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

(Si gned)_

Officer or Administrator of Provider(s)

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	100, 251	-287,833	0	-18, 803	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
4.00	SUBPROVI DER I						4.00
5.00	Swing bed - SNF	0	-17, 456	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		60, 360		0	10.00
10.01	RURAL HEALTH CLINIC II	0		33, 513		0	10.01
10.02	RURAL HEALTH CLINIC III	0		5, 417		0	10.02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
200.00	Total	0	82, 795	-188, 543	0	-18, 803	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.

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	PUTNAM COUNT I DENTI FI CATI ON DATA		er CCN: 1		Period: From 01/01/ To 12/31/	2017	Workshe Part I Date/Ti 5/29/20	me Pre	2 epare
	1.00	2.00		3.00			4.00	5/ 27/ 20	10 10:	20 d
	Hospital and Hospital Health Care C									
00	Street: 1542 SOUTH BLOOMINGTON ST	PO Box:								1.
00	City: GREENCASTLE	State: IN Component Name		e: 46135- CBSA	Provi der	y: PUTNAM	Dovime	ent Syst	om (D	2.
		component Name	CCN Number	Number	Type	Date Certified		, 0, or		
			- Number	Number	'Jpc		V			1
		1.00	2.00	3.00	4.00	5.00	6.00		8.00	1
	Hospital and Hospital-Based Compone	nt Identification:								
0	Hospi tal	PUTNAM COUNTY HOSPITAL	151333	26900	1	12/31/2005	N	0	0	3
0	Subprovider - IPF									4
0	Subprovider - IRF									5
0 0	Subprovider - (Other) Swing Beds - SNF	PUTNAM COUNTY HOSPITAL	15Z333	26900		12/31/2005	N	0	N	6
))	Swing Beds - NF	FUTNAM COUNTY HOSFITAL	152555	20900		12/ 31/ 2003			IN	8
))	Hospital -Based SNF									9
00	Hospital-Based NF									10
00	Hospital-Based OLTC									11
00	Hospital-Based HHA						1			12
00	Separately Certified ASC									13
00 00	Hospital-Based Hospice Hospital-Based Health Clinic - RHC	PPIM	158515	26900		02/23/2015	N	0	N	14
)U)1	Hospital-Based Health Clinic - RHC	FMC	158515	26900		02/23/2015	N	0	N	15
, ,		T MO	130313	20700		02/23/2013			1	
)2	Hospital-Based Health Clinic - RHC	NPFH	158514	26900		03/17/2015	N	0	N	15
	111									
00	Hospital-Based Health Clinic - FQHC									16
00	Hospital-Based (CMHC) I									17
10 00	Hospital-Based (CORF) Renal Dialysis						1			17
	Other									10
						From:		To		
						1.00		2. C	0	
00	Cost Reporting Period (mm/dd/yyyy)					01/01/20	017	12/31/	2017	20
00	Type of Control (see instructions)					9				21
	Inpatient PPS Information									
00	Does this facility qualify and is in share hospital adjustment, in accord									22
	for yes or "N" for no. Is this facil									
	amendment hospital?) In column 2, er			12. 100(0)	(2)(11000	C				
)1	Did this hospital receive interim u			is cost r	reporting	N		Ν		22
	period? Enter in column 1, "Y" for									
	reporting period occurring prior to									
	for no for the portion of the cost (see instructions)	reporting period occurri	ng on or	arter uci	tober I.					
12	Is this a newly merged hospital that	t requires final uncompe	ensated ca	re navmer	nts to he	N		Ν		22
~	determined at cost report settlemen									22
						1				1
	or "N" for no, for the portion of th	ne cost reporting period	l prior to	October	1. Enter					
	in column 2, "Y" for yes or "N" for	ne cost reporting period	l prior to	October reporting	1. Enter	on				
	in column 2, "Y" for yes or "N" for or after October 1.	ne cost reporting period no, for the portion of	l prior to the cost	reportinç	1. Enter g period c					
)3	in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograpl	ne cost reporting period no, for the portion of nic reclassification fro	l prior to the cost om urban t	reporting prurala	1. Enter g period c as a resul	t N		N		22
03	in column 2, "Y" for yes or "N" for or after October 1. Did this hospital receive a geograph of the OMB standards for delineating	ne cost reporting period no, for the portion of nic reclassification fro g statistical areas adop	l prior to the cost om urban t oted by CM	reporting p rural a S in FY20	1. Enter g period c as a resul 015? Enter	t N		Ν		22
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA I	Provider CC	N: 15-1333	Period: From 01/0 To 12/3 Out-of		5/29/2018	e Prepared: 3 10:26 am
	Medicaid paid days	Medi cai d el i gi bl e unpai d days	State Medicaid paid days	State Medi cai d el i gi bl e unpai d	HMO da <u>y</u>	ys Medic day	caid /s
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.		2.00	3.00	4.00		0	25.00
					Rural S 00	Date of G 2.00	eogr
 26.00 Enter your standard geographic classification (not cost reporting period. Enter "1" for urban or "2" to Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban enter the effective date of the geographic reclassi 35.00 If this is a sole community hospital (SCH), enter the effective date of the geographic standard to the geographic standard to the stand	for rural. wage) status or "2" for r ification in	s at the en rural. If a column 2.	d of the cos pplicable,	st	1 1 0		26.00 27.00 35.00
effect in the cost reporting period.				Begi n	ni na:	Endi ng	:
2/ 00 Estas and include having include and and include of COU	atatus Cuba		2/ fam	1.	00	2.00	
 36.00 Enter applicable beginning and ending dates of SCH of periods in excess of one and enter subsequent da 37.00 If this is a Medicare dependent hospital (MDH), entis in effect in the cost reporting period. 	ates.	·			О		36.00 37.00
37.01 Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y" instructions)				i i	N		37.01
38.00 If line 37 is 1, enter the beginning and ending dat greater than 1, subscript this line for the number enter subsequent dates.							38.00
					/N 00	Y/N 2.00	
39.00 Does this facility qualify for the inpatient hospithospitals in accordance with 42 CFR §412.101(b)(2) for yes or "N" for no. Does the facility meet the mith 42 CFR 412.101(b)(2)(i) or (ii)? Enter in columnstructions)	(i) or (ii)? mileage requi	Enter in c rements in	olumn 1 "Y" accordance	ume f	N	N	39.00
40.00 Is this hospital subject to the HAC program reducti "N" for no in column 1, for discharges prior to Oc no in column 2, for discharges on or after October	tober 1. Ente	er "Y" for			N	N	40.00
					V 1.00		XI X 3. 00
Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payr	mont for disr		to choro in	accordance	e N	N	N 45.00
							N 45.00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment ex	xception for	extraordi n	ary circums	tances	N	N	N 46.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete WP Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 	xception for kst. L, Pt. I S capital? E	extraordin II and Wks Inter "Y fo	ary circums t. L-1, Pt. r yes or "N'	tances I through ' for no.		N N N	N 46.00 N 47.00 N 48.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete WP Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 	, xception for kst. L, Pt. I S capital? E ent? Enter "	extraordin II and Wks Inter "Y fo Y" for yes	ary circums [;] t. L-1, Pt. r yes or "N" or "N" for	tances I through ' for no. no.	N	N	N 47.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete Wi Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital payment Teaching Hospitals 	xception for kst. L, Pt. I S capital? E ent? Enter " in approved C g period duri	extraordin II and Wks Inter "Y fo Y" for yes ME program ng which r	ary circums t. L-1, Pt. r yes or "N" or "N" for s? Enter "` esidents in	tances I through ' for no. no. (" for yes approved	N N	N	N 47.00 N 48.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete Wi Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital payment federal capital payment federal capital payment federal capital payment federal set of the facility election of the federal capital payment federal capital payment federal capital payment federal capital payment federal set of the federal capital payment federal set of the federal capital payment federal capital payment federal capital payment federal set of the federal capital payment federal set of the federal set of the federal capital payment federal set of the f	xception for kst. L, Pt. I S capital? E ent? Enter " in approved C g period duri for yes or "N onth of this "Y", complet	extraordin II and Wks Inter "Y fo Y" for yes GME program ng which r " for no i cost repor	ary circums t. L-1, Pt. r yes or "N" or "N" for s? Enter "` esidents in n column 1. ting period	tances through ' for no. no. (" for yes approved f column ? Enter "	N N N 1 Y"	N	N 47.00 N 48.00 56.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete Wi Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymed Teaching Hospitals 56.00 Is this a hospital involved in training residents i or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" i is "Y" did residents start training in the first more for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. 58.00 If line 56 is yes, did this facility elect cost reidefined in CMS Pub. 15-1, chapter 21, §2148? If yes 	xception for kst. L, Pt. I S capital? E ent? Enter " in approved C g period duri for yes or "N onth of this "Y", complet II, if appli imbursement f s, complete W	extraordin II and Wks Ther "Y fo 'Y" for yes ME program ng which r " for no i cost repor e Workshee cable. For physici Wkst. D-5.	ary circums t. L-1, Pt. or "N" for s? Enter "` esidents in n column 1. ting period t E-4. If co ans' service	tances through ' for no. no. (" for yes approved f column ? Enter " olumn 2 is	N N 1 Y" N	N	N 47.00 N 48.00 56.00 57.00 58.00 58.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete Wi Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymed Teaching Hospitals 56.00 Is this a hospital involved in training residents i or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" is "Y" did residents start training in the first me for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. 58.00 If line 56 is yes, did this facility elect cost reional start training in the first me for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. 	xception for kst. L, Pt. I S capital? E ent? Enter " in approved C g period duri for yes or "N onth of this "Y", complet II, if appli imbursement f s, complete W	extraordin II and Wks Ther "Y fo 'Y" for yes ME program ng which r " for no i cost repor e Workshee cable. For physici Wkst. D-5.	ary circums t. L-1, Pt. or "N" for s? Enter "` esidents in n column 1. ting period t E-4. If co ans' service	tances 1 through ' for no. no. (" for yes approved 1f column ? Enter "' olumn 2 is es as 15 Worksl	N N Y" N N neet A	N N Pass-Thrc Qual i fi ca Cri teri i	N 47.00 48.00 56.00 57.00 58.00 59.00 59.00
 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete Wi Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymed Teaching Hospitals 56.00 Is this a hospital involved in training residents i or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" i is "Y" did residents start training in the first more for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. 58.00 If line 56 is yes, did this facility elect cost reidefined in CMS Pub. 15-1, chapter 21, §2148? If yes 	xception for kst. L, Pt. I S capital? E ent? Enter " in approved C g period duri for yes or "N onth of this "Y", complet II, if appli mbursement f s, complete W yes, complete	extraordin II and Wks Inter "Y fo Y" for yes GME program ng which r " for no i cost repor cable. cost cepor cable. for physici. Vkst. D-5.	ary circums t. L-1, Pt. r yes or "N" or "N" for s? Enter "`` esidents in n column 1. ting period' t E-4. If co ans' servico , Pt. I. NAHE 413.8	tances I through ' for no. no. (" for yes approved If column ? Enter "' olumn 2 is es as 5 Worksl Lin	N N Y" N N neet A	N N Pass-Thrc Qual i fi ca	N 47.00 48.00 56.00 57.00 58.00 59.00 59.00

SPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C		eriod: rom 01/01/2017	Worksheet S-2 Part I	2
				Te		Date/Time Pre 5/29/2018 10:	
		Y/N	IME	Direct GME	I ME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in				0.00	0.00	61.
	column 1. (see instructions)						
. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports						61.
	ending and submitted before March 23, 2010. (see						
00	instructions)						111
. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61.
	and primary care FTEs added under section 5503 of						
. 03	ACA). (see instructions) Enter the base line FTE count for primary care						61.
	and/or general surgery residents, which is used for						
	determining compliance with the 75% test. (see instructions)						
. 04	Enter the number of unweighted primary care/or						61.
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						
. 05	Enter the difference between the baseline primary						61.
	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						
	61.04 minus line 61.03). (see instructions)						
. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.
	care or general surgery. (see instructions)		NI	D			
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME	
			1.00	0.00	2.00	FTE Count	-
. 10	Of the FTEs in line 61.05, specify each new program		1.00	2.00	3.00	4.00) 61.
	specialty, if any, and the number of FTE residents						
	for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the						
	program code. Enter in column 3, the IME FTE						
	unweighted count. Enter in column 4, the direct GME FTE unweighted count.						
. 20	Of the FTEs in line 61.05, specify each expanded				0.00	0. 00	61
	program specialty, if any, and the number of FTE residents for each expanded program. (see						
	instructions) Enter in column 1, the program name.						
	Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,						
	the direct GME FTE unweighted count.						
						1.00	-
00	ACA Provisions Affecting the Health Resources and Ser						
. 00	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruct		d in this cost	reporting per	iod for which	0.00	J 62
. 01	Enter the number of FTE residents that rotated from a	a Teach			your hospital	0.00	62
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide			ons)			
. 00	Has your facility trained residents in nonprovider se	ettings	during this c	1 5		Ν	63.
	"Y" for yes or "N" for no in column 1. If yes, comple	ete IIn	es 64 through	Unweighted	Unweighted	Ratio (col.	
				FTĔs	FTEs in	1/ (col. 1 +	
				Nonprovider Site	Hospi tal	col. 2))	
	<u> </u>			1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor	•	0	-This base year	is your cost	reporti ng	
. 00	Enter in column 1, if line 63 is yes, or your facilit	ty trai	ned residents	0.00	0.00	0. 000000	64.
	in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in						
				1	1		1
	settings. Enter in column 2 the number of unweighted		rimary care				

	EX IDENTIFICATION D	ATA Provider (eriod: .om 01/01/2017	Worksheet S-2 Part I	
			Tc		Date/Time Pre	pare
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	5/29/2018 10: Ratio (col. 3/ (col. 3 + col. 4))	<u>26 a</u>
	1.00	2.00	3.00	4.00	5.00	
.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			0.00	0.00	0. 000000	
divided by (column 3 + column 4)). (see instructions)			Unweighted	Unweighted	Ratio (col.	
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Settin	ngsEffective f	or cost report	ing periods	
		irv care resident	0.00	0.00	0 000000	66
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp unweighted non-prima al. Enter in column	ry care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +	66.
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. mry care resident 3 the ratio of <u>structions</u>) Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	66.
 FTEs attributable to rotations of Enter in column 2 the number of the FTEs that trained in your hospita (column 1 divided by (column 1 + 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 	ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir	provider settings. Try care resident 3 the ratio of Istructions)	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	-
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 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	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. mry care resident 3 the ratio of <u>structions</u>) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	-
 FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 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 3 divided by (column 3 + column 4) 	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name	provider settings. mry care resident 3 the ratio of <u>structions</u>) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	-
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 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)	ccurring in all nonp unweighted non-prima al. Enter in column <u>column 2)). (see ir</u> Program Name <u>1.00</u>	Provider settings. Incry care resident 3 the ratio of Instructions) Program Code 2.00	Unwei ghted FTEs Nonprovi der Si te 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	67.
 FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 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 3 divided by (column 1 divided by (column 3 divi	Courring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00 1.00 PS ychiatric Facility (the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii	<pre>provider settings. rry care resident 3 the ratio of istructions) Program Code 2.00 2.00 (IPF), or does it cor in approved GME teach 004? Enter "Y" for illty train resident)(D)? Enter "Y" for</pre>	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	-
FTEs attributable to rotations of Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 + 	ccurring in all nonp unweighted non-prima al. Enter in column column 2)). (see ir Program Name 1.00 1.00 PS ychiatric Facility (the facility have a efore November 15, 2 lumn 2: Did this fac R 412.424 (d)(1)(iii cate which program y	<pre>provider settings. rry care resident 3 the ratio of istructions) Program Code 2.00 2.00 (IPF), or does it cor in approved GME teach 004? Enter "Y" for illty train resident)(D)? Enter "Y" for</pre>	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see ni ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000	67.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	rovider CCN: 15-1333	Period: From 01/01/2017 To 12/31/2017		epared
		1.0	0 0 0 0 0	-
6.00 If line 75 is yes: Column 1: Did the facility have an approved of recent cost reporting period ending on or before November 15, 20 no. Column 2: Did this facility train residents in a new teaching CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column cate which program year began during this cost reporting period.	004? Enter "Y" for yes ng program in accordar umn 3: If column 2 is	n the most s or "N" for nce with 42 s Y,	0 2.00 3.00 0	76.0
Long Term Care Hospital PPS			1.00	
 D. 00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and 1. 00 Is this a LTCH co-located within another hospital for part or al "Y" for yes and "N" for no. TEFRA Providers 		ng period? Enter	N N	80. 0 81. 0
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEL 6.00 Did this facility establish a new Other subprovider (excluded un			N	85. C 86. C
 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 7.00 Is this hospital an extended neoplastic disease care hospital cl 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. 	assified under sectio	n	N	87.0
		V 1.00	XI X 2.00	
Title V and XIX Services D. 00 Does this facility have title V and/or XIX inpatient hospital so yes or "N" for no in the applicable column.	ervices? Enter "Y" for	N	Y	90.0
.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the applical	cost report either in ble column.	N	Ν	91.
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual o instructions) Enter "Y" for yes or "N" for no in the applicable	certification)? (see column.		N	92.
B. 00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column. B. 00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and			N	93.
applicable column. 5.00 ffline 94 is "Y", enter the reduction percentage in the applica	able column.	N 0.00	N 0. 00	95.
 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column. If line 96 is "Y", enter the reduction percentage in the application. 	able column.	N 0. 00	N 0. 00	96. 97.
B. OD Does title V or XIX follow Medicare (title XVIII) for the intern stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for column 1 for title V, and in column 2 for title XIX.		Y	Y	98.
B. 01 Does title V or XIX follow Medicare (title XVIII) for the report C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title title XIX.			Y	98.
B. 02 Does title V or XIX follow Medicare (title XVIII) for the calcul bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "I for title V, and in column 2 for title XIX.		Y	Y	98.
8.03 Does title V or XIX follow Medicare (title XVIII) for a critical reimbursed 101% of inpatient services cost? Enter "Y" for yes of			N	98.
for title V, and in column 2 for title XIX. 8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH rein outpatient services cost? Enter "Y" for yes or "N" for no in col		N	N	98.
in column 2 for title XIX. 8.05 Does title V or XIX follow Medicare (title XVIII) and add back Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in colum			Y	98.
 column 2 for title XIX. .06 Does title V or XIX follow Medicare (title XVIII) when cost rein Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 column 2 for title XIX. 	nbursed for Wkst. D, for title V, and in	Y	Y	98.
Rural Providers 5.00Does this hospital qualify as a CAH?		Y		105.
6.00 f this facility qualifies as a CAH, has it elected the all-incl for outpatient services? (see instructions)	usive method of payme			105.
7.00 If this facility qualifies as a CAH, is it eligible for cost rei training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25	(see instructions) If			107.
reimbursed. If yes complete Wkst. D-2, Pt. II. 08.00 Is this a rural hospital qualifying for an exception to the CRN/ CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	A fee schedule? See 4	2 N		108.

	Provider C		eriod: rom 01/01/	2017	Workshe Part I	eet S-2	2
		Te			Date/Ti 5/29/20	me Pre	epared
	Physi cal	Occupati onal	Speec		Respi r	ratory	
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	<u>1.00</u> Y	2.00 Y	3.00 Y		4. (N		109.0
				-	1. (00	-
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter ' complete Worksheet E, Part A, lines 200 through 218, and Wor applicable.	"Y" for yes or	"N" for no. I	f yes,	5		J	110. (
			1.00		2. (00	-
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this constrained on the Project (FCHIP) demonstration for the constrained on the Provide the Provided on the Prov	ost reporting olumn 1 is Y, rticipating ir	period? Enter enter the column 2.	N				111. (
				1.00	2.00	3.00	
 Miscellaneous Cost Reporting Information 5.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 6.00 Is this facility classified as a referral center? Enter "Y" 	. If column 2 nt for long te rs) based on 1 for yes or "N	is "E", enter erm care (inclu the definition V" for no.	in column des in CMS	N		0	115. (
7.00 Is this facility legally-required to carry malpractice insur- no.		5		Y			117. (
8.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1			2	<u> </u>		118.
		Premiums	Losse	5	Insur	ance	
		1.00	2.00		3. (
8.01 List amounts of malpractice premiums and paid losses:		181, 093		0		C	0118.
8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo and amounts contained therein.			1.00 N		2. (00	118.
9.00 DO NOT USE THIS LINE 10.00 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 qualified to the second s	n column 1, "\ ualifies for 1	(" for yes or the Outpatient	N		N	I	119. 120.
Hold Harmless provision in ACA §3121 and applicable amendmen							121.
Enter in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost impla	antable device	es charged to	N				
Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	fined in §1903	3(w)(3) of the	N				122.
Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defected to the cost report contain healthcare related taxes as defected to the taxes as defected to the taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for the taxes are included.	fined in §1903 1 is "Y", ente	B(w)(3) of the er in column 2					
Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter and the second seco	fined in §1903 1 is "Y", ente or yes and "N' nter the certi	3(w)(3) of the er in column 2	N				125.
 Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entire in column 1 and termination date, if applicable, in column 2. 	fined in §1903 1 is "Y", ente or yes and "N' nter the certi 2. ter the certi1	3(w)(3) of the er in column 2	N				125. 126.
 Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 	fined in §1903 1 is "Y", ente or yes and "N" nter the certi 2. ter the certif 2. ter the certif	8(w)(3) of the er in column 2 f for no. If fication date	N				125. 126. 127.
 Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implationation patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defected act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entir column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, entir no column 1 and termination date, if applicable, in column 2. 	fined in §1903 1 is "Y", enter or yes and "N" nter the certi 2. ter the certif 2. ter the certif 2.	3(w)(3) of the er in column 2 f for no. If fication date fication date	N				125. 126. 127. 128.
 Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defact?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 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2. 	fined in §1903 1 is "Y", enter or yes and "N' nter the certi 2. ter the certif 2. er the certifi enter the certifi	3(w)(3) of the er in column 2 f for no. If fication date fication date fication date cation date in	N				125. 126. 127. 128. 129.
 Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as defended act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 8.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified pancreas transplant center, end in column 1 and termination date, if applicable, in column 2 	fined in §1903 1 is "Y", enter or yes and "N" nter the certi 2. ter the certif 2. ter the certif en the certifi enter the cer lumn 2. r, enter the cer	3(w)(3) of the er in column 2 f for no. If fication date fication date fication date cation date in rtification certification	N				125. 126. 127. 128. 129. 130. 131.
 Enter in column 2, "Y" for yes or "N" for no. 1.00 Did this facility incur and report costs for high cost implate patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain heal thcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 5.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, end in column 1 and termination date, if applicable, in column 2 7.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified liver transplant center, end in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified pancreas transplant center, end in column 1 and termination date, if applicable, in column 2 0.00 If this is a Medicare certified pancreas transplant center, end column 1 and termination date, if applicable, in column 2 	fined in §1903 1 is "Y", enter or yes and "N" nter the certif 2. ter the certif 2. er the certifi enter the certifi lumn 2. r, enter the certifi tumn 2. ter the certifi	3(w)(3) of the er in column 2 f for no. If fication date fication date fication date cation date in rtification certification	N				 122. 125. 126. 127. 128. 129. 130. 131. 132.

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL				In Lieu	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-133			/01/2017 /31/2017	Worksheet S-2 Part I Date/Time Pre 5/29/2018 10:	pared:
				_	1	. 00	2.00	-
140.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the 1.00	'N" for no in column 1. It	f yes, and home <u>r. (see instruc</u>	office c			N 3.00	2.00	140.00
If this facility is part of a cha			ough 143 t	the nam	e and		of the home	
office and enter the home office 141.00Name:	<u>contractor name and contra</u> Contractor's Name:	actor number.	Contr	actor's	e Num	bor:		141.00
142. 00 Street: 143. 00 Ci ty:	PO Box: State:		Zip C		3 1101	iber .		142.00 143.00
							1.00	-
144.00 Are provider based physicians' cos	sts included in Worksheet	Α?					Y	144.00
				-	1	. 00	2.00	-
145.00 If costs for renal services are cl inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	' for yes or "N" for no in clude Medicare utilization for no in column 2.	n column 1. lf n for this cost	column 1 reportin	ng			2.00	145.00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/d	n column 1. (See CMS Pub.	ously filed cos 15-2, chapter	t report? 40, §4020)) If		N		146.00
							1.00	-
147.00 Was there a change in the statist							N	147.00
148.00 Was there a change in the order or 149.00 Was there a change to the simplifi				for n	_		N N	148.00 149.00
149. John as there a change to the shipith		Part A	Part			tle V	Title XIX	149.00
		1.00	2.00		3	3. 00	4.00	1
Does this facility contain a prov or charges? Enter "Y" for yes or								
155.00Hospi tal		N	N N		00 12	N	N	155.00
156.00 Subprovi der – IPF		N	N			N	N	156.00
157. 00 Subprovi der – IRF 158. 00 SUBPROVI DER		N	N N			Ν	Ν	157.00 158.00
159. 00 SNF		N	N			N	Ν	159.00
160.00 HOME HEALTH AGENCY		N	N			N	N	160.00
161. 00 CMHC 161. 10 CORF			N N			N N	N	161.00 161.10
				I				
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.							N	165.00
	Name 0	County 1.00	State 2.00	Zip Co 3.00		CBSA 4.00	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								166.00
							1.00	
Health Information Technology (HI					Act		N/	1/7 00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the l	D5 is "Y") and is a meanin HIT assets (see instruction	ngful user (lin ons)	e 167 is	"Y"), e			Y	167.00 168.00
168.01 If this provider is a CAH and is a exception under §413.70(a)(6)(ii)?					hard	shi p		168.01
169.00 If this provider is a meaningful transition factor. (see instruction	user (line 167 is "Y") and							169.00
					<u>v</u>	i nni ng 1. 00	Endi ng 2. 00	-
170.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	beginning date and ending	date for the r	eporting)1/2014		170.00

Health Financial Systems						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENT	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1333				-2	
			From 01/01/2017 To 12/31/2017			
				5/29/2018 10	<u>): 26 am</u>	
			1.00	2.00		
171.00 If line 167 is "Y", does this provider h			N		0171.00	
	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. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					

)SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet S- Part II Date/Time Pr 5/29/2018 10	repared
				Y/N	Date	. 20 ali
				1.00	2.00	-
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	for all NO re	esponses. Ent	ter all dates in	the	
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation	hoginning of	the east	N		1 1
00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	olumn 2 (see	instructions			1.
	roperting period in yes, enter the date of the enange in e	(000	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members or of directors through ownership, control, or family and othe relationships? (see instructions)	offices, drug ler or its of the board	N			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	N			4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	_
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?		he provider i			6.
00 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N N		7.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	IS.		n N N		9. 10.
	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I			N		11.
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N 1.00	
	Bad Debts				1.00	
2.00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			cost reporting	Y N	12. 13.
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement		J .		Ν	14.
b. 00	Did total beds available change from the prior cost reporti		<u>yes, see ins</u> t A	structions. Par	N 1	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
o. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	Ν		N		16.
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	03/23/2018	Y	03/23/2018	17.
3. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
	cost report? If yes, see instructions.					19.

