CENTERS						1112 00
113.00 11300 INTEREST EXPENSE 118.00  SUBTOTALS (SUM OF LINES 1 through 117)	256, 151	832, 501		0 187, 161	37, 529, 701	113.00
NONREI MBURSABLE COST CENTERS	230, 131	032, 301		0 107, 101	37, 327, 701	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	O	o		0 0	6, 807, 589	192. 00
192. 01 19201 JOHNSON/NI CHOLS WI C	0	0		0 0	480, 871	
192. 02 19203 RHEUMATOLOGY	0	0		0 0		192. 02 193. 00
193. 00 19300  NONPAI D WORKERS 193. 01 19301  DME		0		0 0		193.00
193. 02 19302 LACTATION CONSULTING		0		0 0		193. 01
193. 03 19303 DI ABETI C COUNSELI NG	O	o		0 0		193. 03
194. 00 07950 VACANT SPACE	0	o		0 0		194. 00
194. 01 07951 BOARD OF HEALTH	0	0		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		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	256, 151	832, 501		0 187, 161		1
		• • •			•	•

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet B | From 01/01/2020 | Part I | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-1333

Case   Countier Description   Case				To 12/31/2020 Date/Time Pre	
Cost & Post   Adjustments	Cost Center Description	Intern &	Total	17 1372021 2.2	, piii
Siripathons					
A					
STATEST   STAT					
CEREBAL SERVICE COST CONTECNTES   1.00			26.00		
0.0100  WR CAP   PEL COST S-BLDE & FIXT	GENERAL SERVICE COST CENTERS	20.00	20.00		
0.000   0.00	1.00 O0100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00   0.0700   COPEDATION OF PLANT					
B. DO   OBDOG   LANDRY & I LINE STRVICE					
0.000   0.0000   0.00000   0.000000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.00000000					
10.00   1000   ETARY					
11.00   01100   CAFETERIA     11.00   13.00					
13.00   01300   NURSING ADMINISTRATION     10.00   17.00   1					
16. 00   10400   MEDICAL RECORDS & LIBRARY					
17.01					16. 00
IMPATI ENT ROUTINE SERVICE COST CENTERS   30 00	17. 00   01700   SOCI AL   SERVI CE				17. 00
30.00					17. 01
31.00			0.055.554		00.00
13. 00   04300   NURSERY   0   0   0   0   0   0   0   0   0		1			
## ANCILLARY SERVICE COST CENTERS  50.00   GOSDO   DEPARTIN RO RODROM   0   27,799,857   50.00   51.00   05100   RECOVERY RODM   0   25,001   0   51.00   05200   DELIVERY RODM & LABOR ROOM   0   0   52.00   53.00   05300   ANESTHESIOLOGY   0   430,829   53.00   54.01   05401   NUCLEAR MEDICINE-ID JACKOSTIC   0   172,112   54.01   54.02   03450   NUCLEAR MEDICINE-ID JACKOSTIC   0   172,112   54.01   55.00   05700   OSCORIO MINCELER MEDICINE-ID JACKOSTIC   0   172,112   54.01   56.00   05600   MACETICE RESONANCE IMAGING (MRI)   0   654,195   57.00   57.00   05700   OT SCAR   0   0   0   55.00   58.00   05600   MACETICE RESONANCE IMAGING (MRI)   0   0   0   50.00   58.00   05600   MACETICE RESONANCE IMAGING (MRI)   0   0   0   0   59.00   05600   04600   04600   04600   04600   0   60.00   05600   04600   04600   04600   04600   04600   04600   60.00   05600   04600   04600   04600   04600   04600   04600   04600   60.00   05600   04600		· ·			
50.00		<u> </u>	0		43.00
52.00   05200   DELUTERY ROOM & LABOR ROOM   0   0   0   0   0   0   0   0   0		0	2, 769, 857		50.00
153.00   05300   ANESTHESI OLGGY   0   430,829   53.00   54.00   55.	51.00   05100   RECOVERY ROOM	o	250, 212		51.00
54. 00   05400   RADIOLOGY-DI AGNOSTI C   0   2, 350, 319   54. 00   54. 01   540   01   05400   NUCLEAR MEDIC INTE-DIAGNOSTI C   0   172, 112   54. 01   54. 02   33480   NUCLEOR MEDIC INTE-DIAGNOSTI C   0   570, 00   570, 00   570, 00   580, 00   05800   OSBOOM MAGNETI C RESONANCE I MAGI NO (MRI )   0   0   0   58. 00   590, 00   5		- 1	- 1		
19.4   0.   0.6401   MUCLEAR MEDICINE-DIAGNOSTIC   0   172, 112   54, 01   54, 02   3360   0x00Locy   0   4, 873, 053   54, 02   57. 00   05700   CT SCAN   0   654, 195   57. 00   658, 00   05800   0x400 MACNETIC RESONANCE IMAGINS (MRI ) 0   0   0   0   59. 00   0.05900   0x600 ACC ASTHETERIZATION   0   0   0   0   0.059. 00   0.000   0x000   ACC ASTHETERIZATION   0   0   0   0   0.000   0.000   ACC ASTHETERIZATION   0   0   0   0   0.000   0.000   ACC ASTHETERIZATION   0   0   0   0   0   0.000   0.000   ACC ASTHETERIZATION   0   0   0   0   0.000   0.000   ACC ASTHETERIZATION   0   0   0   0   0   0   0   0   0		1			
54.02   03480   ONCOLOGY		- 1			
57.00   OSTOOL CT SCAN   S. 00   S.		1 -1			
18.8   0   05800   MAGNETIC RESONANCE I MACI NG (MRI )		1			
99.00   05900   CARDIA C CATHETER ZATION   0   0   0   0   0   0   0   0   0		1			
60.01   60.01   60.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   66.00   67.0		o	O		59. 00
64.0   0   0   0   0   0   0   0   0   0	60. 00   06000   LABORATORY	0	3, 497, 951		60.00
65. 00   0.650   0.650   0.650   0.650   0.650   0.650   0.650   0.650   0.670   0.680   0.6800   0.6900   0.6800   0.6900   0.6800   0.6900   0.6800   0.6900		1	- 1		
66. 00   06600   060000   060000   060000   060000   060000   060000   0600000   06000000   060000000   0600000000		1 -1	-1		
67. 00 667.00 668.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 69.		1			
68. 00   06800   SPEECH PATHOLOGY   0   54,075   69,00   69. 01   06900   LECTROCARDI OLOGY   0   208,977   69,00   69. 01   06900   LECTROCARDI OLOGY   0   208,977   69,00   69. 01   06901   CARDI AC REHAB   0   498,403   69,01   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   71,00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   1,751,165   73,00   73. 01   07300   DRUGS CHARGED TO PATIENTS   0   1,751,165   73,01   007300   DRUGS CHARGED TO PATIENTS   0   1,751,165   73,01   007747   177,00   07300   07300   07300   07300   073,000   073,000   073,000   073,000   007747   1877   SERVI CE COST CENTERS   73,01   007747   1878		1			
69. 00   06900   ELECTROCARDI OLOGY   0   208,977   69. 00   07. 0		· I			
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   72. 00   72. 00   72. 00   72. 00   72. 00   73. 01   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   73. 01   73. 00   7		o			
72. 00   07200   IMPL DEV. CHARGED TO PATIENT   0   249, 907   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   1,751, 165   73. 00   073.00   DRUGS CHARGED TO PATIENTS   0   1,751, 165   73. 00   073.00   DRUGS CHARGED TO PATIENTS   0   1,751, 165   73. 00   073.00   DRUGS CHARGED TO PATIENTS   0   1,751, 165   73. 00   073.00   07	69. 01   06901   CARDI AC REHAB	o	498, 403		69. 01
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   1,751,165   73. 00   03950   ONCOLOGY   0   0   0   0   0   0   0   0   0		1	-1		
73. 01   03950   NOCOLOGY   0   0   0   0   0   0   0   0   0		l l			
OUTPAT_LENT_SERVICE_COST_CENTERS		1			
88. 00   08800   PUTNAM PEDI ATRICS AND INTERNAL MED   0   2,716,686   88. 01   08801   FAMI LY MEDICI NE OF CLOVERDALE   0   2,334,233   88. 01   08802   NORTH PUTNAM FAMI LY HEALTHCARE   0   2,349,210   88. 02   09. 00   09000   CLI NI C   0   10,230   90. 00   99. 00		<u> </u>	U		73.01
88. 01 08801 FAMILLY MEDICINE OF CLOVERDALE 0 2, 323, 423 88. 01 88. 01 88. 02 08802 NORTH PUTNAM FAMILLY HEALTHCARE 0 1, 2349, 210 88. 02 90. 00 09000 CLINIC 0 10, 230 90. 00 90. 00 9000 CLINIC 0 4, 620, 873 90. 00 90. 01 90. 00 9000 EMERGENCY 0 4, 620, 873 90. 01 90. 00 9000 EMERGENCY 0 90. 00 9000 EMERGENCY 0 4, 620, 873 91. 00 9000 EMERGENCY 0 90. 00 90. 00 90. 00 9000 EMERGENCY 0 90		O	2, 716, 686		88. 00
90. 00   09000   CLINIC   0   10,230   90. 00   90. 01   90. 01   90. 01   90. 01   90. 01   90. 01   8HEUMATOLOGY   0   421,730   90. 01   90. 01   91. 00   92. 00   0900   BRERGENCY   0   4,620,873   92. 00   92. 00   0958ERVATION BEDS (NON-DISTINCT PART)   0   92. 00   09910   CORF   0   0   99. 10   99.					
90. 01 09001 RHEUMATOLOGY 0 421, 730 91. 00 91. 00 09100 EMERGENCY 0 4, 620, 873 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92. 00 0THER REIMBURSABLE COST CENTERS  99. 10 09910 CORF 0 0 0 99. 10 SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 37, 529, 701 NONNER IMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 30, 121 191. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 6, 807, 589 192. 00 192. 01 19201 JOHNSON/NI CHOLS WI C 0 480, 871 192. 01 193. 00 19300 INDRAID WORKERS 0 0 0 0 193. 00 193. 01 19301 DME 0 0 0 0 1930. 00 193. 01 19301 DME 0 0 0 0 1930. 00 193. 01 19301 DME 0 0 0 0 193. 00 194. 00 07950 VACANT SPACE 0 0 0 194. 00 194. 01 07951 BOARD OF HEALTH 0 0 43, 759 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 194. 02 201. 00 Negative Cost Centers 0 0 0 0 194. 02 201. 00 Negative Cost Centers 0 0 0 0 194. 02 201. 00 Negative Cost Centers 0 0 0 0 194. 02 201. 00 Negative Cost Centers 0 0 0 0 0 194. 02 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1			
91. 00   09100   EMERGENCY   0   4,620,873   91. 00   92. 00   09200   085ERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0		1			
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   0		- 1			
OTHER REIMBURSABLE COST CENTERS   O9910   ORF   O O O   O		1	4,020,073		
99. 10		<u> </u>			72.00
113. 00	99. 10 09910 CORF	0	0		99. 10
118. 00   SUBTOTALS (SUM OF LINES 1 through 117)   0   37, 529, 701   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   30, 121   190. 00   192. 00   19200   PHYSI CI ANS' PRI VATE OFFICES   0   6, 807, 589   192. 00   192. 01   19201   JOHNSON/NI CHOLS WI C   0   480, 871   192. 01   192. 02   19203   RHEUMATOLOGY   0   0   0   193.00   193.00   19300   NONPAI D WORKERS   0   0   0   193. 01   193. 01   19301   DME   0   0   0   193. 01   193. 01   19302   LACTATI ON CONSULTI NG   0   0   193. 02   193.03   19303   DI ABETI C COUNSELI NG   0   0   193. 03   194. 00   197. 07950   NORCANT SPACE   0   0   194. 00   194. 01   197. 02   197. 02   197. 03   197. 05					
NONRE   MBURSABLE   COST   CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   30, 121   190. 00   192. 00   19200   PHYSI CI ANS'   PRI VATE OFFI CES   0   6, 807, 589   192. 00   192. 01   19201   JOHNSON/NI CHOLS WI C   0   480, 871   192. 01   192. 02   19203   RHEUMATOLOGY   0   0   0   192. 02   193. 00   19300   NONPAI D   WORKERS   0   0   0   193. 00   193. 01   19301   DME   0   0   0   193. 01   193. 01   193. 02   19302   LACTATI ON CONSULTI NG   0   0   193. 02   193. 03   19303   DI ABETI C   COUNSELI NG   0   0   193. 03   194. 00   197. 07950   NORPAI D   NORPAI			07 500 704		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 01 192. 02 192. 03 192. 01 192. 02 192. 03 192. 03 192. 01 192. 02 192. 03 192. 01 192. 02 192. 03 192. 01 192. 02 192. 03 192. 01 192. 02 192. 02 192. 03 192. 00 192. 00 192. 01 193. 02 193. 03 193. 03 193. 03 194. 00 195. 03 194. 00 195. 03 194. 00 195. 03 196. 03 197.		l 0	37, 529, 701		118.00
192. 00			30, 121		190 00
192. 01   19201   19201   JOHNSON/NI CHOLS WI C		- 1			
193. 00       19300       NONPAI D WORKERS       0       0       193. 00         193. 01       19301       DME       0       0       193. 01         193. 02       19302       LACTATI ON CONSULTI NG       0       0       193. 02         193. 03       19303       DI ABETI C COUNSELI NG       0       0       193. 03         194. 00       07950       VACANT SPACE       0       0       194. 00         194. 01       07951       BOARD OF HEALTH       0       43, 759       194. 01         194. 02       07952       PUTNAM/HENRY PRENATAL       0       0       194. 02         200. 00       Cross Foot Adj ustments       0       0       200. 00         201. 00       Negati ve Cost Centers       0       0       201. 00		o			
193. 01     19301     DME     0     0     193. 01       193. 02     19302     LACTATI ON CONSULTI NG     0     0     193. 02       193. 03     19303     DI ABETI C COUNSELI NG     0     0     193. 03       194. 00     07950     VACANT SPACE     0     0     194. 00       194. 01     07951     BOARD OF HEALTH     0     43, 759     194. 00       194. 02     07952     PUTNAM/HENRY PRENATAL     0     0     194. 02       200. 00     Cross Foot Adj ustments     0     0     200. 00       201. 00     Negati ve Cost Centers     0     0     201. 00		0	0		
193. 02     19302     LACTATI ON CONSULTI NG     0     0       193. 03     19303     DI ABETI C COUNSELI NG     0     0       194. 00     07950     VACANT SPACE     0     0       194. 01     079751     BOARD OF HEALTH     0     43, 759       194. 02     079752     PUTNAM/HENRY PRENATAL     0     0       200. 00     Cross Foot Adjustments     0     0       201. 00     Negati ve Cost Centers     0     0		0	0		
193. 03   19303   DI ABETI C COUNSELI NG		0	0		
194. 00   07950   VACANT SPACE   0 0 0 194. 01   194. 02   194. 03		0	0		
194. 01     07951     BOARD OF HEALTH     0     43,759     194. 01       194. 02     07952     PUTNAM/HENRY PRENATAL     0     0     194. 02       200. 00     Cross Foot Adjustments     0     0     200. 00       201. 00     Negative Cost Centers     0     0     0			0		
194. 02     07952     PUTNAM/HENRY PRENATAL     0     0     194. 02       200. 00     Cross Foot Adjustments     0     0     0       201. 00     Negative Cost Centers     0     0     0		0	43. 759		
200.00       Cross Foot Adjustments       0       0       200.00         201.00       Negative Cost Centers       0       0       0		o o	0		
201.00   Negative Cost Centers   0   0   201.00	200.00 Cross Foot Adjustments	0	o		200. 00
202.00   TOTAL (sum lines 118 through 201)   0  44,892,041    202.00	201.00 Negative Cost Centers		0		
	202.00   TOTAL (sum lines 118 through 201)	0	44, 892, 041		202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS | Peri od: | Worksheet B | From 01/01/2020 | Part I I | To | 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-1333

					10	) 12/31/2020	Date/lime Pre   7/15/2021 2:2	
		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIV E & GENERAL	
			0	1. 00	2A	4. 00	5. 00	
4 00		AL SERVICE COST CENTERS			I .			
1. 00 4. 00	1	NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	0	3, 552	3, 552	3, 552		1.00 4.00
5. 00		ADMINISTRATIVE & GENERAL	0	330, 171		442	330, 613	5.00
7. 00	1	OPERATION OF PLANT	o	240, 163		52	14, 767	7. 00
8.00	00800	LAUNDRY & LINEN SERVICE	0	15, 694		5	2, 070	8. 00
9. 00		HOUSEKEEPI NG	0	14, 672		68	5, 720	9. 00
10.00	1	DIETARY	0	81, 184		18	3, 434	•
11. 00 13. 00		CAFETERIA NURSING ADMINISTRATION	0	37, 237 15, 438		44 17	6, 611 1, 683	11. 00 13. 00
16. 00		MEDICAL RECORDS & LIBRARY	o	91, 747		39	4, 751	16.00
17. 00		SOCI AL SERVI CE	0	0		0	0	17. 00
17. 01		UTILIZATION REVIEW	0	7, 731	7, 731	15	1, 225	17. 01
		IENT ROUTINE SERVICE COST CENTERS		107.000	407.000	001	47.400	
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	137, 899 65, 955		326 109	17, 429 10, 113	30. 00 31. 00
43.00		NURSERY	0	03, 433		0	0	43.00
10.00		LARY SERVICE COST CENTERS	<u> </u>		<u> </u>	<u> </u>		10.00
50.00	1	OPERATING ROOM	0	189, 925		115	15, 497	50. 00
51.00	05100	RECOVERY ROOM	0	53, 279		7	1, 188	•
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0	·	0 124	0	52. 00 53. 00
54.00		RADI OLOGY-DI AGNOSTI C	0	70, 366	·	166	3, 027 15, 471	54.00
54. 01	1	NUCLEAR MEDICINE-DIAGNOSTIC	ő	3, 250		0	1, 231	54. 01
54. 02		ONCOLOGY	0	112, 757		48	34, 279	54. 02
57. 00	1	CT SCAN	0	30, 644		27	4, 313	
58.00		MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	0	58.00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0	0 58, 271	58, 271	0 120	0 24, 231	59. 00 60. 00
60. 01		BLOOD LABORATORY	o	0	0	0	0	60.01
64. 00		INTRAVENOUS THERAPY	O	0	0	0	0	64.00
65.00		RESPI RATORY THERAPY	0	16, 251	16, 251	64	6, 069	65.00
66.00		PHYSI CAL THERAPY	0	39, 559		0	4, 655	•
67. 00 68. 00		OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0	0		0	951 398	67. 00 68. 00
69.00	1	ELECTROCARDI OLOGY	0	2, 322	·	9	1, 460	
69. 01		CARDI AC REHAB	o	37, 516		38	3, 097	69. 01
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72.00		IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	1, 840	•
73. 00 73. 01		DRUGS CHARGED TO PATIENTS ONCOLOGY	0	20, 801 0	20, 801 0	49 0	12, 436 0	73. 00 73. 01
73.01		TIENT SERVICE COST CENTERS	<u> </u>	0	0	U	0	73.01
88. 00		PUTNAM PEDIATRICS AND INTERNAL MED	0	112, 270		216	18, 692	88. 00
		FAMILY MEDICINE OF CLOVERDALE	0	150, 900		177	15, 963	
		NORTH PUTNAM FAMILY HEALTHCARE	0	150, 900		175	16, 153	•
90. 00 90. 01		CLI NI C RHEUMATOLOGY	0	3, 761 10, 934		0 61	33 2, 739	
91.00		EMERGENCY	0	134, 789		477	28, 316	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)			0			92.00
	OTHER	REIMBURSABLE COST CENTERS						
99. 10			0	0	0	0	0	99. 10
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118.00	1	SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 239, 938	2, 239, 938	3, 008	279, 842	
		IMBURSABLE COST CENTERS	-1			2, 223		
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11, 074	11, 074	0		190. 00
		PHYSICIANS' PRIVATE OFFICES	0	249, 426	249, 426	504	47, 302	•
	1	JOHNSON/NI CHOLS WI C	0	0	0	40 0		192. 01
		RHEUMATOLOGY NONPALD WORKERS	0	0	0	0		192. 02 193. 00
193. 01			ő	0	Ö	0		193. 01
		LACTATION CONSULTING	0	0	0	0	0	193. 02
		DI ABETI C COUNSELI NG	0	0	0	0		193. 03
		VACANT SPACE	0	0	0	0		194.00
	1	BOARD OF HEALTH PUTNAM/HENRY PRENATAL		16, 088 0	16, 088	0		194. 01 194. 02
200.00		Cross Foot Adjustments		0		U		200.00
201.00	1	Negative Cost Centers		0	0	0		201. 00
202.00	)	TOTAL (sum lines 118 through 201)	0	2, 516, 526	2, 516, 526	3, 552	330, 613	202. 00

Provider CCN: 15-1333

| Peri od: | Worksheet B | From 01/01/2020 | Part I I | To | 12/31/2020 | Date/Time Prepared:

				10	12/31/2020	Date/IIme Pre   7/15/2021 2:2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	, biii
	·		LINEN SERVICE				
	CENEDAL CEDVICE COCT CENTEDS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 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	00700 OPERATION OF PLANT	254, 982					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	2, 060	19, 829				8. 00
9. 00	00900 HOUSEKEEPI NG	1, 926	111	22, 497			9. 00
10.00	01000 DI ETARY	10, 656	82		96, 522		10.00
11. 00	01100 CAFETERI A	4, 888	0		0	49, 306	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 026	0	218	0	207	13.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY	12, 042	0	1, 297	0	2, 419	16.00
17. 00	01700   SOCIAL SERVICE   01701   UTILIZATION REVIEW	0 1, 015	0	0 109	0	0 460	17. 00 17. 01
17.01	INPATIENT ROUTINE SERVICE COST CENTERS	1,015		107	<u> </u>	400	17.01
30. 00	03000 ADULTS & PEDIATRICS	18, 100	4, 314	1, 950	82, 319	5, 854	30.00
31.00	03100 INTENSIVE CARE UNIT	8, 657	3, 331	933	14, 203	3, 320	31.00
43.00	04300 NURSERY	0	0	0	0	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	24, 929	2, 815		0	3, 108	50.00
51.00	05100 RECOVERY ROOM	6, 993	305		0	144	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0 224	1 403	0	0	1, 025	53.00
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   05401  NUCLEAR MEDI CI NE-DI AGNOSTI C	9, 236 427	1, 483 0	1	0	6, 175 0	54. 00 54. 01
54. 01	03480 ONCOLOGY	14, 800	637	1, 594	0	1, 868	54.01
57. 00	05700 CT SCAN	4, 022	037		0	1, 115	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	0	O	o	0	59.00
60.00	06000 LABORATORY	7, 648	0	824	0	6, 102	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	2, 133	0		0	2, 111	65.00
66.00	06600 PHYSI CAL THERAPY	5, 192	548		0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	305	0	0 33	0	0 370	68. 00 69. 00
69. 00	06901 CARDI AC REHAB	4, 924	0	530	0	1, 057	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	o o	0	Ö	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 730	0	294	O	1, 585	
73. 01	03950 ONCOLOGY	0	0	0	0	0	73. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 PUTNAM PEDIATRICS AND INTERNAL MED	14, 736	444	1, 587	0	0	88. 00
88. 01	08801 FAMILY MEDICINE OF CLOVERDALE	19, 806	0	0	0	0	88. 01
88. 02	08802 NORTH PUTNAM FAMILY HEALTHCARE	19, 806	0	0	0	0	88. 02
90. 00 90. 01	09000   CLI NI C   09001   RHEUMATOLOGY	494 1, 435	0	53 155	0	0 1, 709	90. 00 90. 01
	09100 EMERGENCY	17, 692	4, 828		0	8, 500	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	17,072	4, 020	1, 700	J	0, 300	92.00
,2.00	OTHER REIMBURSABLE COST CENTERS						/2.00
99. 10	09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS	·		•	'		
113.00	11300 I NTEREST EXPENSE						113.00
118.00		218, 678	18, 898	18, 858	96, 522	47, 129	118. 00
	NONREI MBURSABLE COST CENTERS			1	.1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 453	0		0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	32, 739	931	3, 255	0		192.00
	1 19201 JOHNSON/NI CHOLS WI C	0	0	1	0	· ·	192.01
	2 19203 RHEUMATOLOGY D 19300 NONPALD WORKERS	0	0	0	0		192. 02 193. 00
	1 19301 DME		0	0	0		193.00
	2 19302 LACTATION CONSULTING		0	0	0		193.01
	3 19303 DI ABETI C COUNSELI NG		0	Ö	0		193. 03
	07950 VACANT SPACE		0	ا	o O		194.00
	107951 BOARD OF HEALTH	2, 112	0	227	o		194. 01
	2 07952 PUTNAM/HENRY PRENATAL	o	0	o	o		194. 02
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	o		201. 00
202.00	TOTAL (sum lines 118 through 201)	254, 982	19, 829	22, 497	96, 522	49, 306	202.00

| Peri od: | Worksheet B | From 01/01/2020 | Part | I | To | 12/31/2020 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1333

			-	Го 12/31/2020	Date/Time Pre 7/15/2021 2:2	
Cost Center Description	NURSI NG ADMI NI STRATI O	MEDI CAL RECORDS &	SOCI AL SERVI CE	UTI LI ZATI ON REVI EW	Subtotal	Į į
	N 13. 00	16. 00	17. 00	17. 01	24. 00	
GENERAL SERVI CE COST CENTERS		,				
1. 00   00100   NEW CAP REL COSTS-BLDG & FIXT 4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMI NI STRATI VE & GENERAL 7. 00   00700   OPERATI ON OF PLANT 8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY						1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00
11. 00   01100   CAFETERIA 13. 00   01300   NURSI NG   ADMINISTRATION 16. 00   01600   MEDICAL   RECORDS & LIBRARY	19, 589 0	112, 295				11. 00 13. 00 16. 00
17. 00   01700   SOCIAL SERVICE 17. 01   01701   UTILIZATION REVIEW	0	0		10, 555		17. 00 17. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 43. 00   04300   NURSERY	6, 489 3, 680 0	47, 276 0 0	(	9, 002 1, 553 0 0	330, 958 111, 854 0	30. 00 31. 00 43. 00
ANCILLARY SERVICE COST CENTERS						
50.00   05000   0PERATING ROOM 51.00   05100   RECOVERY ROOM	0	36, 746 0			275, 820 62, 669	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	o o	Ö			02,007	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	(		4, 176	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C	0	0	(		103, 892 4, 954	1
54. 02   03480   ONCOLOGY	l o	o			165, 983	1
57. 00   05700   CT   SCAN	0	o	(		40, 554	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(		0	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	0	0 35			0 97, 231	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	o o	O	(		0	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY	0	0			26, 858	
67. 00   06700   OCCUPATI ONAL THERAPY	0	0			50, 513 951	
68. 00 06800 SPEECH PATHOLOGY	o o	Ö	(		398	1
69. 00 06900 ELECTROCARDI OLOGY	0	0	(		4, 499	
69. 01   06901   CARDI AC REHAB 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	(		47, 162 0	69. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	l o	Ö	·		1, 840	1
73.00 07300 DRUGS CHARGED TO PATIENTS	O	o			37, 895	1
73. 01 03950 ONCOLOGY	0	0	(	0	0	73. 01
0UTPATIENT SERVICE COST CENTERS  88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	ol		ol	147, 945	88. 00
88. 01 08801 FAMILY MEDICINE OF CLOVERDALE	O	Ö			186, 846	
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE	0	0	(	0	187, 034	1
90. 00   09000  CLI NI C 90. 01   09001  RHEUMATOLOGY	0	0		0 0	4, 341	
90. 01   09001   RHEUMATOLOGY 91. 00   09100   EMERGENCY	9, 420	28, 238			17, 033 234, 166	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	,					92.00
OTHER REIMBURSABLE COST CENTERS	I a	ما		J 0		00.10
99. 10   09910   CORF   SPECI AL PURPOSE COST CENTERS	0	0		0	0	99. 10
113. 00 11300 I NTEREST EXPENSE						113.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS  190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19, 589	112, 295		10, 555	2, 145, 572	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0			334, 157	190. 00 192. 00
192. 01 19201 JOHNSON/NI CHOLS WI C	o	ō			5, 448	192. 01
192. 02 19203 RHEUMATOLOGY	0	O				192.02
193. 00 19300 NONPALD WORKERS 193. 01 19301 DME	0	0				193. 00 193. 01
193.02 19301 DME 193.02 19302 LACTATION CONSULTING		ol	(	ól ől		193.01
193. 03 19303 DI ABETI C COUNSELI NG		ō	(		0	193. 03
194. 00 07950 VACANT SPACE	0	O	(			194.00
194. 01 07951 BOARD OF HEALTH 194. 02 07952 PUTNAM/HENRY PRENATAL	0	0				194. 01 194. 02
200.00 Cross Foot Adjustments		ď	,	1 4		200.00
201.00 Negative Cost Centers	0	О		o	0	201.00
202.00   TOTAL (sum lines 118 through 201)	19, 589	112, 295	(	10, 555	2, 516, 526	202. 00

PUTNAM COUNTY HOSPITAL

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

			1/15/2021 2: 2	/ pm
Cost Center Description	Intern &	Total		
	Resi dents			
	Cost & Post			
	Stepdown			
	Adjustments			
	25. 00	24 00		
OFNEDAL CEDITION OCCUPANTEDO	25.00	26. 00		
GENERAL SERVICE COST CENTERS				
1.00  00100 NEW CAP REL COSTS-BLDG & FLXT				1.00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	i i			5.00
7. 00   00700   OPERATION OF PLANT				7. 00
· · · · · · · · · · · · · · · · · · ·	1			
8.00   00800   LAUNDRY & LINEN SERVICE				8. 00
9. 00   00900   HOUSEKEEPI NG				9. 00
10. 00  01000 DI ETARY				10.00
11. 00   01100   CAFETERI A	1			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1			13.00
	1			
16.00 01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00  01700  SOCIAL SERVICE				17.00
17.01 01701 UTILIZATION REVIEW				17. 01
INPATIENT ROUTINE SERVICE COST CENTERS	1			
30. 00   03000   ADULTS & PEDIATRICS		330, 958		30.00
	0			
31.00  03100 INTENSIVE CARE UNIT	0	111, 854		31.00
43. 00   04300   NURSERY	0	0		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	O	275, 820		50.00
51. 00   05100   RECOVERY ROOM	0	62, 669		51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0		52.00
53. 00   05300   ANESTHESI OLOGY	O	4, 176		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	103, 892		54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	o o	4, 954		54. 01
	1			
54. 02   03480   ONCOLOGY	0	165, 983		54. 02
57. 00  05700 CT SCAN	0	40, 554		57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	l ol	ol		59.00
60. 00   06000   LABORATORY	o o	97, 231		60.00
	1			
60. 01  06001 BLOOD LABORATORY	0	0		60. 01
64.00   06400   I NTRAVENOUS THERAPY	0	0		64.00
65. 00 06500 RESPIRATORY THERAPY	l ol	26, 858		65.00
66. 00 06600 PHYSI CAL THERAPY	o	50, 513		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	951		67.00
	١			
68.00   06800   SPEECH PATHOLOGY	l ol	398		68. 00
69. 00  06900  ELECTROCARDI OLOGY	0	4, 499		69.00
69. 01   06901   CARDI AC   REHAB	l ol	47, 162		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		71.00
	0	-1		
	- 1	1, 840		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	37, 895		73. 00
73. 01  03950  ONCOLOGY	0	0		73. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	147, 945		88. 00
	1			
88. 01   08801   FAMILY MEDICINE OF CLOVERDALE	0	186, 846		88. 01
88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE	0	187, 034		88. 02
90. 00  09000   CLI NI C	0	4, 341		90.00
90. 01 09001 RHEUMATOLOGY	O	17, 033		90. 01
91. 00 09100 EMERGENCY	o	234, 166		91.00
		234, 100		
	0			92.00
OTHER REIMBURSABLE COST CENTERS				
99. 10 09910 CORF	0	0		99. 10
SPECIAL PURPOSE COST CENTERS				
113. 00 11300   NTEREST EXPENSE				113. 00
· · · · · · · · · · · · · · · · · · ·		2 145 570		
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	0	2, 145, 572		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 781		190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	334, 157		192.00
192. 01 19201 JOHNSON/NI CHOLS WI C	o o	5, 448		192. 01
		5, 440		
192. 02 19203 RHEUMATOLOGY		이		192. 02
193.00 19300 NONPALD WORKERS	0	0		193. 00
193. 01 19301 DME	0	ol		193. 01
193. 02 19302 LACTATION CONSULTING	ام	n		193. 02
193. 03 19303 DI ABETI C COUNSELI NG		0		193. 02
	ا ا	٥		
194.00 07950 VACANT SPACE	0	0		194. 00
194. 01 07951 B0ARD OF HEALTH	0	18, 568		194. 01
194.02 07952 PUTNAM/HENRY PRENATAL	l ol	ol		194. 02
200.00 Cross Foot Adjustments	0	0		200.00
		0		
201.00 Negative Cost Centers	0	0 0		201.00
202.00   TOTAL (sum lines 118 through 201)	0	2, 516, 526		202. 00

	Financial Systems	PUTNAM COUNTY		011 45 4000 5		u or form CMS	
COST	NLLOCATION - STATISTICAL BASIS		Provi der C	F	Period: From 01/01/2020 To 12/31/2020	Worksheet B-1 Date/Time Pre 7/15/2021 2:2	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1. 00	4. 00	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FLXT	108, 399	22 524 024				1.00
4. 00 5. 00	OO4OO  EMPLOYEE BENEFITS DEPARTMENT   OO5OO  ADMINISTRATIVE & GENERAL	153 14, 222	23, 524, 934 2, 927, 796	1	37, 756, 963		4. 00 5. 00
7. 00	00700 OPERATION OF PLANT	10, 345	2, 927, 790 344, 451			83, 679	7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE	676	30, 820	1		676	ı
9. 00	00900 HOUSEKEEPI NG	632	447, 938		653, 266	632	9.00
10.00	01000 DI ETARY	3, 497	117, 944			3, 497	10.00
11. 00	01100 CAFETERI A	1, 604	289, 062	.  C	755, 063	1, 604	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	665	110, 531		,	665	
16.00	01600 MEDI CAL RECORDS & LI BRARY	3, 952	260, 842			3, 952	
17.00	O1700   SOCIAL SERVICE   O1701   UTILIZATION REVIEW	333	100 023			0	17.00
17.01	INPATIENT ROUTINE SERVICE COST CENTERS	333	100, 923	<u>C</u>	139, 960	333	17. 01
30.00	03000 ADULTS & PEDIATRICS	5, 940	2, 160, 333	C	1, 990, 511	5, 940	30.00
31. 00	03100   NTENSI VE CARE UNI T	2, 841	721, 930				
43.00	04300 NURSERY	0	0	1			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	8, 181	760, 314		1, 769, 833	8, 181	
51.00	05100 RECOVERY ROOM	2, 295	47, 129	1		2, 295	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1		0	52.00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	0	819, 435	1		0	53. 00 54. 00
54. 00	05400  RADI OLOGY-DI AGNOSTI C   05401  NUCLEAR   MEDI CI NE-DI AGNOSTI C	3, 031 140	1, 098, 985		1, 766, 885 140, 572	3, 031 140	•
54. 02	03480 ONCOLOGY	4, 857	320, 298		3, 914, 881	4, 857	•
57. 00	05700 CT SCAN	1, 320	178, 892	1	492, 594	1, 320	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	) c		0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	) c	0	0	
60.00	06000 LABORATORY	2, 510	791, 681	1		2, 510	1
60. 01	06001 BLOOD LABORATORY	0	0		_	0	60.01
64. 00 65. 00	06400 I NTRAVENOUS THERAPY	0 700	424 440		_	0	64. 00 65. 00
66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	1, 704	426, 448			700 1, 704	ı
67.00	06700 OCCUPATI ONAL THERAPY	1, 704	0			1, 704	67.00
68. 00	06800 SPEECH PATHOLOGY	l o	0				ı
69.00	06900 ELECTROCARDI OLOGY	100	60, 733	d			
69. 01	06901 CARDI AC REHAB	1, 616	249, 825	i c	353, 675	1, 616	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	) C		0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	) C		0	
	07300 DRUGS CHARGED TO PATIENTS	896	326, 055				73.00
73.01	O3950   ONCOLOGY   OUTPATIENT SERVICE COST CENTERS	0	0	) <u> </u>	0	0	73. 01
88. 00	08800 PUTNAM PEDIATRICS AND INTERNAL MED	4, 836	1, 433, 736	ol c	2, 134, 742	4, 836	88.00
88. 01	08801 FAMILY MEDICINE OF CLOVERDALE	6, 500	1, 169, 018				1
88. 02	08802 NORTH PUTNAM FAMILY HEALTHCARE	6, 500	1, 156, 295			6, 500	
90.00	09000 CLI NI C	162	0	) c	-,	162	
90. 01	09001 RHEUMATOLOGY	471	402, 908	1		471	
91.00	09100 EMERGENCY	5, 806	3, 160, 248	C	3, 233, 922	5, 806	
92. 00	O9200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS						92.00
99 10	09910 CORF	0	0	) c	0	0	99. 10
77. 10	SPECIAL PURPOSE COST CENTERS	<u> </u>		1	,		77.10
113.00	11300   INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	96, 485	19, 914, 570	-7, 135, 078	31, 959, 990	71, 765	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	477	0	) C			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	10, 744	3, 344, 375				192.00
	19201 JOHNSON/NICHOLS WIC  19203 RHEUMATOLOGY	0	265, 989				192. 01 192. 02
	19203 RHEUWATOLOGT 19300 NONPALD WORKERS	0	0		_		192.02
	19301 DME	o	0		_		193.01
	19302 LACTATION CONSULTING	l o	0		o o		193.02
	19303 DI ABETI C COUNSELI NG	0	0		o		193. 03
	07950 VACANT SPACE	0	0	) c	0		194. 00
	07951 BOARD OF HEALTH	693	0	) C	16, 088		194. 01
	07952 PUTNAM/HENRY PRENATAL	0	0	) C	0	0	194. 02
200.00							200.00
201.00	Negative Cost Centers	ı I		I	1	l	201. 00

Health Fi	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der C		Peri od:	Worksheet B-1	
					From 01/01/2020 To 12/31/2020		
		CAPI TAL RELATED COSTS					
	Cost Center Description	NEW BLDG &	EMPLOYEE		ADMI NI STRATI V		
		FIXT (SQUARE	BENEFITS DEPARTMENT	n	E & GENERAL (ACCUM.	PLANT (SQUARE FEET)	
		FEET)	(GROSS		COST)	(SQUARE LELT)	
			SALARI ES)		0031)		
		1. 00	4. 00	5A	5. 00	7. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 516, 526	5, 620, 735		7, 135, 078	2, 005, 231	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 215399	0. 238927		0. 188974	23. 963372	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)		3, 552		330, 613	254, 982	204.00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000151		0. 008756	3. 047144	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

| Period: | Worksheet B-1 | From 01/01/2020 | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-1333