	Financial Systems PUTNAM COUNT				u of Form CM	
HUSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	JN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet S Part II Date/Time F 5/29/2018 1	Prepared:
		Descri		Y/N	Y/N	
20.00	If Line 14 or 17 is yes were adjustments made to DSVD	C)	1.00 N	3.00 N	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:			IN	IN	20.00
		Y/N	Date	Y/N	Date	
21.00	We the set assess and sales with a the assessment	1.00 N	2.00	3.00 N	4.00	21.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	IN		11		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense		sals made du	ring the cost	N N	22.00
23.00	reporting period? If yes, see instructions.	The cost	IN IN	23.00		
24.00	Were new leases and/or amendments to existing leases entere If yes, see instructions	eporting period?	Y	24.00		
25.00	Have there been new capitalized leases entered into during	the cost repor	rting period	?lfyes, see	Y	25.00
26.00	instructions. Were assets subject to Sec.2314 of DEFRA acquired during th	ne cost reporti	ng period?	lfyes, see	N	26.00
27.00	instructions. Has the provider's capitalization policy changed during the	e cost reportir	ng period? I	fyes, submit	N	27.00
	copy. Interest Expense		51	J		_
28.00	Were new loans, mortgage agreements or letters of credit er	ntered into dur	ing the cos	t reporting	Y	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	bond funds (De	ebt Service	Reserve Fund)	Y	29.00
30.00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If ve	s. see	Ν	30,00
31.00	instructions. Has debt been recalled before scheduled maturity without is	-	-		N	31.00
31.00	instructions.			3, 366	11	
32.00	Purchased Services Have changes or new agreements occurred in patient care ser	rvi ces furni she	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		ng to compet	itive bidding? If	N	33.00
	no, see instructions. Provider-Based Physicians					_
34.00	Are services furnished at the provider facility under an ar	rrangement with	n provider-b	ased physi ci ans?	Y	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agreemen	nts with the	provi der-based	Y	35.00
	physicians during the cost reporting period? If yes, see in			-		
				Y/N 1.00	Date 2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pr	repared by the	home office	7 N		36.00 37.00
	If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off					38.00
	the provider? If yes, enter in column 2 the fiscal year end	d of the home o	offi ce.			
	If line 36 is yes, did the provider render services to othe see instructions.		5			39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see			40.00
		1.	00	2	00	
	Cost Report Preparer Contact Information	00				
41.00		TINA		SEVERS		41.00
	respectively.	BLUE & CO., LL	C			42.00
42 00	Litter the employer company name of the cost report			12.00		
	preparer. Enter the telephone number and email address of the cost	317-713-7946		TSEVERS@BLUEAN		43.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QU	JESTI ONNAI RE	Provi der	- CCN: 15-1333	Period:	Worksheet S-2	
			_		From 01/01/2017 To 12/31/2017		pared: <u>26 am</u>
				3.00			
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the tit	le/position	MANAGER				41.00
	held by the cost report preparer in columns	1, 2, and 3,					
	respectively.						
42.00	Enter the employer/company name of the cost	report					42.00
	preparer.						
43.00	Enter the telephone number and email addres	s of the cost					43.00
	report preparer in columns 1 and 2, respect	i vel y.					

iospi 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre	
						5/29/2018 10:	26 am
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number	2.00	Avai I abl e	4.00	F 00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1.00	2.00	3.00	4.00 35 41,928.00	5.00	1.00
. 00	8 exclude Swing Bed, Observation Bed and	30.00	17	0, 7	41, 720.00	0	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovi der						3.00
1.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
o. 00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation		19	6,9	41, 928. 00	0	7.00
	beds) (see instructions)						
3. 00	INTENSIVE CARE UNIT	31.00	6	2, 1	6, 240. 00	0	8.00
0. 00	CORONARY CARE UNIT						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGICAL INTENSIVE CARE UNIT						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY	43.00				0	
4.00	Total (see instructions)		25	9, 1	25 48, 168. 00	0	
5.00	CAH visits					0	
6.00	SUBPROVIDER - IPF		_			_	16.00
7.00	SUBPROVIDER - IRF	41.00	C		0	0	
8.00	SUBPROVI DER	42.00	C		0	0	
9.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY						21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)						22.00
24.00	HOSPICE						23.00
24.00	HOSPICE HOSPICE (non-distinct part)	30, 00					24.00
25.00	CMHC - CMHC	50.00					25.00
25.10	CMHC - CORF	99. 10				0	
26.00	RURAL HEALTH CLINIC	88.00				0	
26.01	RURAL HEALTH CLINIC II	88.01				0	
26. 02	RURAL HEALTH CLINIC III	88.02				0	
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)	07.00	25			0	27.00
8.00	Observation Bed Days					0	
9.00	Ambul ance Trips						29.00
0.00	Employee discount days (see instruction)						30.00
1.00	Employee discount days - IRF						31.00
2.00	Labor & delivery days (see instructions)		C		0		32.00
2. 01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
3. 00	LTCH non-covered days						33.00
2 01	LTCH site neutral days and discharges						33.01

HOSPI 7	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	PUTNAM COUNTY AL DATA	Provi der CC	CN: 15-1333	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2017 To 12/31/2017	Part I	epared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	1,003	19	1, 64		10.00	1.0
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	0	0				2.0
3.00 4.00	HMO I PF Subprovi der HMO I RF Subprovi der	0 0	0 0				3. C 4. C
5.00 5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	331	0	33	31 47		5.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 334	19	2,02	21		7.0
3.00 9.00 10.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T	130	0	24	11		8. (9. (10. (
1.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						11.
3.00	NURSERY		0		0		13.
4.00 5.00	Total (see instructions) CAH visits	1, 464 0	19 0	2,26	62 0.00 0	288.09	15.
6.00 7.00	SUBPROVIDER - IPF SUBPROVIDER - IRF	О	0		0 0.00	0.00	16. 17.
8.00 9.00	SUBPROVIDER SKILLED NURSING FACILITY		0		0 0.00	0.00	18. 19.
0.00	NURSING FACILITY OTHER LONG TERM CARE						20. 21.
2.00 3.00	HOME HEALTH AGENCY AMBULATORY SURGI CAL CENTER (D. P.)						22. 23.
4.00	HOSPICE HOSPICE (non-distinct part)	0	0		0		24. 24.
5.00 5.10	CMHC - CMHC CMHC - CORF	0	0		0 0.00	0.00	25. 25.
6.00 6.01	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II	1, 257 2, 133	0	10, 12 8, 51	0.00	3. 92	26.
6. 02	RURAL HEALTH CLINIC III	484	0	3, 43	. 00	2.99	26.
6. 25 7. 00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0	0		0 0.00 0.00		27.
8.00 9.00	Observation Bed Days Ambulance Trips	о	0	1, 15	56		28. 29.
0. 00 1. 00	Employee discount days (see instruction) Employee discount days - IRF				0		30. 31.
2.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room	О	0		0		32. 32.
33.00	LTCH non-covered days	0					33.
	LTCH site neutral days and discharges	Ő					33

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017		pared
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Patients	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00	13.00	14.00 77 5	15.00	1.0
. 00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		C	5	5	030	1.0
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)				0 0		2.0
. 00	HMO I PF Subprovi der				0		3.0
. 00	HMO IRF Subprovider				0		4.0
. 00	Hospital Adults & Peds. Swing Bed SNF						5.0
. 00	Hospital Adults & Peds. Swing Bed NF						6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.0
. 00	INTENSIVE CARE UNIT						8.
. 00	CORONARY CARE UNIT						9.
D. 00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY						13.
4.00	Total (see instructions)	0.00	C	3	77 5	636	
5.00	CAH visits						15.
5.00	SUBPROVIDER - IPF						16.
. 00	SUBPROVIDER - IRF	0.00	C		0 0	-	
3.00	SUBPROVI DER	0.00	C		0	0	18.
. 00	SKILLED NURSING FACILITY						19.
. 00	NURSING FACILITY						20.
. 00	OTHER LONG TERM CARE						21.
. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						22.
. 00	HOSPICE						23.
. 10	HOSPICE (non-distinct part)						24.
. 00	CMHC - CMHC						25.
. 10	CMHC - CORF	0,00					25
. 00	RURAL HEALTH CLINIC	0.00					26
. 01	RURAL HEALTH CLINIC II	0.00					26.
0.02	RURAL HEALTH CLINIC III	0.00					26.
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.
. 00	Total (sum of lines 14-26)	0.00					27.
. 00	Observation Bed Days						28.
. 00	Ambul ance Trips						29.
. 00	Employee discount days (see instruction)						30.
. 00	Employee discount days - IRF						31.
. 00	Labor & delivery days (see instructions)						32.
. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32.
8.00	LTCH non-covered days				0		33.
. 01	LTCH site neutral days and discharges				0		33

Component CCN: 15-8515 From 01/01/2017 To Da RHC I RHC I	orksheet S-8 ate/Time Prep /29/2018 10:2 Cost	
Component CCN: 15-8515 To 12/31/2017 Da	<u>/29/2018_10:2</u>	
	Cost	
1.00		
Clinic Address and Identification 1.00 Street 1542 S. BLOOMINGTO	ON STREET,	1.00
STE 1200 City State	ZIP Code	
1.00 2.00	3.00	
2.00 City, State, ZIP Code, County GREENCASTLE IN 461		2.00
	1.00	
3.00 HOSPITAL-BASED FQHCs ONLY: Designation - Enter "R" for rural or "U" for urban	1.00	3.00
Grant Award	Date	0100
1.00	2.00	
Source of Federal Funds 4.00 Community Health Center (Section 330(d), PHS Act) 5.00 Migrant Health Center (Section 329(d), PHS Act) 6.00 Health Services for the Homeless (Section 340(d), PHS Act) 7.00 Appal achian Regional Commission 8.00 Look-Alikes 9.00 OTHER (SPECIFY)		4.00 5.00 6.00 7.00 8.00 9.00
1.00	2.00	
10.00 Does this facility operate as other than a hospital-based RHC or FQHC? Enter "Y" for N yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) N	0	10.00
	Tuesday	
from to from to 1.00 2.00 3.00 4.00	from 5.00	
Facility hours of operations (1)	5.00	
11. 00 CLINIC 08: 00 17: 00 08: 1	00	11.00
1.00	2.00	
12.00 Have you received an approval for an exception to the productivity standard? N 13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section N 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. N	0	12.00 13.00
Provi der name CO	CCN number	
1.00 14.00 RHC/FQHC name, CCN number	2.00	14.00
	otal Visits	14.00
1.00 2.00 3.00 4.00	5.00	
15.00 Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)		15.00
County		
2.00 Ci ty, State, ZI P Code, County PUTNAM		2.00
Tuesday Wednesday Thursday	ay	2.00
to from to from	to	
6.00 7.00 8.00 9.00 Facility hours of operations (1) 6.00 7.00 8.00 9.00	10.00	
11. 00 CLINIC 17: 00 08: 00 17: 00 08: 00 17: 0	00	11.00

Health Financial Systems	PUTNAM COUNT	TY HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Period: From 01/01/2017	Worksheet S-8	
		Component	CCN: 15-8515	To 12/31/2017	Date/Time Pre 5/29/2018 10:	
	_			RHC I	Cost	
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC	08: 00	17:00				11.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 01/01/201 To 12/31/201		
					RHC II	Cost	
					1	. 00	-
	Clinic Address and Identification						
1.00	Street		1		51 E. MARKET		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		CLOVERDALE	00		N 46120	2.00
				-	4		
2.00	HOSPITAL PASED FOLICE ONLY. Decimpetian Ent	on "D" for run	al an "II" fan	ushan		1.00	2.00
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ent	er k for rur	al or U for		Award	Date	3.00
					00	2.00	
	Source of Federal Funds			1		1	
4.00 5.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						4.00
5.00 6.00	Health Services for the Homeless (Section 34						6.00
7.00	Appal achi an Regi onal Commissi on						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h				N	0	10.00
	yes or "N" for no in column 1. If yes, indic. 2.(Enter in subscripts of line 11 the type o						
	hours.)	i otner operat	ron(s) and the	operating			
			iday		nday	Tuesday	
		from 1 00	to	from 2.00	to	from F 00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	5.00	
11.00	CLINIC			08: 00	18:00	08: 00	11.00
12.00	Have you received an approval for an exception	on to the prod	uctivity stand	ard?	1.00 N	2.00	12.00
	Is this a consolidated cost report as define				N	0	
	30.8? Enter "Y" for yes or "N" for no in col						
	number of providers included in this report. numbers below.	List the name	s of all provi	ders and			
				Provi d	er name	CCN number	
	r		-	1.	00	2.00	
14.00	RHC/FOHC name, CCN number	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all		2100	0.00		0.00	15.00
	GME cost? Enter "Y" for yes or "N" for no in						
	column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider. (see instructions)						
			Cou	unty		-	
				00			
2.00	City, State, ZIP Code, County	Tuesday	PUTNAM	esday	Thu	irsday	2.00
		to	from	to	from	to	
		6. 00	7.00	8.00	9.00	10.00	
44 05	Facility hours of operations (1)	10.00				40.00	11.00
11.00	CLINIC	18: 00	08: 00	18:00	08: 00	18: 00	11.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1333	Period: From 01/01/2017	Worksheet S-8	}
		Component	CCN: 15-8513	To 12/31/2017	Date/Time Pre 5/29/2018 10:	
				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	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 01/01/2017 To 12/31/2017		
					RHC III	Cost	
					1.	. 00	-
	Clinic Address and Identification						
1.00	Street			4	440 E. PAT RAD		1.00
				ty 00	State 2.00	ZIP Code 3.00	
2.00	City, State, ZIP Code, County		BAI NBRI DGE			46105	2.00
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur:	al or "II" for	urban		1.00	3.00
5.00	Those the brock tenes over besignation ent				t Award	Date	3.00
				1	. 00	2.00	
4.00 5.00 6.00 7.00	Source of Federal Funds Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34 Appalachian Regional Commission	ct)					4.00 5.00 6.00 7.00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)						8.00 9.00
					1.00	2.00	
10.00	Does this facility operate as other than a h 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	N	0	10.00
			day		nday	Tuesday	
		from 1.00	to 2.00	from 3.00	4.00	from 5.00	
	Facility hours of operations (1)	1.00	2.00	3.00	4.00		
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	2.00	12.00
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Ν	0	
					der name	CCN number	
14.00	RHC/FQHC name, CCN number			1	. 00	2.00	14.00
14.00		Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				inty	-		
2.00	City, State, ZIP Code, County		4. PUTNAM	00			2.00
2.00	or cyr, oraco, zrr oodo, oourry	Tuesday		esday	Thu	rsday	2.00
		to	from	to	from	to	
	Facility hours of operations (1)	6.00	7.00	8.00	9.00	10.00	
11.00		17: 00	08: 00	17:00	08: 00	17:00	11.00

Health Financial Systems	PUTNAM COUNT	TY HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
HOSPI TAL-BASED RHC/FQHC STATI STI CAL DATA		Provi der C	CN: 15-1333	Period: From 01/01/2017	Worksheet S-8	
		Component	CCN: 15-8514	To 12/31/2017	Date/Time Pre 5/29/2018 10:	
				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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	/ HOSPI TAL		In Lie	u of Form CMS-	2552-10
	Provider CO	CN: 15-1333	Peri od:	Worksheet S-1	0
			From 01/01/2017 To 12/31/2017		
Uncompared and indigent ears east computation				1.00	
Uncompensated and indigent care cost computation 1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3	dividod by Li	ino 202 colum	n 9)	0. 356385	1.00
Medicaid (see instructions for each line)			11 0)	0. 330303	1 1.00
2.00 Net revenue from Medicaid				2, 801, 215	2.00
3.00 Did you receive DSH or supplemental payments from Medicaid?)			Y	3.00
1.00 If line 3 is yes, does line 2 include all DSH and/or supple		ts from Medic	ai d?	N	4.00
.00 If line 4 is no, then enter DSH and/or supplemental payment	s from Medicai	id		109, 740	
. 00 Medicaid charges				11, 988, 019	
.00 Medicaid cost (line 1 times line 6)	<i>(</i> 1.1. - .	<u> </u>		4, 272, 350	
.00 Difference between net revenue and costs for Medicaid progr < zero then enter zero)	•		nes 2 and 5; if	1, 361, 395	8.00
Children's Health Insurance Program (CHIP) (see instruction	s for each lir	ne)			
.00 Net revenue from stand-alone CHIP				0	
0.00 Stand-alone CHIP charges 1.00 Stand-alone CHIP cost (line 1 times line 10)				0	
2.00 Difference between net revenue and costs for stand-alone CH	IIP (line 11 mi	inus line 9 [.]	if < zero then		•
enter zero)		indo inic 7,		0	12.00
Other state or local government indigent care program (see	instructions f	for each line)	1	
3.00 Net revenue from state or local indigent care program (Not	included on li	ines 2, 5 or	9)	0	13.00
4.00 Charges for patients covered under state or local indigent	care program	(Not included	in lines 6 or	0	14.00
10)				_	
5.00 State or local indigent care program cost (line 1 times lin				0	
 Difference between net revenue and costs for state or local 13; if < zero then enter zero) 	indigent care	e program (II	ne 15 minus line	0	16.00
Grants, donations and total unreimbursed cost for Medicaid,	CHIP and stat	te/local indi	gent care progra	ams (see	
instructions for each line) 7.00 Private grants, donations, or endowment income restricted t	o funding char	rity care		0	17.00
3.00 Government grants, appropriations or transfers for support				0	
			s (sum of lines	1, 361, 395	
9.00 TOTAL UNLETINDUISED COST FOR MEDICALD, CHIP and State and F	ocal indigent			1, 301, 373	•
8, 12 and 16)	ocal Indigent	1 3		1, 301, 393	•
	ocal Indigent	Uni nsured	Insured	Total (col. 1	•
	ocal Indigent	Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	•
8, 12 and 16)	ocal Indigent	Uni nsured	Insured	Total (col. 1	•
8, 12 and 16) Uncompensated Care (see instructions for each line)		Uni nsured pati ents 1.00	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	19.00
8, 12 and 16) Uncompensated Care (see instructions for each line) O. 00 Charity care charges and uninsured discounts for the entire		Uni nsured pati ents	Insured patients 2.00	Total (col. 1 + col. 2) 3.00	19.00
8, 12 and 16) Uncompensated Care (see instructions for each line) 0.00 Charity care charges and uninsured discounts for the entire (see instructions)	e facility	Uni nsured pati ents 1.00	I nsured patients 2.00	Total (col. 1 + col. 2) 3.00 749,534	19.00 20.00
8, 12 and 16) Uncompensated Care (see instructions for each line) 0.00 Charity care charges and uninsured discounts for the entire (see instructions)	e facility	Uni nsured pati ents 1.00 749, 53	I nsured patients 2.00	Total (col. 1 + col. 2) 3.00 749,534	19.00 20.00
 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire (see instructions) Cost of patients approved for charity care and uninsured di instructions) O0 Payments received from patients for amounts previously writ 	e facility scounts (see	Uni nsured pati ents 1.00 749, 53	I nsured patients 2.00	Total (col. 1 + col. 2) 3.00 749, 534 267, 123	19.00 20.00 21.00
 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire (see instructions) OC Cost of patients approved for charity care and uninsured di instructions) OC OP Payments received from patients for amounts previously writ charity care 	e facility scounts (see	Uni nsured pati ents 1.00 749, 53 267, 12	I nsured pati ents 2.00 34 0 23 0 0 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0	19.00 20.00 21.00 22.00
 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire (see instructions) Cost of patients approved for charity care and uninsured di instructions) O0 Payments received from patients for amounts previously writ charity care 	e facility scounts (see	Uni nsured pati ents 1.00 749, 53	I nsured pati ents 2.00 34 0 23 0 0 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0	19.00 20.00 21.00 22.00
 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire (see instructions) Cost of patients approved for charity care and uninsured di instructions) O0 Payments received from patients for amounts previously writ charity care 	e facility scounts (see	Uni nsured pati ents 1.00 749, 53 267, 12	I nsured pati ents 2.00 34 0 23 0 0 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0 267,123	19.00 20.00 21.00 22.00
 8, 12 and 16) Uncompensated Care (see instructions for each line) 0.00 Charity care charges and uninsured discounts for the entire (see instructions) 1.00 Cost of patients approved for charity care and uninsured di instructions) 2.00 Payments received from patients for amounts previously writ charity care 3.00 Cost of charity care (line 21 minus line 22) 	e facility scounts (see ten off as	Uni nsured pati ents 1.00 749, 53 267, 12 267, 12	I nsured patients 2.00 34 0 23 0 0 0 23 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0	19.00 20.00 21.00 22.00 23.00
 8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire (see instructions) Cost of patients approved for charity care and uninsured di instructions) Payments received from patients for amounts previously writ charity care Cost of charity care (line 21 minus line 22) 4.00 Does the amount on line 20 column 2, include charges for patients 	e facility scounts (see ten off as	Uni nsured pati ents 1.00 749, 53 267, 12 267, 12	I nsured patients 2.00 34 0 23 0 0 0 23 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0 267,123	19.00 20.00 21.00 22.00 23.00
8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire (see instructions) 1.00 Cost of patients approved for charity care and uninsured di instructions) 2.00 Payments received from patients for amounts previously writ charity care 3.00 Cost of charity care (line 21 minus line 22) 4.00 Does the amount on line 20 column 2, include charges for paint patients covered by Medicaid or other indigent control of the charges for patient days beyon	e facility scounts (see ten off as tient days be care program?	Uni nsured pati ents 1.00 749, 53 267, 12 267, 12 yond a Length	I nsured patients 2.00 34 0 23 0 0 0 23 0 0 0 23 0 0 0 23 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0 267,123	19.00 20.00 21.00 22.00 23.00 24.00
8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire (see instructions) 1.00 Cost of patients approved for charity care and uninsured di instructions) 2.00 Payments received from patients for amounts previously writ charity care 3.00 Cost of charity care (line 21 minus line 22) 4.00 Does the amount on line 20 column 2, include charges for pa imposed on patients covered by Medicaid or other indigent control inf line 24 is yes, enter the charges for patient days beyon stay limit	e facility scounts (see ten off as tient days be are program?	Uni nsured pati ents 1.00 749, 53 267, 12 267, 12 yond a Length t care progra	I nsured patients 2.00 34 0 23 0 0 0 23 0 0 0 23 0 0 0 23 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0 267,123 1.00 0	19.00 20.00 21.00 22.00 23.00 24.00 25.00
8, 12 and 16) Uncompensated Care (see instructions for each line) 0.00 Charity care charges and uninsured discounts for the entire (see instructions) 1.00 Cost of patients approved for charity care and uninsured di instructions) 2.00 Payments received from patients for amounts previously writ charity care 3.00 Cost of charity care (line 21 minus line 22) 4.00 Does the amount on line 20 column 2, include charges for patients covered by Medicaid or other indigent control of the patients covered by Medicaid or other indigent control of the patient charges for patient days beyon stay limit 6.00 Total bad debt expense for the entire hospital complex (see	e facility scounts (see ten off as tient days bey are program? d the indigent e instructions)	Uni nsured pati ents 1.00 749, 53 267, 12 267, 12 yond a Length t care progra	I nsured patients 2.00 34 0 23 0 0 0 23 0 0 0 23 0 0 0 23 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0 267,123 1.00	19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00
 8, 12 and 16) Uncompensated Care (see instructions for each line) 0.00 Charity care charges and uninsured discounts for the entire (see instructions) 1.00 Cost of patients approved for charity care and uninsured di instructions) 2.00 Payments received from patients for amounts previously writ charity care 3.00 Cost of charity care (line 21 minus line 22) 4.00 Does the amount on line 20 column 2, include charges for patients covered by Medicaid or other indigent or stay limit 6.00 Total bad debt expense for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare reimbursable bad debts for the entire ho	e facility scounts (see ten off as tient days bey care program? id the indigent e instructions) pplex (see inst	Uni nsured pati ents 1.00 749, 53 267, 12 267, 12 yond a Length t care progra	I nsured patients 2.00 34 0 23 0 0 0 23 0 0 0 23 0 0 0 23 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0 267,123 1.00 0 3,022,231	19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00
8, 12 and 16) Uncompensated Care (see instructions for each line) 0.00 Charity care charges and uninsured discounts for the entire (see instructions) 1.00 Cost of patients approved for charity care and uninsured di instructions) 2.00 Payments received from patients for amounts previously writ charity care 3.00 Cost of charity care (line 21 minus line 22) 4.00 Does the amount on line 20 column 2, include charges for patients generated by Medicaid or other indigent of stay limit 6.00 Total bad debt expense for the entire hospital complex (see 7.00 Medicare allowable bad debts for the entire hospital complex	e facility scounts (see ten off as tient days bey care program? id the indigent e instructions) pplex (see inst	Uni nsured pati ents 1.00 749, 53 267, 12 267, 12 yond a Length t care progra	I nsured patients 2.00 34 0 23 0 0 0 23 0 0 0 23 0 0 0 23 0	Total (col. 1 + col. 2) 3.00 749,534 267,123 0 267,123 1.00 0 3,022,231 402,694	19.00 20.00 21.00 22.00 23.00 23.00 25.00 25.00 26.00 27.00 27.01
8, 12 and 16) Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire (see instructions) C1.00 Cost of patients approved for charity care and uninsured di instructions) P2.00 Payments received from patients for amounts previously writ charity care C3.00 Cost of charity care (line 21 minus line 22) P4.00 Does the amount on line 20 column 2, include charges for patients covered by Medicaid or other indigent cline 24 is yes, enter the charges for patient days beyon stay limit P6.00 Total bad debt expense for the entire hospital complex (see Medicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see Medicare bad debt expense (see instructions) P7.00 Non-Medicare bad debt expense (see instructions) P7.00 Cost of non-Medicare and non-reimbursable Medicare bad debt	e facility scounts (see ten off as tient days be are program? d the indigent instructions) plex (see instructions)	Uni nsured pati ents 1.00 749, 53 267, 12 267, 12	Insured patients 2.00 34 0 23 0 0 0 23 0 of stay limit m's length of	Total (col. 1 + col. 2) 3.00 749,534 267,123 0 267,123 0 267,123 0 3,022,231 402,694 619,530 2,402,701 1,073,123	19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.00 27.01 28.00 29.00
Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire (see instructions) 21.00 Cost of patients approved for charity care and uninsured di instructions) 22.00 Payments received from patients for amounts previously writ charity care 23.00 Cost of charity care (line 21 minus line 22) 24.00 Does the amount on line 20 column 2, include charges for pa imposed on patients covered by Medicaid or other indigent c 25.00 If line 24 is yes, enter the charges for patient days beyon stay limit 26.00 Total bad debt expense for the entire hospital complex (see 27.00 Medicare reimbursable bad debts for the entire hospital complex	e facility scounts (see ten off as tient days be are program? d the indigent instructions) plex (see instruct x (see instruct expense (see	Uni nsured pati ents 1.00 749, 53 267, 12 267, 12	Insured patients 2.00 34 0 23 0 0 0 23 0 of stay limit m's length of	Total (col. 1 + col. 2) 3.00 749, 534 267, 123 0 267, 123 1.00 0 3, 022, 231 402, 694 619, 530 2, 402, 701	19.00 20.00 21.00 22.00 23.00 24.00 25.00 26.00 27.01 28.00 29.00 30.00

				Te	rom 01/01/2017 p 12/31/2017	Date/Time Pre 5/29/2018 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1		Recl assi fi ed	20 2
				+ col. 2)	ions (See A-6)	Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	-
	GENERAL SERVICE COST CENTERS						
)0)0	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	33, 361	2, 589, 366 4, 671, 214	2, 589, 366 4, 704, 575	470, 224 0	3, 059, 590 4, 704, 575	
00	00500 ADMI NI STRATI VE & GENERAL	2, 341, 128	3, 691, 869	6, 032, 997	-94, 598		
00	00700 OPERATION OF PLANT	295, 348	967, 187	1, 262, 535	27, 140	1, 289, 675	
00	00800 LAUNDRY & LINEN SERVICE	18, 373	156, 832	175, 205	0	175, 205	
00 00	00900 HOUSEKEEPI NG 01000 DI ETARY	371, 304 337, 169	98, 782 467, 331	470, 086 804, 500	0 -567, 523	470, 086 236, 977	
00	01100 CAFETERI A	0	0	001,000	567, 523	567, 523	
00	01300 NURSING ADMINISTRATION	70, 383	29, 837	100, 220	0	100, 220	
00	01600 MEDICAL RECORDS & LIBRARY	349, 005	178, 500	527, 505	0	527, 505	
00 01	01700 SOCIAL SERVICE 01701 UTILIZATION REVIEW	57, 764	0 5, 824	0 63, 588	0	0 63, 588	
01	INPATIENT ROUTINE SERVICE COST CENTERS	07,701	0, 02 1	00,000		00,000	
00	03000 ADULTS & PEDIATRICS	1, 014, 617	41, 948	1, 056, 565	0	1, 056, 565	
00 00	03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER – I RF	694, 156 0	49, 876 0	744, 032 0	0	744, 032 0	
00	04100 SUBPROVIDER - TRF 04200 SUBPROVIDER	0	0	0	0	0	
00	04300 NURSERY	0	0	0	0	0	
	ANCILLARY SERVICE COST CENTERS						
00	05000 OPERATING ROOM	606, 978	1, 157, 727	1, 764, 705	28, 153	1, 792, 858	
00 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	61, 654 0	15, 975 0	77, 629 0	0	77, 629 0	
00	05300 ANESTHESI OLOGY	591, 415	151, 690	743, 105	0	743, 105	
00	05400 RADI OLOGY-DI AGNOSTI C	861, 357	368, 125	1, 229, 482	0	1, 229, 482	
01	05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	169, 291	169, 291	0	169, 291	
00 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	160, 633 0	263, 024 0	423, 657 0	0	423, 657 0	
00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
00	06000 LABORATORY	627, 271	1, 394, 219	2, 021, 490	0	2, 021, 490	60
01	06001 BLOOD LABORATORY	0	0	0	0	0	
00 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 320, 439	0 98, 432	0 418, 871	0	0 418, 871	
00	06600 PHYSI CAL THERAPY	520, 437	564, 612	564, 612	0	564, 612	
00	06700 OCCUPATI ONAL THERAPY	0	101, 837	101, 837	0	101, 837	
00	06800 SPEECH PATHOLOGY	0	37, 211	37, 211	0	37, 211	
00 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	73, 274 238, 835	92, 658 8, 559	165, 932 247, 394	0	165, 932 247, 394	
00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	230, 033	28, 153	247, 374 28, 153	-28, 153	247, 374	
00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72
	07300 DRUGS CHARGED TO PATIENTS	173, 096	1, 273, 968		0	1, 447, 064	
01	07301 ONCOLOGY OUTPATI ENT SERVI CE COST CENTERS	272, 818	2, 782, 662	3, 055, 480	0	3, 055, 480	/3
00	08800 RURAL HEALTH CLINIC	1,007,635	312, 986	1, 320, 621	-113, 905	1, 206, 716	88
01	08801 RURAL HEALTH CLINIC II	901, 817	323, 987	1, 225, 804	-88, 851	1, 136, 953	88
02	08802 RURAL HEALTH CLINIC III	526, 979	176, 102	703, 081	-42, 736	660, 345	
00 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0	0	0	0	
00	09100 EMERGENCY	2, 693, 011	915, 368	3, 608, 379	0	3, 608, 379	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
10	OTHER REIMBURSABLE COST CENTERS						
10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99
. 00	10900 PANCREAS ACQUI SI TI ON	0	0	0	0	0	109
	11000 INTESTINAL ACQUISITION	0	0	0	0		110
	11100 I SLET ACQUI SI TI ON	0	0	0	0		111
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF	0	0	0	0		113
. 00		14, 699, 820	23, 185, 152	37, 884, 972	157, 274	38, 042, 246	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	157.074		190
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 JOHNSON/NI CHOLS WI C	2, 780, 157 75, 495	847, 486 36, 175	3, 627, 643 111, 670	-157, 274 0	3, 470, 369 111, 670	
	19300 NONPALD WORKERS	, 3, 473	0	8	0		193
8. 01	19301 DME	0	0	0	0	0	193
	19302 LACTATION CONSULTING	0	0	0	0		193
	19303 DI ABETI C COUNSELI NG 07950 VACANT SPACE	0	0	0	0		193 194
	07950 VACANT SPACE 07951 BOARD OF HEALTH	0	0	0	0		194
	07952 PUTNAM/HENRY PRENATAL	0	0	0	0		194
	TOTAL (SUM OF LINES 118 through 199)	17, 555, 480	24, 068, 813	41, 624, 293	0	41, 624, 293	1