				To	12/31/2020		
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERIA (MANHOURS)	7/15/2021 2: 2 NURSI NG ADMI NI STRATI 0 N (DI RECT NRSI NG HRS)	7 pm
		8. 00	9. 00	10.00	11. 00	13.00	
4.00	GENERAL SERVICE COST CENTERS	1	I				1
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 01701 UTILIZATION REVIEW INPATIENT ROUTINE SERVICE COST CENTERS	178, 564 1, 002 740 0 0 0 0	68, 538 3, 497 1, 604 665 3, 952	2, 195 0	268, 534 1, 125 13, 177 0 2, 508	96, 251 0 0 0	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00
30.00	03000 ADULTS & PEDIATRICS	38, 845	5, 940	1, 872	31, 885	31, 885	30.00
31.00	03100   NTENSI VE CARE UNI T	29, 996		323	18, 082	18, 082	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	43.00
50. 00 51. 00 52. 00 53. 00 54. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	25, 348 2, 746 0 0 13, 358	2, 295 0 0	0 0 0 0	16, 928 784 0 5, 585 33, 631	0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	140	_	0	0	54. 01
54. 02	03480 ONCOLOGY	5, 740		0	10, 176	0	54. 02 57. 00
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 320 0	0 0	6, 075 0	0	57.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	2, 510 0	0	33, 233 0	0	60. 00 60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65.00	06500 RESPIRATORY THERAPY	0	700	0	11, 495	0	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	4, 931 0	1, 704 0	0	0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		1	_	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	100	0	2, 015	0	69. 00
69. 01	06901 CARDI AC REHAB	0	1, 616	0	5, 754	0	69. 01
71. 00 72. 00	O7100   MEDICAL SUPPLIES CHARGED TO PATIENTS   O7200   IMPL. DEV. CHARGED TO PATIENT	0	0	] 0	0	0	71.00 72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	Ö	1	0	8, 635	0	73.00
73. 01	03950 ONCOLOGY	0	0	0	0	0	73. 01
88. 00	OUTPATIENT SERVICE COST CENTERS  08800 PUTNAM PEDIATRICS AND INTERNAL MED	3, 997	4, 836	0	0	0	88. 00
88. 01	08801 FAMILY MEDICINE OF CLOVERDALE	0					
	08802 NORTH PUTNAM FAMILY HEALTHCARE	0			0	0	
90. 00 90. 01	09000 CLINIC 09001 RHEUMATOLOGY	0	162 471		0 9, 308	0	90. 00 90. 01
	09100 EMERGENCY	43, 479			46, 284		1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
00 10	OTHER REIMBURSABLE COST CENTERS  09910 CORF	0	0	O	0	0	99. 10
77. 10	SPECIAL PURPOSE COST CENTERS		<u> </u>	0		0	] 77.10
	11300 I NTEREST EXPENSE						113.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)   NONREIMBURSABLE COST CENTERS	170, 182	57, 457	2, 195	256, 680	96, 251	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	477	0	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	8, 382			0	0	192.00
	19201 JOHNSON/NI CHOLS WI C	0	1		11, 854		192. 01
	2 19203 RHEUMATOLOGY   19300 NONPALD WORKERS	0			0		192. 02 193. 00
	19301 DME	Ö	Ö		0		193. 01
	19302 LACTATION CONSULTING	0	0	_	0		193. 02
	3 19303 DIABETIC COUNSELING  07950 VACANT SPACE	0	0	0	0		193. 03 194. 00
	07951 BOARD OF HEALTH		693	-	0		194. 00
194. 02	07952 PUTNAM/HENRY PRENATAL	0	0	0	0		194. 02
200. 00 201. 00	, ,						200. 00 201. 00
201.00		297, 297	793, 529	591, 876	954, 758	256, 151	1
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 664932	11. 577942	269. 647380	3. 555445	2. 661281	203.00

Heal th Fi	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2020	Worksheet B-1	
					To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG		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	
204. 00	Cost to be allocated (per Wkst. B, Part II)	19, 829	22, 497	96, 52	2 49, 306	19, 589	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 111047	0. 328241	43. 97357	0. 183612	0. 203520	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10

Peri od: Worksheet B-1 From 01/01/2020 Date/Time Prepared: 7/15/2021 2: 27 pm Provi der CCN: 15-1333

			To	12/31/2020 Date/Time Pro 7/15/2021 2:2	
Cost Center Description	MEDI CAL	SOCI AL	UTI LI ZATI ON	, , , , , , , , , , , , , , , , , , , ,	
	RECORDS & LI BRARY	SERVI CE (PATI ENT	REVI EW (PATI ENT		
	(TIME SPENT)	DAYS)	DAYS)		
CENEDAL CEDALOF COCT CENTEDS	16. 00	17. 00	17. 01		
GENERAL SERVICE COST CENTERS  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   00700   OPERATION OF PLANT					7.00
8. 00   00800   LAUNDRY & LI NEN SERVI CE 9. 00   00900   HOUSEKEEPI NG					8. 00 9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13. 00   01300   NURSING ADMINISTRATION 16. 00   01600   MEDICAL RECORDS & LIBRARY	102, 989				13.00
17. 00 01700 SOCI AL SERVI CE	0	0			17. 00
17. 01 01701 UTILIZATION REVIEW	0	0	2, 195		17. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	42.250	٥	1 070		20.00
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   NTENSIVE CARE UNIT	43, 358 0	0	1, 872 323		30.00
43. 00 04300 NURSERY	o o	Ö	0		43.00
ANCILLARY SERVICE COST CENTERS		_			
50.00   05000   0PERATING ROOM 51.00   05100   RECOVERY ROOM	33, 701 0	0	0		50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0		53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	0		54.00
54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C 54. 02   03480   ONCOLOGY	0	0	0		54. 01 54. 02
57. 00 05700 CT SCAN	o	0	0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0		59.00
60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY	32	0	0		60. 00 60. 01
64. 00 06400 I NTRAVENOUS THERAPY	o	0	0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	0		65. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0	0	0		66. 00 67. 00
68. 00   06800   SPEECH PATHOLOGY	0	0	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0		69.00
69. 01 06901 CARDI AC REHAB	0	0	0		69. 01
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 O7200 IMPL. DEV. CHARGED TO PATIENT	0	0	0		71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0	0		73.00
73. 01 03950 ONCOLOGY	0	0	0		73. 01
0UTPATIENT SERVICE COST CENTERS  88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	O	0		88. 00
88. 01   08801   FAMILY MEDICINE OF CLOVERDALE	0	0	0		88. 01
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE	O	0	0		88. 02
90. 00   09000   CLI NI C	0	0	0		90.00
90. 01   09001   RHEUMATOLOGY 91. 00   09100   EMERGENCY	0 25, 898	0	0		90.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	20,070	Ŭ.	Ü		92.00
OTHER REIMBURSABLE COST CENTERS		_			
99. 10   09910   CORF   SPECI AL PURPOSE COST CENTERS	0	0	0		99. 10
113. 00 11300   NTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	102, 989	0	2, 195		118. 00
NONREI MBURSABLE COST CENTERS		0	0		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0		190. 00 192. 00
192. 01 19201 JOHNSON/NI CHOLS WI C	O	Ö	0		192. 01
192. 02 19203 RHEUMATOLOGY	0	0	0		192. 02
193. 00 19300 NONPALD WORKERS	0	0	0		193. 00 193. 01
193. 01 19301 DME 193. 02 19302 LACTATION CONSULTING		0	0		193. 01
193. 03 19303 DI ABETI C COUNSELI NG	0	o	0		193. 03
194. 00 07950 VACANT SPACE	0	0	0		194.00
194. 01 07951 BOARD OF HEALTH 194. 02 07952 PUTNAM/HENRY PRENATAL	0	0	0		194. 01 194. 02
200.00 Cross Foot Adjustments		U I	U		200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	832, 501	0	187, 161		202. 00
203.00   Unit cost multiplier (Wkst. B, Part I)	8. 083397	0. 000000	85. 266970		203. 00
	. '				•

Health Fin	ancial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOC	ATION - STATISTICAL BASIS		Provi der C	CN: 15-1333	Peri od:	Worksheet B-1
					From 01/01/2020 To 12/31/2020	
	Cost Center Description	MEDI CAL	SOCI AL	UTI LI ZATI ON	1	
		RECORDS &	SERVI CE	REVI EW		
		LI BRARY	(PATI ENT	(PATI ENT		
		(TIME SPENT)	DAYS)	DAYS)		
		16. 00	17. 00	17. 01		
204.00	Cost to be allocated (per Wkst. B,	112, 295	0	10, 5	55	204. 00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	1. 090359	0. 000000	4. 8086	56	205.00
	11)					
206. 00	NAHE adjustment amount to be allocated					206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,					207.00
	Parts III and IV)					
'	,	1		1	1	'

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1333	Period: Worksheet C From 01/01/2020 Part I

To 12/31/2020 Date/Time Prepared: 7/15/2021 2: 27 pm Title XVIII Hospi tal Cost 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) 1. 00 4. 00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 855, 554 3, 855, 554 0 0 30.00 03100 INTENSIVE CARE UNIT 1, 751, 202 1, 751, 202 0 0 31.00 31.00 43.00 04300 NURSERY 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 769, 857 2, 769, 857 0 50.00 51.00 05100 RECOVERY ROOM 250, 212 250, 212 0 0 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 05300 ANESTHESI OLOGY 430, 829 53 00 430, 829 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 350, 319 2, 350, 319 0 0 0 0 0 0 0 0 54.00 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 172, 112 172, 112 0 54.01 03480 ONCOLOGY 54.02 4, 873, 053 4, 873, 053 0 54.02 57.00 05700 CT SCAN 654, 195 654, 195 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 3, 497, 951 3, 497, 951 60.00 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06400 INTRAVENOUS THERAPY 64.00 0 0 0 0 0 0 0 0 64.00 06500 RESPIRATORY THERAPY 889, 836 889, 836 65.00 0 65.00 06600 PHYSI CAL THERAPY 66.00 700, 816 0 700, 816 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 129,086 0 129,086 0 67.00 06800 SPEECH PATHOLOGY 68.00 54,075 54,075 0 68.00 69 00 06900 ELECTROCARDI OLOGY 208.977 208.977 Ω 69 00 69.01 06901 CARDI AC REHAB 498, 403 498, 403 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 o 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 249.907 249, 907 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 751, 165 1, 751, 165 0 73.00 73.01 03950 ONCOLOGY 0 73.01 OUTPATIENT SERVICE COST CENTERS 88 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED 2, 716, 686 2, 716, 686 0 n 88.00 o 08801 FAMILY MEDICINE OF CLOVERDALE 88.01 2, 323, 423 2, 323, 423 0 88.01 88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE 2, 349, 210 2, 349, 210 0 0 88.02 ol 90.00 09000 CLI NI C 10, 230 10, 230 0 90.00 90 01 09001 RHFUMATOLOGY o 90 01 421, 730 421, 730 0 09100 EMERGENCY 91.00 91.00 4, 620, 873 4, 620, 873 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 914, 716 914, 716 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 99.10 99.10 09910 CORE 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 38, 444, 417 38, 444, 417 0 200. 00 200.00 Subtotal (see instructions) 0 0 201.00 914, 716 914, 716 Less Observation Beds 0 201.00 202.00 Total (see instructions) 37, 529, 701 37, 529, 701 0 202.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1333	Period: Worksheet C From 01/01/2020 Part I

To 12/31/2020 Date/Time Prepared: 7/15/2021 2:27 pm Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col. 7) Ratio I npati ent Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 4, 388, 115 30.00 03000 ADULTS & PEDIATRICS 4, 388, 115 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 448, 476 1, 448, 476 31.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 544.346 2, 815, 101 3, 359, 447 0.824498 0.000000 50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM 63, 883 332, 323 396, 206 0.631520 0.000000 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52 00 05300 ANESTHESI OLOGY 26.484 282, 032 308.516 1.396456 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 819, 840 7,085,261 7, 905, 101 0.297317 0.000000 54 00 32, 644 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 1, 111, 922 1, 144, 566 0.150373 0.000000 54.01 54.02 03480 ONCOLOGY 3, 931 8, 176, 810 8, 180, 741 0.595674 0.000000 54.02 05700 CT SCAN 593, 046 16, 512, 531 17, 105, 577 0.038245 0.000000 57 00 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59 00 0.000000 59.00 13, 497, 929 06000 LABORATORY 15, 030, 631 0.232722 0.000000 60.00 1, 532, 702 60.00 06001 BLOOD LABORATORY 60.01 Ω 0 0.000000 0.000000 60 01 06400 I NTRAVENOUS THERAPY 0.000000 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 1, 345, 083 741, 485 2,086,568 0.426459 0.000000 65.00 06600 PHYSI CAL THERAPY 1, 987, 519 66.00 523, 555 2, 511, 074 0.279090 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 169, 028 325, 230 494, 258 0. 261171 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 44, 228 164, 319 208, 547 0.259294 0.000000 68.00 06900 ELECTROCARDI OLOGY 234, 494 872, 119 0.188844 0.000000 69.00 1, 106, 613 69.00 69.01 06901 CARDI AC REHAB 4, 906 597, 313 602, 219 0.827611 0.000000 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0.000000 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENT 130, 794 343, 482 72.00 212, 688 0.727569 0.000000 72.00 2, 979, 834 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 1, 110, 936 1,868,898 0.587672 03950 ONCOLOGY 73.01 0.000000 0.000000 73.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED 0 2, 061, 932 2, 061, 932 88.00 88 01 08801 FAMILY MEDICINE OF CLOVERDALE 0 2, 139, 152 2 139 152 88 01 08802 NORTH PUTNAM FAMILY HEALTHCARE 0 88.02 1,543,201 1,543,201 88.02 90.00 09000 CLI NI C 0 2.718576 0.000000 90.00 3, 763 3.763 90.01 09001 RHEUMATOLOGY 0 11, 779 11,779 35.803549 0.000000 90.01 09100 EMERGENCY 0 278937 0.000000 91 00 334, 266 16, 231, 757 16, 566, 023 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1,068,645 1,068,645 0.855959 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 99 10 09910 CORE 0 0 99 10 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 13, 350, 757 79, 643, 709 92, 994, 466 200.00 Subtotal (see instructions) 201 00 201.00 Less Observation Beds 202.00 Total (see instructions) 13, 350, 757 79, 643, 709 92, 994, 466 202.00 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: From 01/01/2020 To 12/31/2020 Date/Time Prepared: 7/15/2021 2: 27 pm

			To 12/31/2020	Date/Time Prepared: 7/15/2021 2:27 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31. 00   03100   INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	0.00000			
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 I MAGING (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	0. 000000			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
73. 01 03950 ONCOLOGY	0. 000000			73. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED				88.00
88. 01   08801   FAMILY MEDICINE OF CLOVERDALE				88. 01
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE				88. 02
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				00.10
99. 10   09910   CORF				99. 10
SPECIAL PURPOSE COST CENTERS				110.00
113. 00 11300 INTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00   Total (see instructions)				202. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1333	Peri od: Worksheet C
		From 01/01/2020   Part

					rom 01/01/2020 o 12/31/2020		pared:
			Ti tl	e XIX	Hospi tal	Cost	. / 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) 1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00	03000 ADULTS & PEDIATRICS	3, 855, 554		3, 855, 554	0	3, 855, 554	30.00
31. 00	03100 I NTENSI VE CARE UNI T	1, 751, 202		1, 751, 202		1, 751, 202	1
43. 00	04300 NURSERY	0		1,701,202		0	1
	ANCILLARY SERVICE COST CENTERS	_		_			1
50.00	05000 OPERATING ROOM	2, 769, 857		2, 769, 857	0	2, 769, 857	50.00
51.00	05100 RECOVERY ROOM	250, 212		250, 212	0	250, 212	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	430, 829		430, 829	0	430, 829	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	2, 350, 319		2, 350, 319	0	2, 350, 319	54.00
54. 01	05401   NUCLEAR   MEDICINE-DI AGNOSTI C	172, 112		172, 112	0	172, 112	54. 01
54. 02	03480 ONCOLOGY	4, 873, 053		4, 873, 053		4, 873, 053	1
57. 00	05700 CT SCAN	654, 195		654, 195		654, 195	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0		0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59.00
60.00	06000 LABORATORY	3, 497, 951		3, 497, 951	0	3, 497, 951	1
60. 01	06001 BLOOD LABORATORY	0		0	_	0	60.01
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	889, 836	0	000 024	0	0 889, 836	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	700, 816	l .	889, 836 700, 816		700, 816	1
67. 00	06700 OCCUPATI ONAL THERAPY	129, 086	l .	129, 086		129, 086	1
68. 00	06800 SPEECH PATHOLOGY	54, 075		54, 075		54, 075	1
69. 00	06900 ELECTROCARDI OLOGY	208, 977		208, 977		208, 977	
69. 01	06901 CARDI AC REHAB	498, 403		498, 403		498, 403	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1		0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	249, 907		249, 907	0	249, 907	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 751, 165		1, 751, 165		1, 751, 165	1
73. 01	03950 ONCOLOGY	0		0	0	0	73. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 PUTNAM PEDIATRICS AND INTERNAL MED	2, 716, 686		2, 716, 686	0	2, 716, 686	88. 00
88. 01	08801 FAMILY MEDICINE OF CLOVERDALE	2, 323, 423		2, 323, 423		2, 323, 423	
88. 02	08802 NORTH PUTNAM FAMILY HEALTHCARE	2, 349, 210	l .	2, 349, 210		2, 349, 210	1
90.00	09000 CLI NI C	10, 230		10, 230		10, 230	1
90. 01	09001 RHEUMATOLOGY	421, 730		421, 730		421, 730	1
91.00	09100 EMERGENCY	4, 620, 873	l .	4, 620, 873		4, 620, 873	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	914, 716		914, 716		914, 716	92.00
00.40	OTHER REIMBURSABLE COST CENTERS			1 0			00.40
99. 10	09910 CORF	0		0		0	99. 10
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE			1			113.00
200.00	l I	38, 444, 417	0	38, 444, 417	0	38, 444, 417	
200.00	,	914, 716	_	914, 716		914, 716	1
201.00	l I	37, 529, 701	l o				
202.00	1.564 (566 11156 466 6115)	07, 027, 701	1	1 37, 327, 701	1	37, 327, 701	1-02.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form C		
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1333	Peri od: From 01/01/2020	Worksheet C Part I	

					To 12/31/2020		epared: 27 pm
			Ti tl	e XIX	Hospi tal	Cost	
	Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent	
						Ratio	
	T	6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			T			
30.00	03000 ADULTS & PEDI ATRI CS	4, 388, 115		4, 388, 11			30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 448, 476		1, 448, 47			31.00
43.00	04300 NURSERY	0			)		43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	544, 346	2, 815, 101			0. 000000	1
51.00	05100 RECOVERY ROOM	63, 883	332, 323	1		0. 000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	1
53.00	05300 ANESTHESI OLOGY	26, 484	282, 032	1		0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	819, 840	7, 085, 261			0. 000000	
54. 01	05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C	32, 644	1, 111, 922			0. 000000	
54. 02	03480 ONCOLOGY	3, 931	8, 176, 810			0. 000000	1
57.00	05700 CT SCAN	593, 046	16, 512, 531	17, 105, 57		0. 000000	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0.000000	0. 000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0.000000	0. 000000	
60.00	06000 LABORATORY	1, 532, 702	13, 497, 929	15, 030, 63	0. 232722	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	)	0.000000	0. 000000	60. 01
64.00	06400 I NTRAVENOUS THERAPY	0	0	)	0.000000	0. 000000	64.00
65.00	06500 RESPI RATORY THERAPY	1, 345, 083	741, 485	2, 086, 56	0. 426459	0. 000000	65.00
66.00	06600 PHYSI CAL THERAPY	523, 555	1, 987, 519	2, 511, 07	4 0. 279090	0. 000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	169, 028	325, 230	494, 25	0. 261171	0. 000000	67.00
68.00	06800 SPEECH PATHOLOGY	44, 228	164, 319	208, 54	7 0. 259294	0. 000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	234, 494	872, 119	1, 106, 61	0. 188844	0. 000000	69. 00
69. 01	06901 CARDI AC REHAB	4, 906	597, 313	602, 21	9 0. 827611	0. 000000	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	1	0.000000	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	130, 794	212, 688	343, 48	0. 727569	0. 000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 110, 936	1, 868, 898	2, 979, 83	4 0. 587672	0. 000000	73.00
73. 01	03950 ONCOLOGY	0	0		0.000000	0. 000000	73. 01
	OUTPATIENT SERVICE COST CENTERS				<u> </u>		
88.00	08800 PUTNAM PEDIATRICS AND INTERNAL MED	0	2, 061, 932	2, 061, 93	2 1. 317544	0. 000000	88. 00
88. 01	08801 FAMILY MEDICINE OF CLOVERDALE	o	2, 139, 152	2, 139, 15	1. 086142	0. 000000	88. 01
88. 02	08802 NORTH PUTNAM FAMILY HEALTHCARE	o	1, 543, 201	1, 543, 20	1 1. 522297	0. 000000	88. 02
90.00	09000 CLI NI C	O	3, 763		2. 718576	0. 000000	90.00
90. 01	09001 RHEUMATOLOGY	O	11, 779	11, 77	9 35. 803549	0. 000000	90. 01
91.00	09100 EMERGENCY	334, 266	16, 231, 757	16, 566, 02		0. 000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	1, 068, 645	1, 068, 64	0. 855959	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	·					
99. 10	09910 CORF	0	0		o		99. 10
	SPECIAL PURPOSE COST CENTERS			•			
113.00	11300 I NTEREST EXPENSE						113.00
200.00	1	13, 350, 757	79, 643, 709	92, 994, 46	6		200.00
201.00			, = .=, . 0,				201.00
202.00	i i	13, 350, 757	79, 643, 709	92, 994, 46	6		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:
From 01/01/2020
To 12/31/2020
Date/Time Prepared:
7/15/2021 2: 27 pm

			10 12/31/2020	7/15/2021 2:27 pm
		Ti tle XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient	THE ALX	iloopi tui	9991
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
54. 01   05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000			54. 01
54. 02 03480 ONCOLOGY	0. 000000			54.02
57. 00 05700 CT SCAN	0. 000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00   06000   LABORATORY	0. 000000			60.00
60. 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	0. 000000			69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
73. 01   03950   ONCOLOGY	0. 000000			73. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	0. 000000			88.00
88.01 08801 FAMILY MEDICINE OF CLOVERDALE	0. 000000			88. 01
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE	0. 000000			88. 02
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				
113. 00 11300   NTEREST EXPENSE			<u> </u>	113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2020	Part II	
				To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
		Ti +l c	XVIII	Hospi tal	77 137 2021 2.2 Cost	/ pili
Cost Center Description	Capi tal	Total Charges			Capital Costs	
oust defiter bescription	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)	onal ges	cor anni 1)	
	col. 26)	33.1 3)	55 27			
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	11.22		2. 2.			
50. 00 05000 OPERATING ROOM	275, 820	3, 359, 447	0. 08210	3 190, 752	15, 661	50.00
51.00   05100   RECOVERY ROOM	62, 669	396, 206	0. 15817	3 22, 847	3, 614	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	ol	0	52.00
53. 00 05300 ANESTHESI OLOGY	4, 176	308, 516	0. 01353	6 11, 448	155	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	103, 892		0. 01314		5, 120	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	4, 954	1, 144, 566	0.00432	8 22, 776	99	54.01
54. 02 03480 ONCOLOGY	165, 983			9 279	6	54.02
57. 00 05700 CT SCAN	40, 554			1 280, 029	664	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	o o	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	ol ol	0	59.00
60. 00   06000   LABORATORY	97, 231	15, 030, 631	0.00646	9 694, 226	4, 491	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0.00000	o	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	0	0	0.00000	ol ol	0	64.00
65. 00 06500 RESPIRATORY THERAPY	26, 858	2, 086, 568	0. 01287	2 580, 140	7, 468	65.00
66. 00 06600 PHYSI CAL THERAPY	50, 513	2, 511, 074	0. 02011	6 168, 470	3, 389	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	951	494, 258	0.00192	4 69, 651	134	67.00
68. 00 06800 SPEECH PATHOLOGY	398	208, 547	0.00190	8 20, 128	38	68.00
69. 00 06900 ELECTROCARDI OLOGY	4, 499	1, 106, 613	0.00406	6 17, 054	69	69.00
69. 01   06901   CARDI AC   REHAB	47, 162	602, 219	0. 07831	4 3, 908	306	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.00000	ol	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	1, 840	343, 482	0.00535	7 26, 693	143	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	37, 895	2, 979, 834	0.01271	7 503, 304	6, 401	73.00
73. 01 03950 ONCOLOGY	0	0	0.00000	ol	0	73. 01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED	147, 945	2, 061, 932	0. 07175	1 0	0	88. 00
88.01 08801 FAMILY MEDICINE OF CLOVERDALE	186, 846	2, 139, 152	0.08734	6 0	0	88. 01
88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE	187, 034	1, 543, 201	0. 12119	9 0	0	88. 02
90. 00  09000 CLI NI C	4, 341	3, 763	1. 15360	1 0	0	90.00
90. 01 09001 RHEUMATOLOGY	17, 033	11, 779	1. 44604	8  o	0	90. 01
91. 00 09100 EMERGENCY	234, 166	16, 566, 023	0. 01413	5 10, 928	154	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	78, 518	1, 068, 645	0. 07347	4 0	0	92.00
200.00   Total (lines 50 through 199)	1, 781, 278	87, 157, 875		3, 012, 229	47, 912	200. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS   Provider CCN: 15-1333	
		F 01 /01 /0000   D+ 11/

From 01/01/2020 | Part IV To 12/31/2020 | Date/Time Prepared: THROUGH COSTS 7/15/2021 2: 27 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 000000000000000000000000 0 0 51.00 05100 RECOVERY ROOM 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 0 53.00 05300 ANESTHESI OLOGY 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) 0 58.00 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 0 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 69.00 0 69.01 06901 CARDI AC REHAB 0 69.01 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0 0 0 0 o 73.01 03950 ONCOLOGY 0 0 73.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED 0 0 0 0 88.00 08801 FAMILY MEDICINE OF CLOVERDALE 0 88. 01 0 0 0 0 0 0 0 0 0 88.01 08802 NORTH PUTNAM FAMILY HEALTHCARE 0 0 88.02 88.02 0 90. 00 09000 CLINIC 0 0 90.00 0 09001 RHEUMATOLOGY 0 0 90.01

0

0

91.00

92.00 0

0 200.00

0

0

0

90. 01

200.00

91. 00 09100 EMERGENCY

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

Total (lines 50 through 199)

Health Financial Systems		PUTNAM CO	UNTY HOSPITAL		In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	/OUTPATIENT ANCILLARY	SERVICE OTHER I	PASS Provi der	CCN: 15-1333	Peri od:	Worksheet D

From 01/01/2020 | Part IV To 12/31/2020 | Date/Time Prepared: THROUGH COSTS 7/15/2021 2: 27 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) (see instructions) 4. 00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 3, 359, 447 0.000000 50.00 05100 RECOVERY ROOM 0 0 396, 206 0.000000 51.00 00000000000000000000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 0 0 308, 516 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 7, 905, 101 0.000000 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0 1, 144, 566 0.000000 54.01 54.01 54.02 03480 ONCOLOGY 0 0 8, 180, 741 0.000000 54.02 57.00 05700 CT SCAN 0 17, 105, 577 0.000000 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 59.00 0 06000 LABORATORY 0 15, 030, 631 0.000000 60.00 60.00 60.01 06001 BLOOD LABORATORY 0 0.000000 60.01 06400 I NTRAVENOUS THERAPY 0 0 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 2, 086, 568 0 0.000000 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 0 2, 511, 074 0.000000 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 494, 258 0.000000 67.00 06800 SPEECH PATHOLOGY 68.00 208, 547 0.000000 68.00 06900 ELECTROCARDI OLOGY 0 1, 106, 613 0.000000 69 00 0 69 00 0 69.01 06901 CARDI AC REHAB 0 602, 219 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 0 0 343, 482 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 2, 979, 834 0.000000 73.00 73.00 03950 ONCOLOGY 73.01 0 0.000000 73.01 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED 2, 061, 932 0.000000 88.00 08801 FAMILY MEDICINE OF CLOVERDALE 0 0 0.000000 88.01 88.01 2, 139, 152 88.02 08802 NORTH PUTNAM FAMILY HEALTHCARE 0000 0 0 1, 543, 201 0.000000 88.02 09000 CLI NI C 90.00 0 0 3, 763 0.000000 90.00 01 0 09001 RHEUMATOLOGY 0.000000 90.01 11, 779 90 01 0 91. 00 09100 EMERGENCY 0 16, 566, 023 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 068, 645 92.00 0.000000 Total (lines 50 through 199) 0 87, 157, 875 200.00

200.00

Health Financial Systems	PUTNAM COUNTY H	IOSPI TAL	In Li	eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-1333	Peri od:	Worksheet D

From 01/01/2020 Part IV
To 12/31/2020 Date/Time Prepared: THROUGH COSTS 7/15/2021 2: 27 pm Title XVIII Hospi tal Cost Outpati ent I npati ent I npati ent Outpati ent Cost Center Description Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges (col. 6 ÷ col. 7) Costs (col. 8 Costs (col. x col. 12) 13.00 x col. 10) 9. 00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0.000000 190, 752 50.00 0 05100 RECOVERY ROOM 0.000000 22, 847 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0.000000 11, 448 0 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 389, 596 0 54.00 0 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.000000 22, 776 0 54.01 54.02 03480 ONCOLOGY 0.000000 279 0 0 54.02 05700 CT SCAN 0.000000 0 57 00 280, 029 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0.000000 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 0 60.00 06000 LABORATORY 0.000000 694, 226 0 60.00 06001 BLOOD LABORATORY 0 0.000000 0 60.01 60.01 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0.000000 580, 140 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0.000000 168, 470 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0.000000 69, 651 0 67.00 06800 SPEECH PATHOLOGY 0.000000 20, 128 0 0 68.00 68.00 06900 ELECTROCARDI OLOGY 0 0.000000 17, 054 0 69.00 69.00 06901 CARDI AC REHAB 0 69.01 0.000000 3, 908 0 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 72.00 0.000000 26, 693 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 503, 304 0 73.00 03950 ONCOLOGY 0 0 73.01 0.000000 0 0 73.01 OUTPATIENT SERVICE COST CENTERS 08800 PUTNAM PEDIATRICS AND INTERNAL MED 88.00 0.000000 0 0 0 88.00 0 08801 FAMILY MEDICINE OF CLOVERDALE 0.000000 0 0 0 0 0 88 01 Ω 0 88.01 08802 NORTH PUTNAM FAMILY HEALTHCARE 0.000000 88.02 0 0 88.02 90.00 09000 CLI NI C 0.000000 0 0 90.00 09001 RHEUMATOLOGY 0 90.01 0.000000 0 90.01 0 91. 00 09100 EMERGENCY 0.000000 10, 928 91.00 0

0.000000

3, 012, 229

0

0 92.00

0 200.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (lines 50 through 199)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 15-1333 Peri od: Worksheet D From 01/01/2020 Part V 12/31/2020 Date/Time Prepared: 7/15/2021 2:27 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 810, 909 0.824498 50.00 05100 RECOVERY ROOM 60, 820 0 0.631520 51.00 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 53.00 05300 ANESTHESI OLOGY 1.396456 54,658 0 0 53.00 ol 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 297317 1, 639, 841 0 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 54.01 0.150373 313, 516 0 0 54.01 54.02 03480 ONCOLOGY 0.595674 3, 852, 406 787 0 54.02 57.00 05700 CT SCAN 0.038245 4, 421, 355 27 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0.000000 0 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 59.00 59 00  $\cap$ 0 60.00 06000 LABORATORY 0. 232722 4, 324, 343 0 0 60.00 06001 BLOOD LABORATORY 60.01 0.000000 0 0 0 0 0 0 0 0 60.01 06400 INTRAVENOUS THERAPY 64 00 0.000000 0 64 00 65.00 06500 RESPIRATORY THERAPY 0. 426459 135, 570 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.279090 472, 492 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0. 261171 78, 123 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 0 259294 32, 391 Ω 68 00 69.00 06900 ELECTROCARDI OLOGY 0.188844 0 334, 742 0 69.00 0 06901 CARDI AC REHAB 0.827611 159, 455 0 69.01 69.01 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.727569 0 61, 769 72.00 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0.587672 0 521, 142 0 73.00 03950 ONCOLOGY 0.000000 0 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 08800 PUTNAM PEDIATRICS AND INTERNAL MED 88.00 88 00 88. 01 08801 FAMILY MEDICINE OF CLOVERDALE 88.01 08802 NORTH PUTNAM FAMILY HEALTHCARE 88. 02 88.02 09000 CLI NI C 90 00 90 00 2 718576 477 0 0 90.01 09001 RHEUMATOLOGY 35. 803549 0 90.01 09100 EMERGENCY 0. 278937 3, 550, 798 91.00 91.00 2, 300 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.855959 0 297,009 0 92.00 0 200.00 21, 121, 816 200.00 Subtotal (see instructions) 0 3.170 201.00 Less PBP Clinic Lab. Services-Program 201.00

21, 121, 816

3, 170

0 202.00

Only Charges

Net Charges (line 200 - line 201)

202.00

Health Financial Systems	PUTNAM COUNTY HOS	SPI TAL	In Lieu	of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST P	Provider CCN: 15-1333	Peri od: From 01/01/2020	Worksheet D Part V

12/31/2020 Date/Time Prepared: 7/15/2021 2:27 pm Title XVIII Hospi tal Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 668, 593 50.00 05100 RECOVERY ROOM 51.00 38, 409 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 76, 327 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 487, 553 0 54.00 05401 NUCLEAR MEDICINE-DIAGNOSTIC 47, 144 54.01 Ω 54.01 54.02 03480 ONCOLOGY 2, 294, 778 469 54.02 57.00 05700 CT SCAN 169, 095 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 58.00 0 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 60.00 06000 LABORATORY 1,006,370 0 60.00 06001 BLOOD LABORATORY 60.01 0 60.01 06400 INTRAVENOUS THERAPY 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 57, 815 0 65.00 66.00 06600 PHYSI CAL THERAPY 131, 868 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 20, 403 67.00 06800 SPEECH PATHOLOGY 8, 399 0 68 00 68 00 0 69.00 06900 ELECTROCARDI OLOGY 63, 214 69.00 69.01 06901 CARDI AC REHAB 131, 967 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 44, 941 72 00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 306, 261 33 73.00 03950 ONCOLOGY 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 08800 PUTNAM PEDIATRICS AND INTERNAL MED 88.00 88.00 88. 01 08801 FAMILY MEDICINE OF CLOVERDALE 88.01 08802 NORTH PUTNAM FAMILY HEALTHCARE 88.02 88.02 09000 CLI NI C 1, 297 90 00 Ω 90 00 90.01 09001 RHEUMATOLOGY C 90.01 91.00 09100 EMERGENCY 990, 449 91.00 642 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 254, 228 92.00 6, 799, 111 200.00 200.00 Subtotal (see instructions) 1, 145 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

6, 799, 111

1, 145

202.00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1333	Peri od: From 01/01/2020	Worksheet D-1	
			Date/Time Pre 7/15/2021 2:2	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				

		Title XVIII	Hospi tal	7/15/2021 2: 2 Cost	7 pm
	Cost Center Description	THE AVIII	1103pi tui	0031	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	excluding newborn)		2, 685	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			2, 506	2. 00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
	do not complete this line.			4 070	
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation between Total swing-bed SNF type inpatient days (including private ro		or 21 of the cost	1, 872 165	4. 00 5. 00
5.00	reporting period	on days) through becember	si Si di tile cost	105	5.00
6.00	Total swing-bed SNF type inpatient days (including 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 (including private roo	m days) through December	31 of the cost	14	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roo	m days) after December 3	11 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	iii days) arter becember e	or the cost	O	0.00
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	905	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	125	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom davs) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, e			_	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00
12.00	through December 31 of the cost reporting period	V (:		0	10.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13. 00
14. 00	Medically necessary private room days applicable to the Progr			0	14.00
15.00	Total nursery days (title V or XIX only)	. 3 3	,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16.00
17.00	SWING BED ADJUSTMENT	and the same Denomber 21	£ 11		17.00
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 (	or the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	137. 42	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 21 of t	ho cost	0.00	20. 00
20.00	reporting period	s arter becember 31 or 1	ile cost	0.00	20.00
21.00	Total general inpatient routine service cost (see instruction	s)		3, 855, 554	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	. 0	22.00
22.00	5 x line 17)	21 of the cost reporting	na norted (line (	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporter	ig period (iine d	0	23. 00
24.00		r 31 of the cost reporti	ng period (line	1, 924	24.00
	7 x line 19)	·			
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			239, 981	26. 00
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 615, 573	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	,			
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	
29. 00				0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	. 11116 20)		0. 00	32.00
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 mi		ctions)	0. 00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	35.00
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 di	fferential (line	0 3, 615, 573	36. 00 37. 00
37.00	27 minus line 36)	and private room cost ur	risisiitiai (IIII	5,010,075	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			1, 442. 77	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	•		1, 305, 707 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39			1, 305, 707	
	, , , , , , , , , , , , , , , , , , , ,	,	'		

	Financial Systems	PUTNAM COUNTY		ON 45 4000		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2020 To 12/31/2020	Date/Time Pre	pared:
			Ti +l 4	e XVIII	Hospi tal	7/15/2021 2: 2 Cost	7 pm
	Cost Center Description	Total I npati ent Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)	0	C	0.0	0 0	0	42.00
44.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	1, 751, 202	323	5, 421. 6	8 133	721, 083	43. 00 44. 00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						45. 00 46. 00 47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			1, 121, 923	48. 00
	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	<b>y</b> , ,		,		3, 148, 713	
50. 00	Pass through costs applicable to Program inpull)		·				
51. 00	Pass through costs applicable to Program inpand IV)	-	y services (f	rom Wkst. D, s	sum of Parts II	0	
52. 00 53. 00	Total Program excludable cost (sum of lines I Total Program inpatient operating cost exclu- medical education costs (line 49 minus line I	ding capital rel	ated, non-ph	ysician anesth	netist, and	0	
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)			lt Ez ete e	11	0	
57.00 58.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	rget amount (	line 56 minus	11ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	endi ng 1996,	updated and co	ompounded by the	-	
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, upo	dated by the	market basket		0.00	60.00
61. 00	of the amount by 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)						61.00
62.00 Relief payment (see instructions) 63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						0	62. 00 63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decen	nber 31 of th	e cost reporti	ng period (See	180, 346	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	er 31 of the	cost reportino	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 6	64 plus line	65)(title XVII	I only). For	180, 346	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e 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 PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service co	ity/ICF/IID rout	tine service	cost (line 37)	)		70.00 71.00
72. 00	Program routine service cost (line 9 x line		110 70 . 11110	2)			72.00
73.00	Medically necessary private room cost application						73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•		,	Part II, column		74. 00 75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu:						78.00
79. 00	Aggregate charges to beneficiaries for exces	, ,		•	==>		79. 00
80. 00 81. 00	Total Program routine service costs for company inpatient routine service cost per diem limi		ost limitatio	n (line 78 mir	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem frim		)				82.00
83.00	Reasonable inpatient routine service costs (	see instructions					83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ne)				84. 00 85. 00
	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<i>,</i>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			634 1, 442. 77	•
	Observation bed cost (line 87 x line 88) (see	•	2)			914, 716	

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2020 To 12/31/2020		
		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	330, 958	3, 855, 554	0. 08583	9 914, 716	78, 518	90.00
91.00 Nursing School cost	0	3, 855, 554	0.00000	0 914, 716	0	91.00
92.00 Allied health cost	0	3, 855, 554	0.00000	0 914, 716	0	92.00
93.00 All other Medical Education	0	3, 855, 554	0. 00000	0 914, 716	0	93. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1333	Peri od: From 01/01/2020 To 12/31/2020	Date/Time Pre	
	Title XIX	Hospi tal	7/15/2021 2: 2 Cost	7 pm
Cost Center Description		1.2 / 2.00		

		Title XIX	Hospi tal	7/15/2021 2: 2 Cost	7 pm
	Cost Center Description	THE XIX	поэрг саг	0031	
	E			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		2, 685	1.00
2.00	Inpatient days (including private room days, excluding swing-			2, 506	2. 00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	rivate room days,	0	3.00
4 00	do not complete this line.	ad daya)		1 072	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	1, 872 165	4. 00 5. 00
0.00	reporting period	om days) tri odgr becombe	01 01 110 0031	100	0.00
6.00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
7 00	reporting period (if calendar year, enter 0 on this line)		04 6 11	ا	7.00
7. 00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	14	7. 00
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	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 t	o the Program (excluding	g swing-bed and	42	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	soom days)	165	10.00
10.00	through December 31 of the cost reporting period (see instruc		oolii days)	100	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, e				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12.00
13 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	Y only (including privat	e room days)	o	13.00
13.00	after December 31 of the cost reporting period (if calendar y			,	13.00
14.00	Medically necessary private room days applicable to the Progr			0	14.00
15.00				0	15.00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost		17. 00
17.00	reporting period	es till odgir becember 51 c	or the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
40.00	reporting period			107.10	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through December 31 of	the cost	137. 42	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0.00	20. 00
	reporting period				
21. 00	, ,			3, 855, 554	
22. 00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 1$ ine 17)	er 31 of the cost report	ing period (line	0	22. 00
23. 00		31 of the cost reportir	na period (line 6	0	23. 00
	x line 18)		5   1		
24. 00	] 3	r 31 of the cost reporti	ng period (line	1, 924	24.00
25 00	7 x line 19)	21 of the cost reporting	noried (line 0	0	25. 00
25.00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	j period (iine 8	١	25.00
26.00	Total swing-bed cost (see instructions)			239, 981	26.00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 615, 573	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT				00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cr	narges)	0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	
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 mi		ctions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0. 00 0	35. 00 36. 00
37.00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line		
	27 minus line 36)	,		.,,	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			1 440 77	20.00
38.00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 442. 77 60, 596	38. 00 39. 00
	Medically necessary private room cost applicable to the Progr	•		00, 590	40.00
	Total Program general inpatient routine service cost (line 39	,		60, 596	
			!		