	inancial Systems FICATION AND ADJUSTMENTS OF TRIAL BALANCE C	PUTNAM COUNT OF EXPENSES	Provider CC	N: 15-1333	Period: From 01/01/	U Lieu of Form C Worksheet	A
					To 12/31/	2017 Date/Time 5/29/2018	
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8)	For Allocation				
		6.00	7.00				
	ENERAL SERVICE COST CENTERS						
	0100 NEW CAP REL COSTS-BLDG & FIXT	-369, 081					1
	0400 EMPLOYEE BENEFITS DEPARTMENT	-4, 554					4
	0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT	-1, 293, 216					5
	0800 LAUNDRY & LINEN SERVICE	-5, 045	1, 284, 630 175, 205				8
	0900 HOUSEKEEPING	0	470, 086				9
	1000 DI ETARY	0	236, 977				10
00 0	1100 CAFETERI A	-61, 761	505, 762				11
	1300 NURSING ADMINISTRATION	0	100, 220				13
	1600 MEDI CAL RECORDS & LI BRARY	-261	527, 244				16
	1700 SOCIAL SERVICE	0					17
	1701 UTILIZATION REVIEW NPATIENT ROUTINE SERVICE COST CENTERS	0	63, 588				17
	3000 ADULTS & PEDIATRICS	0	1, 056, 565				30
	3100 I NTENSI VE CARE UNI T	0	744, 032				31
	4100 SUBPROVI DER – I RF	0	0				41
1	4200 SUBPROVI DER	0					42
	4300 NURSERY	0	0				43
	NCILLARY SERVICE COST CENTERS	~	1 702 050				
	5000 OPERATING ROOM 5100 RECOVERY ROOM	0					50
	5200 DELIVERY ROOM & LABOR ROOM		0				52
	5300 ANESTHESI OLOGY	-616, 617					53
	5400 RADI OLOGY-DI AGNOSTI C	-746					54
01 05	5401 NUCLEAR MEDICINE-DIAGNOSTIC	0	169, 291				54
	5700 CT SCAN	0	423, 657				57
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58
	5900 CARDI AC CATHETERI ZATI ON 6000 LABORATORY	0	0 2,021,490				59
	6001 BLOOD LABORATORY		2,021,490				60
	6400 I NTRAVENOUS THERAPY	0	0				64
00 00	6500 RESPI RATORY THERAPY	0	418, 871				65
	6600 PHYSI CAL THERAPY	-6, 715					66
	6700 OCCUPATI ONAL THERAPY	0					67
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	0	37, 211 165, 932				68
	6901 CARDI AC REHAB		247, 394				69
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71
	7200 IMPL. DEV. CHARGED TO PATIENT	0	0				72
00 0	7300 DRUGS CHARGED TO PATIENTS	-86, 871	1, 360, 193				73
	7301 ONCOLOGY	0	3, 055, 480				73
	JTPATIENT SERVICE COST CENTERS		1 00(74(
	8800 RURAL HEALTH CLINIC 8801 RURAL HEALTH CLINIC II	0 -2, 500	1,200,110				88
	8801 RURAL HEALTH CLINIC III 8802 RURAL HEALTH CLINIC III	-2, 300	1, 134, 453 660, 345				88
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0	000, 343				89
	9000 CLINIC	0	0				90
	9100 EMERGENCY	-1, 759, 119	1, 849, 260				91
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	THER REIMBURSABLE COST CENTERS	^	o				
	9910 CORF PECIAL PURPOSE COST CENTERS	0	0				99
	0900 PANCREAS ACQUISITION	0	0				109
	1000 I NTESTI NAL ACQUI SI TI ON	0	0				110
	1100 I SLET ACQUI SI TI ON	0	0				111
1	1300 INTEREST EXPENSE	0	0				113
	1400 UTI LI ZATI ON REVI EW-SNF	0					114
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	-4, 206, 486	33, 835, 760				118
	DNREIMBURSABLE COST CENTERS 9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190
	9200 PHYSICIANS' PRIVATE OFFICES						190
	9201 JOHNSON/NI CHOLS WI C		111, 670				192
	9300 NONPAI D WORKERS	0	8				193
	9301 DME	0	0				193
	9302 LACTATI ON CONSULTI NG	0	0				193
	9303 DI ABETI C COUNSELI NG	0	0				193
	7950 VACANT SPACE	0	0				194
	7951 BOARD OF HEALTH 7952 PUTNAM/HENRY PRENATAL						194 194
		I U	1 U				200

Heal th	Financial Systems		PUTNAM COUNTY	Y HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLAS	SI FI CATI ONS			Provider (CCN: 15-1333	Peri od:	Worksheet A-	-6
						From 01/01/2017 To 12/31/2017	Date/Time Pr 5/29/2018 10	repared:):26 am
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - CLINIC RECLASS				1			_
1.00	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	338, 970				1.00
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	1, 915				2.00
3.00	OPERATION OF PLANT	7.00	0	27, 140				3.00
4.00		0.00	0	0				4.00
	TOTALS		0	368, 025				
	B - PHYSICIAN PRACTICE A&G							
1.00	ADMI NI STRATI VE & GENERAL	5.00	<u> </u>	0				1.00
	TOTALS		26, 641	0				
	C – CAFE RECLASS				1			
1.00	CAFETERI A	<u>11.</u> 00	23 <u>7, 8</u> 51	<u>329, 672</u>				1.00
	TOTALS		237, 851	329, 672				
	D - INSURANCE RECLASS				1			_
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	123, 154				1.00
	FIXT		+		-			
	TOTALS		0	123, 154				_
1 00	E - PPO DEPRECIATION	1 00		0.100	1			1 00
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	8, 100				1.00
2.00	FIXT	0.00	0	0				2.00
2.00		0.00	0	0				2.00
3.00 4.00		0.00	0	0				4.00
4.00	TOTALS		0	<u>8, 100</u>	-			4.00
	G - MED SUPPLY		U	6, 100				-
1.00	OPERATING ROOM	50.00	0	28, 153				1.00
1.00	TOTALS	<u>50.00</u>	— — — 0	28, 153				1.00
500 00	Grand Total: Increases		264, 492	857, 104				500.00
500.00		I	207, 772	007,104	I			1000.00

Heal th	Financial Systems		PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der (CCN: 15-1333	Period:	Worksheet A-	-6
					_	From 01/01/2017 To 12/31/2017		repared: D:26 am
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	Ē.		
	6.00	7.00	8.00	9.00	10.00			
	A - CLINIC RECLASS							
1.00	RURAL HEALTH CLINIC	88.00	0	111, 968		9		1.00
2.00	RURAL HEALTH CLINIC II	88. 01	0	86, 691		0		2.00
3.00	RURAL HEALTH CLINIC III	88. 02	0	41, 484		0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	127, 882		0		4.00
	TOTALS	T	0	368, 025	· · · · · · · · · · · · · · · · · · ·	1		
	B - PHYSICIAN PRACTICE A&G		•					
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	26, 641	C)	0		1.00
	TOTALS		26, 641	o		1		
	C - CAFE RECLASS	1		-		1		
1.00	DI ETARY	10.00	237, 851	329, 672		0		1.00
	TOTALS		237, 851	329,672		1		
	D - INSURANCE RECLASS	I				1		
1.00	ADMI NI STRATI VE & GENERAL	5,00	0	123, 154	. 1	12		1.00
	TOTALS	+		123, 154		-		
	E - PPO DEPRECIATION	I	i			1		
1.00	RURAL HEALTH CLINIC	88.00	0	1, 937		9		1.00
2.00	RURAL HEALTH CLINIC II	88.01	0	2, 160		0		2.00
3.00	RURAL HEALTH CLINIC III	88.02	0	1, 252		0		3.00
4.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2, 751		0		4.00
	TOTALS			8, 100		-		
	G - MED SUPPLY		-	-,				
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	28, 153		0		1.00
	PATIENTS		Ű	20,100		-		
	TOTALS	+		28, 153		1		
500 00	Grand Total: Decreases		264, 492	857, 104		-		500.00
300.00			201, 172	007,104	1	1		1000.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017		pared:
			Acquisition		5/29/2018 10: 	20 811
	Begi nni ng	Purchases	Donation	Total	Disposals and	
	Balances	i ui chases	Donation	10141	Retirements	
	1,00	2.00	3.00	4,00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		2100	0100		0.00	
1.00 Land	159, 364	0		0 0	0 0	1.00
2.00 Land Improvements	329, 844	0		0 0	0	2.00
3.00 Buildings and Fixtures	30, 951, 035	0		0 0	224, 018	3.00
4.00 Building Improvements	0	0		0 0	0 0	
5.00 Fixed Equipment	0	0		0 0	0 0	5.00
6.00 Movable Equipment	21, 906, 550	1, 190, 226		0 1, 190, 226	0	6.00
7.00 HIT designated Assets	0	0		0 0	0 0	7.00
8.00 Subtotal (sum of lines 1-7)	53, 346, 793	1, 190, 226		0 1, 190, 226	224, 018	8.00
9.00 Reconciling Items	0	0		0 0	0 0	9.00
10.00 Total (line 8 minus line 9)	53, 346, 793	1, 190, 226		0 1, 190, 226	224, 018	10.00
	Endi ng	Fully				
	Bal ance	Depreci ated				
		Assets				
	6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00 Land	159, 364	0				1.00
2.00 Land Improvements	329, 844	0				2.00
3.00 Buildings and Fixtures	30, 727, 017	0				3.00
4.00 Building Improvements	0	0				4.00
5.00 Fixed Equipment	0	0				5.00
6.00 Movable Equipment	23, 096, 776	0				6.00
7.00 HIT designated Assets	0	0				7.00
8.00 Subtotal (sum of lines 1-7)	54, 313, 001	0				8.00
9.00 Reconciling Items	0	0				9.00
10.00 Total (line 8 minus line 9)	54, 313, 001	0				10.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 15-1333		Period:WorksheetFrom 01/01/2017Part IITo12/31/2017Date/Time		pared:
		SL	IMMARY OF CAP	I TAL	5/29/2018 10:	<u>26 am</u>
Cost Center Description	Depreciation	Lease	Interest	I nsurance (see i nstructi ons)	Taxes (see instructions)	
	9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUN	<u>/N 2, LINES 1 a</u>	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	2, 589, 366	0		0 0	0	1.00
3.00 Total (sum of lines 1-2)	2, 589, 366	0		0 0	0	3.00
	SUMMARY O	F CAPI TAL				
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, COLUN	IN 2, LINES 1 a	and 2			
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	2, 589, 366				1.00
3.00 Total (sum of lines 1-2)	0	2, 589, 366				3.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2017	Worksheet A-7	
				To 12/31/2017	Date/Time Pre	
					5/29/2018 10:	<u>26 am</u>
	COMF	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT	30, 727, 017	0	30, 727, 01	7 1.000000	0	1.00
3.00 Total (sum of lines 1-2)	30, 727, 017	0	30, 727, 01	7 1.000000	0	3.00
	ALLOCAT	FION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at				
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS		1	1		
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	-		0 2, 636, 060		1.00
3.00 Total (sum of lines 1-2)	0	0		0 2, 636, 060	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
		(see	instructions)	Capi tal -Rel at	(sum of cols.	
		instructions)		ed Costs (see	9 through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00 NEW CAP REL COSTS-BLDG & FIXT	-68, 705	123, 154		0 0	2, 690, 509	1.00
3.00 Total (sum of lines 1-2)	-68, 705	123, 154		0 0	2, 690, 509	3.00

Health Financial Systems		PUTNAM COUN			u of Form CMS-2	
ADJUSTMENTS TO EXPENSES			Fi	eriod: rom 01/01/2017	Worksheet A-8	
					Date/Time Pre 5/29/2018 10:	
			Expense Classification on To/From Which the Amount is			
Cost Center Descr		Amount	Cost Center	Line #	Wkst. A-7	
	(2)	2.00	3.00	4.00	Ref. 5.00	
1.00 Investment income - NEV REL COSTS-BLDG & FIXT		(DNEW CAP REL COSTS-BLDG & FLXT	1.00	0	1.00
2) 2.00 Investment income - CAN		()*** Cost Center Deleted ***	2.00	0	2.00
COSTS-MVBLE EQUIP (chap 3.00 Investment income - oth		(D	0.00	0	3.00
(chapter 2) 4.00 Trade, quantity, and ti	me	(2	0.00	0	4.00
di scounts (chapter 8) 5.00 Refunds and rebates of					0	5.00
expenses (chapter 8)				0.00		
6.00 Rental of provider spaces suppliers (chapter 8)	-			0.00	0	6.00
7.00 Tel ephone services (pa stations excluded) (cha		(0	0.00	0	7.00
8.00 Tel evi si on and radio se	ervi ce	0	D	0.00	0	8.00
(chapter 21) 9.00 Parking lot (chapter 2'	1)	0	D	0. 00	0	9.00
10.00 Provider-based physicia adjustment	an A-8-2	-2, 375, 736	5		0	10.00
11.00 Sale of scrap, waste, ((chapter 23)	etc.	(ס	0.00	0	11.00
12.00 Related organization transactions (chapter	A-8-1	(D		0	12.00
13.00 Laundry and Linen servi	ice	(D	0.00	0	
14.00Cafeteria-employees and15.00Rental of quarters to e				0.00 0.00	0 0	14.00 15.00
and others 16.00 Sale of medical and su	rgi cal	(D	0.00	0	16.00
supplies to other than patients						
17.00 Sale of drugs to other patients	than	(D	0.00	0	17.00
18.00 Sale of medical records	s and	(D	0.00	0	18.00
19.00 Nursing and allied heal education (tuition, fee		0	ס	0.00	0	19.00
books, etc.)				0.00		
20.00 Vending machines 21.00 Income from imposition	of			0.00 0.00	0 0	20. 00 21. 00
interest, finance or pe charges (chapter 21)	enal ty					
22.00 Interest expense on Med overpayments and borrow		(0.00	0	22.00
repay Medicare overpay 23.00 Adjustment for respira	ments	(DRESPI RATORY THERAPY	65.00		23.00
therapy costs in excess	s of			05.00		23.00
24.00 Adjustment for physical	A-8-3	-6, 715	5 PHYSI CAL THERAPY	66.00		24.00
therapy costs in excess limitation (chapter 14)						
25.00 Utilization review - physicians' compensation	on	(DUTILIZATION REVIEW-SNF	114.00		25.00
(chapter 21) 26.00 Depreciation - NEW CAP		(DNEW CAP REL COSTS-BLDG &	1.00	0	26.00
COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL			FIXT D*** Cost Center Deleted ***	2.00	0	
28.00 Non-physician Anestheti			D*** Cost Center Deleted ***	19.00	0	28.00
29.00 Physi ci ans' assi stant		0	D	0.00	0	29.00
30.00 Adjustment for occupati therapy costs in excess	s of	(OCCUPATI ONAL THERAPY	67.00		30.00
limitation (chapter 14) 30.99 Hospice (non-distinct)			DADULTS & PEDIATRICS	30. 00		30. 99
instructions)						

Heal th	Fi nanci a	l Systems	
	MENTS TO	EXPENSES	

Heal th	Financial Systems		PUTNAM COUNT	Y HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2017 To 12/31/2017	Worksheet A-8 Date/Time Pre 5/29/2018 10:	pared:
				Expense Classification or To/From Which the Amount is			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
	-	(2) 1.00	2.00	3.00	4.00	Ref. 5.00	
31.00	Adjustment for speech	A-8-3		SPEECH PATHOLOGY	68.00		31.00
32.00	pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32.00
33.00	Depreciation and Interest DISCOUNTS		0		0.00	0	33.00
33.01	VENDOR REBATE/REFUND	В	-8, 504	ADMINISTRATIVE & GENERAL	5.00	0	1
33.02	PHARMACY REBATES	В		DRUGS CHARGED TO PATIENTS	73.00		
33. 03 33. 04	SILVER RECOVERY DIABETIC COUNSELING OTHER INCOME	B B	0	RADI OLOGY-DI AGNOSTI C	54.00 0.00	0 0	33.04
33.05 33.06	MEDICAL RECORDS FEES VENDING MACHINES	B B		MEDICAL RECORDS & LIBRARY	16.00	0	
33.00	CAFETERIA SALES	В	0 -61, 761	CAFETERIA	0. 00 11. 00	0	
33.08	MI SC REVENUE-CBO	В		ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	PHARMACY MISC REV	В		DRUGS CHARGED TO PATIENTS	73.00	0	
33. 10 33. 11	OTHER MISC INCOME NON-ALLOWABLE INTEREST EXPENSE	B A		ADMINISTRATIVE & GENERAL NEW CAP REL COSTS-BLDG &	5.00 1.00	0 11	
33. 12	INVESTMENT INCOME		0	FLXT	0.00	0	33.12
33. 13 33. 14	LOBBYING OFFSET ADVERTIISNG OFFSET	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5.00 5.00	0	33.13 33.14
33.15	COMMUNITY RELATIONS OFFSET	A		ADMI NI STRATI VE & GENERAL	5.00	0	•
33.16	COMMUNITY RELATIONS OFFSET	A		EMPLOYEE BENEFITS DEPARTMEN		0	
33. 17 33. 18	TELEPHONE WAGES TELEPHONE BENEFITS	A A		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMEN	5.00 T 4.00	0	
33.19	TELEPHONE OTHER	A		ADMI NI STRATI VE & GENERAL	5.00	0	•
33.20	TELEVI SON OFFSET	A		OPERATION OF PLANT	7.00	0	
33. 21 33. 22	PHYSICIAN RECRUITMENT PHYSICIAN RECRUITMENT	A A		ADMINISTRATIVE & GENERAL RURAL HEALTH CLINIC II	5. 00 88. 01	0	
33.23	HAF EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.23
33.24	EHR DEPRECIATION	A	-300, 376	NEW CAP REL COSTS-BLDG & FLXT	1.00	9	33.24
33. 25	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	
33.26	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.26
33. 27	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33. 27
33. 28	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.28
33. 29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33. 29
33.30	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.30
33. 31	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33. 31
33. 32	OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33. 32
33.33	OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33. 33
33.34	OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33.34
33.35	OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33.35
33.36	OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33.36
33. 37	OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33. 37
33. 38	OTHER ADJUSTMENTS (SPECI FY) (3)		0		0.00	0	33. 38
33.39	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.39
	(3)	1				۱	

Health Financial Systems		PUTNAM COUNT	Y HOSPI TAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Provider CCN: 15-1333	Period:	Worksheet A-8		
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 10:	pared: 26 am	
			Expense Classification o				
			To/From Which the Amount is	s to be Adjusted			
Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7		
	(2)				Ref.		
	1.00	2.00	3.00	4.00	5.00		
50.00 TOTAL (sum of lines 1 thru 49)		-4, 206, 486				50.00	
(Transfer to Worksheet A,							
column 6, line 200.)							

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Syste	ems	PUTNAM COUN	TY HOSPI TAL		In Lie	eu of Form CMS-	2552-10
	ER BASED PHYSIC			Provider (Peri od:	Worksheet A-8	3-2
			_			From 01/01/2017 To 12/31/2017		
	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, 069, 552	1, 759, 119	310, 433	3 0	0	1.00
2.00	73.01	ONCOLOGY	224, 228	0	224, 228	3 0	0	2.00
3.00	60.00	LABORATORY	45, 002	0	45,002	2 0	0	3.00
4.00	53.00	ANESTHESI OLOGY	675, 040		58, 423		0	4.00
5.00	0.00		0	0	(ol o	0	5.00
6.00	0.00		0	0	(ol o	0	6.00
7.00	0,00		0	0	(0	0	
8.00	0.00		0	0	(0	
9.00	0.00		0	0				
10.00	0.00			0		-	-	
200.00	0.00		3, 013, 822	2, 375, 736		°		200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
	WKSL A LINE #	I denti fi er		Unadjusted RCE			of Malpractice	
		Identifier		Limit	Continuing	Component Share of col.	Insurance	
							Insurance	
	1.00	2.00	0.00	0.00	Education	12	14.00	
1 00	1.00	2.00	8.00	9.00	12.00	13.00	14.00	1 00
1.00		EMERGENCY	0					
2.00		ONCOLOGY	0	-		0	-	
3.00		LABORATORY	0			0		
4.00		ANESTHESI OLOGY	0	0		-	, i i i i i i i i i i i i i i i i i i i	
5.00	0.00		0	0		0 0	-	
6.00	0.00		0	0	(°	, s	
7.00	0.00		0	0	(0 0	0	7.00
8.00	0.00		0	0	(0 0	0	8.00
9.00	0.00		0	0	(0 0	0	9.00
10.00	0.00		0	0	(o o	0	10.00
200.00			0	0	(o o	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	1	
1.00	91.00	EMERGENCY	0	0	(1, 759, 119		1.00
2.00		ONCOLOGY	0	0	(0 0		2.00
3.00		LABORATORY	0	0				3.00
4.00		ANESTHESI OLOGY	0	0				4.00
5.00	0.00		0	0				5.00
6.00	0.00		0	0		°		6.00
7.00	0.00		0	, s				7.00
8.00	0.00		0					8.00
8.00 9.00	0.00		0	-				9.00
	0.00			0				9.00
10.00	0.00		, °	-		-		
200.00	I		0	0	(2, 375, 736	1	200.00

OUTSIE	Financial Systems IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	PUTNAM COUNTY FURNI SHED BY	Provi der C	CN: 15-1333	Peri od: From 01/01/2017 To 12/31/2017 Physi cal Therapy	Date/Time Pre 5/29/2018 10:	-3 pared:
						1.00	
	PART I - GENERAL INFORMATION					1.00	
1.00	Total number of weeks worked (excluding aide	s) (see instruc	tions)			52	•
2.00 3.00	Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervi	sor or theranis	t was on provi	idor sito (s	en instructions)	780	•
4.00	Number of unduplicated days in which therapy					232	
	nor therapist was on provider site (see inst						
5.00	Number of unduplicated offsite visits - supe					0	
6.00	Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the					0	6.00
	i nstructi ons)			,			
7.00	Standard travel expense rate					0.00	•
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stant	s Ai des	0.00 Trai nees	8.00
		1.00	2.00	3.00	4. 00	5.00	
9.00	Total hours worked	0.00	3, 897.00				9.00
10.00	AHSEA (see instructions)	0.00	81.04		. 78 0. 00	0.00	•
11.00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	40. 52	40. 52	30.	. 39		11.00
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0 0		0		12.01
13.00	Number of miles driven (provider site)	0	0		0		13.00
					-		
						1.00	
14.00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1	line 10)				0	14.00
15.00	Therapists (column 2, line 9 times column 2,					315, 813	
16.00	Assistants (column 3, line 9 times column 3,	line10)				130, 616	16.00
17.00	Subtotal allowance amount (sum of lines 14 a	nd 15 for respi	ratory therapy	y or lines 1	14-16 for all	446, 429	17.00
18.00	others) Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, l					0	
20.00	Total allowance amount (sum of lines 17-19 f						20.00
	If the sum of columns 1 and 2 for respiratory occupational therapy, line 9, is greater that						
	amount from line 20. Otherwise complete line		lo entires on	Times 21 ai	iu zz aliu elitel ol	TTTTE 25 the	
21.00	Weighted average rate excluding aides and tr	ainees (line 17		um of columr	ns 1 and 2, line 4	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3,						22.00
22.00 23.00	Weighted allowance excluding aides and train Total salary equivalency (see instructions)	ees (inne z tinn	es fine 21)			0 446, 429	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVEL	EXPENSE COM	PUTATION - F	PROVIDER SITE	1,	
	Standard Travel Allowance					10.7(4	
24.00 25.00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					12, 764 7, 050	•
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 24	4 and 25 for a	all others)		19, 814	•
27.00	Standard travel expense (line 7 times line 3				s 3 and 4 for all	0	27.00
28.00	others) Total standard travel allowance and standard	travel expense	at the provid	dor cito (cu	m of lines 24 and	19, 814	28.00
20.00	27)	ti avei expense	at the provid			17,014	20.00
	Optional Travel Allowance and Optional Trave					1	1
29.00	Therapists (column 2, line 10 times the sum Assistants (column 3, line 10 times column 3		d 2, line 12))		0	•
30.00 31.00	Subtotal (line 29 for respiratory therapy or	. ,	and 30 for a	all others)		0	
32.00	Optional travel expense (line 8 times column				apy or sum of	0	1
~~ ~~	columns 1-3, line 13 for all others)						
33.00 34.00	Standard travel allowance and standard trave Optional travel allowance and standard trave			nd 31)		19, 814	1
35.00	Optional travel allowance and optional trave					0	
	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW	ANCE AND TRAVEL	EXPENSE COMPL	JTATION - SE	ERVICES OUTSIDE PR	ROVIDER SITE	
36.00	Standard Travel Expense Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	
38.00	Subtotal (sum of lines 36 and 37)					0	38.00
39.00	Standard travel expense (line 7 times the su		d 6)			0	39.00
40.00	Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.		2 line 10)			0	40.00
40.00	Assistants (column 3, line 12.01 times column		<u>_, inic io</u> ,			0	•
42.00	Subtotal (sum of lines 40 and 41)					0	42.00
12 00	Optional travel expense (line 8 times the su Total Travel Allowance and Travel Expense - (l owing these l'	0	43.00
43.00		JISILE Services	s, comprete or	ie of the fo	nowing three In	ies 44, 45, or	
43.00	· · ·						
43.00	46, as appropriate. Standard travel allowance and standard trave	l expense (sum o	oflines 38 ar	nd 39 - see	instructions)		44.00 45.00

)UTSI D	IABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider CC	CN: 15-1333	Period: From 01/ To 12/	′01/2017 ′31/2017	Worksheet A-8 Parts I-VI Date/Time Pre 5/29/2018 10:	pared:
					Physi cal	Therapy	Cost	
							1.00	
16.00	Optional travel allowance and optional travel	expense (sum c	of lines 42 ar	nd 43 - see i	nstructi	ons)		46.00
		Therapi sts	Assi stants	Ai des		nees	Total	
		1.00	2.00	3.00	4.	00	5.00	
	PART V - OVERTIME COMPUTATION			1				
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.0	00	0. 00	0.00	47.00
8.00	Overtime rate (see instructions)	0.00	0.00	0.0	00	0.00		48.00
19.00	Total overtime (including base and overtime	0.00	0.00	0.0	00	0.00		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,	0.00	0.00	0.0	00	0.00	0.00	50.00
51.00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0.00	0.00	0. 0	00	0. 00	0.00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE	I		1				
2.00	Adjusted hourly salary equivalency amount (see instructions)	81.04	60. 78	0.0	00	0.00		52.00
3.00	Overtime cost limitation (line 51 times line 52)	0	0		0	0		53.00
4.00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0	0		54.00
5.00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	O	0		0	0		55.00
6.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for	0	0		0	0	0	56.00
	respiratory therapy and columns 1 through 3 for all others.)							
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT				1.00	
7.00	Salary equivalency amount (from line 23)						446, 429	57.00
8.00	Travel allowance and expense - provider site	(from lines 33,	34, or 35))				19, 814	58.00
9.00	Travel allowance and expense - Offsite service	es (from lines	44, 45, or 46	6)			0	59.00
0.00	Overtime allowance (from column 5, line 56)						0	60.00
1.00	Equipment cost (see instructions)						0	61.00
2.00	Supplies (see instructions)						0	62.00
3.00 4.00	Total allowance (sum of lines 57-62)	vour recorde)					466, 243 472, 958	
4.00 5.00		J .	optor zoro)					
5.00	LINE 33 CALCULATION	5 - TT negative,	enter zero)				0, 715	65.00
	Line 26 = line 24 for respiratory therapy or	sum of lines 24	l and 25 for a	all others			19, 814	100 00
00 00	Line 27 = line 7 times line 3 for respiratory				others			100.00
		therapy or sui					19, 814	
00. 01	Line 33 = line 28 = sum of lines 26 and 27							
00. 01 00. 02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION	therapy or sum	oflines 3 :	and 4 for all	others		0	101 00
00. 01 00. 02 01. 00 01. 01	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31				others		0	101. 00 101. 01 101. 02
00. 01 00. 02 01. 00 01. 01 01. 02 02. 00	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or	sum of lines 29 sum of lines 29	9 and 30 for a	all others		, line	000000000000000000000000000000000000000	101. 01