	Financial Systems	PUTNAM COUNT				u of Form CMS-2	
COMPUTATION OF INPATIENT OPERATING COST			Provi der C		Period: Worksheet D-1 From 01/01/2020		
					To 12/31/2020	Date/Time Pre 7/15/2021 2:2	pared: 7 pm
				e XIX	Hospi tal	Cost	
	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)	
40.00	NUDGEDY (1) II. M. A. W. V. J. A.	1. 00	2.00	3.00	4. 00	5. 00	40.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	0 0	0	42.00
43.00	INTENSIVE CARE UNIT	1, 751, 202	323	5, 421. 6	8 0	0	
44.00	CORONARY CARE UNIT						44.00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)			98, 930	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		159, 526	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	sarvicas (fro	m Wket D sur	n of Parts I and	0	50.00
30.00	III)	attent routine	services (110	III WKSt. D, Sui	or raits rain		30.00
51.00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	0	51.00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	netist, and	0	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0. 00 0	
56. 00 57. 00	Target amount (line 54 x line 55)						56. 00 57. 00
58. 00							
59. 00	0.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the 0.00 5						
60. 00	market basket  OU Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket  OU Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket  OU Lesser of Lines 53/54 or 55 from prior year cost report, updated by the market basket						
61. 00	If line 53/54 is less than the lower of line				the amount by	0	1
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	f the target		
62. 00	amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions)						62.00
63. 00	00 Allowable Inpatient cost plus incentive payment (see instructions)						
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  ON Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See 238,057)						
01.00	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See						65.00
66. 00	instructions)(title XVIII only)					238, 057	66.00
<b>.</b>	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68. 00	00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						68. 00
69. 00	(line 13 x line 20)  On Total title V or XIX swing-had NE innation, routing costs (line 67 + line 68)					0	69.00
09.00	0 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)  PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						09.00
70.00	Skilled nursing facility/other nursing facil				)		70.00
71. 00 72. 00							71. 00 72. 00
73. 00							73.00
74.00	Total Program general inpatient routine serv	•		•	Dant II galumn		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	worksneet B, F	art II, column		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	,					76. 00
77. 00 78. 00							77. 00 78. 00
79. 00							79.00
80.00							80.00
81. 00 82. 00							81. 00 82. 00
83.00	0 Reasonable inpatient routine service costs (see instructions)						83. 00
84.00	Program inpatient ancillary services (see in		one)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	<u> </u>				
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	÷ line 2)			634 1, 442. 77	1
	Observation bed cost (line 87 x line 88) (se	•				914, 716	

Health Financial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1		
				From 01/01/2020 To 12/31/2020			
		Ti tl	Ti tle XIX		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	330, 958	3, 855, 554	0. 08583	9 914, 716	78, 518	90.00	
91.00 Nursing School cost	0	3, 855, 554	0.00000	0 914, 716	0	91.00	
92.00 Allied health cost	0	3, 855, 554	0.00000	0 914, 716	0	92.00	
93.00 All other Medical Education	0	3, 855, 554	0. 00000	0 914, 716	0	93. 00	

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	PUTNAM COUNTY HOSPITAL Provider CO	N: 15_1333	Peri od:	u of Form CMS-2 Worksheet D-3	
THE ATTEM AND LEART SERVICE COST AFFORTIONWENT	FI OVI del CC		From 01/01/2020		
			To 12/31/2020		
	Title	XVIII	Hospi tal	7/15/2021 2:2 Cost	/ рііі
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
		ŭ	Charges	(col. 1 x	
			ŭ	col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					4
30. 00 03000 ADULTS & PEDIATRICS			1, 537, 645		30.00
31.00 03100 INTENSIVE CARE UNIT			555, 465		31.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS		0.00446	100 750	457.075	1
50. 00   05000   OPERATING ROOM		0. 82449		157, 275	
51. 00   05100   RECOVERY ROOM		0. 63152		14, 428	
52.00   05200   DELIVERY ROOM & LABOR ROOM 53.00   05300   ANESTHESIOLOGY		0.00000		15 007	
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C		1. 39645 0. 29731		15, 987 115, 834	
54. 00   05400  RADI OLOGI - DI AGNOSTI C 54. 01   05401  NUCLEAR   MEDI CI NE-DI AGNOSTI C		0. 29731		3, 425	
54. 02   03480   0NCOLOGY		0. 19037		166	
57. 00 05700 CT SCAN		0. 03824		10, 710	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 00000		0,710	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 00000		0	
60. 00 06000 LABORATORY		0. 23272		161, 562	1
60. 01   06001   BLOOD   LABORATORY		0.00000		0	
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	
65. 00 06500 RESPIRATORY THERAPY		0. 42645	580, 140	247, 406	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 27909	168, 470	47, 018	66.0
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26117	1 69, 651	18, 191	67.0
68.00 06800 SPEECH PATHOLOGY		0. 25929	20, 128	5, 219	68.0
69. 00 06900 ELECTROCARDI OLOGY		0. 18884	17, 054	3, 221	69.0
69. 01   06901   CARDI AC REHAB		0. 82761		3, 234	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.00000		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 72756		19, 421	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 58767		295, 778	
73. 01 03950 ONCOLOGY		0. 00000	00	0	73.0
OUTPATIENT SERVICE COST CENTERS			_1		4
88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED		0.00000		0	
88. 01 08801 FAMILY MEDICINE OF CLOVERDALE		0.00000		0	1
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE		0.00000		0	
90. 00   09000   CLI NI C		2. 71857		0	1
90. 01   09001   RHEUMATOLOGY		35. 80354	·9  0	0	90.0

0. 278937

0.855959

3, 012, 229

91.00

92.00 0

201. 00 202. 00

3, 048

1, 121, 923 200. 00

91. 00 09100 EMERGENCY

200.00 201. 00 202. 00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	PUTNAM COUNTY HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der (		Peri od:	Worksheet D-3	
	Component		From 01/01/2020 To 12/31/2020	Date/Time Pre	pared.
	Compensite			7/15/2021 2:2	
	Ti tl		Swing Beds - SNF		
Cost Center Description		Ratio of Cost		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	col . 2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00   03100   NTENSIVE CARE UNIT			0		31.00
43. 00   04300   NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					45.00
50. 00 05000 OPERATING ROOM		0. 82449	8 8, 496	7, 005	50.00
51. 00   05100   RECOVERY   ROOM		0. 63152		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
53. 00   05300   ANESTHESI OLOGY		1. 39645	6 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 29731	7 2, 007	597	54.00
54. 01   05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 15037	3 0	0	54.01
54. 02   03480   ONCOLOGY		0. 59567		0	54.02
57. 00   05700   CT   SCAN		0. 03824		0	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	59.00
60. 00   06000   LABORATORY		0. 23272		4, 759	
60. 01   06001   BL00D   LABORATORY		0.00000		0	60. 01
64. 00   06400   I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 42645		6, 238	
66. 00 06600 PHYSI CAL THERAPY		0. 27909		•	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26117		8, 287	
68. 00   06800   SPEECH PATHOLOGY		0. 25929		1, 397	68.00
69. 00   06900   ELECTROCARDI OLOGY		0. 18884		541 0	69.00
69. 01   06901   CARDI AC REHAB 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 82761			69. 01 71. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATTENTS 72.00 07200 IMPL. DEV. CHARGED TO PATTENT		0. 00000 0. 72756		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 72756			
73. 00   07300   DROGS CHARGED TO PATTENTS  73. 01   03950   ONCOLOGY		0. 00000		7,700	1
OUTPATIENT SERVICE COST CENTERS		0.00000	U <sub>I</sub> U	0	1 /3.01
88. 00 08800 PUTNAM PEDIATRICS AND INTERNAL MED		0.00000		0	88. 00
99 01 09901 FAMILY MEDICINE OF CLOVEDIALE		0.00000		_	00.00

0.000000 0. 000000

2.718576

35. 803549

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148, 909

148, 909

88. 01 88. 02

90.00

90.01

91.00 0

92.00 0

201. 00 202. 00

0

0

50, 545 200. 00

90.00

200.00

201.00 202.00

88. 01 08801 FAMILY MEDICINE OF CLOVERDALE 88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

09000 CLI NI C

90. 01 09001 RHEUMATOLOGY

91. 00 09100 EMERGENCY

DUTNAM CO	OUNTY HOODI TAI		1 1	of Form CMC :	0550 10
Health Financial Systems PUTNAM CO INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Period: From 01/01/2020 To 12/31/2020	Worksheet D-3  Date/Time Pre 7/15/2021 2:2	pared:
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					1
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 43. 00   04300   NURSERY			17, 070 10, 478 0		30. 00 31. 00 43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATING ROOM		0. 82449			50.00
51. 00   05100   RECOVERY ROOM		0. 63152			
52. 00   O5200   DELIVERY ROOM & LABOR ROOM		0.00000		_	
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C		1. 39645 0. 29731		9, 679 5, 802	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   NUCLEAR   MEDI CI NE-DI AGNOSTI C		0. 29731			1
54. 02   03480   0NCOLOGY		0. 13037		02	54.01
57. 00   05700   CT   SCAN		0. 03824		_	
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)		0.00000			58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON		0. 00000		0	59.00
60. 00   06000   LABORATORY		0. 23272			
60. 01   06001   BLOOD   LABORATORY		0. 00000		1	1
64. 00 06400 I NTRAVENOUS THERAPY		0. 00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY		0. 42645		9, 967	1
66. 00   06600   PHYSI CAL THERAPY		0. 27909			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 26117			67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 25929			68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 18884			69.00
69. 01 06901 CARDI AC REHAB		0. 82761		0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000	00	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 72756	9 298	217	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 58767	72 34, 856	20, 484	73.00
73. 01 03950 ONCOLOGY		0. 00000	00	0	73. 01
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 PUTNAM PEDIATRICS AND INTERNAL MED		1. 31754		_	00.00
88.01 08801 FAMILY MEDICINE OF CLOVERDALE		1. 08614		_	88. 01
88. 02 08802 NORTH PUTNAM FAMILY HEALTHCARE		1. 52229		_	
an an Inganal CLINIC		2 71957	16	Λ.	

2.718576

35. 803549

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0.855959

257, 668

90.00 90.01

91.00

92.00 0

201. 00 202. 00

0

98, 930 200. 00

11, 644

90.00

200.00

201.00 202.00

09000 CLI NI C

90. 01 09001 RHEUMATOLOGY

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

91. 00 09100 EMERGENCY

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1333	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E Part B Date/Time Prepared: 7/15/2021 2:27 pm

-		Title XVIII	Hospi tal	7/15/2021 2: 2 Cost	7 pm
		II the Aviii	nospi tai	COST	
				1. 00	
•	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6, 800, 256	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		0 0	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)				3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)			ĺ	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0.000	•
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	
8.00	Transitional corridor payment (see instructions)	IV and 12 line 200		0 0	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	1 V, COI. 13, 11 Ne 200			9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 800, 256	
	COMPUTATION OF LESSER OF COST OR CHARGES			,	
	Reasonable charges				
12.00	Ancillary service charges			l e	12.00
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ine 69)		0	
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
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			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	
18. 00 19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete on	ly if line 18 exceeds li	no 11) (soo	0 0	18. 00 19. 00
17.00	instructions)	Ty IT TITLE TO EXCEEUS IT	116 11) (366	٥	19.00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21.00	Lesser of cost or charges (see instructions)			6, 868, 259	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	ructions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	ructions)			24.00
2 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				200
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	s)		68, 899	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on lin			3, 353, 977	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	and 23] (see	3, 445, 383	27. 00
28. 00	instructions) 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)			Ö	29. 00
30.00	Subtotal (sum of lines 27 through 29)			3, 445, 383	30.00
31.00	Primary payer payments			2, 673	
32. 00	Subtotal (line 30 minus line 31)	CFC)		3, 442, 710	32.00
33. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI Composite rate ESRD (from Wkst. I-5, line 11)	CES)		0	33.00
34. 00	Allowable bad debts (see instructions)			674, 431	•
35.00	Adjusted reimbursable bad debts (see instructions)			438, 380	•
36. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		551, 466	
	Subtotal (see instructions)			3, 881, 090	
38. 00 39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				38. 00 39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	5)		l o	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 instruc	tions)	0	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			3, 881, 090	
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			25, 615 0	40. 01 40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			Ĭ	40. 03
41.00	Interim payments			3, 095, 091	
41. 01	Interim payments-PARHM				41. 01
42.00	Tentative settlement (for contractors use only)			0	
42. 01 43. 00	Tentative settlement-PARHM (for contractor use only) Balance due provider/program (see instructions)			760 201	42.01
43.00	Balance due provider/program-PARHM (see instructions)			760, 384	43. 00 43. 01
44. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	
	§115. 2	<u> </u>	·		
00	TO BE COMPLETED BY CONTRACTOR				00.5-
	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91. 00 92. 00
93. 00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			l e	94. 00

Health Financial Systems PUT
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: Provi der CCN: 15-1333

				10 12/31/2020	7/15/2021 2: 2	
		Title	e XVIII	Hospi tal	Cost	
	<u> </u>	Inpatie	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Total interim normente neid to provider	1. 00	2.00	3.00	4. 00	1 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		2, 487, 64	0	3, 095, 091 0	1. 00 2. 00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER		T	0	0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER			0		3. 01
3. 03				0	l o	3. 03
3. 04				o	l ol	3. 04
3. 05				Ö	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3. 51				0	0	3. 51
3. 52				0	0	3. 52
3.53				0	0	3.53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 54 3. 99
3. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 487, 64	14	3, 095, 091	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as		, , .			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR				1	
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			0	0	5. 01
5. 02				O	o	5. 02
5. 03				0	0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52	Subtatal (sum of lines E 01 E 40 minus sum of lines			0	0	5. 52 5. 99
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			U	ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6.00
5. 55	the cost report. (1)					5. 55
6. 01	SETTLEMENT TO PROVIDER		358, 35	54	760, 384	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		2, 845, 99		3, 855, 475	7. 00
				Contractor	NPR Date	
			0	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		U	1.00	2.00	8. 00
0.00	mano or contractor	l		T.	ı	0.00

Health Financial Systems PUT
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1333 | Period: | Worksheet E-1 | From 01/01/2020 | Part | To 12/31/2020 | Date/Time Prepared: | 7/15/2021 | 2:27 pm Provi der CCN: 15-1333

		'			7/15/2021 2: 2	.'pm 7
				wing Beds - SNF		
		Inpatien	nt Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		195, 67	4	0	1
2.00	Interim payments payable on individual bills, either			D	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1			1
3. 01	ADJUSTMENTS TO PROVIDER				0	3.01
3. 02					0	3. 02
3.03				)	0	3.03
3.04				)	0	3.04
3.05				O	0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM				0	
3. 51			1	D	0	
3. 52			1	O	0	
3. 53			1	0	0	0.00
3. 54			l .	0	0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		1	O	0	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		195, 67	1	0	4.00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		175, 07	+	0	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		'	<b>'</b>	ļ.	1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					1
5. 01	TENTATI VE TO PROVI DER				0	
5. 02				0	0	
5. 03	Dravi dan ta Dragnam			D	0	5.03
5. 50	Provider to Program TENTATIVE TO PROGRAM		1 ,		0	5.50
5. 51	TENTATIVE TO FROGRAM				0	
5. 52			l .		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		1	o l	0	
0. ,,	5. 50-5. 98)					0.77
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		33, 71	3	0	
6. 02	SETTLEMENT TO PROGRAM		1	D	0	
7. 00	Total Medicare program liability (see instructions)		229, 38		0	7.00
				Contractor	NPR Date	
			0	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		0	1. 00	2. 00	8.00
0.00	INAIIIE OI COITTI ACTOI	l		Ţ	I	0.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-1333   Period: From 01/01/2020   To 12/31/2020   Date/Time Prepare 7/15/2021 2: 27 pm  Title XVIII   Hospital   Cost					
To 12/31/2020 Date/Time Prepare 7/15/2021 2:27 pm					
	<u></u>				
1.00					
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00   Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14   1.	. 00				
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	. 00				
	. 00				
	. 00				
	. 00				
	. 00				
	. 00				
line 168					
	. 00				
	. 00				
	. 00				
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	. 00				
	. 00				
32.00  Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)   3:					

Health Financial Systems	PUTNAM COUNTY I	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provi der CCN: 15-1333	Peri od: From 01/01/2020	Worksheet E-2
		Component CCN: 15-Z333	To 12/31/2020	Date/Time Prepared:

		Component CCN: 15-Z333	To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1. 00	2. 00	
1 00	COMPUTATION OF NET COST OF COVERED SERVICES		100 140	0	1 00
1. 00 2. 00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		182, 149	0	1.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	t Δ and sum of Wkst D	51, 050	0	
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swir		31,030		3.00
	instructions)	.g zou pass till sugil, ses			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4.00
	instructions)				
5.00	Program days		125	0	1
6. 00 7. 00	Interns and residents not in approved teaching program (see in			0	6. 00 7. 00
8. 00	Utilization review - physician compensation - SNF optional met Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thod only	233, 199	0	
9. 00	Primary payer payments (see instructions)		233, 177	0	
10. 00	Subtotal (line 8 minus line 9)		233, 199	0	
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	Ö	
	professional services)				
12.00	Subtotal (line 10 minus line 11)		233, 199	0	12.00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	2, 288	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)		000 011	0	
15.00	Subtotal (see instructions)		230, 911	0	
16. 00 16. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	-)	0	U	16. 00 16. 50
16. 50	Rural community hospital demonstration project (§410A Demonstr		0		16. 50
10. 55	adjustment (see instructions)	ation, payment			10.55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18.00
19.00	Total (see instructions)		230, 911	0	19.00
19. 01	Sequestration adjustment (see instructions)		1, 524	0	
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs			_	19. 03
20.00	Interim payments		195, 674	0	
20. 01 21. 00	Interim payments-PARHM		0	0	20.01
21.00	Tentative settlement (for contractor use only) Tentative settlement-PARHM (for contractor use only)		U	U	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	33, 713	0	
22. 01	Balance due provider/program-PARHM (see instructions)	and 21)	00,710	Ŭ	22. 01
23. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr				
200.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200.00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
201 00	Cost Reimbursement	West D 1 Dt II line	1		201 00
201.00	Medicare swing-bed SNF inpatient routine service costs (from V 66 (title XVIII hospital))	rkSt. D-1, Pt. 11, Tine			201.00
202 00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst D-3 col 3 line	_		202.00
202.00	200 (title XVIII swing-bed SNF))				202.00
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	first year of the current	nt 5-year demons	trati on	
	peri od)				1
	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				207.00
	07.00 Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2  and 3)	'		208. 00	
209 00	and 3)  Adjustment to Medicare swing-bed SNF PPS payments (see instruc	rtions)			209. 00
	Reserved for future use	2013)			210.00
	Comparision of PPS versus Cost Reimbursement		1		1
215.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)	, ,			
			· ·		

Health Financial Systems	PUTNAM COUNTY H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1333	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part V Date/Time Prep 7/15/2021 2:2	pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
PART V - CALCULATION OF REIMBURSEME	NT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	Γ REI MBURSEMENT		
1.00 Inpatient services				3, 148, 713	1.00
2.00 Nursing and Allied Health Managed Care payment (see instructions)				0	2.00
3.00 Organ acquisition				o	3.00
4 00 Subtotal (sum of lines 1 through 3)				3 1/10 713	4 00