	E SUPPLIERS	PUTNAM COUNTY FURNI SHED BY	Provider CC	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet A-8 Parts I-VI Date/Time Pre 5/29/2018 10:	-3 pared:
					Occupational Therapy	Cost	
						1.00	
1.00	PART I - GENERAL INFORMATION Total number of weeks worked (excluding aide	s) (see instruc	tions)			52	1.00
2.00	Line 1 multiplied by 15 hours per week	, .	,			780	2.00
3.00 4.00	Number of unduplicated days in which supervi Number of unduplicated days in which therapy					241	3.00 4.00
	nor therapist was on provider site (see inst	ructions)				-	
5.00 6.00	Number of unduplicated offsite visits - supe Number of unduplicated offsite visits - ther assistant and on which supervisor and/or the instructions)	apy assistants	(include only	visits made		0	5.00 6.00
7.00	Standard travel expense rate					0.00	
8.00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8.00
	1	1.00	2.00	3.00	4.00	5.00	
9.00 10.00	Total hours worked AHSEA (see instructions)	0.00 0.00	1, 522. 00 76. 82	0. (0. (0.00	
11.00	Standard travel allowance (columns 1 and 2,	38.41	38.41	0.0		0.00	11.00
	one-half of column 2, line 10; column 3,						
12.00	one-half of column 3, line 10) Number of travel hours (provider site)	0	о		0		12.00
12.01	Number of travel hours (offsite)	0	0		0		12.01
13.00 13.01	Number of miles driven (provider site) Number of miles driven (offsite)	0	0		0		13.00 13.01
			-1		-		
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14.00	Supervisors (column 1, line 9 times column 1					0	
15.00 16.00						116, 920 0	
17.00	Subtotal allowance amount (sum of lines 14 a		ratory therapy	or lines 14	-16 for all	116, 920	
18.00	others)	10)				0	18.00
19.00	0 Trainees (column 5, line 9 times column 5, line 10)						19.00
20.00	Total allowance amount (sum of lines 17-19 f						20.00
	If the sum of columns 1 and 2 for respirators occupational therapy, line 9, is greater that	n line 2, make					
21.00	amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr		divided by su	m of columns	1 and 2, line 9	0.00	21.00
22.00	for respiratory therapy or columns 1 thru 3, line 9 for all others)						22.00
22.00 23.00	5 5 7					0	
	lotal salary equivalency (see instructions)						
	PART III - STANDARD AND OPTIONAL TRAVEL ALLO	WANCE AND TRAVE	L EXPENSE COMP	UTATION - PR	OVIDER SITE	116, 920	
24 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance	WANCE AND TRAVE	L EXPENSE COMP	PUTATION - PR	OVIDER SITE	116, 920	23.00
24. 00 25. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)				OVIDER SITE		23.00 24.00
25.00 26.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	III others)		116, 920 9, 257 0 9, 257	23.00 24.00 25.00 26.00
25.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)	sum of lines 2	4 and 25 for a	III others)		116, 920 9, 257 0	23.00 24.00 25.00 26.00
25.00 26.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3	sum of lines 2 for respirator	4 and 25 for a y therapy or s	ull others) sum of lines	3 and 4 for all	116, 920 9, 257 0 9, 257 0	23.00 24.00 25.00 26.00 27.00
25.00 26.00 27.00 28.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27) Optional Travel Allowance and Optional Trave	sum of lines 2 for respirator travel expense Expense	4 and 25 for a y therapy or s at the provic	ull others) sum of lines der site (sum	3 and 4 for all	116, 920 9, 257 0 9, 257 0 9, 257	23.00 24.00 25.00 26.00 27.00 28.00
25. 00 26. 00 27. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLO Standard Travel Allowance Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3 others) Total standard travel allowance and standard 27)	sum of lines 2 for respirator travel expense I Expense of columns 1 ar	4 and 25 for a y therapy or s at the provic	ull others) sum of lines der site (sum	3 and 4 for all	116, 920 9, 257 0 9, 257 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy or	sum of lines 2 for respirator travel expense I Expense of columns 1 ar , line 12) sum of lines 2	4 and 25 for a y therapy or s at the provic d 2, line 12) 9 and 30 for a	ull others) sum of lines der site (sum ull others)	3 and 4 for all of lines 26 and	116, 920 9, 257 0 9, 257 0 9, 257 0 9, 257 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00
25.00 26.00 27.00 28.00 29.00 30.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3	sum of lines 2 for respirator travel expense I Expense of columns 1 ar , line 12) sum of lines 2	4 and 25 for a y therapy or s at the provic d 2, line 12) 9 and 30 for a	ull others) sum of lines der site (sum ull others)	3 and 4 for all of lines 26 and	116, 920 9, 257 0 9, 257 0 9, 257 0 9, 257 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 29.00 30.00 31.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional Travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Standard travel allowance and standard travel	sum of lines 2 for respirator travel expense <u>I Expense</u> of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line I expense (line	4 and 25 for a y therapy or s at the provic d 2, line 12) 9 and 30 for a 13 for respir	II others) sum of lines ler site (sum ll others) ratory therap	3 and 4 for all of lines 26 and	116, 920 9, 257 0 9, 257 0 9, 257 0 9, 257 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and standard traveOptional travel allowance and standard traveOptional travel allowance and standard trave	sum of lines 2 for respirator travel expense <u>I Expense</u> of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line I expense (line	24 and 25 for a y therapy or s a at the provic d 2, line 12) 9 and 30 for a a 13 for respir 2 28) of lines 27 ar	ull others) sum of lines der site (sum ull others) ratory therap nd 31)	3 and 4 for all of lines 26 and	116, 920 9, 257 0 9, 257 0 9, 257 0 0 0 0 0 0 0 9, 257 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and Standard27)Optional Travel Allowance and Optional TravelTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveStandard travel allowance and standard traveOptional travel allowance and potional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOW	sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	4 and 25 for a y therapy or s a at the provic d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 31 ar	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	116, 920 9, 257 9, 257 0 9, 257 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TraveTherapists (column 2, line 10 times the sumAssistants (column 2, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 13 for all others)Standard travel allowance and standard traveOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel Expense	sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	4 and 25 for a y therapy or s a at the provic d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 31 ar	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	116, 920 9, 257 0 9, 257 0 1 9, 257 0 0 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and optional TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional Travel Allowance and Optional TraveTherapists (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)	sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line expense (sum expense (sum	4 and 25 for a y therapy or s a at the provic d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 31 ar	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	116, 920 9, 257 0 9, 257 0 1 9, 257 0 0 0 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and standard traveStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37) <td>sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum ANCE AND TRAVEL</td> <td>24 and 25 for a by therapy or s at the provid d 2, line 12) 29 and 30 for a a 13 for respir a 28) of lines 27 ar of lines 31 ar EXPENSE COMPU</td> <td>ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)</td> <td>3 and 4 for all of lines 26 and y or sum of</td> <td>116, 920 9, 257 0 9, 257 0 9, 257 0 0 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</td> <td>23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00</td>	sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum l expense (sum ANCE AND TRAVEL	24 and 25 for a by therapy or s at the provid d 2, line 12) 29 and 30 for a a 13 for respir a 28) of lines 27 ar of lines 31 ar EXPENSE COMPU	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	116, 920 9, 257 0 9, 257 0 9, 257 0 0 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveCoptional travel allowance and standard traveStandard travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the suOptional Travel Allowance and Optional Trave	sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum ANCE AND TRAVEL m of lines 5 ar Expense	24 and 25 for a by therapy or s at the provic ad 2, line 12) 29 and 30 for a a 13 for respire a 28) of lines 27 ar of lines 31 ar EXPENSE COMPU ad 6)	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	116, 920 9, 257 0 9, 257 0 9, 257 0 9, 257 0 0 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 35.00 36.00 37.00 38.00 39.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the suOptional Travel Allowance and Optional TraveTherapists (sum of columns 1 and 2, line 12.	sum of lines 2 for respirator travel expense of columns 1 ar, line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum ANCE AND TRAVEL m of lines 5 ar <u>L Expense</u> 01 times column	24 and 25 for a by therapy or s at the provic ad 2, line 12) 29 and 30 for a a 13 for respire a 28) of lines 27 ar of lines 31 ar EXPENSE COMPU ad 6)	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	116, 920 9, 257 0 9, 257 0 9, 257 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveCoptional travel allowance and standard traveStandard travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 3, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the suOptional Travel Allowance and Optional Trave	sum of lines 2 for respirator travel expense of columns 1 ar, line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum ANCE AND TRAVEL m of lines 5 ar <u>L Expense</u> 01 times column	24 and 25 for a by therapy or s at the provic ad 2, line 12) 29 and 30 for a a 13 for respire a 28) of lines 27 ar of lines 31 ar EXPENSE COMPU ad 6)	ull others) sum of lines ler site (sum ull others) ratory therap ud 31) ud 32)	3 and 4 for all of lines 26 and y or sum of	116, 920 9, 257 0 9, 257 0 9, 257 0 9, 257 0 0 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00
25.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 33.00 34.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TraveTherapists (column 2, line 10 times the sumAssistants (column 3, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel expense (line 8 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the suOptional Travel Allowance and Optional TraveTherapists (column 3, line 12.01 times column 3, line 12.Assistants (column 3, line 12.01 times column 3, line 12.Assistants (column 3, line 40 and 41)Optional travel expense (line 8 times the su	sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum expense (sum ANCE AND TRAVEL m of lines 5 ar l Expense 01 times column n 3, line 10) m of columns 1-	A and 25 for a by therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 27 ar of lines 31 ar EXPENSE COMPU d 6) 12, line 10) 3, line 13.01)	II others) sum of lines ler site (sum all others) atory therap ad 31) ad 32) ITATION - SER	3 and 4 for all n of lines 26 and ny or sum of NICES OUTSIDE PR	116, 920 9, 257 0 9, 257 0 9, 257 0 0 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00
25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00 36. 00 37. 00 38. 00 39. 00 40. 00 41. 00 42. 00	PART III - STANDARD AND OPTIONAL TRAVEL ALLOUStandard Travel AllowanceTherapists (line 3 times column 2, line 11)Assistants (line 4 times column 3, line 11)Subtotal (line 24 for respiratory therapy orStandard travel expense (line 7 times line 3others)Total standard travel allowance and standard27)Optional Travel Allowance and Optional TraveTherapists (column 2, line 10 times column 3Subtotal (line 29 for respiratory therapy orOptional travel allowance and standard traveColumns 1-3, line 13 for all others)Standard travel allowance and standard traveOptional travel allowance and optional travePart IV - STANDARD AND OPTIONAL TRAVEL ALLOWStandard Travel ExpenseTherapists (line 5 times column 2, line 11)Assistants (line 6 times column 3, line 11)Subtotal (sum of lines 36 and 37)Standard travel expense (line 7 times the suOptional Travel Allowance and Optional TraveTherapists (sum of columns 1 and 2, line 12.Assistants (column 3, line 12.01 times columnSubtotal (sum of lines 40 and 41)	sum of lines 2 for respirator travel expense of columns 1 ar , line 12) sum of lines 2 s 1 and 2, line l expense (line l expense (sum expense (sum ANCE AND TRAVEL m of lines 5 ar l Expense 01 times column n 3, line 10) m of columns 1-	A and 25 for a by therapy or s at the provid d 2, line 12) 9 and 30 for a 13 for respir 28) of lines 27 ar of lines 27 ar of lines 31 ar EXPENSE COMPU d 6) 12, line 10) 3, line 13.01)	II others) sum of lines ler site (sum all others) atory therap ad 31) ad 32) ITATION - SER	3 and 4 for all n of lines 26 and ny or sum of NICES OUTSIDE PR	116, 920 9, 257 0 9, 257 0 9, 257 0 0 0 9, 257 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00 24.00 25.00 26.00 27.00 28.00 30.00 31.00 32.00 33.00 34.00 35.00 35.00 36.00 37.00 38.00 39.00 40.00 41.00 42.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider C	1	Period: From 01/01/2017 To 12/31/2017 Occupational		pared:
					Therapy	COST	
						1.00	
	Optional travel allowance and standard travel		of lines 39 a			0	
46.00	Optional travel allowance and optional travel		of lines 42 a	nd 43 - see ir Aides			46.00
		Therapists 1.00	Assistants 2.00	3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION						
47.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0.00	0.00	0.00	47.00
18.00	Overtime rate (see instructions)	0.00	0.00	0.00	0.00		48.00
19.00	Total overtime (including base and overtime	0.00	0.00	0.00	0.00		49.00
	<u>allowance) (multiply line 47 times line 48) </u> 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,	0.00	0.00	0.00	0.00	0. 00	50.00
51.00	line 47) Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0.00	0.00	0. 00	51.00
	DETERMINATION OF OVERTIME ALLOWANCE	74.00	0.00				
2.00 3.00	Adjusted hourly salary equivalency amount (see instructions) Overtime cost limitation (line 51 times line	76. 82 0	0.00		0.00 0 0		52.00 53.00
	52) Maximum overtime cost (enter the lesser of	0	0		0 0		54.00
5.00	line 49 or line 53) Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0	(0 0		55.00
6. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0	(0 0	0	56.00
				I			
	Part VI - COMPUTATION OF THERAPY LIMITATION A					1.00	
7.00 8.00 9.00 0.00 1.00 2.00 3.00 4.00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site Travel allowance and expense - Offsite servic Overtime allowance (from column 5, line 56) Equipment cost (see instructions) Supplies (see instructions) Total allowance (sum of lines 57-62) Total cost of outside supplier services (from Excess over limitation (line 64 minus line 63 LINE 33 CALCULATION	(from lines 3: ces (from lines n your records)	3, 34, or 35)) s 44, 45, or 4)	6)		0 126, 177 94, 799	58.00 59.00 60.00 61.00 62.00 63.00
00. 01	Line 26 = line 24 for respiratory therapy or Line 27 = line 7 times line 3 for respiratory Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION				others	0	100. 00 100. 01 100. 02
01. 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
01.02	LINE 35 CALCULATION						

REASON	Financial Systems HABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	PUTNAM COUNTY FURNI SHED BY	Provi der C	CN: 15-1333	In Lie Period: From 01/01/2017 To 12/31/2017 Speech Pathology	Date/Time Pre 5/29/2018 10:	-3 pared:
						1.00	
	PART I – GENERAL INFORMATION						
1.00	Total number of weeks worked (excluding aide	s) (see instruc	tions)			52	
2.00	Line 1 multiplied by 15 hours per week					780	•
3.00	Number of unduplicated days in which supervi					161	•
4.00	Number of unduplicated days in which therapy		on provider si	ite but neit	her supervisor	0	4.00
5.00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - supe		anists (soo ii	nstructions)		0	5.00
6.00	Number of unduplicated offsite visits - supe					0	6.00
0.00	assistant and on which supervisor and/or the					, i i i i i i i i i i i i i i i i i i i	0.00
	instructions)						
7.00	Standard travel expense rate					0.00	
8.00	Optional travel expense rate per mile	<u> </u>	T 1			0.00	8.00
		Supervi sors 1.00	Therapists 2.00	Assi stants 3.00	Ai des 4.00	Trai nees 5.00	
9.00	Total hours worked	0.00	631.00		00 0.00		9.00
10.00	AHSEA (see instructions)	0.00	73.84		00 0.00		•
11.00	Standard travel allowance (columns 1 and 2,	36.92	36.92		00		11.00
	one-half of column 2, line 10; column 3,						
	one-half of column 3, line 10)						
12.00	Number of travel hours (provider site)	0	0		0		12.00
12.01 13.00	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12.01
13.00	Number of miles driven (provider site)	0	0		0		13.00
15.01	Number of milles driver (offsite)	9	0	1	0		13.01
						1.00	
	Part II - SALARY EQUIVALENCY COMPUTATION						
14.00	Supervisors (column 1, line 9 times column 1					0	
15.00	Therapists (column 2, line 9 times column 2,					46, 593	•
16.00 17.00	Assistants (column 3, line 9 times column 3, Subtotal allowance amount (sum of lines 14 a		ratory thoron	an Linco 1	4 16 fam all	0 46, 593	16.00
17.00	others)	nu is ioi respi	ratory therap	y of titles i	4-10 101 411	40, 393	17.00
18.00	Aides (column 4, line 9 times column 4, line	10)				0	18.00
19.00	Trainees (column 5, line 9 times column 5, l					0	19.00
20.00	Total allowance amount (sum of lines 17-19 f						20.00
	If the sum of columns 1 and 2 for respiratory						
	occupational therapy, line 9, is greater than		no entries on	Tines 21 an	d 22 and enter or	n line 23 the	
21.00	amount from line 20. Otherwise complete line Weighted average rate excluding aides and tr		divided by si	um of column	s 1 and 2 line (73.84	21.00
21.00	for respiratory therapy or columns 1 thru 3,	line 9 for all	others)			/3.04	21.00
22.00	Weighted allowance excluding aides and train	ees (line 2 tim	es line 21)			57, 595	22.00
23.00	Total salary equivalency (see instructions)					57, 595	23.00
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVE	L EXPENSE COM	PUTATION - F	ROVIDER SITE		-
24.00	Standard Travel Allowance					E 014	24.00
24.00 25.00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					5,944	
26.00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for a	all others)		5, 944	•
27.00	Standard travel expense (line 7 times line 3				3 and 4 for all	0	1
	others)		5 15				
28.00	Total standard travel allowance and standard	travel expense	at the provi	der site (su	m of lines 26 and	5, 944	28.00
	27) Onti angl. Traval. Allowanga and Onti angl. Traval	Evenence					-
29.00	Optional Travel Allowance and Optional Travel Therapists (column 2, line 10 times the sum		d 2 line 12)		0	29.00
30.00	Assistants (column 3, line 10 times column 3)		0	•
31.00	Subtotal (line 29 for respiratory therapy or		9 and 30 for a	all others)		0	
32.00	Optional travel expense (line 8 times column				py or sum of	0	32.00
	columns 1-3, line 13 for all others)						
33.00	Standard travel allowance and standard trave					5, 944	
34.00	Optional travel allowance and standard trave					0	
35.00	Optional travel allowance and optional trave Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW						35.00
	Standard Travel Expense	ANGL AND TRAVEL	EXTENSE COMP	JIAHON - JL	KITCES OUTSTDE TI	OVIDER SITE	1
36.00	Therapists (line 5 times column 2, line 11)					0	36.00
37.00	Assistants (line 6 times column 3, line 11)					0	
38.00	Subtotal (sum of lines 36 and 37)					0	
39.00	Standard travel expense (line 7 times the su		d 6)			0	39.00
40.00	Optional Travel Allowance and Optional Travel		2 1100 10				10.00
40.00 41.00	Therapists (sum of columns 1 and 2, line 12. Assistants (column 3, line 12.01 times colum		∠, ine iu)			0	•
41.00	Subtotal (sum of lines 40 and 41)	, ine io)				0	
43.00	Optional travel expense (line 8 times the su	m of columns 1-	3, line 13.01 [°])		0	•
	Total Travel Allowance and Travel Expense - (llowing three lin		1
	46, as appropriate.		<u></u>	1.05			
44.00	Standard travel allowance and standard trave						44.00
45.00	Optional travel allowance and standard trave						45.00

	ABLE COST DETERMINATION FOR THERAPY SERVICES E SUPPLIERS	FURNI SHED BY	Provider C	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017		pared:
					Speech Pathology	Cost	
						1.00	
5.00	Optional travel allowance and optional travel	expense (sum	of lines 42 a	nd 43 - see i	nstructions)	0	46.00
	optional traver arrenares and optional trave	Therapists	Assi stants	Aides	Trai nees	Total	10100
		1.00	2.00	3.00	4.00	5.00	
	PART V - OVERTIME COMPUTATION			-	-		
7.00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0.00	0.00	0. 0	0.00	0.00	47.00
3.00	Overtime rate (see instructions)	0.00	0.00	0.0	0.00		48.00
9.00	Total overtime (including base and overtime	0.00	0.00	0.0	0.00		49.00
	allowance) (multiply line 47 times line 48)						
	CALCULATION OF LIMIT	0.00				0.00	50.00
0. 00	Percentage of overtime hours by category	0.00	0.00	0.0	0.00	0.00	50.00
	(divide the hours in each column on line 47 by the total overtime worked - column 5,						
	line 47)						
I. 00	Allocation of provider's standard work year	0.00	0.00	0.0	0.00	0.00	51.00
	for one full-time employee times the						
	percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE	70.04			0.00		50.00
2.00	Adjusted hourly salary equivalency amount (see instructions)	73.84	0.00	0.0	0.00		52.00
3. 00	Overtime cost limitation (line 51 times line	0	C		0 0		53.00
. 00	52)	0	0		0		00.00
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						
00	line 47 times line 52) Overtime allowance (line 54 minute line 55	0	0		0 0	0	56.00
5.00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	U	,	0 0	0	50.00
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3						
	for all others.)						
						1.00	
7.00	Part VI - COMPUTATION OF THERAPY LIMITATION A Salary equivalency amount (from line 23)	IND EXCESS CUST	ADJUSTMENT			57, 595	57.00
3.00	Travel allowance and expense - provider site	(from lines 33	3 34 or 35))			5, 944	
9.00	Travel allowance and expense - Offsite service					0	59.00
0. 00	Overtime allowance (from column 5, line 56)					0	60.0
I. 00	Equipment cost (see instructions)					0	61.00
2.00	Supplies (see instructions)					0	62.00
	Total allowance (sum of lines 57-62)					63, 539	
1.00	Total cost of outside supplier services (from Excess over limitation (line 64 minus line 65					37,036	
5.00	LINE 33 CALCULATION	s - II negative	e, enter zero)			0	65.0
00 00	Line 26 = line 24 for respiratory therapy or	sum of lines 3	24 and 25 for	all others		5, 944	100 0
	others		100.0				
0. 02			100.02				
	LINE 34 CALCULATION						
	Line 27 = line 7 times line 3 for respiratory				others		101.00
	Line 31 = line 29 for respiratory therapy or	sum of lines 2	29 and 30 for	all others			101. 0'
1 00	Line 34 = sum of lines 27 and 31					0	101.02
01.02	LINE 35 CALCULATION						
						-	
02.00	Line 31 = line 29 for respiratory therapy or				umpc 1 2 1:5-		102.00
02.00					umns 1-3, line		102. 0 102. 0