		1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT		
1.00	Inpatient services	3, 148, 713	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3.00	Organ acquisition	o	3.00
4.00	Subtotal (sum of lines 1 through 3)	3, 148, 713	4.00
5.00	Primary payer payments	3, 236	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	3, 176, 964	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
7.00	Routi ne servi ce charges	0	7.00
8.00	Ancillary service charges	ol	8.00
9. 00	Organ acquisition charges, net of revenue	o	9. 00
10.00	Total reasonable charges	ol	10.00
	Customary charges	_	
11. 00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	11.00
12. 00	Amounts that would have been realized from patients liable for payment for services on a charge basis	ol	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)	-	1
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	0. 000000	13.00
14. 00	Total customary charges (see instructions)	0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	ol	15. 00
	instructions)	-	1
16. 00	Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see	0	16.00
	instructions)		
17. 00	Cost of physicians' services in a teaching hospital (see instructions)	o	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18. 00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	3, 176, 964	19.00
20.00	Deductibles (exclude professional component)	330, 792	20.00
21. 00	Excess reasonable cost (from line 16)	0	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)	2, 846, 172	22.00
23. 00	Coinsurance	0	23.00
24. 00	Subtotal (line 22 minus line 23)	2, 846, 172	24.00
25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	28, 821	
26. 00	Adjusted reimbursable bad debts (see instructions)	18. 734	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	- ,	27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	2, 864, 906	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	o l	29.50
29. 99	Demonstration payment adjustment amount before sequestration	0	29. 99
30. 00	Subtotal (see instructions)	2, 864, 906	
30. 00	Sequestration adjustment (see instructions)	18, 908	
30. 01		10, 900	30.01
30. 02	Sequestration adjustment-PARHM	۷	30. 02
31. 00	Interim payments	2, 487, 644	
		2, 407, 044	31.00
31. 01 32. 00	Interim payments-PARHM Tentative settlement (for contractor use only)	0	32.00
	·	٥Į	
32. 01	Tentative settlement-PARHM (for contractor use only)	250 254	32.01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32)	358, 354	
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01)		33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	34.00
	§115. 2	I	

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1333	Peri od: From 01/01/2020 To 12/31/2020	Worksheet E-3 Part VII Date/Time Prepared: 7/15/2021 2:27 pm

TILLE XIX			-	To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
Input tent			Title XIX	Hospi tal		7 piii
PART VIII - CALCULATION OF RET MBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
PART VII - CALCULATION OF RELIMBURSCHEMI - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES						
COMPUTATION OF NET COST OF COVERED SERVICES   1.00   1.0		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	CES FOR TITLES V OR XI			
Medical and other services						
Organ acquisition (certified transplant centers only)	1.00	Inpatient hospital/SNF/NF services		159, 526		1.00
Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services			0	2.00
Inpati ent primary payer payments   0   0   0.00	3.00	Organ acquisition (certified transplant centers only)		0		3.00
0.0   Outpatient primary payer payments   0.6	4.00	Subtotal (sum of lines 1, 2 and 3)		159, 526	0	4.00
159,526   0, 7, 00	5.00	Inpatient primary payer payments		0		5.00
COMPUTATION OF LESSER OF COST OR CHARGES   Reasonable Charges   Routine service charges   27,548   8.00   4.00   Another service charges   27,548   8.00   4.00   Another service charges   27,548   8.00   4.00						
Reasonable Charges   8.00   Routine service charges   27, 548   8.00   9.00   Ancil Ilary service charges   27, 548   0.00   0	7.00			159, 526	0	7.00
Routine service charges   27,548   8.00   0.00   0.00   Ancillary service charges, net of revenue   257,668   0.9.00   0.00						
0.00   Ancillary service charges   257,668   0   9.00		9				
10.00   Organ acquisition charges, net of revenue   0   10.00   11.00   10.01   10.0					_	
11.00   Incentive from target amount computation   285, 216   0   11.00				· .	0	
12. 00   Total reasonable charges (sum of lines 8 through 11)   285, 216   0   12. 00   12. 00   13. 00   13. 00   14. 00   15.				ı .		
A				١	0	•
13.00   Amount actually collected from patients liable for payment for services on a charge   0   0   13.00	12.00			285, 216	0	12.00
basis	12 00		anyl coc on a charge		0	12 00
14. 00   Amounts that would have been realized from patients Liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413. 13(e)   0.000000   0.000000   15. 00   16. 00   17. 00   18. 00   19. 00	13.00		er vi ces on a charge	٥	U	13.00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e)  Ratio of line 13 to line 14 (not to exceed 1.00000)  16.00 Total customary charges (see instructions)  17.00 Excess of customary charges (see instructions)  18.00 Excess of reasonable cost over reasonable cost (complete only if line 16 exceeds 1125,690	14 00		avment for services or	0	0	14 00
15. 00	14.00			٩	O	14.00
16. 00   Total customary charges (see instructions)   285, 216   0   16. 00   17. 00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   125, 690   17. 00   17. 00   17. 00   17. 00   17. 00   18. 00	15. 00		0.11 31.01 10(0)	0. 000000	0.000000	15.00
17.00   Excess of customary charges over reasonable cost (complete only if line 16 exceeds   125,690   0   17.00	16.00					1
18.00   Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)   16) (see instructions)   17.00   10.	17.00		if line 16 exceeds	125, 690	0	17.00
16) (see instructions)		line 4) (see instructions)				
19.00   Interns and Residents (see instructions)   0   0   19.00   20.00   2	18.00	Excess of reasonable cost over customary charges (complete only i	if line 4 exceeds line	0	0	18. 00
20.00   Cost of physicians' services in a teaching hospital (see instructions)   0   159,526   0   21.00						
21.00				١	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.			ti ons)	- 1	-	
22.00   Other than outlier payments   0   0   22.00	21. 00			<del></del>	0	21.00
23.00       Outlier payments       0       0       23.00         24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0       25.00         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         29.00       Titles V or XIX (sum of lines 21 and 27)       159,526       0       29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT         30.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       159,526       0       31.00         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       159,526       0       31.00         32.00       Deductibles       0       0       32.00         33.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       33.00         35.00       Utilization review       0       0       35.00         36.00       Subtotal (sum o	00.00		mpleted for PPS provid			00.00
24.00       Program capital payments       0       24.00         25.00       Capital exception payments (see instructions)       0       25.00         26.00       Routine and Ancillary service other pass through costs       0       0.26.00         27.00       Subtotal (sum of lines 22 through 26)       0       0.27.00         28.00       Customary charges (title V or XIX PPS covered services only)       0       0       28.00         29.00       Titles V or XIX (sum of lines 21 and 27)       159,526       0       29.00         COMPUTATION OF REIMBURSEMENT SETTLEMENT       30.00       Excess of reasonable cost (from line 18)       0       0       0       30.00         31.00       Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)       159,526       0       31.00         32.00       Deductible s       0       0       32.00         33.00       Coinsurance       0       0       33.00         34.00       Allowable bad debts (see instructions)       0       0       34.00         35.00       Utilization review       0       0       35.00         36.00       Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)       159,526       0       36.00         37.				1	-	
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  COMPUTATION OF REIMBURSEMENT SETTLEMENT  Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coinsurance 31.00 Allowable bad debts (see instructions) 32.00 Utilization review 33.00 Utilization review 34.00 Allowable (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  25.00 26.00 26.00 26.00 27.00 28.00 29.00				-	Ü	
26.00 Routine and Ancillary service other pass through costs  27.00 Subtotal (sum of lines 22 through 26)  28.00 Customary charges (title V or XIX PPS covered services only)  29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Excess of reasonable cost (from line 18)  30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  31.00 Deductibles  30.00 Coinsurance  41 lowable bad debts (see instructions)  31.00 Utilization review  32.00 Utilization review  33.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  36.00 Subtotal (line 36 ± line 37)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Bal ance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 27.00  0 0 27.00  0 0 27.00  0 0 27.00  0 0 27.00  0 0 28.00  0 159,526  0 0 30.00  0 0 30.00  159,526  0 0 0 37.00  159,526  0 0 41.00  159,526  0 41.00  159,526  0 42.00  159,526				-		
27. 00 Subtotal (sum of lines 22 through 26) 0 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 159, 526 0  30. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT  30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 159, 526 0 31. 00 31. 00 Deductibles 0 0 0 32. 00 33. 00 Coinsurance 0 0 0 34. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 159, 526 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 159, 526 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 159, 526 0 40. 00 41. 00 Interim payments 134, 758 0 41. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00				-	0	1
28. 00 Customary charges (title V or XIX PPS covered services only)  7				١		
29.00 Titles V or XIX (sum of lines 21 and 27)  COMPUTATION OF REIMBURSEMENT SETTLEMENT  30.00 Excess of reasonable cost (from line 18)  Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  Deductibles  Coinsurance  Allowable bad debts (see instructions)  Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  Titles V or XIX (sum of lines 21 and 27)  Deductibles  Coinsurance  Co		, ,		١	-	
30.00   Excess of reasonable cost (from line 18)   0   30.00     31.00   Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)   159,526   0   31.00     32.00   Deductibles   0   0   0   32.00     33.00   Coinsurance   0   0   0   34.00     34.00   Allowable bad debts (see instructions)   0   0   34.00     35.00   Utilization review   0   35.00     36.00   Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)   159,526   0   36.00     37.00   OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)   0   0   37.00     38.00   Subtotal (line 36 ± line 37)   159,526   0   38.00     39.00   Direct graduate medical education payments (from Wkst. E-4)   0   39.00     40.00   Total amount payable to the provider (sum of lines 38 and 39)   159,526   0   40.00     41.00   Interim payments   134,758   0   41.00     42.00   Balance due provider/program (line 40 minus line 41)   24,768   0   42.00     43.00   Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,   0   0   43.00		) ) ) )		159, 526		
30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 31. 00 0 32. 00 0 0 32. 00 0 0 33. 00 0 0 34. 00 0 0 35. 00 0 35. 00 0 36. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 43. 00	27.00			1077 020		27.00
31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)  32. 00 Deductibles  33. 00 Coinsurance  34. 00 Allowable bad debts (see instructions)  35. 00 Utilization review  36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 0 31. 00  0 32. 00  0 32. 00  0 33. 00  0 34. 00  0 35. 00  35. 00  0 36. 00  37. 00  38. 00  37. 00  38. 00  159, 526  0 40. 00  159, 526  0 41. 00  42. 00  43. 00	30.00			0	0	30.00
32. 00 Deductibles 0 0 32. 00 33. 00 Coinsurance 0 0 0 33. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 159, 526 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 159, 526 0 38. 00 39. 00 Direct graduate medical education payments (from Wkst. E-4) 0 10 Total amount payable to the provider (sum of lines 38 and 39) 159, 526 0 40. 00 41. 00 Interim payments 134, 758 0 41. 00 42. 00 Balance due provider/program (line 40 minus line 41) 24, 768 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00	31.00			159, 526	0	31.00
34.00   Allowable bad debts (see instructions)	32.00			0	0	32.00
35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 35.00 35.00 35.00 36.00 37.00 37.00 37.00 38.00 39.00 39.00 39.00 39.00 39.00 39.00 40.00 41.00 42.00 43.00	33.00	Coinsurance		0	0	33.00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)  37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38.00 Subtotal (line 36 ± line 37)  39.00 Direct graduate medical education payments (from Wkst. E-4)  40.00 Total amount payable to the provider (sum of lines 38 and 39)  41.00 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 36.00  0 36.00  37.00  38.00  39.00  159,526  0 38.00  159,526  0 40.00  159,526  0 41.00  24,768  0 42.00	34.00	Allowable bad debts (see instructions)		0	0	34.00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  38. 00 Subtotal (line 36 ± line 37)  39. 00 Direct graduate medical education payments (from Wkst. E-4)  40. 00 Total amount payable to the provider (sum of lines 38 and 39)  41. 00 Interim payments  42. 00 Balance due provider/program (line 40 minus line 41)  43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  0 37. 00  37. 00  37. 00  39. 00  39. 00  39. 00  41. 00  41. 00  42. 00  43. 00  43. 00	35.00	Utilization review		0		35.00
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  159,526 0 38.00 39.00 159,526 0 40.00 41.00 42.00 43.00			3)	159, 526		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,  39.00 40.00 41.00 41.00 42.00 43.00				0	-	
40.00 Total amount payable to the provider (sum of lines 38 and 39)  159, 526  134, 758  0 40.00  1 Interim payments  1 Interim payments  2 Interim payments  2 Interim payments  42.00 Balance due provider/program (line 40 minus line 41)  2 Interim payments  2 Interim payments  2 Interim payments  3 Interim payments  4 Interi		, ,		159, 526	0	
41.00 Interim payments 134,758 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 24,768 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				0		
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 42.00		, , , , , , , , , , , , , , , , , , , ,		1	-	
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 43.00				1		
		, , ,	with CMC Dut 15 0		-	
Cliapte  1, 3113.2	43.00		WILII CMS PUD 15-2,	١	0	43.00
		Chiapter   1, 3110.2		1 I		I

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: Worksheet G
From 01/01/2020
To 12/31/2020 Date/Time Prepared: 7/15/2021 2: 27 pm

Unit y)					7/15/2021 2: 2	7 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund 2.00	Fund 3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1.00	Cash on hand in banks	13, 998, 806	0	0	0	1.00
2.00	Temporary investments	0	0	0		2.00
3.00	Notes receivable	0	0	0	1	3.00
4. 00	Accounts recei vable	3, 909, 170		0	0	4.00
5.00	Other receivable	3, 212, 000		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable			0	0	6.00
7. 00 8. 00	Inventory Prepai d expenses	873, 674		0	0	7. 00 8. 00
9. 00	Other current assets	508, 270		0	0	9.00
10. 00	Due from other funds			0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	17, 286, 601	1	0		11.00
	FIXED ASSETS			-		
12.00	Land	195, 501	0	0	0	12.00
13.00	Land improvements	391, 896		0	0	13.00
14.00	Accumulated depreciation	-273, 908	0	0	0	14.00
15. 00	Bui I di ngs	35, 564, 661		0	1	15.00
16. 00	Accumulated depreciation	-24, 407, 684		0	0	16.00
17. 00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19. 00 20. 00	Fixed equipment	0		0	0	19. 00 20. 00
21. 00	Accumulated depreciation Automobiles and trucks			0	0	20.00
21.00	Accumulated depreciation			0		22.00
23. 00	Major movable equipment	24, 908, 511	_	0		23.00
24. 00	Accumulated depreciation	-21, 511, 346		0	0	24.00
25. 00	Mi nor equi pment depreci abl e	21,011,010		0	l ő	25.00
26. 00	Accumulated depreciation	0	o	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	_	29. 00
30.00	Total fixed assets (sum of lines 12-29)	14, 867, 631	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	3, 525, 373		0	_	31.00
32.00	Deposits on Leases	0	0	0	_	32.00
33. 00 34. 00	Due from owners/officers Other assets	244, 800		0	0	33. 00 34. 00
35. 00	Total other assets (sum of lines 31-34)	3, 770, 173		0		35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	35, 924, 405		0	•	36.00
00.00	CURRENT LIABILITIES	00, 721, 100	<u>,                                    </u>			00.00
37.00	Accounts payable	4, 727, 986	0	0	0	37.00
38.00	Salaries, wages, and fees payable	142, 663		0	0	38. 00
39.00	Payrol I taxes payable	257, 758	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	2, 014, 902	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	4, 889, 981		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	12, 033, 290	0	0	0	45. 00
44 00	LONG TERM LIABILITIES  Mortgage payable	1 0	ol	0		44 00
46. 00 47. 00	Notes payable	5, 562, 759		0	1	46. 00 47. 00
48. 00	Unsecured Loans	3, 302, 739		0		48.00
49. 00	Other long term liabilities			0		49.00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	5, 562, 759		0		50.00
51. 00	Total liabilities (sum of lines 45 and 50)	17, 596, 049		0		51.00
01.00	CAPI TAL ACCOUNTS	1770707017	<u> </u>			01.00
52.00	General fund balance	18, 328, 356	,			52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 00	replacement, and expansion	10 000 0=:	_	_	_	F0 00
59.00	Total fund balances (sum of lines 52 thru 58)	18, 328, 356		0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and 59)	35, 924, 405		0	0	60.00
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Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES PUTNAM COUNTY HOSPITAL

Provi der CCN: 15-1333

					From 01/01/2020 To 12/31/2020		
		Genera	I Fund	Special P	urpose Fund	Endowment Fund	, p
1 00		1. 00	2.00	3. 00	4. 00	5. 00	1.00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)		27, 138, 332 -8, 809, 976		0		1.00 2.00
3. 00	Total (sum of line 1 and line 2)		18, 328, 356		0		3.00
4. 00	Additions (credit adjustments) (specify)	0	10,020,000		o	0	
5.00	, , , , , , , , , , , , , , , , , , , ,	0			O	0	5.00
6.00		0			O	0	
7.00		0		9	)	0	1
8. 00 9. 00		0			)	0	
10. 00	Total additions (sum of line 4-9)		0	,	0	1	10.00
11. 00	Subtotal (line 3 plus line 10)		18, 328, 356		0		11.00
12.00	Deductions (debit adjustments) (specify)	0			O	0	
13.00		0			O	0	
14. 00 15. 00		0			0	0	
16.00		0		1		0	
17. 00		0			0	ĺ	
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19. 00	Fund balance at end of period per balance		18, 328, 356		0		19. 00
	sheet (line 11 minus line 18)	Endowment	DI ont	Fund			
		Fund	Frant	Tuliu			
1 00		6. 00	7. 00	8. 00			1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0		(	ס		1.00 2.00
3. 00	Total (sum of line 1 and line 2)	0			o		3.00
4. 00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5.00
6. 00			0				6.00
7. 00 8. 00			0				7. 00 8. 00
9. 00							9.00
10.00	Total additions (sum of line 4-9)	0	Ĭ		o		10.00
11.00	Subtotal (line 3 plus line 10)	0			O		11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14. 00 15. 00							14. 00 15. 00
16. 00							16.00
17. 00			Ö				17. 00
18.00	Total deductions (sum of lines 12-17)	0		1	O		18. 00
19. 00	Fund balance at end of period per balance	0			ס		19. 00
	sheet (line 11 minus line 18)	I	I	I	I		I

| Peri od: | Worksheet G-2 | From 01/01/2020 | Parts | & II | To 12/31/2020 | Date/Time Prepared: Health Financial Systems
STATEMENT OF PATLENT REVENUES AND OPERATING EXPENSES Provi der CCN: 15-1333

			To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
	Cost Center Description	I npati ent	Outpati ent	Total	, piii
	oust defited beschiption	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				1
1.00	Hospi tal	4, 388, 07	6	4, 388, 076	1.00
2. 00	SUBPROVI DER - I PF	1,000,01		1,000,070	2.00
3. 00	SUBPROVI DER - I RF				3.00
4. 00	SUBPROVI DER				4.00
5. 00	Swing bed - SNF		0	0	5.00
6. 00	Swing bed - NF		0	0	6.00
7. 00	SKILLED NURSING FACILITY				7.00
8. 00	NURSING FACILITY				8.00
9. 00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	4, 388, 07	6	4, 388, 076	10.00
10.00	Intensive Care Type Inpatient Hospital Services	1, 000, 07	o <sub>1</sub>	1,000,070	10.00
11. 00	INTENSIVE CARE UNIT	1, 448, 32	0	1, 448, 320	11.00
12. 00	CORONARY CARE UNIT	1,110,02		1, 1.10, 020	12.00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGI CAL I NTENSI VE CARE UNI T				14.00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15.00
16. 00	Total intensive care type inpatient hospital services (sum of lines	1, 448, 32	0	1, 448, 320	16.00
	11-15)	1,,		.,,	
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	5, 836, 39	6	5, 836, 396	17.00
18. 00	Ancillary services	7, 030, 01			18.00
19. 00	Outpatient services	445, 94		23, 261, 786	19.00
20. 00	PUTNAM PEDIATRICS AND INTERNAL MED	<b>I</b>	0 2, 061, 932	2, 061, 932	•
20. 01	FAMILY MEDICINE OF CLOVERDALE		0 2, 139, 152	2, 139, 152	20. 01
20. 02	NORTH PUTNAM FAMILY HEALTHCARE		0 1, 543, 201	1, 543, 201	20. 02
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24.00
24. 10	CORF		o	0	24. 10
25. 00	AMBULATORY SURGI CAL CENTER (D. P. )				25.00
26. 00	HOSPI CE				26.00
27.00	PHYSICIAN PRIVATE OFFICES	125, 88	6 4, 701, 976	4, 827, 862	27.00
27. 01	JOHNSON NI CHOLS / WI C		0 380, 858		27. 01
27. 02	RHEUMATOLOGY		0 0	0	27. 02
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wks	t. 13, 438, 24	0 90, 376, 831	103, 815, 071	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		51, 887, 342		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33.00
34.00			0		34.00
35.00			0		35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)		0		37.00
38. 00			0		38. 00
39.00			0		39. 00
40.00			0		40. 00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	sfer	51, 887, 342		43.00
	to Wkst. G-3, line 4)	I			l

Heal th	Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provi der CCN: 15-1333	Peri od:	Worksheet G-3	
			From 01/01/2020 To 12/31/2020	Date/Time Pre	narod:
			10 12/31/2020	7/15/2021 2: 2	
					•
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part			103, 815, 071	1.00
2.00	Less contractual allowances and discounts on	patients' accounts		68, 836, 945	2.00
3.00	Net patient revenues (line 1 minus line 2)			34, 978, 126	
4.00	Less total operating expenses (from Wkst. G-			51, 887, 342	
5. 00	Net income from service to patients (line 3 m	minus line 4)		-16, 909, 216	5.00
	OTHER I NCOME				
6. 00	Contributions, donations, bequests, etc			0	
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneo	ous communication services		0	
9.00	Revenue from television and radio service			0	
10.00	Purchase di scounts			0	
11.00	Rebates and refunds of expenses			0	
12. 00 13. 00	Parking lot receipts Revenue from laundry and linen service			0	
14. 00	1	0+0		0	14.00
15.00	Revenue from meals sold to employees and gues Revenue from rental of living quarters	515		0	
16. 00	Revenue from sale of medical and surgical su	nnling to other than notionts		0	
17. 00	Revenue from sale of drugs to other than pati			- 1	17.00
18.00	Revenue from sale of medical records and abs			0	
					19.00
20.00	Revenue from gifts, flowers, coffee shops, and			0	ı
21.00		na carreen		0	
22. 00	Rental of hospital space			0	22.00
23. 00	Governmental appropriations			0	1
24. 00	OTHER OPERATING AND NON-OPERATING IN			2, 904, 601	
24. 50				5, 194, 639	
	9			8, 099, 240	
	Total (line 5 plus line 25)			-8, 809, 976	
27. 00				0	1
28.00	Total other expenses (sum of line 27 and subs	scripts)		0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)		-8, 809, 976	29.00

	Financial Systems	PUTNAM COUNT		ON 4E 4000		u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	JN: 15-1333	Peri od: From 01/01/2020	Worksheet M-1	
			Component	CCN: 15-8515	To 12/31/2020	Date/Time Pre 7/15/2021 2:2	pared: 7 pm
					RHC I	Cost	
		Compensation	Other Costs		1 Reclassi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	2.22	2.22	4 00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	FE7 OFF	0	FF7 0		FF7 0FF	1
1.00	Physician	557, 955	0	557, 9		557, 955	1
2.00	Physician Assistant	0	0	27/ 5	0 0	0	2.0
3.00	Nurse Practitioner	276, 577	0	276, 5		276, 577	3.0
4. 00 5. 00	Visiting Nurse	0	0		0 0	0	
6. 00	Other Nurse	104 494	0	104 4	0	_	
7. 00	Clinical Psychologist Clinical Social Worker	104, 684	0	104, 68	0 0	104, 684 0	
7. 00 B. 00	Laboratory Techni ci an	0	0		0	0	
9. 00	Other Facility Health Care Staff Costs	0	0		0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	939, 216	0	939, 2 <sup>.</sup>	0	939, 216	
11.00	Physician Services Under Agreement	939, 210	0	737, 2	0 0	939, 210	1
12.00	Physician Supervision Under Agreement	0	0			0	
13. 00	Other Costs Under Agreement	0	0		0 0	0	1
14. 00	Subtotal (sum of lines 11 through 13)	0	0		0 0	0	1
15. 00	Medical Supplies	0	0		0 0	ő	
16. 00	Transportation (Health Care Staff)	0	0		0 0	0	16.0
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	17. C
18. 00	Professional Liability Insurance	0	0		0 0	0	18. C
19. 00		0	0		0 0	0	19.0
20.00	Allowable GME Costs						20.0
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0 0	0	21.0
22. 00	Total Cost of Health Care Services (sum of	939, 216	0	939, 2 <sup>-</sup>	16 0	939, 216	22.0
	lines 10, 14, and 21)						]
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23. 00	Pharmacy	0	0		0 0	0	
24. 00	Dental	0	0		0 0	0	
25. 00	Optometry	0	0		0 0	0	-0.0
25. 01	Tel eheal th	31, 409	600	32, 00	09 0	32, 009	
25. 02	Chronic Care Management	0	0		0	0	
26. 00	All other nonreimbursable costs	0	0		0	0	26.0
27. 00	Nonallowable GME costs				-		27.0
28. 00	Total Nonreimbursable Costs (sum of lines 23	31, 409	600	32, 00	09	32, 009	28. 0
	through 27)						-
29. 00	FACILITY OVERHEAD	0	0		0 0	0	29. 0
	Facility Costs Administrative Costs	463, 111	342, 079	805, 19	-		
JU. UU	Admini Strati ve COStS	403, 111	342,019	000, 1	, <sub>0</sub> - 70, 240	100, 744	1 50.0

463, 111

1, 433, 736

Total Facility Overhead (sum of lines 29 and

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

342, 079

342, 679

805, 190

1, 776, 415

-96, 246

-96, 246

31.00

32.00

708, 944

1, 680, 169

31.00

32.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1333	Peri od: From 01/01/2020	Worksheet M-1
	Component CCN: 15-8515		
		RHC I	Cost

			component	CCN: 15-8515	10	12/31/2020	7/15/2021 2:	
						RHC I	Cost	г рііі
		Adjustments	Net Expenses		-	1	0001	
		riaj do timorreo	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00	1				
	FACILITY HEALTH CARE STAFF COSTS							
1.00	Physi ci an	0	557, 955	5				1.00
2.00	Physici an Assistant	o	. (	ol				2.00
3.00	Nurse Practitioner	o	276, 577	7				3.00
4.00	Visiting Nurse	0	(	. 1				4.00
5.00	Other Nurse	0	(					5. 00
6.00	Clinical Psychologist	0	104, 684	1				6. 00
7. 00	Clinical Social Worker	0	(	1				7. 00
8.00	Laboratory Techni ci an	0	(					8.00
9. 00	Other Facility Health Care Staff Costs	0						9.00
10.00	Subtotal (sum of lines 1 through 9)	0	939, 216	5				10.00
11. 00	Physician Services Under Agreement	0	(	1				11.00
12. 00	Physician Supervision Under Agreement	0						12.00
	Other Costs Under Agreement	0	(					13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	Č					14.00
15. 00	Medical Supplies	0	(					15.00
16. 00	Transportation (Health Care Staff)	0	(					16.00
	Depreciation-Medical Equipment	0	(					17.00
18. 00	Professional Liability Insurance	0	(					18.00
	Other Health Care Costs	0	(					19.00
20.00	Allowable GME Costs	J		1				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	939, 216					22. 00
22.00	lines 10, 14, and 21)	Ö	707, 210	1				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23 00	Pharmacy	0	(					23.00
24. 00	Dental	0	(					24.00
25. 00	Optometry	0	(					25.00
25. 01	Tel eheal th	0	32, 009					25. 01
25. 02	i i	0	(2)	1				25. 02
26. 00	All other nonreimbursable costs	0	(	- 1				26.00
27. 00	Nonallowable GME costs		`	1				27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	32, 009					28.00
20.00	through 27)	Ö	02,00					20.00
	FACILITY OVERHEAD							1
29.00	Facility Costs	0	(					29. 00
30.00	Administrative Costs	-255	708, 689					30.00
31. 00	Total Facility Overhead (sum of lines 29 and		708, 689	1				31.00
500	30)	255	700,00					00
32.00	Total facility costs (sum of lines 22, 28	-255	1, 679, 914	1				32.00
	and 31)	200	., = , , .					
		'		1				1

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1333	Peri od:	Worksheet M-1	
			Component	CCN: 15-8513	From 01/01/2020 To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
					RHC II	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
		·		+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	281, 196	0	281, 19	96 0	281, 196	1.00
2.00	Physician Assistant	446, 465	0	446, 46	55 0	446, 465	2.00
3.00	Nurse Practitioner	0	0		0	0	3.00
4.00	Visiting Nurse	0	0		0	0	4.00
5.00	Other Nurse	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	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	727, 661	0	727, 66	51 0	727, 661	10.00
11.00	Physician Services Under Agreement	0	0		0	0	11.00
12.00	Physician Supervision Under Agreement	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	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	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	727, 661	0	727, 66	51 0	727, 661	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0	0	23. 00
24.00	Dental	0	0		0	0	24.00
25.00	Optometry	0	0		0	0	
25. 01	Tel eheal th	24, 093	600	24, 69	93 0	24, 693	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	24, 093	600	24, 69	93 0	24, 693	28. 00
	through 27)						
	FACILITY OVERHEAD						
	Facility Costs	0	0		0	0	
	Administrative Costs	417, 264	394, 959	,	· ·	715, 572	
31 00	Total Facility Overhead (sum of lines 29 and	417 264	394 959	812 23	-96 651	715 572	1 31 00

417, 264

1, 169, 018

Total Facility Overhead (sum of lines 29 and

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

394, 959

395, 559

812, 223

1, 564, 577

-96, 651

-96, 651

31.00

32.00

715, 572

1, 467, 926

31.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1333	Peri od: From 01/01/2020	Worksheet M-1
	Component CCN: 15-8513	To 12/31/2020	Date/Time Prepared: 7/15/2021 2:27 pm
		RHC II	Cost

						7/15/2021 2: 2	7 pm
					RHC II	Cost	<u> </u>
	·	Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1.00	Physi ci an	0	281, 196				1.00
2. 00	Physician Assistant	0	446, 465				2.00
3. 00	Nurse Practitioner	0	440, 403	1			3.00
4. 00	Visiting Nurse	0	0				4.00
5. 00	Other Nurse	0	0	1			5.00
	1	0	0				1
6.00	Clinical Psychologist	U O	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					9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	727, 661	1			10.00
11. 00	Physician Services Under Agreement	0	0	1			11. 00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	0				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0				14.00
15.00	Medical Supplies	0	0				15.00
16.00	Transportation (Health Care Staff)	o	0				16.00
17.00	Depreciation-Medical Equipment	o	0				17.00
18.00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	0	0				18.00
19.00	Other Health Care Costs	0	0				19.00
20. 00	Allowable GME Costs	_					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0				21.00
22. 00	Total Cost of Health Care Services (sum of	0	727, 661				22.00
22.00	lines 10, 14, and 21)	٥	727,001				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						1
33 NO	Pharmacy Pharmacy	0	0				23. 00
24. 00	Dental	0	0	1			24.00
25. 00	Optometry	0	0				25.00
25. 00	Tel eheal th	0	24, 693				25.00
25. 01	4	0	24, 093				25.01
	Chronic Care Management	0	0				26.00
26.00	All other nonreimbursable costs	U	U				
27. 00	Nonallowable GME costs		0.4.400				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	24, 693				28. 00
	through 27)						1
	FACILITY OVERHEAD			T			
	Facility Costs	0	0				29. 00
30. 00	Administrative Costs	-75, 000	640, 572	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	-75, 000	640, 572				31.00
	30)						
32.00	,	-75, 000	1, 392, 926				32. 00
	and 31)						

	Financial Systems	PUTNAM COUNT		011 45 4000		eu of Form CMS-	
ALYSI:	S OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co	UN: 15-1333	Peri od: From 01/01/2020	Worksheet M-1	
			Component	CCN: 15-8514	To 12/31/2020		
					RHC III	Cost	
		Compensation	Other Costs	,	1 Reclassi fi cat		
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1. 00	2. 00	3.00	4.00	col . 4) 5.00	
E	ACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	5.00	
_	Physician	334, 727	0	334, 7	27 (	334, 727	1.0
	Physician Assistant	116, 544	0				
	Nurse Practitioner	285, 835	0	285, 8			1
	/isiting Nurse	0	0	200,0	0		1
	Other Nurse	Ö	0		o d		
	Clinical Psychologist	0	0		0	o	1
- 1	Clinical Social Worker	0	0		0	0	7.0
00 L	_aboratory Techni ci an	0	0		0	0	8.0
00 0	Other Facility Health Care Staff Costs	0	0		0	0	9. (
00   5	Subtotal (sum of lines 1 through 9)	737, 106	0	737, 10	06	737, 106	10.
.00 F	Physician Services Under Agreement	0	0		0	0	11.
. 00 F	Physician Supervision Under Agreement	0	0		0	0	12.
	Other Costs Under Agreement	0	0		0	0	13.
	Subtotal (sum of lines 11 through 13)	0	0		0	0	1
	Medical Supplies	0	0		0	0	1
	Transportation (Health Care Staff)	0	0		0	0	
- 1	Depreciation-Medical Equipment	0	0		0	0	1
	Professional Liability Insurance	0	0		0	0	1
	Other Health Care Costs	U	0		0	0	
	Allowable GME Costs	0	0			o	20. 21.
	Subtotal (sum of lines 15 through 20) Total Cost of Health Care Services (sum of	737, 106	0		06 (		1
	ines 10, 14, and 21)	737, 100	U	/3/, 1		737, 100	22.
C	COSTS OTHER THAN RHC/FQHC SERVICES						
	Pharmacy	0	0		0 (	0	23.
	Dental	0	0		0	o o	24.
.00 0	Optometry	0	0		0	0	25.
.01   1	Tel eheal th	11, 722	600	12, 3:	22 (	12, 322	25.
.02 0	Chronic Care Management	0	0		0	0	25.
	All other nonreimbursable costs	0	0		0	0	
.00	Nonallowable GME costs						27.
	Total Nonreimbursable Costs (sum of lines 23	11, 722	600	12, 3:	22 (	12, 322	28.
	through 27)						
	ACILITY OVERHEAD	=1	=			.l -	
		- 1	_				
		·					
00 F	Administrative Costs	0 407, 466 407, 466	0 366, 715 366, 715	774, 1		688	

407, 466

1, 156, 294

Total Facility Overhead (sum of lines 29 and

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

366, 715

367, 315

774, 181

1, 523, 609

31.00

32.00

688, 218

1, 437, 646

-85, 963

-85, 963

32.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Peri od: From 01/01/2020	Worksheet M-1
	Component CCN: 15-8514		Date/Time Prepared: 7/15/2021 2:27 pm
		DUIG LILI	

			Component	CCN. 15-0514	10 12/31/2020	7/15/2021 2: 2	
					RHC III	Cost	
		Adjustments	Net Expenses				
		,	for				
			Allocation				
			(col. 5 +				
			col . 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	0	334, 727				1.00
2.00	Physician Assistant	0	116, 544				2.00
3.00	Nurse Practitioner	0	285, 835				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	737, 106				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)	o	0				14.00
15.00	Medical Supplies	0	0				15.00
16.00	Transportation (Health Care Staff)	0	0				16.00
17.00	Depreciation-Medical Equipment	o	0				17. 00
18.00	Professional Liability Insurance	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)	o	0				21.00
22.00	Total Cost of Health Care Services (sum of	o	737, 106				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	12, 322				25. 01
25. 02	Chronic Care Management	0	0				25. 02
26.00	All other nonreimbursable costs	0	0				26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	12, 322				28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	0				29. 00
30.00	Administrative Costs	-19, 992	668, 226				30.00
31.00	Total Facility Overhead (sum of lines 29 and	-19, 992	668, 226				31.00
	30)						
32.00	, , ,	-19, 992	1, 417, 654				32.00
	and 31)						

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	PUTNAM COUNT SERVICES	Provi der C		Peri od:	u of Form CMS-2 Worksheet M-2	
			Component	CCN: 15-8515	From 01/01/2020 To 12/31/2020	Date/Time Pre	nared:
			Component	0011. 10 0010	10 12/01/2020	7/15/2021 2: 2	
					RHC I	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		T	-1 -1		
1.00	Physi ci an	1. 68		1	1 2		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	2. 47			1 2	0.540	3.00
4.00	Subtotal (sum of lines 1 through 3)	4. 15			4	8, 563	
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0. 90				1, 132	6.00
7.00	Clinical Social Worker	0.00	l .			0	7. 00 7. 01
7. 01 7. 02	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	U			Ü	7.02
8. 00	Total FTEs and Visits (sum of lines 4	5. 05	9, 695			9, 695	8.00
0.00	through 7)	5.05	7, 073			7, 073	0.00
9. 00	Physician Services Under Agreements		0			0	9.00
7.00	Triffer or all oor vi dear order rigi demorita						7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			939, 216	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line:	28)			32, 009	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			971, 225	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			0. 967043	13.00
14.00	, , ,					708, 689	14.00
15.00	5.00 Parent provider overhead allocated to facility (see instructions)					1, 036, 772	15.00
16.00					1, 745, 461	16.00	
17.00	Allowable GME overhead (see instructions)					0	17. 00
	Enter the amount from line 16					1, 745, 461	
	Overhead applicable to hospital-based RHC/FQ					1, 687, 936	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (	sum of lines 10	0 and 19)		2, 627, 152	20.00

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	PUTNAM COUNT SERVICES	Y HOSPITAL Provi der C	CN: 15-1333	Period:	wof Form CMS-2 Worksheet M-2	
					From 01/01/2020	D. I. (T' D	
			Component	CCN: 15-8513	To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
					RHC II	Cost	
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1.00	0.00	0.00	1 x col . 3)	col . 4	
	VISITS AND PRODUCTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	Positions						1
1. 00	Physi ci an	0. 94	1, 832	1	1 1		1.00
2. 00	Physician Assistant	3. 39			1 3		2.00
3. 00	Nurse Practitioner	0.05			1 0		3.00
4. 00	Subtotal (sum of lines 1 through 3)	4. 38	l e		4	9, 821	4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00	0			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)						
8. 00	Total FTEs and Visits (sum of lines 4	4. 38	9, 821			9, 821	8. 00
9. 00	through 7) Physician Services Under Agreements		0			0	9.00
9.00	Physician services under Agreements					U	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVICES		1.00	
	Total costs of health care services (from Wk					727, 661	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			24, 693	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			752, 354	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 967179	13.00
14.00						640, 572	
15.00						930, 497	
16.00	Total overhead (sum of lines 14 and 15)					1, 571, 069	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	IIC comit cos (1	ino 12 v li	10)		1, 571, 069	
	Overhead applicable to hospital-based RHC/FQ Total allowable cost of hospital-based RHC/F					1, 519, 505 2, 247, 166	
∠∪. ∪∪	Tiotal allowable cost of hospital-based RHC/F	unc services (	Sum OF FIRES II	o ailu 19)	I	2, 247, 100	I 20.00

	Financial Systems TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	PUTNAM COUNT	Y HOSPITAL Provi der C	CN: 15_1333	In Lie	u of Form CMS-2 Worksheet M-2	
ALLOGA	THOM OF OVERHEAD TO HOST TIME BASED KNOT WHO S	DERVI CES	Trovider o	ON. 15 1555	From 01/01/2020	WOTKSTICCE W 2	
			Component	CCN: 15-8514	To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
					RHC III	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						
	Posi ti ons						
1.00	Physi ci an	1. 62			1 2		1.00
2.00	Physician Assistant	0. 90			1 1		2.00
3.00	Nurse Practitioner	1. 75			1 2		3.00
4.00	Subtotal (sum of lines 1 through 3)	4. 27			5	7, 802	4.00
5.00	Visiting Nurse	0.00	l e	1		0	5.00
6.00	Clinical Psychologist	0.00	l .	1		0	6.00
7.00	Clinical Social Worker	0.00	0	1		0	7. 00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0	1		0	7. 01
7.02	Diabetes Self Management Training (FQHC	0.00	0	1		0	7. 02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	4. 27	7, 802			7, 802	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO			RVI CES			
	Total costs of health care services (from Wk					737, 106	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					12, 322	ı
12.00	Cost of all services (excluding overhead) (s					749, 428	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 983558	
14.00						668, 226	
15.00						931, 556	
16.00	p.00 Total overhead (sum of lines 14 and 15)			1, 599, 782			
17.00	Allowable GME overhead (see instructions)					0	17.00
	Enter the amount from line 16					1, 599, 782	
	Overhead applicable to hospital-based RHC/FQ					1, 573, 478	
20.00	Total allowable cost of hospital-based RHC/F	QHC services (	sum of lines 10	0 and 19)		2, 310, 584	20.00