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1333 Period: From 01/01/2017 Period: To 12/31/2017 Period: To 23/31/2017 Period: To 23/31/2017 Period: To 23/31/2017 Period: To 23/	pared: 27 am
Cost Center Description Net Expenses for Cost Al Local to Cost (from Wkst A col. 7) EMPLOYEE Fixt Not Cost Al Local to Cost (from Wkst A col. 7) EMPLOYEE ENPLOYEE ENPLOYEE Fixt Not Cost All Cost (from Wkst A col. 7) Subtotal ADMINISTRATIV E & GENERAL 1.00 GENERAL SERVICE COST CENTERS 0 1.00 4.00 4.00 4.00 0.0100 NEW CAP REL COST SENTERS 0 1.00 4.00 4.00 4.00 0.0000 ADMINSTRATIVE & GENERAL 5.00 0.00000 ADMINSTRATIVE & GENERAL 4.045, 183 4.149 4.704, 170 4.00 5.00 000000 ADMINSTRATIVE & GENERAL 9.00 4.645, 183 383, 601 635, 675 5, 664, 459 5, 664, 459 9.00 000000 ADMINSTRATIVE & GENERAL 9.00 4.00 4.149 4.704, 170 35, 675 5, 664, 459 5, 664, 459 5, 664, 459 5, 664, 459 5, 664, 459 10.4, 630 277, 810 79, 292 1, 641, 132 292, 86 800 10.4, 630 277, 810 79, 292 1, 641, 132 292, 86 10.4, 630 277, 810 79, 292 1, 641, 132 292, 86 10.4, 630 277, 810 79, 292 1, 61, 793 79,	pared: 27 am
Cost Center Description Net Expenses for Cost (Figure Wist A col. 7) CAPI TAL ELELATED COSTS For Cost (Figure Wist A col. 7) EVELDOSTS (Figure Cost DEPARTMENT Subtotal ADMINISTRATIVE E & GENERAL 0 0 1.00 4.00 <	
Cost Center Description Net Expenses Allocation (from West A col. 7) Net Expenses Fixt Net MeDDXE Fixt EMPLOYEE DEPARTMENT Subtotal EXPLOYE ADMI NI STRATIV E & GENERAL 100 OTOO NEW CAP REL COST-CENTERS	
First BENEFITS E & GENERAL 1.00 0 1.00 4.00 4.0 4.0 1.00 0.0100 NEW CAP REL COST CENTERS 0 4.704,170 4.704,170 4.00 0.0000 EMPLOYCE REMET TS DEPARTINENT 4.700,021 4.704,170 635,675 5.664,459 5.00 0.00500 ADMIN ISTRATI VE & GENERAL 4.645,183 383,601 635,675 5.664,459 5.664,459 9.00 00000 LAUMDRY & LINEN SERVICE 175,205 18,333 4.933 198,471 3198,471 3198,471 3198,471 9.00 00000 LIAUMDRY & LINEN SERVICE 175,205 18,333 4.933 198,471 199,472 265,575 100,731	
All location (from Wist A ool. 7) DEPARTMENT DEPARTMENT 1.00 00100 NEW GA PRU CE COST CENTERS 0 1.00 4.00 4A 5.00 1.00 00100 NEW GA PRU CE COST CENTERS 0 1.40 0.00400 EMPL OR ST SUDG & FLXT 2.690, 509 4.149 4.704, 170 5.00 00500 ADMIN STRATIVE & GENERAL 4.645, 183 38.301 635, 675 5.664, 459 5.664, 459 7.00 00700 OPERATION OF PLANT 1.284, 630 277, 810 79, 292, 26 8.00 0.00500 HOUSENEEPI NG 470, 066 17, 139 99, 684 566, 909 104, 49 0.00 01000 DI CLARVEN K LINEN SERVICE 175, 205 18, 333 4, 933 198, 471 35, 40 10.00 01000 DI CLARVEN K 236, 977 93, 480 26, 664 357, 121 63, 70 10.00 01000 AUETAR LINRAY 236, 977 93, 480 137, 150 24, 40 10.00 0100 AUETAR LINRAY 527, 244 107, 176 93, 577 728, 117 129, 88 10.00 <td></td>	
Col. 7) 0 4.00 GENERAL SERVICE COST CENTERS 0 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 6HERAL SERVICE COST CENTERS 5.00 5.00 5.00 5.00 5.00 5.00 5.00 64.00 4.149 4.749 4.749 4.749 4.749 4.749 4.749 4.749 4.741 72.22,26 5.00 5.06 64.17,732 292,26 66 3.57 5.664,459 5.664,459 5.664,459 5.00 60.00 900 00900 HOUSENCEREN ING 172,20 18.33 4.933 198,471 35,40 10.00 01000 DID CAFETERI A 550,762 43,489 63,856 613,171 109,937 13.00 01300 NURSI NG ADMINISTRATION 100,220 18.034 18,896 137,150 24.46 10.00 01700 SOCI AL SERVICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
O 1.00 4.00 4A 5.00 I.00 O100 NEW CAP REL COST CENTERS 2.600,509 2.600,509 4.70,70,70 5.664,459 5.664,457 5.664,459 5.664,457 5.661,000,010,000 <td></td>	
GENERAL SERVICE COST CENTERS Control 1.00 CONDON NEW CAP REL COSTS-BLDG & FIXT 2, 690, 509 4, 149 4, 704, 170 5.00 Obdod EMPLOYER BENCFITS DEPARTMENT 4, 700, 021 4, 149 4, 704, 170 5.00 ODSOO ADMI NI STRATI VE & GENERAL 4, 645, 183 383, 601 635, 675 5, 664, 459 5.00 ODSOO OPERATION OF PLANT 1, 284, 630 277, 810 79, 292 1, 641, 732 292, 66 8.00 OBSOO LAUNDRY & LINEN SERVICE 175, 205 18, 333 4, 933 198, 471 35, 40 10.00 OIDOO HOUSEKEEPI NG 470, 086 17, 139 99, 64 586, 699 104, 69 10.00 OIDOO CAFETERIA 505, 762 43, 499 63, 856 613, 117 109, 37 11.00 CATERIA 505, 756, 565 100, 717, 76 93, 697 728, 117 129, 86 11.00 CALE SERVICE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
1.00 ODIOD NEW CAP REL COSTS-BLDC & FLXT 2, 690, 509 2, 690, 509 4.00 OOdOD EMPCHYED ENFERTIS DEPARTMENT 4, 700, 021 4, 149 4, 704, 170 5.00 00500 ADMINISTRATIVE & GENERAL 4, 645, 183 383, 601 635, 675 5, 664, 459 5, 664, 459 7.00 00700 PERATION OF PLANT 1, 284, 630 227, 810 79, 292 1, 641, 732 292, 86 8.00 00800 LAUNDRY & LINEN SERVICE 175, 205 18, 333 4, 993 198, 471 63, 70 0.00 00900 HOLSKEEPING 470, 086 17, 139 99, 684 586, 909 104, 69 10.00 OLGOD DI ETARY 226, 977 93, 480 26, 664 337, 150 24, 46 10.00 01400 MEDIARINI STRATION 100, 220 18, 034 18, 896 137, 150 24, 46 11.00 01400 MEDIARINESTATION 100, 220 18, 035 677 54, 469 137, 150 24, 46 12.00 10400 MEDIARINE	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 700, 021 4, 149 4, 704, 170 5.00 00500 ADMI INSTRATIVE & GENERAL 4, 645, 183 383, 601 635, 675 5, 664, 459 7.00 00700 OPERATI ON OF PLANT 1, 284, 630 277, 810 79, 292 1, 641, 732 292, 86 8.00 00800 LAUMORY & LINEN SERVICE 175, 205 18, 333 4, 933 198, 471 35, 40 9.00 00900 HOUSEKEEPING 470, 086 17, 739 99, 684 566, 75 37, 71 700 0100 CAFETERI A 505, 75, 24, 43, 499 63, 856 613, 117 109, 37 10.00 01000 ODICAL EXERVICE 127, 244 107, 176 93, 607 728, 117 129, 88 17. 00 10700 SOCI AL SERVICE 527, 244 107, 176 93, 607 728, 117 129, 88 17. 00 10700 DULTS & SEPULE WINT 70, 645, 555 160, 763 272, 394 1, 489, 722 265, 75 30.00 03000 ADMULTS & FEDI ATRICS 1, 055, 556 160, 763 272, 394 1, 489, 722 265, 75 <td>1.00</td>	1.00
7.00 00700 0PERATION OF PLANT 1, 284, 630 277, 810 79, 292 1, 641, 732 292, 86 8.00 00800 LAUNDRY & LINEN SERVICE 175, 205 18, 333 4, 933 198, 471 35, 40 9.00 00900 HOUSEKEEPI NG 470, 086 17, 139 99, 684 586, 909 104, 69 10.00 01100 CAFETERI A 505, 762 433, 499 63, 856 613, 117 109, 37 13.00 01300 NURSI NG ADMI NI STRATI ON 100, 220 18, 034 18, 896 137, 150 24, 46 17.00 O1700 SOCI AL SERVI CE 0 </td <td>4.00</td>	4.00
8 00 00000 LUNDRY & LINEN SERVICE 175,205 18,333 4,933 198,471 35,409 9,00 000900 HOUSEKEEPING 470,086 17,139 99,684 586,909 104,69 10.00 01000 DI ETARY 236,977 93,480 26,664 357,121 63,70 13.00 01300 NURSI NG ADMI NI STRATION 100,220 18,034 18,896 137,150 244,46 16.00 01600 KEDI CAL RECORDS & LIBRARY 527,244 107,176 93,697 728,117 129,88 17.01 01701 UTI LI ZATI ON REVIEW 63,588 9,031 15,508 88,127 15,72 INPATI ENT ROUTI NE SERVICE COST CENTERS 0	
9.00 00900 HOUSEKEEPING 470,086 17,139 99,684 586,909 104,69 10.00 01100 DI ETARY 236,977 93,480 26,664 357,121 63,70 11.00 01100 CAFETERIA 505,762 43,499 63,856 613,117 109,37 13.00 01300 NURSI NG ADMINISTRATION 100,220 18,034 18,896 137,150 24,46 10.00 10170 SOCI AL SERVICE 0	7.00
10.00 01000 01 FTARY 236, 977 93, 480 26, 664 357, 121 63, 70 11.00 01000 CAFETERIA 505, 762 43, 499 63, 856 613, 117 109, 37 13.00 01300 NURSING ADMINISTRATION 100, 220 18, 034 18, 896 137, 150 24, 466 16.00 01600 BEDI CAL RECORDS & LIBRARY 527, 244 107, 176 93, 697 728, 117 129, 88 17.00 01701 UTILIZATION REVIEW 63, 588 9, 031 15, 508 88, 127 15, 72 INPATIENT ROUTINE SERVICE COST CENTERS INPATIENT ROUTINE SERVICE COST CENTERS INPATIENT ROUTINE SERVICE COST CENTERS O 00000 ADULTS & PEDI ATRI CS 1, 056, 565 160, 763 272, 394 1, 489, 722 265, 753 31.00 03100 INTENSI VE CARE UNIT 744, 032 77, 046 186, 360 1, 007, 438 179, 714 41.00 04100 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	
11.00 01100 CAFETERIA 505,762 43,499 63,856 613,117 109,37 13.00 01300 NURSI NG ADMI NI STRATI ON 100,220 18,034 18,896 137,150 24,46 16.00 01000 MEDICAL RECORDS & LI BRARY 527,244 107,176 93,697 728,117 129,88 17.00 01700 SOCI AL SERVI CE 0 <td></td>	
16.00 01600 MEDI CAL RECORDS & LI BRARY 527, 244 107, 176 93, 697 728, 117 129, 88 17.00 01700 SOCI AL SERVI CE 0 0 0 0 0 17.01 0111 LIZATI ON REVI EW 63, 588 9, 031 15, 508 88, 127 15, 72 100 03000 ADULTS & PEDI ATRI CS 1, 056, 565 160, 763 272, 394 1, 489, 722 265, 755 31.00 03000 INTENSI VE CARE UNI T 744, 032 77, 046 186, 360 1, 007, 438 179, 71 41.00 04100 SUBPROVI DER - I RF 0 <td></td>	
17.00 01700 SOCI AL SERVICE 0 0 0 0 17.01 01701 UTILLZATION REVIEW 63,588 9,031 15,508 88,127 15,72 30.00 ADULTS & PEDIATRICS 1,056,565 160,763 272,394 1,489,722 265,755 31.00 0300 INTENSIVE CARE UNIT 744,032 77,046 186,360 1,007,438 179,71 42.00 0400 SUBPROVI DER - IRF 0	
17.01 01701 UTI LI ZATI ON REVIEW 63,588 9,031 15,508 88,127 15,72 INPATI ENT ROUTI NE SERVICE COST CENTERS INPATI ENT ROUTI NE SERVICE COST CENTERS 265,751 31.00 03000 ADULTS & PEDI ATRICS 1,056,565 160,763 272,394 1,489,722 265,751 31.00 O3000 ADULTS & PEDI ATRICS 1,056,565 160,763 272,394 1,489,722 265,751 31.00 O3100 INTENSI VE CARE UNI T 744,032 77,046 186,360 1,007,438 179,714 41.00 O4100 SUBPROVI DER 0 <	
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS 1,056,565 160,763 272,394 1,489,722 265,755 31. 00 03100 INTENSI VE CARE UNI T 744,032 77,046 186,360 1,007,438 179,714 41. 00 04100 SUBPROVI DER - IRF 0 <td></td>	
30. 00 03000 ADULTS & PEDIATRICS 1,056,565 160,763 272,394 1,489,722 265,755 31. 00 03100 INTENSIVE CARE UNIT 744,032 77,046 186,360 1,007,438 179,711 41. 00 04100 SUBPROVI DER - IRF 0 0 0 0 0 0 42. 00 04200 SUBPROVI DER 0	17.01
31.00 03100 INTENSIVE CARE UNIT 744,032 77,046 186,360 1,007,438 179,710 41.00 SUBPROVI DER - I RF 0 0 0 0 0 0 42.00 O4200 SUBPROVI DER 0 0 0 0 0 0 0 43.00 04300 NURSERY 0	30.00
42.00 04200 SUBPROVI DER 0	31.00
43.00 04300 NURSERY 0 0 0 0 ANCILLARY SERVICE COST CENTERS	41.00
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 1, 792, 858 232, 440 162, 955 2, 188, 253 390, 360 51.00 05100 RECOVERY ROOM 77, 629 62, 239 16, 552 156, 420 27, 90 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 </td <td>42.00</td>	42.00
50.00 05000 OPERATI NG ROOM 1,792,858 232,440 162,955 2,188,253 390,366 51.00 05100 RECOVERY ROOM 77,629 62,239 16,552 156,420 27,90 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 53.00 05300 ANESTHESI OLOGY 126,488 0 158,777 285,265 50,883 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,228,736 82,199 231,249 1,542,184 275,100 54.01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 169,291 3,797 0 173,088 30,87 57.00 05700 CT SCAN 423,657 35,798 43,125 502,580 89,655 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0	43.00
51.00 05100 RECOVERY ROOM 77, 629 62, 239 16, 552 156, 420 27, 90 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 53.00 05300 ANESTHESI OLOGY 126, 488 0 158, 777 285, 265 50, 88 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 228, 736 82, 199 231, 249 1, 542, 184 275, 100 54.01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 169, 291 3, 797 0 173, 088 30, 87 57.00 05700 CT SCAN 423, 657 35, 798 43, 125 502, 580 89, 65 58.00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 0 </td <td>50.00</td>	50.00
53.00 05300 ANESTHESI OLOGY 126,488 0 158,777 285,265 50,883 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,228,736 82,199 231,249 1,542,184 275,100 54.01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 169,291 3,797 0 173,088 30,87 57.00 05700 CT SCAN 423,657 35,798 43,125 502,580 89,653 58.00 05800 MAGNETI C RESONANCE IMAGING (MRI) 0	
54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 228, 736 82, 199 231, 249 1, 542, 184 275, 100 54.01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 169, 291 3, 797 0 173, 088 30, 87 57.00 05700 CT SCAN 423, 657 35, 798 43, 125 502, 580 89, 65 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 <td>52.00</td>	52.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 169, 291 3, 797 0 173, 088 30, 87 57. 00 05700 CT SCAN 423, 657 35, 798 43, 125 502, 580 89, 653 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0	
57.00 05700 CT SCAN 423,657 35,798 43,125 502,580 89,653 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0<	
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0	
60.00 06000 LABORATORY 2,021,490 68,070 168,403 2,257,963 402,794 60.01 06001 BLOOD LABORATORY 0	58.00
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 64. 00 06400 I NTRAVENOUS THERAPY 0	59.00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 65.00 06500 RESPI RATORY THERAPY 418, 871 18, 984 86, 028 523, 883 93, 453 66.00 06600 PHYSI CAL THERAPY 557, 897 87, 189 0 645, 086 115, 076 67.00 06700 OCCUPATI ONAL THERAPY 101, 837 0 0 101, 837 18, 166 68.00 06800 SPEECH PATHOLOGY 37, 211 0 0 37, 211 6, 633 69.00 06900 ELECTROCARDI OLOGY 165, 932 2, 712 19, 672 188, 316 33, 594	1
65.0006500RESPI RATORY THERAPY418,87118,98486,028523,88393,45566.0006600PHYSI CAL THERAPY557,89787,1890645,086115,07667.0006700OCCUPATI ONAL THERAPY101,83700101,83718,1668.0006800SPEECH PATHOLOGY37,2110037,2116,63369.0006900ELECTROCARDI OLOGY165,9322,71219,672188,31633,594	60.01 64.00
66.00 06600 PHYSI CAL THERAPY 557, 897 87, 189 0 645, 086 115, 076 67.00 06700 OCCUPATI ONAL THERAPY 101, 837 0 0 101, 837 18, 16 68.00 06800 SPEECH PATHOLOGY 37, 211 0 0 37, 211 6, 636 69.00 06900 ELECTROCARDI OLOGY 165, 932 2, 712 19, 672 188, 316 33, 596	1
68.00 06800 SPEECH PATHOLOGY 37, 211 0 0 37, 211 6, 631 69.00 06900 ELECTROCARDI OLOGY 165, 932 2, 712 19, 672 188, 316 33, 594	1
69. 00 06900 ELECTROCARDI OLOGY 165, 932 2, 712 19, 672 188, 316 33, 59	67.00
69. 01 06901 CARDI AC REHAB 247, 394 22, 048 64, 120 333, 562 59, 50- 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0	69.01 71.00
	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 1, 360, 193 24, 299 46, 471 1, 430, 963 255, 26	
73. 01 07301 0NCOLOGY 3, 055, 480 131, 719 73, 243 3, 260, 442 581, 62	73.01
OUTPATIENT SERVICE COST CENTERS	00.00
88.00 08800 RURAL HEALTH CLINIC 1, 206, 716 144, 275 270, 520 1, 621, 511 289, 260 88.01 08801 RURAL HEALTH CLINIC 1, 134, 453 67, 663 242, 111 1, 444, 227 257, 633	
88. 02 08802 RURAL HEALTH CLINIC III 660, 345 34, 333 141, 478 836, 156 149, 16	
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0 0 0 0	1
90. 00 09000 CLINIC 0 4, 393 0 4, 393 78-	
91. 00 09100 EMERGENCY 1, 849, 260 157, 455 722, 993 2, 729, 708 486, 950	
92. 00 09200 OBSERVATION BEDS (NON-DI STINCT PART) 0	92.00
OTHER REI MBURSABLE COST CENTERS 99.10 09910 CORF 0	99.10
SPECIAL PURPOSE COST CENTERS	/ // 10
109.00 DOPANCREAS ACQUISITION 0 0 0 0	109.00
	110.00
	111.00
113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	113.00 114.00
114.00 11400 01112 ATTON REVIEW-SNF 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 33, 835, 760 2, 389, 674 3, 944, 656 32, 775, 411 4, 836, 29	
NONREI MBURSABLE COST CENTERS	
	190.00
	192.00
	192.01 193.00
	193.00
	193.01
	193.03
	194.00
194. 01 07951 BOARD OF HEALTH 0 18, 794 0 18, 794 3, 35	194.01

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2017 To 12/31/2017			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPI TAL RELATED COSTS NEW BLDG & FI XT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI V E & GENERAL		
	0	1.00	4.00	4A	5.00		
194.0207952 PUTNAM/HENRY PRENATAL	0	0		0 0	0	194.02	
200.00 Cross Foot Adjustments				0		200.00	
201.00 Negative Cost Centers		0		0 0		201.00	
202.00 TOTAL (sum lines 118 through 201)	37, 417, 807	2, 690, 509	4, 704, 17	70 37, 417, 807	5, 664, 459	202.00	

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: om 01/01/2017	Worksheet B Part I	
			To	12/31/2017	Date/Time Pre 5/29/2018 10:	pared: 27 am
Cost Center Description	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00 00100 NEW CAP REL COSTS-BLDG & FLXT						1.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINI STRATI VE & GENERAL						4.00
7. 00 00700 OPERATION OF PLANT	1, 934, 599					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	17, 515					8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	16, 375		709, 393	E4E 49E		9.00
11. 00 01100 CAFETERI A	89, 310 41, 559		34, 506 16, 057	545, 685 0	780, 106	•
13. 00 01300 NURSI NG ADMI NI STRATI ON	17, 230	0	6, 657	0	7, 128	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	102, 394	0	39, 561	0	39, 458	•
17. 00 01700 SOCIAL SERVICE 17. 01 01701 UTILIZATION REVIEW	0 8, 628	0	0 3, 333	0	0	•
INPATIENT ROUTINE SERVICE COST CENTERS	0,020	0	3, 333		0	17.01
30. 00 03000 ADULTS & PEDI ATRI CS	153, 591	54, 688	59, 342	486, 222	81, 795	•
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER - I RF	73, 608	42, 230	28, 440 0	59, 463 0	52, 666 0	31.00
42. 00 04200 SUBPROVI DER	0	0	0	0	0	•
43. 00 04300 NURSERY	0	0	0	0	0	43.00
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	222, 069	35, 632	85, 800	0	40.224	50.00
51.00 05100 RECOVERY ROOM	59, 462	35, 632	22, 974	0	49, 334 3, 903	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	8, 250	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	78, 531 3, 627	18, 806 0	30, 342 1, 401	0	77, 146 0	54.00 54.01
57. 00 05700 CT SCAN	34, 200		13, 214	0	13, 200	•
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	65, 032 0		25, 126 0	0	75, 540 0	60.00 60.01
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	18, 137	0	7,007	0	25, 667	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	83, 299	6, 942 0	32, 184 0	0	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	2, 591	0	1,001	0	6, 262	•
69. 01 06901 CARDI AC REHAB	21, 064	0	8, 139	0	16, 127	69.01
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72.00 07200 I MPL. DEV. CHARGED TO PATI ENT	0		0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	23, 215	0	8, 969	0	15, 612	•
73. 01 07301 0NC0L0GY	125, 842	8, 081	48, 621	0	24, 229	73.01
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	137, 838	5, 627	53, 256	0	73 023	88.00
88.01 08801 RURAL HEALTH CLINIC II	64, 644		00,200	0	0	
88.02 08802 RURAL HEALTH CLINIC III	32, 801	0	12, 673	0	0	88.02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 4, 197	0	0 1, 622	0	0	89.00
91. 00 09100 EMERGENCY	150, 430			0	106, 278	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
0THER REIMBURSABLE COST CENTERS 99. 10 09910 CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99.10
109.00 10900 PANCREAS ACQUI SI TI ON	0		0	0		109.00
110.00 11000 INTESTINAL ACQUISITION 111.00 11100 ISLET ACQUISITION	0	0	0	0		110.00
113. 00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 647, 189	239, 590	598, 346	545, 685	675, 618	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	12, 359	0	4, 775	0	0	190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES	257, 096		99, 335	0		192.00
192. 01 19201 JOHNSON/NI CHOLS WI C	0	0	0	0	9, 395	192.01
193. 00 19300 NONPAI D_WORKERS 193. 01 19301 DME	0		0	0		193.00 193.01
193. 02 1930 DME 193. 02 19302 LACTATI ON CONSULTI NG	0	0	0	0		193.01
193. 03 19303 DI ABETI C COUNSELI NG	0	0	0	0	0	193.03
194.00 07950 VACANT SPACE	17.055	0	0	0		194.00
194. 01 07951 BOARD OF HEALTH 194. 02 07952 PUTNAM/HENRY PRENATAL	17, 955		6, 937 0	0		194.01 194.02
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	1, 934, 599	251, 391	709, 393	545, 685	780, 106	202.00

LOST ALLOCATION - CENERAL SERVICE COSTS Provider CDL Te-T33 Period Tomoler CDL Te-T33 Period Tomoler CDL TE-T33	Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL			In Lie	u of Form CMS-2	2552-10
In Distribution Methods & service Use of the service			Provider CC	CN: 15-1333		od:	Worksheet B	
Cost Center Description NUEL NO. Addit ISTRUT SCRIAL LCOSTS & SCRIAL UTILIZION SCRIAL UTILIZION Scriation 100 000000 COST CHITES 13.00 16.00 17.00 17.00 24.00 100 000000 COST CHITES 10.00 17.00 17.00 24.00 100 000000 COST CHITES 10.00 1							Date/Time Pre	pared:
N LIBRARY 17.00 17.00 24.00 1.00 DOTOR/RY CAR PERI COTS -RUPE A FLYT 1.00 1.00 1.00 1.00 0.00 DOTOR (APP CAR EVENT INT A SPLATURE) 1.00 1.00 1.00 1.00 0.00 DOTOR (APP CAR EVENT INT A SPLATURE) 1.00 1.00 1.00 0.00 DOTOR (APP CAR EVENT INT A SPLATURE) 1.00 1.00 1.00 0.00 DOTOR (APP CAR EVENT INT A SPLATURE) 0 1.00 1.00 1.00 DOTOR (APP CAR EVENT INT A SPLATURE) 0 1.03,9,488 0 1.00 1.00 DOTOR (APP CAR EVENT INT A SPLATURE) 0 1.03,9,488 0 1.00 1.00 1.00 DOTOR (APP CAR EVENT INT A SPLATURE) 0 1.03,9,488 0 1.00 1.00 10.00	Cost Center Description				UT			
CEREBAL SERVICE COST CONT CARTERS 1 00 000000000000000000000000000000000000				SERVI CE		REVIEW		
1.00 00000 (NER CAP REC 2015-BLIG & FLYT 4.00 0.00000 (ADM IN STRUCT OR SPARTHERT 5.00 5.00 0.00000 (ADM IN STRUCT OR SPARTHERT 5.00 0.00000 (ADM IN STRUCT OR SPARTHERT 5.00 0.000000 (ADM IN STRUCT OR SPARTHERT 6.00 0.000000 (ADM IN STRUCT OR SPARTHERT 6.00 0.000000 (ADM IN STRUCT OR SPARTHERT 0 1.10.00 0.00000 (ADM IN STRUCT OR SPARTHERT 0 1.10.00 0.00000 (ADM IN STRUCT OR SPARTHERT 0 1.00 1.10.00 0.00000 (ADM IN STRUCT AND IN STRUCT OR SPARTHERT 0 0 1.00 1.10.00 0.0000 (ADM IN STRUCT AND IN STRUCT OR SPARTHERT 0 0 1.00 1.00 1.10.00 0.0000 (ADM IN STRUCT AND IN STRUCT OR SPARTHERT 0 0 1.0				17.00		17.01	24.00	
5.00 00000 AVMIN ISTRUTUPE & EPRETAIL 5.00 000000 LURREY & LIVEN SERVICE 5.00 7.00 0.00 000000 LURREY & LIVEN SERVICE 0 0 0 0.00 0.00 0 11.00 1.009.418 11.00 1.009.418 11.00 1.009.418 11.00 1.009.418 11.00 1.009.418 11.00 1.009.418 11.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1.00</td>								1.00
1. 00 DUZDO DECATI DO GF FLANT								
0.00 00000 MUGENEEPING 9.00 11.00 00100 CAFETERA MUNISTRATION 17.03 11.00<								
10.00 01000 DETARY 10.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
13.100 01300 UNEXT NOT NOT STRATTON 192, 631 1, 039, 118 13, 00 14, 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
16.00 01600 HECCORES & LIBRARY 0 1, 039, 118 16.00 115, 809 117, 00 17, 00		102 (21						
17. 00 01700 03700 03700 17. 00 0 17. 00 17. 00 10.001116 PERATICAT ROUTES PERATICAT PERATICAT ROUTES PERATICAT PE			1, 039, 418					
IDADIT INT. ROUTE SERVICE COST CENTERS IDADIT SA PIDIA INICS 66, 450 IDADIT SA PIDIA INICS 100 01.00 03100 INTERS IVE CARE INIT 42, 142 0 12, 620 1, 66, 323 31, 00 11.00 01100 INTERS IVE CARE INIT 42, 142 0 0 12, 620 1, 66, 323 31, 00 11.00 01100 INTERS IVE CARE INIT 42, 142 0	17.00 01700 SOCIAL SERVICE	-	-			115 000		
11.00 03100 NTERSINE CARE UNIT 42,142 0 0 12,620 1,498,323 31.00 41.00 04200 SUBPROVIDER 0 0 0 0 42.00 31.00 04200 SUBPROVIDER 0 0 0 42.00 31.00 04200 UNSERY 0 0 0 0 42.00 31.00 04200 UNSERY 0 0 0 0 42.00 31.00 04200 UNSERY 0 0 0 0 3.240,515 50.00 51.00 05200 DFLIVERY PROM & LABOR ROW 0 0 0 0 2.02,2116 54.00 52.00 05400 RADIELDRY-DIAGNOSTIC 0 0 0 0 2.02,2116 54.00 53.00 05700 CT SCAN 0.00 0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>115, 809</td> <td></td> <td>17.01</td>		0	0		0	115, 809		17.01
11 00 04100 SUBPROV DER 1 RF 0								•
12.00 04200 SUBPREVIDER 0					-			
NCL LARY SERVICE COST CENTRES 0 0 0.00 000000 (PERATINE RODM 0 240,515 50.00 51.00 05100 RECOVERY RODM 0 0 0 244,515 50.00 52.00 05300 RECOVERY RODM 0 0 0 0 324,0515 50.00 53.00 05300 AMESTIFESI 0LOCY 0 0 0 0 344,403 53.00 54.01 05400 AMESTIFESI 0LOCY 0 0 0 0 228,118 54.00 55.00 05000 AMESTIFER SANDECI IMAGI NE (MRI Y) 0 0 0 228,793 51.01 55.00 05000 CARDIAC CATHETERI ATION 0 0 0 28,6457 60.00 56.00 05000 PINS CLA, THERAPY 0 0 0 28,6457 60.00 66.00 06000 PINS CLA, THERAPY 0 0 0 24,6457 60.00 66.00 06000 PINS CLA, THERAPY 0 0 0 23,846 66.00 70.00	42. 00 04200 SUBPROVI DER	1	-			-		
60.00 65000 (OPERATING ROOM 0 269, 067 0 0 3, 240, 515 50.00 51.00 05300 (PELUYERY ROM & LABOR ROM 0 0 0 0 274, 584 51.00 52.00 05300 (PELUYERY ROM & LABOR ROM 0 0 0 0 274, 584 51.00 53.00 05300 (PELOR V-DI AGMISTI C 0 0 0 0 2, 022, 118 54.00 54.00 06300 (RADI OLGAV-DI AGMISTI C 0 0 0 0 2, 022, 118 54.00 57.00 05700 (CT SCMI 0.00 0		0	0		0	0	0	43.00
52 00 00 00 0 0 00 <td>50.00 05000 OPERATING ROOM</td> <td>1</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	50.00 05000 OPERATING ROOM	1						
53. 00 05300 AMESTRESIDLOGY 0 0 0 344.403 53.00 54. 00 ORGAN PADIOLOGY-DLAGNOSTIC 0 0 0 2,022,118 54.00 54.00 0 0 0 2,022,118 54.00 0 0 0 2,022,118 54.00 0 0 0 0 2,022,118 54.00 0		-	-					
54. 01 OS401 WICLEAR MEDI CINE-OI AGNOSTIC 0 0 0 200, 992 54. 01 57.00 OS500 VACARTIC RESONANCE I MAGING (MRI) 0 0 0 0 0 65.80 0	53.00 05300 ANESTHESI OLOGY	0	0		Ŭ			53.00
57. 00 0 55700 (T SCAN 0 0 652. 849 57. 00 58.00 05500 (ARDAC C ATHETERIZATI ON 0 0 0 0 58.00 58.00 05500 (ARDAC C ATHETERIZATI ON 0 0 0 0 58.00 0 <td< td=""><td></td><td>0</td><td>0</td><td></td><td>-</td><td></td><td></td><td>•</td></td<>		0	0		-			•
55:00 0 0 0 0 0 0 0 <th< td=""><td>57. 00 05700 CT SCAN</td><td>0</td><td>0</td><td></td><td>Ŭ</td><td>0</td><td>652, 849</td><td>57.00</td></th<>	57. 00 05700 CT SCAN	0	0		Ŭ	0	652, 849	57.00
60.00 00000 00000 00000 000000 000000000000000000000000000000000000		0	0		Ŭ	-		
44.00 [Action] Introductions THERAPY 0 0 0 64.00 65.00 [Action] [Action] 0 0 0 68.00 65.00 66.00 [Action] [Action] 0 0 0 88.2 66.00 67.00 [Action] [Action] 0 0 0 88.2 67.00 67.00 [Action] [Action] 0 0 0 38.49 68.00 67.00 [Action] [Action] 0 0 0 38.49 69.01 67.00 [Action] [Action] [Action] 0 0 0 72.00 0 0 0 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 73.00 0 1.756.50 88.01 1.756.50 88.01 1.756.50 88.01 1.766.50 88.01 1.766.50 88.01 1.99.02 0 0 1.99.02 0 0 1.99.02 0 0 1.99.02 0 0 0	60. 00 06000 LABORATORY	0	0		0			
65.00 0c500 PESPI PATORY THERAPY 0 0 0 66.149 65.00 66.00 0c600 PPSI CAL THERAPY 0 0 0 120.004 67.00 0 120.004 67.00 0 120.004 67.00 0 120.004 67.00 0 120.004 67.00 0 0 120.004 67.00 0 0 120.004 67.00 0 0 0 120.004 67.00 0 0 120.004 68.00 68.00 68.00 0 0 120.004 68.00 0 0 0 120.001 0 120.001 0 120.001 0 0 0 0 0 0 0 0 0 0 0 17.00 0 17.00 0 17.00 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>Ŭ</td> <td>0</td> <td></td> <td></td>		0	0		Ŭ	0		
67.00 06700 0CUPATIONAL THERRAPY 0 0 0 120,004 67.00 66.00 066000 SPECE HATHOLOGY 0 0 0 438.36 68.00 67.00 071.00 DICANDAC REHAB 0 0 0 438.36 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 72.00 07300 DRUSS CHARGED TO PATIENTS 0 0 0 1, 734.027 73.00 73.01 07301 DRUSS CHARGED TO PATIENTS 0 0 0 1, 734.027 73.00 73.01 07301 DRUSS CHARGED TO PATIENTS 0 0 0 1, 736.55 88.00 88.00 08800 RURAL HEALTH CLINIC II 0 0 0 0 1, 736.55 88.00 89.00 08000 FEDERALLY DUALIFIED HEALTH CENTER 0 0 0 0 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00	65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	668, 149	65.00
68.00 OBSOND SPECH PATHOLOGY 0 0 0 43,849 68.00 69.00 GOOD CELCTROCARDIOLOGY 0 0 0 438,396 69.00 71.00 OTIOD MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 72.00 OT2001 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 73.00 73.00 73.00 73.01<		0	0		-	0		
69.01 CARDIAC REHAB 0 0 0 438, 396 69.01 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 71.00 72.00	68.00 06800 SPEECH PATHOLOGY	0	0		0	0		
17.1 00 00 00 0 0 0 0 71.00 72.00 7200 172.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 72.00 73.00		0	0		0	0		
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 1, 734, 027 73. 00 73. 01 07301 DRUGS CHARGED TO PATIENTS 0 26, 932 0 0 4, 757, 74 73. 01 00 017301 DRUGOLOGY 0 0 0 0 2, 180, 515 88. 00 88. 00 08800 RURAL HEALTH CLINIC II 0 0 0 0 1, 766, 555 88. 01 88. 00 08900 CRIAL HEALTH CLINIC III 0		0	0		0	0		
73. 01 07301 0VICOLOCY 0 26, 932 0 0 4, 075, 774 73. 01 00TPATIENT SERVICE COST CENTERS 0 0 0 2, 180, 515 88. 00 88. 00 08800 RURAL HEALTH CLINIC II 0 0 0 1, 766, 505 88. 01 89. 00 08800 RURAL HEALTH CLINIC III 0 0 0 1, 766, 505 88. 02 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 1, 00, 996 90, 00 90. 00 09000 CLINIC 0 0 0 0 10, 996 90, 00 91, 00 91, 00 91, 00 92, 00 0 90, 00 92, 00 9910 [CORF 0 0 0 0 0 91, 00 92, 00 9910 [CORF 0		0	0		0	0	-	
88. 00 06800 RURAL HEALTH CLINIC 0 0 0 2,180,515 88.01 88. 01 08801 RURAL HEALTH CLINIC 0 0 0 1,766,505 88.01 89. 00 08900 FEDERALLY QUALIFIED HEALTH 0 0 0 1,766,505 88.01 89. 00 08900 FEDERALLY QUALIFIED HEALTH 0 0 0 0 1,766,505 88.01 90. 00 09000 CLINIC 0 0 0 0 0 90.00 90.00 90.00 OSO00 CLINIC 0 0 0 0 3,901,425 91.00 92.00 OSO00 DESERVATION 0 <td< td=""><td>73.01 07301 ONCOLOGY</td><td>-</td><td>26, 932</td><td></td><td>-</td><td></td><td></td><td></td></td<>	73.01 07301 ONCOLOGY	-	26, 932		-			
88.01 08801 RURAL HEALTH CLINIC II 0 0 0 1,766,505 88.01 88.02 08002 RURAL HEALTH CLINIC III 0 0 0 1,766,505 88.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.02 90.00 09000 CLINIC 0 0 0 0 1,766,505 88.01 91.00 09000 CLINIC 0 0 0 0 0 10,996 90.00 92.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 91.00 92.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 99.10 0910 CORF 0			0		0	0	2 190 515	00 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 </td <td></td> <td>-</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>1, 766, 505</td> <td>88.01</td>		-	0		0	0	1, 766, 505	88.01
90.00 09000 CLINIC 0 0 0 10,996 90.00 91.00 09100 EMERGENCY 85,039 223,689 0 0 3,901,425 91.00 92.00 085ERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 92.00 09100 CORF 0 0 0 0 0 0 92.00 09101 CORF 0 0 0 0 0 0 92.00 09101 CORF 0 0 0 0 0 0 99.10 99.10 OP9101 INTERSTINAL ACQUISITION 0 0 0 0 0 110.00 111.00 112.01 114.00 114.00 1		0	0		0	0		
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 92.00 0THER REI MBURSABLE COST CENTERS 0 10 0 10 0 10 0 0 0 0 0 110.00 111.00 <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0		0	0		
OTHER REI MBURSABLE COST CENTERS 99. 10 O9910 CORF 0 110.00 110.00 110.00 110.00 110.00 110.00 111.00 <td></td> <td>85, 039</td> <td>223, 689</td> <td></td> <td>0</td> <td>0</td> <td>3, 901, 425</td> <td></td>		85, 039	223, 689		0	0	3, 901, 425	
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUI SI TI ON 0	OTHER REIMBURSABLE COST CENTERS		I					92.00
109.00 10900 PANCREAS ACQUI SI TI ON 0 110.00 111.00		0	0		0	0	0	99.10
111.00 1SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 113.00 114.00 114.00 UTI LIZATION REVIEW-SNF 110.00 113.00 114.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 192,631 1,039,418 0 115,809 31,432,503 18.00 190.00 IPODO GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 32,378 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 164,869 192.01 192.01 19200 JOHNSON/NI CHOLS WI C 0 0 0 0 141.93.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 141.93.00 193.01 JME 0 0 0 0 0 0 14193.00 193.02 19302 LACTATI ON CONSULTING 0 0 0 0 193.01 193.03 19303 DI ABETI C COUNSELING 0		0	0		0	0	0	109.00
113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 114.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 192,631 1,039,418 0 115,809 31,432,503 118.00 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 31,432,503 118.00 190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 32,378 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 5,741,004 192.00 192.01 JOHNSON/NI CHOLS WI C 0 0 0 0 144 193.00 193.02 19300 NONREL MBURSAERS 0 0 0 0 193.01 193.02 19303 DME 0 0 0 0 0 193.02 193.03 19303 DI ABETI C COUNSELI NG 0 0 0 0 193.03 194.00 07951 BOARD OF HEALTH 0 0 0 0		0	0		-	0		
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 192,631 1,039,418 0 115,809 31,432,503 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 32,378 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 5,741,004 192.00 192.01 JOHNSON/NI CHOLS WI C 0 0 0 0 164,869 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 14 193.00 193.01 19301 DME 0 0 0 193.01 193.02 LACTATI ON CONSULTI NG 0 0 0 0 193.02 193.03 DI ABETI C COUNSELI NG 0 0 0 0 193.03 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 0 0 <t< td=""><td></td><td>0</td><td>0</td><td></td><td>0</td><td>0</td><td>0</td><td></td></t<>		0	0		0	0	0	
NONREI MBURSABLE COST CENTERS 190.00 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 32,378 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 5,741,004 192.00 192.01 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 5,741,004 192.00 192.01 JOHNSON/NI CHOLS WIC 0 0 0 164,869 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 14 193.00 193.01 19301 DME 0 0 0 0 193.01 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 193.02 193.03 19303 DI ABETI C COUNSELI NG 0 0 0 193.03 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 0 0 0 0 194.01 <td>114.00 11400 UTI LI ZATI ON REVI EW-SNF</td> <td>100 (01</td> <td>1 000 110</td> <td></td> <td></td> <td>115 000</td> <td>21 422 502</td> <td>114.00</td>	114.00 11400 UTI LI ZATI ON REVI EW-SNF	100 (01	1 000 110			115 000	21 422 502	114.00
190.00 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 32,378 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 5,741,004 192.00 192.01 19201 JOHNSON/NI CHOLS WIC 0 0 0 164,869 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 0 14193.00 193.01 JOME 0 0 0 0 0 0 193.01 193.02 LACTATI ON CONSULTI NG 0 0 0 0 0 193.02 193.03 IABETI C COUNSELI NG 0 0 0 0 0 193.03 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 0 0 0 0 194.01 194.02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 200.		192, 631	1, 039, 418		0	115, 809	31, 432, 503	118.00
192.01 JOHNSON/NI CHOLS WI C 0 0 0 164,869 192.01 193.00 19300 NONPAI D WORKERS 0 0 0 14 193.00 193.01 19301 DME 0 0 0 0 193.01 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 193.02 193.03 19303 DI ABETI C COUNSELI NG 0 0 0 193.03 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07950 VACANT SPACE 0 0 0 0 194.01 194.02 07952 PUTNAM/HENRY PRENATAL 0 0 0 194.02 200.00 Cross Foot Adj ustments 0 0 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 0 0 0 0 0 0 201.00	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		-	0		
193.00 19300 NONPAID WORKERS 0 0 0 14 193.00 193.01 19301 DME 0 0 0 0 193.01 193.02 19302 LACTATI ON CONSULTI NG 0 0 0 0 193.02 193.03 DI ABETI C COUNSELI NG 0 0 0 0 193.03 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 0 0 0 47,039 194.01 194.02 07952 PUTNAM/HENRY PRENATAL 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negati ve Cost Centers 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td>0</td> <td></td> <td></td>		0	0		-	0		
193.02 19302 LACTATION CONSULTING 0 0 0 193.02 193.03 19303 DI ABETI C COUNSELING 0 0 0 0 193.03 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 0 0 0 0 47,039 194.01 194.02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00	193. 00 19300 NONPAI D WORKERS	0	0		0	0	14	193.00
193.03 19303 DI ABETI C COUNSELING 0 0 0 193.03 194.00 07950 VACANT SPACE 0 0 0 0 194.00 194.01 07951 BOARD OF HEALTH 0 0 0 47,039 194.01 194.02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0		0	0		0	0		•
194.01 07951 BOARD OF HEALTH 0 0 0 47,039 194.01 194.02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0	193. 03 19303 DI ABETI C COUNSELI NG	0	Ö		0	0	0	193.03
194.02 07952 PUTNAM/HENRY PRENATAL 0 0 0 194.02 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00		0	0		0	0		
201.00 Negative Cost Centers 0 </td <td>194.0207952 PUTNAM/HENRY PRENATAL</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>194.02</td>	194.0207952 PUTNAM/HENRY PRENATAL	0	0		0	0	0	194.02
		0	0		0	0		
		192, 631	1, 039, 418		-	115, 809		

<u>Health Fi</u>	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In L	ieu of Form CMS-2	2552-10
COST ALLO	OCATION - GENERAL SERVICE COSTS		Provider CCI	N: 15-1333	Period: From 01/01/20		
					To 12/31/20	17 Date/Time Pre 5/29/2018 10:	epared: 27 am
	Cost Center Description	Intern & Residents	Total				
		Cost & Post					
		Stepdown					
		Adjustments 25.00	26.00				
GE	NERAL SERVICE COST CENTERS	20.00	20.00				
	100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL						4.00 5.00
	700 OPERATION OF PLANT						7.00
	800 LAUNDRY & LINEN SERVICE						8.00
	900 HOUSEKEEPI NG 000 DI ETARY						9.00 10.00
	100 CAFETERI A						11.00
	300 NURSI NG ADMI NI STRATI ON						13.00
	600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE						16.00 17.00
	700 SOCIAL SERVICE 701 UTILIZATION REVIEW						17.00
	PATIENT ROUTINE SERVICE COST CENTERS						
	000 ADULTS & PEDIATRICS 100 INTENSIVE CARE UNIT	0	3, 279, 479 1, 498, 323				30.00 31.00
	100 SUBPROVI DER – I RF	0	1, 490, 323				41.00
	200 SUBPROVI DER	0	0				42.00
	300 NURSERY CI LLARY SERVI CE COST CENTERS	0	0				43.00
	000 OPERATING ROOM	0	3, 240, 515				50.00
	100 RECOVERY ROOM	0	274, 584				51.00
	200 DELI VERY ROOM & LABOR ROOM 300 ANESTHESI OLOGY	0	0				52.00 53.00
	400 RADI OLOGY-DI AGNOSTI C	0	344, 403 2, 022, 118				54.00
54.01 05	401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	208, 993				54.01
	700 CT SCAN	0	652, 849				57.00
	800 MAGNETI C RESONANCE I MAGI NG (MRI) 900 CARDI AC CATHETERI ZATI ON	0	0				58.00 59.00
	000 LABORATORY	0	2, 826, 457				60.00
	001 BLOOD LABORATORY	0	0				60.01
	400 I NTRAVENOUS THERAPY 500 RESPI RATORY THERAPY	0	668, 149				64.00 65.00
	600 PHYSI CAL THERAPY	0	882, 587				66.00
	700 OCCUPATI ONAL THERAPY	0	120, 004				67.00
	800 SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY	0	43, 849 231, 764				68.00 69.00
69.01 06	901 CARDI AC REHAB	0	438, 396				69.01
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	200 IMPL. DEV. CHARGED TO PATIENT 300 DRUGS CHARGED TO PATIENTS	0	1, 734, 027				72.00 73.00
	301 ONCOLOGY	0	4, 075, 774				73.01
	TPATIENT SERVICE COST CENTERS		0.400 545				
	800 RURAL HEALTH CLINIC 801 RURAL HEALTH CLINIC II	0	2, 180, 515 1, 766, 505				88.00 88.01
88.02 08	802 RURAL HEALTH CLINIC III	0	1, 030, 791				88.02
	900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89.00
	000 CLINIC 100 EMERGENCY	0	10, 996 3, 901, 425				90.00 91.00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART)	0					92.00
	HER REIMBURSABLE COST CENTERS		0				00.10
99.10 09 SP	ECIAL PURPOSE COST CENTERS	0	0				99.10
109.0010	900 PANCREAS ACQUI SI TI ON	0	0				109.00
	000 INTESTINAL ACQUISITION	0	0				110.00
	100 I SLET ACQUI SI TI ON 300 I NTEREST EXPENSE	0	0				111.00 113.00
	400 UTILIZATION REVIEW-SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	31, 432, 503				118.00
	NREI MBURSABLE COST CENTERS 000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32, 378				190.00
	200 PHYSI CI ANS' PRI VATE OFFI CES	0	5, 741, 004				192.00
	201 JOHNSON/NI CHOLS WI C	0	164, 869				192.01
193.0019 193.0119	300 NONPALD WORKERS 301 DMF	0	14				193. 00 193. 01
	302 LACTATION CONSULTING	0	0				193.02
	303 DI ABETI C COUNSELI NG	0	O				193.03
	950 VACANT SPACE 951 BOARD OF HEALTH	0	0 47, 039				194. 00 194. 01
194.0207	952 PUTNAM/HENRY PRENATAL	0	47,037				194.02
200.00	Cross Foot Adjustments	0	0				200.00

Heal th Financia	al Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION	N - GENERAL SERVICE COSTS		Provider C	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part I Date/Time Prep 5/29/2018 10:2	ared: 7 am	
Co	st Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total					
		25.00	26.00					
201.00 Neg	gative Cost Centers	0	0			2	201.00	
202.00 TO	TAL (sum lines 118 through 201)	0	37, 417, 807			2	202.00	

	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-1333 P F	eriod: rom 01/01/2017	Worksheet B Part II	
				Т	o 12/31/2017	Date/Time Pre 5/29/2018 10:	pared: 26 am
			CAPI TAL RELATED COSTS				
	Cost Center Description	Di rectl y	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V	
		Assigned New	FI XT		BENEFI TS	E & GENERAL	
		Capital Related Costs			DEPARTMENT		
	GENERAL SERVICE COST CENTERS	0	1.00	2A	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 149	4, 149			4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	383, 601 277, 810	383, 601 277, 810		384, 162 19, 862	
8.00	00800 LAUNDRY & LINEN SERVICE	0	18, 333			2, 401	
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	17, 139 93, 480			7, 100 4, 320	
11.00	01100 CAFETERI A	0	43, 499				
13.00	01300 NURSI NG ADMI NI STRATI ON	0	18, 034			1, 659	
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE		107, 176 0	107, 176	83	8, 809 0	16.00 17.00
	01701 UTI LI ZATI ON REVI EW	0	9, 031	9, 031		-	1
30 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	160, 763	160, 763	240	18, 023	30.00
	03100 I NTENSI VE CARE UNI T	0	77, 046				
	04100 SUBPROVI DER - I RF	0	0	0	-	0	
	04200 SUBPROVI DER 04300 NURSERY		0			0	
	ANCILLARY SERVICE COST CENTERS	-					
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	232, 440 62, 239				
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	02,207	02,20,		0	1
	05300 ANESTHESI OLOGY	0	0	0			
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	82, 199 3, 797	82, 199 3, 797			
57.00	05700 CT SCAN	0	35, 798	35, 798	38	6, 080	57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0		-	0	58.00 59.00
60.00	06000 LABORATORY	0	68, 070	68, 070	-		
60.01	06001 BLOOD LABORATORY	0	0	0		0	60.01
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	18, 984	C 18, 984	-	-	
66.00	06600 PHYSI CAL THERAPY	0	87, 189	87, 189	0	7, 804	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		-	1, 232 450	
69.00	06900 ELECTROCARDI OLOGY	0	2, 712	-	-	2, 278	
69.01	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	22, 048	22,048		4,035	1
		0	0		-		1
73.00	07300 DRUGS CHARGED TO PATIENTS	0				17, 312	73.00
73.01	07301 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	0	131, 719	131, 719	65	39, 445	73.01
	08800 RURAL HEALTH CLINIC	0	144, 275				
	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	0	67, 663 34, 333				
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	0		1
	09000 CLINIC	0	4, 393	4, 393			
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	157, 455	157, 455 0		33, 024	91.00 92.00
	OTHER REIMBURSABLE COST CENTERS	-					
99.10	09910 CORF SPECIAL PURPOSE COST CENTERS	0	0	C	0	0	99.10
109.00	10900 PANCREAS ACQUISITION	0	0	C	0	0	109.00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	11100 I SLET ACQUI SI TI ON 11300 I NTEREST EXPENSE	0	0		0	0	111.00 113.00
114.00	11400 UTILIZATION REVIEW-SNF						114.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	2, 389, 674	2, 389, 674	3, 484	327, 985	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 936	12, 936	0	156	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	269, 105				192.00
	19201 JOHNSON/NI CHOLS WI C 19300 NONPAI D WORKERS				18 0		192.01 193.00
193.01	19301 DME	0	0	0	0	0	193.01
	2 19302 LACTATI ON CONSULTI NG 3 19303 DI ABETI C COUNSELI NG	0	0		0		193. 02 193. 03
194.00	07950 VACANT SPACE	0	0		0	0	194.00
	07951 BOARD OF HEALTH	0	18, 794				194.01
194.02	207952 PUTNAM/HENRY PRENATAL	0	0	0	0	0	194.02

Health Fin	ancial Systems	PUTNAM COUNT	TY HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION	N OF CAPITAL RELATED COSTS	_	Provider C		Period: From 01/01/2017 To 12/31/2017		pared: 26 am	
			CAPI TAL RELATED COSTS					
	Cost Center Description	Di rectl y	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI V		
		Assigned New	FLXT		BENEFI TS	E & GENERAL		
		Capi tal			DEPARTMENT			
		Related Costs						
		0	1.00	2A	4.00	5.00		
200.00	Cross Foot Adjustments				0		200.00	
201.00	Negative Cost Centers		0		0 0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	C	2, 690, 509	2, 690, 50	9 4, 149	384, 162	202.00	

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu	ı of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		eriod: com 01/01/2017	Worksheet B Part II	
			То		Date/Time Pre 5/29/2018 10:	pared: 26 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00 4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	297, 742					7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	2, 696		26, 978			8.00 9.00
10. 00 01000 DI ETARY	13, 745	97	1, 312	112, 978		10.00
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	6, 396 2, 652		611 253	0	57, 979 530	
16.00 01600 MEDICAL RECORDS & LIBRARY	15, 759		1, 505	0	2, 933	•
17. 00 01700 SOCIAL SERVICE	0		0	0	0	
17. 01 01701 UTI LI ZATI ON REVI EW I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 328	0	127	0	0	17.01
30. 00 03000 ADULTS & PEDI ATRI CS	23, 638			100, 667	6, 079	30.00
31. 00 03100 I NTENSI VE CARE UNI T 41. 00 04100 SUBPROVI DER – I RF	11, 329		1, 082 0	12, 311 0	3, 914 0	31.00 41.00
42. 00 04200 SUBPROVI DER	0		0	0	0	42.00
43.00 04300 NURSERY	0	0	0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	34, 177	3, 322	3, 263	0	3, 667	50.00
51.00 05100 RECOVERY ROOM	9, 151	365	874	0	290	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	0	0	0	0	0 613	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 086		-	0	5, 734	
54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	558		53	0	0	54.01
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 264		503 0	0	981 0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	-	0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	10,009	0	956 0	0	5, 614	60.00
60. 01 06001 BLOOD LABORATORY 64. 00 06400 I NTRAVENOUS THERAPY	0	0	0	0	0	60.01 64.00
65. 00 06500 RESPI RATORY THERAPY	2, 791	0	266	0	1, 908	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	12, 820		1, 224 0	0	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	399	0	38	0	465	
69. 01 06901 CARDI AC REHAB 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	3, 242		310 0	0	1, 199 0	69.01 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 01 07301 0NC0L0GY	3, 573 19, 368		341 1, 849	0	1, 160 1, 801	
OUTPATIENT SERVICE COST CENTERS		•		0	1,001	/5.01
88.00 08800 RURAL HEALTH CLINIC	21, 214			0	5, 427	
88.01 08801 RURAL HEALTH CLINIC II 88.02 08802 RURAL HEALTH CLINIC III	9, 949 5, 048		0 482	0	0	88.01 88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY	646 23, 152		62	0	0 7, 899	90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	23, 132	5,700	2, 210	0	7,077	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10 09910 CORF SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	99.10
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	0	0	0	0	0	111.00 113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	253, 510	22, 334	22, 757	112, 978	50, 214	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 902	0	182	0	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	39, 567	1, 100	3, 775	0		192.00
192. 01 19201 JOHNSON/NI CHOLS WI C 193. 00 19300 NONPAI D WORKERS	0		0	0		192.01 193.00
193. 01 19301 DME	0	0	Ő	0	0	193.01
193. 02 19302 LACTATI ON CONSULTI NG 193. 03 19303 DI ABETI C COUNSELI NG	0	0	0	0		193. 02 193. 03
193. 03 19303 DI ABETTO COUNSELING 194. 00 07950 VACANT SPACE	0	0	0	0		193.03 194.00
194.0107951BOARD OF HEALTH	2, 763	0	264	0		194.01
194.02 07952 PUTNAM/HENRY PRENATAL 200.00 Cross Foot Adjustments	0	0	0	0	0	194.02 200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00 TOTAL (sum lines 118 through 201)	297, 742	23, 434	26, 978	112, 978	57, 979	202.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL			In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1333	Perio		Worksheet B Part II	
					12/31/2017	Date/Time Pre 5/29/2018 10:	pared:
Cost Center Description	NURSI NG	MEDI CAL	SOCI AL		LI ZATI ON	Subtotal	
	ADMI NI STRATI O N	RECORDS & LI BRARY	SERVI CE		REVIEW		
	13.00	16.00	17.00		17.01	24.00	
GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT							1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL 7. 00 00700 OPERATI ON OF PLANT							5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE							8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY							9.00 10.00
11. 00 01100 CAFETERI A							11.00
13.00 01300 NURSING ADMINISTRATION	23, 145 0	124 245					13.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	136, 265 0		0			16.00 17.00
17.01 01701 UTI LI ZATI ON REVI EW	0	0		0	11, 566		17.01
30. 00 03000 ADULTS & PEDI ATRI CS	7, 864	68, 135		0	10, 306	403, 070	30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 063	0		0	1, 260	128, 295	31.00
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	0	0		0 0	0	0	41.00 42.00
43. 00 04300 NURSERY	0	0		0	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0	35, 274		0	o	338, 760	50.00
51.00 05100 RECOVERY ROOM	0	0		0	0	74, 826	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0		0	0	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	4, 204 121, 787	53.00
54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C	0	0		0	0	6, 502	54.01
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	48, 664 0	57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0	0		0	0	112, 115 0	60.00 60.01
64.00 06400 I NTRAVENOUS THERAPY	0	0		0	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	30, 363 109, 684	
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	1, 232	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	450	
69. 00 06900 ELECTROCARDI OLOGY 69. 01 06901 CARDI AC REHAB	0	0		0 0	0 0	5, 909 30, 891	69.00 69.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0 46, 726	72.00 73.00
73. 01 07301 ONCOLOGY	0	3, 531		0	0	198, 531	
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC	0	0		0	0	193, 322	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0	0	95, 298	88. 01
88.02 08802 RURAL HEALTH CLINIC III 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	50, 104 0	88.02 89.00
90. 00 09000 CLINIC	0	0		0	0	5, 154	
91.00 09100 EMERGENCY	10, 218	29, 325		0	0	269, 627	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS							92.00
99. 10 09910 CORF	0	0		0	0	0	99.10
SPECI AL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUI SI TI ON	0	0		0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0		0	0	0	110.00
111. 00 11100 I SLET ACQUI SI TI ON 113. 00 11300 I NTEREST EXPENSE	0	0		0	0	0	111.00 113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF							114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	23, 145	136, 265		0	11, 566	2, 275, 514	118.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	15, 176	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	0	375, 459	
192. 01 19201 JOHNSON/NI CHOLS WI C 193. 00 19300 NONPAI D WORKERS	0	0		0	0		192.01 193.00
193. 01 19301 DME	0	0		0	0	0	193.01
193. 02 19302 LACTATI ON CONSULTI NG 193. 03 19303 DI ABETI C COUNSELI NG		0		0 0	0		193. 02 193. 03
194. 00 07950 VACANT SPACE	0	Ö		0	0	0	194.00
194.0107951BOARD OF HEALTH 194.0207952PUTNAM/HENRY PRENATAL	0	0		0	0		194. 01 194. 02
200.00 Cross Foot Adjustments		0		-	0	0	200.00
201.00Negative Cost Centers202.00TOTAL (sum lines 118 through 201)	0 23, 145	0 136, 265		0	0 11, 566	0 2, 690, 509	201.00
202.00 TOTAL (SUM TIMES TTO LIMOUGH 201)	23, 143	130, 203		U U	11, 300	2, 070, 309	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	PUTNAM COUNTY	(HOSPITAL Provider CCN: 15-		of Form CMS-2552-10 Worksheet B
			To 12/31/2017 [Part II Date/Time Prepared:
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total	E	5/29/2018 10:26 am
GENERAL SERVICE COST CENTERS	25.00	26.00		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRATION 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE 17.01 01701 UTILIZATION REVIEW INPATI ENT ROUTINE SERVICE COST CENTERS				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 31. 00 03100 INTENSIVE CARE UNIT	0	403,070		30. 00 31. 00
41.00 04100 SUBPROVI DER I RF 42.00 04200 SUBPROVI DER 04200 SUBPROVI DER 43.00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	000000000000000000000000000000000000000	128, 295 0 0 0		41. 00 42. 00 43. 00
50. 00 05000 OPERATI NG ROOM	0	338, 760		50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		74, 826 0 4, 204 121, 787		51.00 52.00 53.00 54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	6, 502		54.01
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	48, 664 0		57.00 58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0		59.00 60.00
60. 01 06001 BLOOD LABORATORY	0	112, 115 0		60.01
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0	0 30, 363		64.00 65.00
66. 00 06600 PHYSI CAL THERAPY	0	109, 684		66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	1, 232 450		67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	5, 909		69.00
69.01 06901 CARDIAC REHAB 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	30, 891 0		69. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 ONCOLOGY	0	46, 726 198, 531		73.00 73.01
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC		193, 322		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	95, 298		88.01
88.02 08802 RURAL HEALTH CLINIC III 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	50, 104 0		88. 02 89. 00
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0	5, 154		90.00 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	269, 627		91.00
OTHER REIMBURSABLE COST CENTERS 99. 10 09910 CORF	0	0		99.10
SPECIAL PURPOSE COST CENTERS				
109. 00 10900 PANCREAS ACQUI SI TI ON 110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0		109.00 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		111.00
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF				113.00 114.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS) 0	2, 275, 514		118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15, 176		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 01 19201 JOHNSON/NI CHOLS WI C	0	375, 459 2, 312		192.00 192.01
193. 00 19300 NONPAI D WORKERS	0	0		193.00
193. 01 19301 DME 193. 02 19302 LACTATI ON CONSULTI NG	0	0		193. 01 193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	o		193. 03 194. 00
194.00 07950 VACANT_SPACE 194.01 07951 BOARD_OF_HEALTH	0	22, 048		194.01
194.02 07952 PUTNAM/HENRY PRENATAL 200.00 Cross Foot Adjustments	0	0		194. 02 200. 00
		5		1200.00

Heal th Financi	ial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 15-1333		Period: From 01/01/2017 To 12/31/2017		epared: 26 am
C	ost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total				
		25.00	26.00				
	legative Cost Centers OTAL (sum lines 118 through 201)	0 0	0 2, 690, 509				201.00 202.00

	Financial Systems LLOCATION - STATISTICAL BASIS	PUTNAM COUNT	Y HOSPITAL Provider C	CN: 15-1333	In Lie Veriod:	u of Form CMS-2 Worksheet B-1	
0001 A	LEUCATION - STATISTICAL DASIS		TTOVIDET C	F	rom 01/01/2017 o 12/31/2017		
	Cost Center Description	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)		ADMI NI STRATI V E & GENERAL (ACCUM. COST)	572972018 10: OPERATI ON OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
16.00	GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	99, 210 153 14, 145 10, 244 676 632 3, 447 1, 604 665 3, 952 0	17, 522, 119 2, 367, 769 295, 348 18, 373 371, 304 99, 318 237, 851 70, 383 349, 005	-5, 664, 459 C C C C C C C C C C C C C	1, 641, 732 198, 471 586, 909 357, 121 613, 117 137, 150 728, 117	74, 668 676 632 3, 447 1, 604	8.00 9.00 10.00 11.00 13.00 16.00
	01701 UTILIZATION REVIEW	333	57, 764		-	333	1
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY	5, 928 2, 841 0 0 0	1, 014, 617 694, 156 0 0 0		1, 007, 438 0 0	2, 841 0 0	31.00 41.00 42.00
50.00 51.00	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM	8, 571 2, 295	606, 978 61, 654	0	156, 420	2, 295	51.00
52.00 53.00 54.00 54.01 57.00 58.00 59.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05401 NUCLEAR MEDICINE-DIAGNOSTIC 05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0 0 3, 031 140 1, 320 0	0 591, 415 861, 357 0 160, 633 0 0		285, 265 1, 542, 184 173, 088 502, 580 0	3, 031 140	53.00 54.00 54.01 57.00
60.00 60.01 64.00	06000 LABORATORY 06001 BLOOD LABORATORY 06400 I NTRAVENOUS THERAPY	2, 510 0 0	627, 271 0 0		2, 257, 963 0	-	60. 00 60. 01
65.00 66.00 67.00 68.00 69.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	700 3, 215 0 0 100	320, 439 0 0 73, 274		645, 086 101, 837 37, 211 188, 316	3, 215 0 0 100	66.00 67.00 68.00 69.00
72.00 73.00	06901 CARDIAC REHAB 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS	813 0 0 896	238, 835 0 0 173, 096		0 0 1, 430, 963	0 896	71.00 72.00 73.00
	07301 ONCOLOGY OUTPATI ENT SERVI CE COST CENTERS	4, 857	272, 818	C	3, 260, 442	4, 857	73.01
88. 01 88. 02 89. 00 90. 00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	5, 320 2, 495 1, 266 0 162 5, 806	1, 007, 635 901, 817 526, 979 0 2, 693, 011		1, 621, 511 1, 444, 227 836, 156 0 4, 393 2, 729, 708	2, 495 1, 266 0 162	88. 01 88. 02 89. 00 90. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,000	2,075,011		2,727,700	3,000	92.00
99. 10	OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	99.10
110.00 111.00 113.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION 11100 ISLET ACQUISITION 11300 INTEREST EXPENSE 11400 INTEREST EXPENSE	0 0 0	0 0 0	C C C	000000000000000000000000000000000000000	0	109.00 110.00 111.00 113.00
114.00 118.00	11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	88, 117	14, 693, 100	-5, 664, 459	27, 110, 952	63, 575	114.00 118.00
192.00 192.01 193.00 193.01 193.02	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 19201 JOHNSON/NICHOLS WIC 19300 NONPAID WORKERS 19301 DME 19302 LACTATION CONSULTING	477 9, 923 0 0 0 0	0 2, 753, 516 75, 495 8 0 0	C C	12, 936 4, 478, 718 131, 938 10 0	9, 923 0 0 0 0	190.00 192.00 192.01 193.00 193.01 193.02
194.00	19303 DI ABETI C COUNSELI NG 07950 VACANT SPACE 07951 BOARD OF HEALTH	0 0 693	0 0 0		0 0 18, 794	0	193. 03 194. 00 194. 01