	Financial Systems PUTNAM COUNTY F			u of Form CMS-2	
CALCUI SERVI (	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provi der CCN: 15-1333	Peri od: From 01/01/2020	Worksheet M-3	
SERVI	ES	Component CCN: 15-8515	To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
		Title XVIII	RHC I	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			2, 627, 152	1.00
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)		145, 526 2, 481, 626	2. 00 3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			9, 695	4.00
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)			9, 695	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	255.97 of limit (1)	7.00
			car car a tron	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)	0.00	86. 31	8. 00
9. 00	Rate for Program covered visits (see instructions)		255. 97	255. 97	9.00
10. 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	0	878	10.00
11. 00	Program cost excluding costs for mental health services (line		0	224, 742	1
12.00	Program covered visits for mental health services (from contr		0	41	12.00
13.00	Program covered cost from mental health services (line 9 x li	•	0	10, 495	1
14.00	Limit adjustment for mental health services (see instructions	•	0	10, 495	
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	235, 237	15. 00 16. 00
16. 01	Total program charges (see instructions) (from contractor's re			181, 760	•
16. 02	Total program preventive charges (see instructions)(from prov			14, 860	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		19, 232	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	3 and 18) times .80)		158, 681	16. 04
16. 05	Total program cost (see instructions)		0	177, 913	16. 05
17. 00	Primary payer amounts			0	17. 00
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		17, 654	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		29, 593	19. 00
20. 00	records) Net Medicare cost excluding vaccines (see instructions)			177, 913	20.00
21. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		11, 390	•
22. 00	Total reimbursable Program cost (line 20 plus line 21)			189, 303	•
23. 00	Allowable bad debts (see instructions)			0	23.00
23. 01 24. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	23. 01 24. 00
25. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	25.00
25. 50	, , , ,	s)		0	25. 50
	Demonstration payment adjustment amount before sequestration			0	
26. 00 26. 01	Net reimbursable amount (see instructions) Sequestration adjustment (see instructions)			189, 303 1, 249	
26. 01	Demonstration payment adjustment amount after sequestration			1, 249	26.01
	Interim payments			118, 925	
28. 00	Tentative settlement (for contractor use only)			0	28. 00
	Balance due component/program (line 26 minus lines 26.01, 26.			69, 129	
30.00	Protested amounts (nonallowable cost report items) in accorda chapter I, §115.2	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 01/01/2020	Worksheet M-3	
SERVI	.E.S	Component CCN: 15-8513	To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
		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			2, 247, 166	•
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)		165, 196 2, 081, 970	2. 00 3. 00
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			9, 821	4.00
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)			9, 821	6.00
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	211. 99	7.00
			Carcuration	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)	0.00	86. 31	8. 00
9. 00	Rate for Program covered visits (see instructions)		211. 99	211. 99	9. 00
10 00	CALCULATION OF SETTLEMENT  Program covered visits excluding mental health services (from	contractor records)	0	1 250	10.00
10.00	Program cost excluding costs for mental health services (line	•	0	1, 258 266, 683	
12. 00	Program covered visits for mental health services (from contr		0	200, 003	12.00
13.00	Program covered cost from mental health services (line 9 x li	•	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	244 402	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	•	U	266, 683 252, 543	•
16. 02	Total program preventive charges (see instructions) (from prov	•		3, 410	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	*		3, 601	16. 03
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		177, 038	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	180, 639	16. 05
17. 00	Pri mary payer amounts			0	17.00
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		41, 784	18. 00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		41, 457	19.00
20.00	records)			100 (20	20.00
20.00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		180, 639 21, 654	•
22. 00	Total reimbursable Program cost (line 20 plus line 21)	W 4, 1111C 10)		202, 293	•
23. 00	Allowable bad debts (see instructions)			0	23.00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	23. 01
24. 00 25. 00	3	ructions)		0	24. 00 25. 00
25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	(2)		0	
	Demonstration payment adjustment amount before sequestration			0	l
26.00	Net reimbursable amount (see instructions)			202, 293	26.00
26. 01	Sequestration adjustment (see instructions)			1, 335	
26. 02	Demonstration payment adjustment amount after sequestration Interim payments			0 149, 759	26. 02 27. 00
28. 00	Tentative settlement (for contractor use only)			149, 759	28.00
	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		51, 199	
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 01/01/2020	Worksheet M-3	
SERVI	<i>i.</i> L3	Component CCN: 15-8514	To 12/31/2020	Date/Time Pre 7/15/2021 2:2	
		Title XVIII	RHC III	Cost	
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
1.00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			2, 310, 584	
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)		100, 358 2, 210, 226	1
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			7, 802	
5. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6.00	Total adjusted visits (line 4 plus line 5)			7, 802	1
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal aul ati an	283. 29	7.00
			Cal cul ati on	or 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)	0.00	86. 31	8.00
9. 00	Rate for Program covered visits (see instructions)		283. 29	283. 29	9.00
10 00	CALCULATION OF SETTLEMENT	contractor records)	O	1 242	10.00
10. 00 11. 00	Program covered visits excluding mental health services (from Program cost excluding costs for mental health services (line	-	0	1, 242 351, 846	1
12. 00	Program covered visits for mental health services (from contr		0	48	1
13.00	Program covered cost from mental health services (line 9 x li		0	13, 598	13.00
14.00	Limit adjustment for mental health services (see instructions		0	13, 598	1
15. 00 16. 00	Graduate Medical Education Pass Through Cost (see instruction	,	0	245 444	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	365, 444 228, 884	
16. 02	Total program preventive charges (see instructions) (from prov	•		12, 145	1
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		19, 391	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		258, 208	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	277, 599	16. 05
17. 00	Primary payer amounts			0	1
18.00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		23, 293	18.00
19. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		38, 571	19. 00
20.00	records)			277 500	20.00
20.00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		277, 599 12, 762	
22. 00	Total reimbursable Program cost (line 20 plus line 21)	W 4, 1111C 10)		290, 361	1
23. 00	Allowable bad debts (see instructions)			0	23.00
23. 01	Adjusted reimbursable bad debts (see instructions)			0	
24. 00 25. 00	3	ructions)		0	1
25. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instruction	5)		0	
	Demonstration payment adjustment amount before sequestration	-,		0	l
26.00	Net reimbursable amount (see instructions)			290, 361	26.00
26. 01	Sequestration adjustment (see instructions)			1, 916	1
26. 02	Demonstration payment adjustment amount after sequestration Interim payments			0 196, 302	
28. 00	Tentative settlement (for contractor use only)			170, 302	28.00
	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		92, 143	1
30.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II		0	30.00

Health Financial Systems	PUTNAM COUNTY I	HOSPI TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHI VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1333	Peri od: From 01/01/2020	Worksheet M-4
VACCINE COST		Component CCN: 15-8515	To 12/31/2020	Date/Time Prepared: 7/15/2021 2:27 pm
		Title XVIII	RHC I	Cost

					/ pm
		Title XVIII	RHC I	Cost	
			Pneumococcal	l nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		939, 216	939, 216	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0. 001239	0. 005652	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	1, 164	5, 308	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	28, 617	16, 937	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	29, 781	22, 245	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	939, 216	939, 216	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 687, 936	1, 687, 936	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 031708	0. 023685	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	53, 521	39, 979	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	83, 302	62, 224	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections		157		11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1		530. 59	86. 91	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	10	70	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	5, 306	6, 084	14.00
	(line 12 x line 13)				
15. 00				145, 526	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			11, 390	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)			l	

Health Financial Systems	PUTNAM COUNTY F	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	PNEUMOCOCCAL AND INFLUENZA	Provi der CCN: 15-1333	Peri od: From 01/01/2020	Worksheet M-4
WICCINE GOST		Component CCN: 15-8513		Date/Time Prepared: 7/15/2021 2:27 pm
		Title XVIII	RHC LT	Cost

				// 15/2021 2: 2	/ pili
		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)		727, 661	727, 661	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0. 001194	0. 007018	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	869	5, 107	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	21, 729	25, 787	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	s line 4)	22, 598	30, 894	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	727, 661	727, 661	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		1, 519, 505	1, 519, 505	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 031056	0. 042457	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	47, 190	64, 514	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	69, 788	95, 408	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	147	864	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	474. 75	110. 43	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	7	166	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	3, 323	18, 331	14.00
	(line 12 x line 13)				
15.00	00 Total cost of pneumococcal and influenza vaccine and its (their) administration (sum			165, 196	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3	, line 2)			
16.00	Total Program cost of pneumococcal and influenza vaccine and	its (their)		21, 654	16.00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	PUTNAM COUNTY F	IOSPI TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1333	Peri od: From 01/01/2020	Worksheet M-4
VACCINE COST		Component CCN: 15-8514	To 12/31/2020	Date/Time Prepared: 7/15/2021 2:27 pm
		Title XVIII	RHC LLL	Cost

			77 137 2021 2. 2	/ pill
	Title XVIII	RHC III	Cost	
			I nfl uenza	
		1.00	2. 00	
Health care staff cost (from Wkst. M-1, col. 7, line 10)		737, 106	737, 106	1.00
Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff tim	e 0. 000834	0. 004430	2.00
Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	615	3, 265	3.00
Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	14, 403	13, 733	4.00
Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	15, 018	16, 998	5.00
Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22	737, 106	737, 106	6.00
Total overhead (from Wkst. M-2, line 19)		1, 573, 478	1, 573, 478	7.00
Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 020374	0. 023060	8.00
divided by line 6)				
Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	32, 058	36, 284	9.00
Total pneumococcal and influenza vaccine cost and its (their)	administration (sum of	47, 076	53, 282	10.00
lines 5 and 9)				
Total number of pneumococcal and influenza vaccine injections	(from your records)	96	510	11.00
Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	490. 38	104. 47	12.00
Number of pneumococcal and influenza vaccine injections admin	istered to Program	6	94	13.00
benefi ci ari es				
	heir) administration	2, 942	9, 820	14.00
1.				
	,		100, 358	15. 00
			12, 762	16. 00
	amount to Wkst. M-3,			
line 21)			l	
	Ratio of pneumococcal and influenza vaccine staff time to tot Pneumococcal and influenza vaccine health care staff cost (li Medical supplies cost - pneumococcal and influenza vaccine (f Direct cost of pneumococcal and influenza vaccine (line 3 plu Total direct cost of the hospital-based RHC/FQHC (from Worksh Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9) Total number of pneumococcal and influenza vaccine injections Cost per pneumococcal and influenza vaccine injection (line 1 Number of pneumococcal and influenza vaccine injections admin beneficiaries Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (theof cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3 Total Program cost of pneumococcal and influenza vaccine and	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total health care staff time pneumococcal and influenza vaccine health care staff cost (line 1 x line 2) Medical supplies cost - pneumococcal and influenza vaccine (from your records) Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections administered to Program beneficiaries Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their)	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of pneumococcal and influenza vaccine staff time to total health care staff time Pneumococcal and influenza vaccine staff time to total health care staff time Pneumococcal and influenza vaccine health care staff cost (line 1 x line 2)  Medical supplies cost - pneumococcal and influenza vaccine (from your records) Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)  Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22) Total overhead (from Wkst. M-2, line 19) Ratio of pneumococcal and influenza vaccine direct cost to total direct cost (line 5 divided by line 6) Overhead cost - pneumococcal and influenza vaccine (line 7 x line 8) Total pneumococcal and influenza vaccine cost and its (their) administration (sum of lines 5 and 9) Total number of pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections (from your records) Cost per pneumococcal and influenza vaccine injections administration Program cost of pneumococcal and influenza vaccine and its (their) administration (line 12 x line 13) Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,	Title XVIII   RHC III   Cost   Pneumococcal   Influenza   1.00   2.00

Health Financial Systems	PUTNAM COUNTY F	IOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAL		Provider CCN: 15-1333	Peri od: From 01/01/2020	Worksheet M-5
		Component CCN: 15-8515	To 12/31/2020	Date/Time Prepared: 7/15/2021 2:27 pm
			DUO I	0

		component con. 13-8313	10 12/31/2020	7/15/2021 2: 2	
			RHC I	Cost	
			Par	rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			118, 925	1.
00	Interim payments payable on individual bills, either submit	tted or to be submitted to		0	2.
	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 amount	t 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		<u> </u>		
1				0	3
2				0	3
3				0	3
4				0	3
5				0	3
	Provider to Program				
0				0	3
1				0	3
2				0	3
3				0	3
4				0	3
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)		0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	)	118, 925	4
	27)				
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	sk review. Also show date o	of		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
1				0	5
2				0	5
3				0	5
_	Provider to Program			_	
0				0	5
1				0	5
2		00)		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	5
0	Determined net settlement amount (balance due) based on the	e cost report. (1)		(0.400	6
1	SETTLEMENT TO PROVIDER			69, 129	6
2	SETTLEMENT TO PROGRAM			0	6
0	Total Medicare program liability (see instructions)			188, 054	7
			Contractor	NPR Date	
		0	Number	(Mo/Day/Yr)	
	No. of Contraction	0	1.00	2. 00	_
00	Name of Contractor			]	8

Health Financial Systems	PUTNAM COUNTY F	IOSPI TAL	In Lieu	ı of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provi der CCN: 15-1333 Component CCN: 15-8513	Peri od: From 01/01/2020 To 12/31/2020	

				7/15/2021 2: 2	7 pm
			RHC II	Cost	
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			114, 359	1. (
2. 00	Interim payments payable on individual bills, either submit			0	2. (
	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 amount				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				
. 01			11/30/2020	35, 400	3.
. 02				0	3.
03				0	3.
. 04				0	3.
. 05				0	3.
	Provi der to Program			_	_
50				0	3.
51				0	3.
52				0	3.
53				0	3.
54		22)		0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			35, 400	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans	ster to Worksheet M-3, line		149, 759	4.
	27)				
00	TO BE COMPLETED BY CONTRACTOR		s I		-
. 00	List separately each tentative settlement payment after deseach payment. If none, write "NONE" or enter a zero. (1)	sk review. Also snow date of			5.
	Program to Provider				
01	Frogram to Frovider			0	5.
02					5.
03				0	5.
03	Provider to Program				٥.
50	11 ovi dei 16 11 ogi diii			0	5.
51				0	5.
52				l ol	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	98)		0	5.
00	Determined net settlement amount (balance due) based on the				6.
01	SETTLEMENT TO PROVIDER	, eggt : epg: t. (1)		51, 199	6.
02	SETTLEMENT TO PROGRAM			0	6.
00	Total Medicare program liability (see instructions)			200. 958	7.
. 55			Contractor	NPR Date	, ·
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
	Name of Contractor				

Health Financial Systems	PUTNAM COUNTY F	IOSPI TAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIA		Provi der CC		Peri od: From 01/01/2020	Worksheet M-5
SERVICES RENDERED TO PROGRAM BENEFICIA	III LJ	Component C	CCN: 15-8514	To 12/31/2020	Date/Time Prepared: 7/15/2021 2:27 pm
					_

Rec   III			Component Con. 13-8314	10 12/31/2020	7/15/2021 2: 2	
Total interim payments paid to hospital-based RHC/FOHC  Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero  List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) To BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) To BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PRORAM Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PRORAM SETTLEMENT TO PRORAM To SETTLEMENT TO PROR				RHC III		
Total Interim payments paid to hospital-based RHC/FOHC Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero IList separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Program to Provider  Determination of lines 3.01-3.49 minus sum of lines 3.50-3.98) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 196, 302 47) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 3.01-3.49 minus sum of lines 4.550-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 6.01-5.98 Determination of lines 6.01-5.49 minus sum of lines 6.01-5.99 Determination of lines 6.01-5.49 minus s				Pai	rt B	
Total Interim payments paid to hospital-based RHC/FOHC Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero IList separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Program to Provider  Determination of lines 3.01-3.49 minus sum of lines 3.50-3.98) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 196, 302 47) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 1, 2, and 3.99 (transfer to Worksheet M-3, line 27) Determination of lines 3.01-3.49 minus sum of lines 4.550-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 5.50-5.98) Determination of lines 6.01-5.49 minus sum of lines 6.01-5.98 Determination of lines 6.01-5.49 minus sum of lines 6.01-5.99 Determination of lines 6.01-5.49 minus s				mm/dd/vvvv	Amount	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Program to Provider  Provider to Program  Provider to Program  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 196,302 and 197)  To BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROGRAM  To Total Medicare program liability (see instructions)  On 1.00 2.00  PROVIDER SUBJECT OF TOTAL CONTRACTOR  List separately each rentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  On 1.00 2.00  Provider to Program  On 1.00 2.00  Provider to Program  On 1.00 2.00  Provider to Program liability (see instructions)					2.00	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Program to Provider  Provider to Program  Provider to Program  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 196,302 and 197)  To BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROGRAM  To Total Medicare program liability (see instructions)  On 1.00 2.00  PROVIDER SUBJECT OF TOTAL CONTRACTOR  List separately each rentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  On 1.00 2.00  Provider to Program  On 1.00 2.00  Provider to Program  On 1.00 2.00  Provider to Program liability (see instructions)	00	Total interim payments paid to hospital-based RHC/FQHC			196, 302	1.
the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero  List separately each retroactive lump sum adjustment amount based on subsequent revision of the intertim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  O  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  To BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Provider to Program  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROGRAM  O  Total Medicare program liability (see instructions)  O  Contractor Number (Mo/Day/Yr)  Number (Mo/Day/Yr)  Number (Mo/Day/Yr)  NPR Date (Mo/Day/Yr)  Number (Mo/Day/Yr)  NPR Date (Mo/Day/Yr)	00		tted or to be submitted to			2.
NonKE* or enter a zero  List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NonE" or enter a zero. (1)  Program to Provider  Provider to Program  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 196, 302) Total separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NonE" or enter a zero. (1)  Program to Provider  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)  On 1,00 2,00  On 2,						
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  O			•			
Program to Provider   None, write "None" or enter a zero. (1)   Program to Provider   O   O   O   O   O   O   O   O   O	00	List separately each retroactive lump sum adjustment amount	t based on subsequent			3
Program to Provider		revision of the interim rate for the cost reporting period.	Also show date of each			
1		payment. If none, write "NONE" or enter a zero. (1)				
Provider to Program		Program to Provider				
Provider to Program	1				0	3
Provider to Program	2				0	3
Provider to Program  Provider to Program  Provider to Program  O	3				0	3
Provider to Program	4				0	3
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	5				0	3
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O		Provider to Program				
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	0					3
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  Provider to Program  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETILEMENT TO PROVIDER  SETILLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  Subtotal (sum of lines to Contractor NPR Date (Mo/Day/Yr) Number (Mo/Day/Yr) Nu						
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  To BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  Provider to Program  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  NPR Date (Mo/Day/Yr)  O 1.00 2.00						
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  Provider to Program  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  SUBSTITEMENT TO PROGRAM  Total Medicare program liability (see instructions)  Oncompany  Contractor Number (Mo/Day/Yr)  NPR Date (Mo/Day/Yr)  10 2 3 3 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5						-
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  Provider to Program  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)  Provider to Worksheet M-3, line 196, 302 2 2 3 196, 302 2 5 5 6 6 6 7 7 8 8 9 8 9 9 8 9 9 8 9 9 9 9 8 9 9 9 8 9					·	
27) TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider   1					1	
TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  O	0		sfer to Worksheet M-3, line		196, 302	4
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  O  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  New York (Mo/Day/Yr)  O  1.00  2.00						
each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  O			al and the Alexander Laboratory	6		_
Program to Provider    1	O		sk review. Also show date o	DT		5
1						
Provider to Program		Program to Provider				
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0   0   0   0   0   0   0   0   0   0		Provider to Program			0	٦
1					0	5
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Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00	2					5
Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00		Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.	98)		0	5
1 SETTLEMENT TO PROVIDER 2 SETTLEMENT TO PROGRAM 0 Total Medicare program liability (see instructions)						6
2 SETTLEMENT TO PROGRAM 0 Total Medicare program liability (see instructions)			,		92, 143	6
O         Total Medicare program liability (see instructions)         288,445         7           Contractor Number (Mo/Day/Yr)         0         1.00         2.00						6
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00						7
Number         (Mo/Day/Yr)           0         1.00         2.00				Contractor		
0 1.00 2.00						
0 Name of Contractor			0			
	00	Name of Contractor				8