Health Financial Systems		PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL B	ASI S		Provider C		Period:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017		
Cost Center Descrip	iti on	CAPI TAL RELATED COSTS NEW BLDG & FI XT (SOUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMI NI STRATI V E & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	4.00	5A	5.00	7.00	
194.0207952 PUTNAM/HENRY PRENAT	AL	0	0		0 C	0	194.02
200.00 Cross Foot Adjustme	ents						200.00
201.00 Negative Cost Cente	ers	1					201.00
202.00 Cost to be allocate Part I)	d (per Wkst. B,	2, 690, 509	4, 704, 170		5, 664, 459	1, 934, 599	202.00
203.00 Unit cost multiplie	er (Wkst. B, Part I)	27. 119333	0. 268470		0. 178389	25. 909345	203.00
204.00 Cost to be allocate Part II)	d (per Wkst. B,		4, 149		384, 162	297, 742	204.00
205.00 Unit cost multiplie	er (Wkst. B, Part		0. 000237		0. 012098	3. 987545	205.00
206.00 NAHE adjustment amo (per Wkst. B-2)	ount to be allocated						206.00
207.00 NAHE unit cost mult Parts III and IV)	iplier (Wkst. D,						207.00

	ncial Systems TION - STATISTICAL BASIS	PUTNAM COUNT	Y HOSPITAL Provider CO	N· 15_1333 ₽	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
					om 01/01/2017	Date/Time Pre 5/29/2018 10:	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (PATI ENT DAYS)	CAFETERIA (MANHOURS)	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	20 4
		8.00	9.00	10.00	11.00	13.00	
1.00 00100 4.00 00400 5.00 00500 7.00 00700 8.00 00800 9.00 00900 10.00 01000 11.00 01100 13.00 01300 16.00 01600 17.00 01700	AL SERVICE COST CENTERS NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION MEDICAL RECORDS & LIBRARY SOCIAL SERVICE UTILIZATION REVIEW	178, 565 1, 002 740 0 0 0 0 0	70, 865 3, 447 1, 604 665 3, 952 0 333	2, 386 0 0 0 0 0 0	348, 340 3, 183 17, 619 0 0	107, 497 0 0	1.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 16.00 17.00
	TENT ROUTINE SERVICE COST CENTERS	0		0	0	0	17.01
30.00 03000 31.00 03100 41.00 04100 42.00 04200 43.00 04300	ADULTS & PEDIATRICS I NTENSI VE CARE UNI T SUBPROVI DER – I RF SUBPROVI DER NURSERY	38, 845 29, 996 0 0 0	5, 928 2, 841 0 0 0	2, 126 260 0 0 0	36, 524 23, 517 0 0 0	36, 524 23, 517 0 0 0	30. 00 31. 00 41. 00 42. 00 43. 00
50.00 05000 51.00 05100 52.00 05200	LARY SERVICE COST CENTERS OPERATING ROOM RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	25, 310 2, 785 0	8, 571 2, 295 0	0 0 0	22, 029 1, 743 0	0 0 0	50. 00 51. 00 52. 00
54.00 05400 54.01 05401 57.00 05700 58.00 05800 59.00 05900	ANESTHESIOLOGY RADIOLOGY-DIAGNOSTIC NUCLEAR MEDICINE-DIAGNOSTIC CT SCAN MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0 13, 358 0 0 0 0	0 3, 031 140 1, 320 0 0		3, 684 34, 448 0 5, 894 0 0		53.00 54.00 54.01 57.00 58.00 59.00
60.01 06001 64.00 06400 65.00 06500 66.00 06600 67.00 06700	D LABORATORY BLOOD LABORATORY I NTRAVENOUS THERAPY RESPI RATORY THERAPY PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	0 0 0 4, 931 0	2, 510 0 700 3, 215 0 0		33, 731 0 11, 461 0 0 0		60.00 60.01 64.00 65.00 66.00 67.00 68.00
69.00 06900 69.01 06901 71.00 07100 72.00 07200 73.00 07300 73.01 07301	ELECTROCARDI OLOGY CARDI AC REHAB MEDI CAL SUPPLI ES CHARGED TO PATI ENTS I MPL. DEV. CHARGED TO PATI ENT DRUGS CHARGED TO PATI ENTS ONCOLOGY	0 0 0 0 0 5, 740	0 100 813 0 0 896 4, 857	0 0 0 0 0	2, 796 7, 201 0 0 6, 971 10, 819	0 0 0 0 0	69.00 69.01 71.00 72.00
		3, 997	F 330	0	22 (07	0	88.00
88.01 08801 88.02 08802 89.00 08900 90.00 09000 91.00 09100 92.00 09200	RURAL HEALTH CLINIC RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III FEDERALLY QUALIFIED HEALTH CENTER OCLINIC EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	3, 997 0 0 0 0 43, 479	5, 320 0 1, 266 0 162 5, 806	0 0 0 0 0	32, 607 0 0 0 47, 456	0 0 0 0 47, 456	88. 01 88. 02 89. 00 90. 00
99.10 01HER	REIMBURSABLE COST CENTERS	0	0	0	0	0	99.10
SPECI 109.0010900 110.0011000 111.0011100 113.0011300	AL PURPOSE COST CENTERS PANCREAS ACQUISITION INTESTINAL ACQUISITION ISLET ACQUISITION INTEREST EXPENSE	000000000000000000000000000000000000000	0 0 0	0 0 0	0 0 0	0 0 0	109. 00 110. 00 111. 00 113. 00
118.00 NONRE	UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117) IMBURSABLE COST CENTERS	170, 183				107, 497	
192. 00 19200 192. 01 19201 193. 00 19300 193. 01 19301 193. 02 19302	GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES JOHNSON/NICHOLS WIC NONPAID WORKERS DME LACTATION CONSULTING DIABETIC COUNSELING	0 8, 382 0 0 0 0 0 0 0	477 9, 923 0 0 0 0 0 0 0		0 42, 461 4, 195 1 0 0 0	0 0 0 0	190. 00 192. 00 192. 01 193. 00 193. 01 193. 02 193. 03
194. 00 07950 194. 01 07951	VACANT SPACE BOARD OF HEALTH PUTNAM/HENRY PRENATAL Cross Foot Adjustments	000000000000000000000000000000000000000	0 693 0	0 0 0	0 0 0	0 0 0	194. 00 194. 01 194. 02 200. 00

Health I	inancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 10:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(SQUARE FEET)	(PATI ENT	(MANHOURS)	ADMI NI STRATI O	
		(POUNDS OF		DAYS)		N	
		LAUNDRY)				(DI RECT	
						NRSING HRS)	
		8.00	9.00	10.00	11.00	13.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	251, 391	709, 393	545, 68	5 780, 106	192, 631	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 407840	10. 010485	228. 70285	2. 239496	1. 791966	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	23, 434	26, 978	112, 97	57, 979	23, 145	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0. 131235	0. 380696	47.35037	0. 166444	0. 215308	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

	Financial Systems	PUTNAM COUNT		01 45 4000	In Lieu of Form C	
COST A	ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-1333	Period: Worksheet From 01/01/2017 To 12/31/2017 Date/Time	
	Cost Center Description	MEDI CAL	SOCI AL	UTILIZATION	5/29/2018	10: 26 am
	cost center bescription	RECORDS &	SERVI CE	REVI EW		
		LI BRARY (TI ME SPENT)	(PATI ENT DAYS)	(PATI ENT DAYS)		
	GENERAL SERVICE COST CENTERS	16.00	17.00	17.01		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL					4.00 5.00
7.00	00700 OPERATION OF PLANT					7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG					8.00 9.00
10.00	01000 DI ETARY					10.00
11.00 13.00	01100 CAFETERIA 01300 NURSING ADMINISTRATION					11.00 13.00
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	152, 254 0	0			16.00 17.00
		0	0		36	17.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	76, 130	0	2, 12	26	30.00
31.00	03100 INTENSIVE CARE UNIT	0, 130	0		50	31.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0		0	41.00 42.00
	04300 NURSERY	0	0		0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	39, 413	C		0	50.00
51.00	05100 RECOVERY ROOM	0	0		0	51.00
52.00 53.00		0	0		0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	54.00
54.01 57.00	05401 NUCLEAR MEDICINE-DIAGNOSTIC 05700 CT SCAN	0	0		0	54.01 57.00
58.00 59.00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0		0	58.00 59.00
60.00	06000 LABORATORY	0	0		0	60.00
60. 01 64. 00	06001 BLOOD LABORATORY 06400 I NTRAVENOUS THERAPY	0	0		0	60.01 64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0			0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0	68.00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0			0	69.00 69.01
71.00 72.00		0	0		0	71.00 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	72.00
73.01	07301 ONCOLOGY OUTPATI ENT SERVICE COST CENTERS	3, 945	0		0	73.01
88.00	08800 RURAL HEALTH CLINIC	0	C		0	88.00
88. 01 88. 02	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	0			0	88.01 88.02
89.00	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0		0	89.00
	09000 CLINIC 09100 EMERGENCY	0 32, 766			0	90.00 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00
99.10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0		0	99.10
100.00	SPECIAL PURPOSE COST CENTERS	0	0		0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0		0	110.00
	D11100 I SLET ACQUI SI TI ON D11300 I NTEREST EXPENSE	0	C		0	111.00 113.00
114.00	11400 UTILIZATION REVIEW-SNF		_			114.00
118.00	D SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	152, 254	0	2, 38	36	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0			0	192.00 192.01
193.00	19300 NONPALD WORKERS 19301 DME	0	0		0	193. 00 193. 01
193.02	2 19302 LACTATION CONSULTING	0	0		0	193.02
	3 19303 DI ABETI C COUNSELI NG 0 07950 VACANT SPACE	0	0		0	193.03 194.00
194.01	07951 BOARD OF HEALTH	0	0		0	194.01
194. 02 200. 00	207952 PUTNAM/HENRY PRENATAL Cross Foot Adjustments	0	0		0	194.02 200.00
201.00						201.00

Heal th	Financial Systems	PUTNAM COUNTY	' HOSPI TAL		In Lieu	u of Form CMS-2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider C		Period:	Worksheet B-1
					From 01/01/2017 To 12/31/2017	Date/Time Prepared: 5/29/2018 10: <u>26 am</u>
	Cost Center Description	MEDI CAL	SOCI AL	UTI LI ZATI ON		
		RECORDS &	SERVI CE	REVI EW		
		LI BRARY	(PATI ENT	(PATI ENT		
		(TIME SPENT)	DAYS)	DAYS)		
		16.00	17.00	17.01		
202.00	Cost to be allocated (per Wkst. B,	1, 039, 418	0	115, 80	19	202.00
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 826868	0. 000000	48. 53688	32	203.00
204.00	Cost to be allocated (per Wkst. B,	136, 265	0	11, 56	6	204.00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 894985	0. 000000	4.84744	3	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)					

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/29/2018 10:	
		Title	XVIII	Hospi tal	Cost	20 011
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDIATRICS	3, 279, 479		3, 279, 47		0	
31. 00 03100 I NTENSI VE CARE UNI T	1, 498, 323		1, 498, 32		0	•
41. 00 04100 SUBPROVI DER – I RF	0			0 0	0	
42. 00 04200 SUBPROVI DER	0			0 0	0	
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS	0			0 0	0	43.00
50. 00 05000 OPERATING ROOM	3, 240, 515		3, 240, 51	5 0	0	50.00
51. 00 05100 RECOVERY ROOM	274, 584		274, 58		0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	274, 304		274, 30	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	344, 403		344, 40		0	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 022, 118		2, 022, 11		0	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	2, 022, 110		208, 99		0	54.00
57. 00 05700 CT SCAN	652, 849		652, 84		0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0002,047		032,04	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	2, 826, 457		2, 826, 45	-	0	60.00
60. 01 06001 BLOOD LABORATORY	2,020,107		2,020,10	0 0	0	60.01
64. 00 06400 I NTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	668, 149	0	668, 14	9 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	882, 587	0	882, 58		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	120, 004	0	120, 00		0	67.00
68.00 06800 SPEECH PATHOLOGY	43, 849	0	43, 84		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	231, 764		231, 76		0	69.00
69. 01 06901 CARDI AC REHAB	438, 396		438, 39		0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1,734,027		1, 734, 02	.7 0	0	73.00
73.01 07301 ONCOLOGY	4, 075, 774		4, 075, 77	4 0	0	73.01
OUTPATIENT SERVICE COST CENTERS				_		
88.00 08800 RURAL HEALTH CLINIC	2, 180, 515		2, 180, 51	5 0	0	
88.01 08801 RURAL HEALTH CLINIC II	1, 766, 505		1, 766, 50		0	88.01
88.02 08802 RURAL HEALTH CLINIC III	1, 030, 791		1, 030, 79	0 0	0	88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	89.00
90. 00 09000 CLINIC	10, 996		10, 99		0	90.00
91.00 09100 EMERGENCY	3, 901, 425		3, 901, 42		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 211, 211		1, 211, 21	1	0	92.00
OTHER REIMBURSABLE COST CENTERS			1			00.10
99.10 09910 CORF	0			0	0	99.10
SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION	0			0	^	109.00
110. 00 11000 NTESTINAL ACQUISTITION	0			0		1109.00
111. 00 11100 I SLET ACQUISITION	0			0		111.00
113. 00 11300 I NTEREST EXPENSE					0	113.00
114. 00 11400 UTILIZATION REVIEW-SNF						114.00
200.00 Subtotal (see instructions)	32, 643, 714	0	32, 643, 71	4 0	Ω	200.00
201.00 Less Observation Beds	1, 211, 211	0	1, 211, 21		0	200.00
202.00 Total (see instructions)	31, 432, 503	0				202.00
	0.1, 102, 000	0	1 0., .02, 00	-1 01	0	

	nancial Systems	PUTNAM COUNT				u of Form CMS-2	2552-10
COMPUTATI	ON OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre	epared:
			Title	XVIII	Hospi tal	5/29/2018 10: Cost	<u>26 am</u>
			Charges		nospi tui	0031	
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
LN	PATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00	10.00	
	000 ADULTS & PEDIATRICS	1, 652, 514		1, 652, 51	4		30.00
	100 INTENSIVE CARE UNIT	716, 563		716, 56			31.00
	100 SUBPROVI DER – I RF	0			0		41.00
42.00 04	200 SUBPROVI DER	0			0		42.00
43.00 04	300 NURSERY	0			0		43.00
ANG	CILLARY SERVICE COST CENTERS						
	000 OPERATING ROOM	1, 578, 089	4, 991, 026	6, 569, 11		0.00000	
	100 RECOVERY ROOM	81, 747	541, 868	623, 61		0.00000	
52.00 05	200 DELIVERY ROOM & LABOR ROOM	0	0		0.00000	0.00000	52.00
53.00 05	300 ANESTHESI OLOGY	20, 090	456, 188	476, 27	8 0. 723113	0.00000	53.00
54.00 05	400 RADI OLOGY-DI AGNOSTI C	657, 028	7, 476, 109	8, 133, 13	7 0. 248627	0.00000	54.00
	401 NUCLEAR MEDICINE-DIAGNOSTIC	29, 939	1, 257, 275	1, 287, 21		0.00000	
	700 CT SCAN	564, 162	18, 279, 643	18, 843, 80		0.00000	
	800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0.000000	0.00000	
	900 CARDI AC CATHETERI ZATI ON	0	0		0 0. 000000	0.000000	
	000 LABORATORY	1, 226, 376	17, 018, 413	18, 244, 78		0.000000	
	001 BLOOD LABORATORY	0	0		0.000000	0.000000	
	400 I NTRAVENOUS THERAPY	0	0		0.000000	0.000000	
	500 RESPI RATORY THERAPY	796, 386	745, 017	1, 541, 40		0.000000	
	600 PHYSI CAL THERAPY	440, 133	2,064,019	2, 504, 15		0.000000	
	700 OCCUPATIONAL THERAPY	129, 323	340, 586			0.000000	
	800 SPEECH PATHOLOGY	40, 333	102, 710	143, 04		0.000000	
	900 ELECTROCARDI OLOGY	36, 106	1, 409, 340			0.000000	
	901 CARDI AC REHAB	0	661, 622	661, 62		0.000000	
	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0.000000	0.000000	
	200 I MPL. DEV. CHARGED TO PATIENT	0	0		0.000000	0.000000	
	300 DRUGS CHARGED TO PATIENTS	1, 340, 208	3, 207, 443			0.000000	
	301 ONCOLOGY	13, 923	4, 516, 292	4, 530, 21	5 0. 899687	0. 000000	73.01
	TPATI ENT SERVICE COST CENTERS 800 RURAL HEALTH CLINIC	0	2 274 270	2 27 27			
	800 RURAL HEALTH CLINIC 801 RURAL HEALTH CLINIC II	0	2, 276, 278				88.00
	802 RURAL HEALTH CLINIC III	0	1,894,217				88.01 88.02
	900 FEDERALLY QUALIFIED HEALTH CENTER	0	825, 574 0		4 D		89.00
	000 CLINIC	0	4, 345		° I	0.000000	
	100 EMERGENCY	126, 948	8, 629, 107	8, 756, 05		0.000000	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	120, 948	2,051,147	2, 051, 14		0.000000	
	HER REIMBURSABLE COST CENTERS	0	2,031,147	2,031,14	7 0. 590504	0.000000	92.00
	910 CORF	0	0		0		99, 10
	ECIAL PURPOSE COST CENTERS	0	0		0		77.10
	900 PANCREAS ACQUISITION	0	0		0		109.00
	000 INTESTINAL ACQUISITION	0	0		0		110.00
	100 I SLET ACQUI SI TI ON	0	0		0		111.00
	300 INTEREST EXPENSE	0	0				113.00
	400 UTI LI ZATI ON REVI EW-SNF						114.00
114.00114			70 740 040	00 100 00	_		
	Subtotal (see instructions)	9, 449, 868	/8, /48. 219	88, 198, 08	/ 1		200.00
200. 00 201. 00	Subtotal (see instructions) Less Observation Beds	9, 449, 868	78, 748, 219	88, 198, 08	/		200.00

	ancial Systems	PUTNAM COUNTY			u of Form CMS-2	2552-10
COMPUTATIC	ON OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/29/2018 10:	epared:
			Title XVIII	Hospi tal	Cost	20 411
	Cost Center Description	PPS Inpatient		nosprear	0031	
		Ratio				
		11.00				
I NP:	ATIENT ROUTINE SERVICE COST CENTERS	11100				
	00 ADULTS & PEDIATRICS					30.00
	00 INTENSIVE CARE UNIT					31.00
	00 SUBPROVI DER – I RF					41.00
	00 SUBPROVI DER					42.00
	00 NURSERY					43.00
	I LLARY SERVICE COST CENTERS					
	00 OPERATING ROOM	0.000000				50.00
	00 RECOVERY ROOM	0. 000000				51.00
	00 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	00 ANESTHESI OLOGY	0. 000000				53.00
	00 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	01 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000				54.01
	00 CT SCAN	0. 000000				57.00
	00 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000				58.00
	00 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	00 LABORATORY	0. 000000				60.00
	01 BLOOD LABORATORY	0. 000000				60.01
	00 INTRAVENOUS THERAPY	0. 000000				64.00
	00 RESPIRATORY THERAPY	0. 000000				65.00
	00 PHYSI CAL THERAPY	0. 000000				66.00
	00 OCCUPATI ONAL THERAPY	0. 000000				67.00
	00 SPEECH PATHOLOGY	0. 000000				68.00
	00 ELECTROCARDI OLOGY	0. 000000				69.00
	01 CARDI AC REHAB	0. 000000				69.01
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	00 IMPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
	00 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	01 ONCOLOGY	0. 000000				73.01
	PATIENT SERVICE COST CENTERS	0.000000				
	OO RURAL HEALTH CLINIC					88. 00
	01 RURAL HEALTH CLINIC II					88.01
	02 RURAL HEALTH CLINIC III					88.02
	00 FEDERALLY QUALIFIED HEALTH CENTER					89.00
	00 CLINIC	0. 000000				90.00
	00 EMERGENCY	0. 000000				91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART)	0, 000000				92.00
	ER REIMBURSABLE COST CENTERS					1
	10 CORF					99, 10
	CIAL PURPOSE COST CENTERS					1
109.00109	00 PANCREAS ACQUISITION					109.00
	00 INTESTINAL ACQUISITION					110.00
	00 I SLET ACQUI SI TI ON					111.00
	00 INTEREST EXPENSE					113.00
	00 UTILIZATION REVIEW-SNF					114.00
						200.00
200.00	Suptotal (see instructions)					1200.00
200.00 201.00	Subtotal (see instructions) Less Observation Beds					200.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017	Worksheet C Part I	
			-	To 12/31/2017	Date/Time Pre 5/29/2018 10:	
		Ti tl	e XIX	Hospi tal	Cost	20 011
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	3, 279, 479		3, 279, 479		-, ,	1
31. 00 03100 I NTENSI VE CARE UNI T	1, 498, 323		1, 498, 32		.,	
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	0			0	0	
43. 00 04300 NURSERY	0				0	
ANCI LLARY SERVICE COST CENTERS				<u> </u>	ŭ	10.00
50. 00 05000 OPERATI NG ROOM	3, 240, 515		3, 240, 51	ō 0	3, 240, 515	50.00
51.00 05100 RECOVERY ROOM	274, 584		274, 58	4 0	274, 584	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			s	0	
53.00 05300 ANESTHESI OLOGY	344, 403		344, 403		344, 403	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2,022,118		2, 022, 11		2, 022, 118	
54. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C 57. 00 05700 CT SCAN	208, 993 652, 849		208, 993 652, 849		208, 993 652, 849	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	052, 049		052, 64		052, 849	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
60. 00 06000 LABORATORY	2, 826, 457		2, 826, 45	7 0	2, 826, 457	60.00
60.01 06001 BLOOD LABORATORY	0			0 0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	668, 149	0			668, 149	
66. 00 06600 PHYSI CAL THERAPY	882, 587	0	882, 58		882, 587	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	120, 004 43, 849	0	120, 00- 43, 84		120, 004 43, 849	
69. 00 06900 ELECTROCARDI OLOGY	231, 764	0	231, 76		231, 764	
69. 01 06901 CARDI AC REHAB	438, 396		438, 39		438, 396	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		(0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 734, 027		1, 734, 02			73.00
73. 01 07301 ONCOLOGY	4, 075, 774		4, 075, 77	4 0	4, 075, 774	73.01
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLI NI C	2 100 515		2 100 51	5 0	0 100 E1E	00.00
88. 00 08800 RURAL HEALTH CLINIC 88. 01 08801 RURAL HEALTH CLINIC II	2, 180, 515 1, 766, 505		2, 180, 51 1, 766, 50		2, 180, 515 1, 766, 505	1
88. 02 08802 RURAL HEALTH CLINIC III	1, 030, 791		1, 030, 79		1, 030, 791	88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		(0	
90. 00 09000 CLINIC	10, 996		10, 99	6 0	10, 996	90.00
91.00 09100 EMERGENCY	3, 901, 425		3, 901, 42	5 0	3, 901, 425	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1, 211, 211		1, 211, 21	1	1, 211, 211	92.00
OTHER REI MBURSABLE COST CENTERS					0	00.10
99. 10 09910 CORF SPECI AL PURPOSE COST CENTERS	0				0	99.10
109. 00 10900 PANCREAS ACQUI SI TI ON	0			2	0	109.00
110.00 11000 I NTESTI NAL ACQUI SI TI ON	0			5		110.00
111.00 11100 I SLET ACQUI SI TI ON	0					111.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
200.00 Subtotal (see instructions)	32, 643, 714	0				
201.00Less Observation Beds202.00Total (see instructions)	1, 211, 211 31, 432, 503	0	1, 211, 21 31, 432, 50		1, 211, 211 31, 432, 503	
	51,452,505	0	31,432,30		51, 452, 505	202.00

	Financial Systems	PUTNAM COUNTY				u of Form CMS-	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/29/2018 10:	epared:
			Ti tl	e XIX	Hospi tal	Cost	20 811
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	1		1			
	D3000 ADULTS & PEDIATRICS	1, 652, 514		1, 652, 51			30.00
	D3100 INTENSIVE CARE UNIT	716, 563		716, 56			31.00
	04100 SUBPROVI DER – I RF	0			0		41.00
	04200 SUBPROVI DER	0			0		42.00
	04300 NURSERY	0			0		43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	1, 578, 089	4, 991, 026			0.00000	
	D5100 RECOVERY ROOM	81, 747	541, 868			0.00000	
	D5200 DELIVERY ROOM & LABOR ROOM	0	0		0 0. 000000	0.00000	
	05300 ANESTHESI OLOGY	20, 090	456, 188			0.00000	
	05400 RADI OLOGY-DI AGNOSTI C	657, 028	7, 476, 109			0.00000	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	29, 939	1, 257, 275			0.00000	
	D5700 CT SCAN	564, 162	18, 279, 643			0.00000	
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0)	0 0. 000000	0.00000	
	05900 CARDI AC CATHETERI ZATI ON	0	C)	0 0. 000000	0.00000	
	D6000 LABORATORY	1, 226, 376	17, 018, 413	18, 244, 78		0.00000	
	D6001 BLOOD LABORATORY	0	0)	0 0. 000000	0.00000	
	D6400 I NTRAVENOUS THERAPY	0	C)	0 0. 000000	0.00000	
	06500 RESPI RATORY THERAPY	796, 386	745, 017			0.00000	
	06600 PHYSI CAL THERAPY	440, 133	2,064,019			0.00000	
	06700 OCCUPATI ONAL THERAPY	129, 323	340, 586			0.00000	
	D6800 SPEECH PATHOLOGY	40, 333	102, 710			0.00000	
	D6900 ELECTROCARDI OLOGY	36, 106	1, 409, 340			0.00000	
	06901 CARDI AC REHAB	0	661, 622			0.00000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0.000000	0.00000	
	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0.000000	0.00000	
	D7300 DRUGS CHARGED TO PATIENTS	1, 340, 208	3, 207, 443			0.00000	
	07301 ONCOLOGY	13, 923	4, 516, 292	4, 530, 21	5 0. 899687	0.00000	73.01
	DUTPATIENT SERVICE COST CENTERS						
	D8800 RURAL HEALTH CLINIC	0	2, 276, 278			0.00000	
	D8801 RURAL HEALTH CLINIC II	0	1, 894, 217			0.00000	
	08802 RURAL HEALTH CLINIC III	0	825, 574			0.000000	
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.000000	0.000000	
	D9000 CLINIC	0	4, 345			0.000000	
	09100 EMERGENCY	126, 948	8, 629, 107			0.000000	
-	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2,051,147	2, 051, 14	0. 590504	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						00.10
	09910 CORF	0	0		0		99.10
	SPECIAL PURPOSE COST CENTERS		~	J			100.00
	10900 PANCREAS ACQUISITION	0	0		0		109.00
	11000 INTESTINAL ACQUISITION	0	0		0		110.00
	11100 I SLET ACQUI SI TI ON	0	0		0		111.00
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF						114.00
	Subtatal (and instructions)	0 440 0/0	70 740 040				
200.00	Subtotal (see instructions)	9, 449, 868	78, 748, 219	88, 198, 08	37		200.00
	Subtotal (see instructions) Less Observation Beds Total (see instructions)	9, 449, 868 9, 449, 868	78, 748, 219 78, 748, 219				200.00 201.00 202.00

	Financial Systems	PUTNAM COUNTY			u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre	pared.
				10 12/31/2017	5/29/2018 10:	26 am
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	1				
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 I NTENSI VE CARE UNI T					31.00
41.00	04100 SUBPROVI DER - I RF					41.00
42.00	04200 SUBPROVI DER					42.00
43.00	04300 NURSERY					43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	0.000000				
50.00	05000 OPERATING ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
54.01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000				54.01
57.00	05700 CT SCAN	0. 000000				57.00
58.00	05800 MAGNETIC RESONANCE I MAGI NG (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	07301 ONCOLOGY	0. 000000				73.01
	OUTPATIENT SERVICE COST CENTERS	1				
88.00	08800 RURAL HEALTH CLINIC	0. 000000				88.00
88.01	08801 RURAL HEALTH CLINIC II	0. 000000				88.01
88. 02	08802 RURAL HEALTH CLINIC III	0. 000000				88.02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
90.00	09000 CLINIC	0. 000000				90.00
91.00	09100 EMERGENCY	0. 000000				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS	1 1				
99.10	09910 CORF					99.10
	SPECIAL PURPOSE COST CENTERS					
	10900 PANCREAS ACQUISITION					109.00
	11000 INTESTINAL ACQUISITION					110.00
	11100 I SLET ACQUI SI TI ON					111.00
	11300 INTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF					114.00
200.00						200.00
201.00						201.00
202.00) Total (see instructions)	1				202.00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-1333	Peri od:	Worksheet D	
				From 01/01/2017 To 12/31/2017	Part II Date/Time Pre	nared
				10 12/31/2017	5/29/2018 10:	27 am
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	000 7/0	6 5 60 445	0.0545	0 (00, 400)	00.450	50.00
50. 00 05000 OPERATING ROOM	338, 760	6, 569, 115			32, 153	
51.00 05100 RECOVERY ROOM	74, 826	623, 615				
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	
53. 00 05300 ANESTHESI OLOGY	4, 204	476, 278				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	121, 787	8, 133, 137			6, 028	54.00 54.01
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 57. 00 05700 CT SCAN	6, 502	1, 287, 214			71 803	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	48, 664	18, 843, 805	0.00258		803	57.00
59. 00 05900 CARDIAC CATHETERIZATION	0	0	0.00000		0	58.00
60. 00 06000 LABORATORY	112, 115	18, 244, 789			4, 018	
60. 01 06001 BLOOD LABORATORY	112, 115	10, 244, 709	0.0000		4,018	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0			0	
65. 00 06500 RESPIRATORY THERAPY	30, 363	1, 541, 403				
66. 00 06600 PHYSI CAL THERAPY	109, 684	2, 504, 152			6, 398	
67. 00 06700 OCCUPATI ONAL THERAPY	1, 232	469, 909				
68. 00 06800 SPEECH PATHOLOGY	450	143, 043				
69. 00 06900 ELECTROCARDI OLOGY	5, 909	1, 445, 446				
69. 01 06901 CARDI AC REHAB	30, 891	661, 622			0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	001,022			0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0.00000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	46, 726	4, 547, 651			6, 558	
73. 01 07301 ONCOLOGY	198, 531	4, 530, 215	0. 04382	1, 423	62	73.01
OUTPATIENT SERVICE COST CENTERS	· · · · ·	· · ·				1
88.00 08800 RURAL HEALTH CLINIC	193, 322	2, 276, 278	0. 08492	29 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	95, 298	1, 894, 217	0. 05031	0 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	50, 104	825, 574	0. 06069	0 0	0	88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	0 0	0	89.00
90. 00 09000 CLINIC	5, 154				0	
91. 00 09100 EMERGENCY	269, 627	8, 756, 055			590	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	148, 866	2, 051, 147			0	
200.00 Total (lines 50 through 199)	1, 893, 015	85, 829, 010		3, 401, 948	69, 650	200 00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider C	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/29/2018 10:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	School	School	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	-		0 0	0	
51.00 05100 RECOVERY ROOM	0	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 0	0	54.01
57.00 05700 CT SCAN	0	0		0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0		0 0	0	
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0	0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	10.00
73. 01 07301 ONCOLOGY	0	0		0 0	0	73.01
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0		
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	
88.02 08802 RURAL HEALTH CLINIC III	0	0		0 0	0	88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
90. 00 09000 CLINIC	0	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	12.00
200.00 Total (lines 50 through 199)	0	0		0 0	0	200.00

lealth Financial Systems		Y HOSPITAL			u of Form CMS-	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	ERVICE OTHER PAS	S Provider C	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre 5/29/2018 10:	epared: 26 am
		Title	XVIII	Hospi tal	Cost	20 411
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpati ent		to Charges	
	Educati on	through col.	Cost (sum o	f C, Part I,	(col. 5 ÷	
	Cost	4)	col. 2, 3 ar	nd col.8)	col. 7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS	1	I	1			
50.00 05000 OPERATING ROOM	0	-		0 6, 569, 115		
51.00 05100 RECOVERY ROOM	0	0		0 623, 615		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0.00000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 476, 278		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 8, 133, 137	0.00000	
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0		0 1, 287, 214		
57.00 05700 CT SCAN	0	0		0 18, 843, 805		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.00000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0 000	0.00000	
50. 00 06000 LABORATORY	0	0		0 18, 244, 789		
50. 01 06001 BLOOD LABORATORY	0			0 0	0.00000	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0			0	0. 000000 0. 000000	
	0			0 1, 541, 403		
66.00 06600 PHYSI CAL THERAPY 57.00 06700 OCCUPATI ONAL THERAPY	0			0 2, 504, 152 0 469, 909		
58.00 06800 SPEECH PATHOLOGY	0			0 469, 909		
59. 00 06900 ELECTROCARDI OLOGY	0			0 1, 445, 446		
59. 01 06901 CARDI AC REHAB	0			0 661, 622		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 001,022	0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0				0.000000	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 4, 547, 651		
73. 01 07301 ONCOLOGY	0			0 4, 530, 215	0.000000	
OUTPATIENT SERVICE COST CENTERS		<u> </u>	I	1,000,210	0.00000	/0.0
38. 00 08800 RURAL HEALTH CLINIC	0	C		0 2, 276, 278	0.00000	88.00
38. 01 08801 RURAL HEALTH CLINIC II	0			0 1, 894, 217	0. 000000	
38. 02 08802 RURAL HEALTH CLINIC III	0			0 825, 574		
39.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	
20. 00 09000 CLINIC	0	0		0 4, 345		
91.00 09100 EMERGENCY	0	0		0 8, 756, 055		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 2, 051, 147	0.000000	92.00
200.00 Total (lines 50 through 199)	0	l o		0 85, 829, 010		200.00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider CC	CN: 15-1333	Period: From 01/01/2017 To 12/31/2017		pared: 26 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpatient	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
	(col. 6 ÷	-	Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	623, 490		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	31, 586		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	14, 246		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	402, 537		0 0	0	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 000000	14, 062		0 0	0	54.01
57.00 05700 CT SCAN	0. 000000	310, 964		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	653, 921		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
64.00 06400 INTRAVENOUS THERAPY	0.000000	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0.000000	443, 307		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	146, 081		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000	51, 142		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.000000	26, 417		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0.000000	25, 384		0 0	0	69.00
69. 01 06901 CARDI AC REHAB	0.000000	0		0 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000	638, 228		0 0	0	73.00
73.01 07301 ONCOLOGY	0.000000	1, 423		0 0		73.01
OUTPATIENT SERVICE COST CENTERS					· · · ·	
88.00 08800 RURAL HEALTH CLINIC	0.000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0.000000	0		0 0	0	88.01
88.02 08802 RURAL HEALTH CLINIC III	0.000000	0		0 0	0	88.02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89.00
90. 00 09000 CLINIC	0. 000000	0		0 0	-	90.00
91. 00 09100 EMERGENCY	0. 000000	19, 160		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	
200.00 Total (lines 50 through 199)		3, 401, 948		0 0		200.00
	· ·		1	1		

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST	Provider C		Period: From 01/01/2017	Worksheet D Part V	
				To 12/31/2017		epared:
					5/29/2018 10:	26 am
			2 XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see inst.)	Services	Services Not		
	Worksheet C, Part I, col.	Inst.)	Subject To Ded. & Coins.	Subject To Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 493296	0	1, 656, 51	8 0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 440310					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0		
53. 00 05300 ANESTHESI OLOGY	0. 723113					1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 248627				-	1
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 162361		_,,.	-		1
57. 00 05700 CT SCAN	0. 034645				-	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0 0		1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	-	1
60. 00 06000 LABORATORY	0. 154919					1
60. 01 06001 BLOOD LABORATORY	0. 000000			0 0		1
64.00 06400 INTRAVENOUS THERAPY	0.000000			0 0	0	1
65. 00 06500 RESPIRATORY THERAPY	0. 433468		289, 08	9 0	0	1
66. 00 06600 PHYSI CAL THERAPY	0. 352449				0	1
67.00 06700 OCCUPATI ONAL THERAPY	0. 255377				0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 306544	0	14, 57		0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 160341	0	544, 01	8 0	0	69.00
69. 01 06901 CARDI AC REHAB	0. 662608	0	215, 13	8 0	0	69.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 381302		730, 01	1 0	0	73.00
73. 01 07301 ONCOLOGY	0. 899687	0	2, 806, 11	3 0	0	73.01
OUTPATIENT SERVICE COST CENTERS		_			-	
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				0	
88.02 08802 RURAL HEALTH CLINIC III	0. 000000				0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	
90. 00 09000 CLINIC	2. 530725					
91.00 09100 EMERGENCY	0. 445569					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 590504					
200.00 Subtotal (see instructions)		0	2.1, 702, 0.1			200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						1
202.00 Net Charges (line 200 - line 201)		0	24, 952, 34	5 0	_	202.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pr 5/29/2018 10	
				XVIII	Hospi tal	Cost	
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCI LLARY SERVICE COST CENTERS		-				
	05000 OPERATING ROOM	817, 154	0				50.00
	05100 RECOVERY ROOM	62, 802	0				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESI OLOGY	84, 261	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	539, 144	0				54.00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	86, 557	0				54.01
	05700 CT SCAN	198, 906	0				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	946, 439	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60.01
64.00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65.00	06500 RESPI RATORY THERAPY	125, 311	0				65.00
66.00	06600 PHYSI CAL THERAPY	250, 845	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	22, 643	0				67.00
68.00	06800 SPEECH PATHOLOGY	4, 468	0				68.00
69.00	06900 ELECTROCARDI OLOGY	87, 228	0				69.00
69.01	06901 CARDI AC REHAB	142, 552	0				69.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	278, 355	0				73.00
73.01	07301 ONCOLOGY	2, 524, 623	0				73.01
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0				88.00
88.01	08801 RURAL HEALTH CLINIC II	0	0				88.01
88.02	08802 RURAL HEALTH CLINIC III	0	0				88.02
	08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0				89.00
	09000 CLINIC	2, 860	0				90.00
	09100 EMERGENCY	940, 704	0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	574, 483	0				92.00
200.00		7, 689, 335	0				200.00
201.00		0	Ū				201.00
		j ű					1.2
201100	Only Charges						

Heal th Financia	l Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTI ONMENT (OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1333	Peri od:	Worksheet D	
			Component	CCN: 15-Z333	From 01/01/2017 To 12/31/2017		nared
			component	0011. 15 2555	10 12/31/2017	5/29/2018 10:	
			Title	e XVIII	Swing Beds - SNF		
				Charges		Costs	
Cos	st Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins			
		9		(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	Y SERVICE COST CENTERS						
	ERATING ROOM	0. 493296			0 0		
	COVERY ROOM	0. 440310	0		0 0	0	
	LIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
	ESTHESI OLOGY	0. 723113	0		0 0	0	53.00
	DI OLOGY-DI AGNOSTI C	0. 248627	0		0 0	0	54.00
	CLEAR MEDICINE-DIAGNOSTIC	0. 162361	0		0 0	0	54.01
57.00 05700 CT		0. 034645	0		0 0	0	57.00
58.00 05800 MAG	GNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
	RDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00 06000 LAE		0. 154919	0		0 0	0	60.00
	OOD LABORATORY	0. 000000	0		0 0	0	60.01
	TRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
	SPI RATORY THERAPY	0. 433468	0		0 0	0	
	YSI CAL THERAPY	0. 352449	0		0 0	0	
	CUPATI ONAL THERAPY	0. 255377	0		0 0	0	
	EECH PATHOLOGY	0. 306544	0		0 0	0	
	ECTROCARDI OLOGY	0. 160341	0		0 0	0	69.00
	RDI AC REHAB	0. 662608	0		0 0	0	69.01
	DICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	
	PL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	
	UGS CHARGED TO PATIENTS	0. 381302	0		0 0	e e e e e e e e e e e e e e e e e e e	
73.01 07301 ON		0. 899687	0		0 0	0	73.01
	NT SERVICE COST CENTERS						
	RAL HEALTH CLINIC	0. 000000				0	
	RAL HEALTH CLINIC II	0. 000000				0	
	RAL HEALTH CLINIC III	0. 000000				0	88.02
	DERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90.00 09000 CLI		2. 530725	0		0 0	0	
91.00 09100 EME		0. 445569	0		0 0	0	
	SERVATION BEDS (NON-DISTINCT PART)	0. 590504	0		0 0	0	
	btotal (see instructions)		0		0 0	0	200.00
	ss PBP Clinic Lab. Services-Program				0 0		201.00
	ly Charges						
202.00 Net	t Charges (line 200 - line 201)		C	1	0 0	0	202.00

Health Financial Systems	PUTNAM COUNTY	HOSPI TAL		In Lie	u of Form CMS-255	52-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provider C	CN: 15-1333	Peri od:	Worksheet D	
		Component	CCN: 15-Z333	From 01/01/2017	Part V Date/Time Prepar	-
		component (CCN. 10-2333	To 12/31/2017	5/29/2018 10: 26	am
		Title	XVIII	Swing Beds - SNF		
	Cost					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins. I	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				0.0
51.00 05100 RECOVERY ROOM	0	0			51	1.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				2. C
53. 00 05300 ANESTHESI OLOGY	0	0			53	3. C
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				4.0
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0				4.0
7. 00 05700 CT SCAN	0	0				7.0
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				8.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0			59	9. (
0. 00 06000 LABORATORY	0	0			60	0.0
0. 01 06001 BLOOD LABORATORY	0	0				o. 0
54.00 06400 INTRAVENOUS THERAPY	0	0				94. C
5. 00 06500 RESPI RATORY THERAPY	0	0				o5. C
56. 00 06600 PHYSI CAL THERAPY	0	0				6.0
57.00 06700 OCCUPATI ONAL THERAPY	0	0				o7. (
8.00 06800 SPEECH PATHOLOGY	0	0				8.0
9.00 06900 ELECTROCARDI OLOGY	0	0				9. (
9. 01 06901 CARDI AC REHAB	0	0				9. (
1.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0				1.(
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				2.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				3.0
3. 01 07301 ONCOLOGY	0	0			/3	3.0
OUTPATIENT SERVICE COST CENTERS						8. (
8.00 08800 RURAL HEALTH CLINIC	0	0				
8. 01 08801 RURAL HEALTH CLINIC II 8. 02 08802 RURAL HEALTH CLINIC III	0	0				8. (8. (
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				9. (
0. 00 09000 CLINIC	0	0				0. (
1.00 09100 EMERGENCY	0	0				91. (92. (
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				
200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program	0	0			200 201	
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0				201	1.0
202.00 Net Charges (line 200 - line 201)	0	0			201	02.0
Loz. ou liver charges (The 200 - The 201)	I U	0	I		202	2.0

	Financial Systems PUTNAM COUNTY HOSPIT ATION OF INPATIENT OPERATING COST Provi	ider CCN: 15-1333	Period: From 01/01/2017 To 12/31/2017	<u>of Form CMS-2</u> Worksheet D-1 Date/Time Prep	parec
		Title XVIII	Hospi tal	5/29/2018 10:2 Cost	26 an
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
. 00	Inpatient days (including private room days and swing-bed days, exe	cluding newborn)		3, 177	1. (
. 00	Inpatient days (including private room days, excluding swing-bed and			2, 799	2.0
. 00	Private room days (excluding swing-bed and observation bed days). I do not complete this line.	If you have only pr	rivate room days,	0	3.
. 00	Semi-private room days (excluding swing-bed and observation bed day			1, 643	4.
00	Total swing-bed SNF type inpatient days (including private room day	ys) through Decembe	er 31 of the cost	331	5.
00	reporting period Total swing-bed SNF type inpatient days (including private room day	vs) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private room days	s) through December	31 of the cost	48	7.
. 00	reporting period Total swing-bed NF type inpatient days (including private room days	s) after December 3	31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable to the newborn days)	Program (excluding	swing-bed and	1, 003	9.
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (i	including private r	room days)	331	10.
	through December 31 of the cost reporting period (see instructions)				
1.00	Swing-bed SNF type inpatient days applicable to title XVIII only (i December 31 of the cost reporting period (if calendar year, enter (room days) after	0	11.
2.00	Swing-bed NF type inpatient days applicable to titles V or XIX only		e room days)	0	12.
	through December 31 of the cost reporting period			0	10
8. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only after December 31 of the cost reporting period (if calendar year,			0	13.
	Medically necessary private room days applicable to the Program (ex			0	14.
	Total nursery days (title V or XIX only)				15.
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.
. 00	Medicare rate for swing-bed SNF services applicable to services th	rough December 31 d	of the cost		17.
	reporting period	+ D	+ +		10
3. 00	Medicare rate for swing-bed SNF services applicable to services af reporting period	ter December 31 of	the cost		18.
9.00	Medicaid rate for swing-bed NF services applicable to services three	ough December 31 of	the cost	0.00	19.
). 00	reporting period Medicaid rate for swing-bed NF services applicable to services afte	or Docombor 21 of t	ho cost	0.00	20
. 00	reporting period	er beceniber 31 01	the cost	0.00	20.
	Total general inpatient routine service cost (see instructions)			3, 279, 479	
2.00	Swing-bed cost applicable to SNF type services through December 31 5×10^{-10} x line 17)	of the cost report	ing period (line	0	22.
8. 00	Swing-bed cost applicable to SNF type services after December 31 or	f the cost reportir	ng period (line 6	0	23.
	x line 18)				
1.00	Swing-bed cost applicable to NF type services through December 31 (7 x line 19)	of the cost reporti	ng period (line	0	24.
5.00	Swing-bed cost applicable to NF type services after December 31 of	the cost reporting	period (line 8	0	25.
	x line 20)			244 000	~ (
5.00 7.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line	21 minus line 26)		346, 809 2, 932, 670	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	21 millio 11110 20)		217021070	- / ·
	General inpatient routine service charges (excluding swing-bed and	observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 30.
. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line	e 28)		0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.
	Average per diem private room charge differential (line 32 minus li		ctions)	0.00	
	Average per diem private room cost differential (line 34 x line 31))		0.00	35.
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and pu	rivate room cost di	fferential (line	0 2, 932, 670	36. 37.
. 00	27 minus line 36)	i vate ruum cust ui		2, 732, 070	J/.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN			1 047 74	20
	Adjusted general inpatient routine service cost per diem (see inst Program general inpatient routine service cost (line 9 x line 38)	ructions)		1, 047. 76 1, 050, 903	38. 39.
	Medically necessary private room cost applicable to the Program (li	ine 14 x line 35)		1,050,905	40.
	Total Program general inpatient routine service cost (line 39 + lin			1, 050, 903	

COMPLI	n Financial Systems TATION OF INPATIENT OPERATING COST		/ HOSPITAL Provider C	CN: 15-1333	Period:	u of Form CMS- Worksheet D-1	
50111 0					From 01/01/2017 To 12/31/2017	Date/Time Pre	
						5/29/2018 10:	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	Cost Program Cost	
		Inpatient	I npati ent	Diem (col.		(col. 3 x	
		Cost	Days	÷ col. 2)	4.00	<u>col. 4)</u>	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00 0.0	4.00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Unit			<u> </u>	0	0	72.00
43.00		1, 498, 323	241	6, 217. 1	1 130	808, 224	
44.00							44.00
45.00 46.00							45.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					4.00	
48.00	Program inpatient ancillary service cost ()	Wkst D-3 col 3	Line 200)			<u> </u>	48.00
49.00	0			ons)		2, 927, 392	
	PASS THROUGH COST ADJUSTMENTS	U , U					
50.00	5 11 5	npatient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
51.00) Pass through costs applicable to Program in	nnatient ancillar	v services (f	rom Wkst D	sum of Parts II	0	51.00
01.00	and IV)	ipatront anorra	y services (1	rom more b,		0	01.00
52.00						0	
53.00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		lated, non-ph	ysician anest	hetist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	5 52)					1
54.00	Program di scharges					0	
55.00						0.00	
56.00 57.00	5	ating cost and ta	raet amount (line 56 minus	line 53)	0	
58.00	· · ·		inger amount (11110 00)	0	
59.00	Lesser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
40 00	market basket	r cost roport up	datad by the	markat backat		0.00	60.00
60.00 61.00						0.00	
01100	which operating costs (line 53) are less th					0	
	amount (line 56), otherwise enter zero (see	e instructions)					
62.00 63.00		vment (see instru	ctions)			0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	05.00
64.00	5	osts through Dece	mber 31 of th	e cost report	ing period (See	346, 809	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co	asts after Decomb	or 21 of the	cost roportin	a pariod (Soo	0	65.00
05.00	instructions) (title XVIII only)			cost reportin	g period (see	0	05.00
66.00	5 1	tine costs (line	64 plus line	65)(title XVI	II only). For	346, 809	66.00
(7 00	CAH (see instructions)	na aaata thraugh	December 21	of the east m	ananting pariod	0	67.00
67.00	Title V or XIX swing-bed NF inpatient rout (line 12 x line 19)	The costs through	December 31	of the cost r	eporting period	0	67.00
68.00		ine costs after D	ecember 31 of	the cost rep	orting period	0	68.00
(0.00	(line 13 x line 20)			(0)		0	
69.00	Total title V or XIX swing-bed NF inpatien PART III - SKILLED NURSING FACILITY, OTHER					0	69.00
70.00)		70.00
71.00	5 1		ine 70 ÷ line	2)			71.00
72.00	5			ino 25)			72.00
73.00 74.00	5 51 11	, e	•				73.00
75.00	5 5 1				Part II, column		75.00
	26, line 45)						
76.00 77.00							76.00
78.00							78.0
79.00		,	rovi der recor	ds)			79.00
80.00	5	•	ost limitatio	n (line 78 mi	nus line 79)		80.0
81.00 82.00)				81.0 82.0
83.00		•					83.0
84.00	Program inpatient ancillary services (see	instructions)					84.0
85.00	1 5 1	•					85.00
86.00	Total Program inpatient operating costs (su PART IV - COMPUTATION OF OBSERVATION BED PA		rougn 85)				86.00
87.00						1, 156	87.00
	5 (line 2)			1,047.76	
88.00	Observation bed cost (line 87 x line 88) (1, 211, 211	6

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/29/2018 10:	pared: 26 am
		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	403, 070	3, 279, 479	0. 12290	7 1, 211, 211	148, 866	90.00
91.00 Nursing School cost	0	3, 279, 479	0.00000	0 1, 211, 211	0	91.00
92.00 Allied health cost	0	3, 279, 479	0.00000	0 1, 211, 211	0	92.00
93.00 All other Medical Education	0	3, 279, 479	0.00000	0 1, 211, 211	0	93.00

OMPUTATION OF INPATIENT OP	RATING COST		Provider CCN: 15-1333	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Pre	pare
			Title XIX	Hospi tal	5/29/2018 10: Cost	27 2
Cost Center Des	cription			-	1.00	
PART I - ALL PROVIDER	COMPONENTS				1.00	
00 Inpatient days (inclu	ding privato room days	and swing bod da	ys, excluding newborn)	I	3, 177	1 1
			-bed and newborn days)		2, 799	2
00 Private room days (e>	cluding swing-bed and		lays). If you have only p	orivate room days,	0	3
do not complete this		and abconvetion	had days)		1 (4 2	4
	s (excluding swing-bed vpe inpatient davs (in		oom days) through Decemb	per 31 of the cost	1, 643 331	4
reporting period		0 1				
	ype inpatient days (in calendar year, enter O		oom days) after December	31 of the cost	0	6
			om days) through Decembe	er 31 of the cost	48	7
reporting period						
	pe inpatient days (inc calendar year, enter O		om days) after December	31 of the cost	0	8
			to the Program (excludin	ng swing-bed and	19	9
newborn days)		- +- +: +! - \/\/!!!			0	10
	f the cost reporting p		only (including private	room days)	0	10
.00 Swing-bed SNF type ir	patient days applicabl	e to title XVIII	only (including private	room days) after	0	11
	st reporting period (i		enter O on this line) IX only (including priva	to room dave)	0	12
	f the cost reporting p		a voli v (inciduing priva	ite room days)	0	'2
.00 Swing-bed NF type inp	atient days applicable	to titles V or X	IX only (including priva		0	13
after December 31 of 00 Medically necessary p	the cost reporting per rivate room days appli	iod (if calendar cable to the Prog	year, enter O on this li ram (excluding swing-bec	ne)	0	14
. 00 Total nursery days (t		cable to the ring	i am (exer daring swring bee	(uuys)	0	
.00 Nursery days (title)	or XIX only)				0	16
. 00 Medicare rate for swi	ng-bed SNE services an	plicable to servi	ces through December 31	of the cost		17
reporting period	ng bed own services up		des through becomen of			
	ng-bed SNF services ap	plicable to servi	ces after December 31 of	f the cost		18
reporting period .00 Medicaid rate for swi	ng-bed NF services app	licable to servic	es through December 31 c	of the cost	0.00	19
reporting period						
.00 Medicaid rate for swi reporting period	ng-bed NF services app	licable to servic	es after December 31 of	the cost	0.00	20
	nt routine service cos	t (see instructio	ns)		3, 279, 479	21
	able to SNF type servi	ces through Decem	ber 31 of the cost repor	ting period (line	0	22
5 x line 17) .00 Swing-bed cost applic	able to SNF type servi	ces after Decembe	r 31 of the cost reporti	na period (line 6	0	23
x line 18)	51					
.00 Swing-bed cost applic 7 x line 19)	able to NF type servic	es through Decemb	er 31 of the cost report	ing period (line	0	24
	able to NF type servic	es after December	31 of the cost reportin	ng period (line 8	0	25
x line 20)						
.00 Total swing-bed cost .00 General inpatient rou	. ,	of swing-bed cost	(line 21 minus line 26)		346, 809 2, 932, 670	
PRI VATE ROOM DI FFEREN		or swring bed cost			2,702,070	'
			ed and observation bed o	charges)	0	
00 Private room charges 00 Semi-private room cha	(excluaing swing-bed c rges (excluding swing-	5 /			0	29
	tine service cost/char		÷line 28)		0. 000000	
	per diem charge (line				0.00	
	room per diem charge (ate room charge differ		inus line 33)(see instru	ictions)	0.00 0.00	
	ate room cost differen				0.00	
.00 Private room cost dif	ferential adjustment (line 3 x line 35)			0	36
.00 General inpatient rou 27 minus line 36)	τιne service cost net	от swing-bed cost	and private room cost c	urterential (line	2, 932, 670	37
PART II - HOSPITAL AN	SUBPROVIDERS ONLY					1
	RATING COST BEFORE PAS				1 047 74	
	tient routine service ient routine service c				1, 047. 76 19, 907	38
. 00 Medically necessary p					0	40
00 Total Program general	inpatient routine ser	vice cost (line 3	9 + line 40)		19, 907	1 4

	Financial Systems ATION OF INPATIENT OPERATING COST	PUTNAM COUNTY		CN: 15-1333	Period:	u of Form CMS- Worksheet D-1	
	the of the Attent of Electric cost				From 01/01/2017		
					To 12/31/2017	Date/Time Pre 5/29/2018 10:	
				e XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient	Total Inpatient	Average Per Diem (col.		Program Cost (col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	NURSERY (title V & XIX only)	0	C	0.0	0 0	0) 42.
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 498, 323	241	6, 217. 1	1 0	C	43.
	CORONARY CARE UNIT	1, 470, 525	241	0,217.	0		44.
	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT						46.
7.00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
3.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			21, 768	3 48.
	Total Program inpatient costs (sum of lines	41 through 48)(see instructi	ons)		41, 675	49.
	PASS THROUGH COST ADJUSTMENTS						
0. 00	Pass through costs applicable to Program inpa []])	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.
1.00	Pass through costs applicable to Program inp	atient ancillar	v services (f	rom Wkst. D.	sum of Parts II	C	51.
	and IV)						
	Total Program excludable cost (sum of lines					0	
3.00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line 1		lated, non-ph	ysician anest	hetist, and	0	53.
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54.
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)				11	0	
	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	rget amount (line 56 minus	line 53)		
	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996	updated and c	ompounded by the		
	market basket	oor ening porrou	ondring 1770,	apaaroa ana o	ompoundoù by ene	0.00	
	Lesser of lines 53/54 or 55 from prior year					0.00	
1.00	If line 53/54 is less than the lower of line					0	61.
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (Tines 54 x	60), or 1% o	r the target		
2.00	Relief payment (see instructions)					C	62.
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.
	PROGRAM INPATIENT ROUTINE SWING BED COST				ing and (Coo		
4.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is inrough Dece	mper 31 of th	e cost report	ing period (see	0	64.
5.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	O	65.
	instructions)(title XVIII only)						
5.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.
7.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	- costs through	December 31	of the cost r	eporting period	, o	67.
	(line 12 x line 19)		becomber of	01 110 0031 1	opor tring porrod		
3. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68.
	(line 13 x line 20)			- (0)			
	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.
	Skilled nursing facility/other nursing facil)		70.
. 00	Adjusted general inpatient routine service c	ost per diem (l					71.
	Program routine service cost (line 9 x line						72.
	Medically necessary private room cost applic Total Program general inpatient routine serv						73.
	Capital -related cost allocated to inpatient	•		·	Part II column		75.
	26, line 45)				,		
	Per diem capital-related costs (line 75 ÷ li						76.
	Program capital -related costs (line 9 x line						77.
	Inpatient routine service cost (line 74 minu: Aggregate charges to beneficiaries for exces		rovider recor	ds)			78.
	Total Program routine service costs for compa	• •			nus line 79)		80.
. 00	Inpatient routine service cost per diem limi	tation		-	,		81.
	Inpatient routine service cost limitation (I						82.
	Reasonable inpatient routine service costs (:		s)				83.
	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)				84.
	Total Program inpatient operating costs (sum						86.
+	PART IV - COMPUTATION OF OBSERVATION BED PAS						
7.00	Total observation bed days (see instructions					1, 156	
8.00	Adjusted general inpatient routine cost per o Observation bed cost (line 87 x line 88) (se	•	line 2)			1, 047. 76 1, 211, 211	
n n l							

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 10:	pared: 27 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	403, 070	3, 279, 479	0. 12290	7 1, 211, 211	148, 866	90.00
91.00 Nursing School cost	0	3, 279, 479	0.00000	0 1, 211, 211	0	91.00
92.00 Allied health cost	0	3, 279, 479	0.00000	0 1, 211, 211	0	92.00
93.00 All other Medical Education	0	3, 279, 479	0.00000	0 1, 211, 211	0	93.00

VPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1333	Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	
			10 12/31/2017	5/29/2018 10:	
	Title	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	<u>col.2)</u> 3.00	<u> </u>
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	-
D. 00 03000 ADULTS & PEDI ATRI CS			809, 972		30.
I. 00 03100 INTENSIVE CARE UNIT			216, 923		31.
I. 00 04100 SUBPROVI DER – I RF			0		41.
2. 00 04200 SUBPROVI DER			0		42.
3. 00 04300 NURSERY					43.
ANCILLARY SERVICE COST CENTERS					
D. 00 05000 OPERATING ROOM		0. 4932		307, 565	
I. 00 05100 RECOVERY ROOM		0. 4403		13, 908	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		0	52
3. 00 05300 ANESTHESI OLOGY		0. 7231		10, 301	53
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 24862		100, 082	54
4. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 16236		2, 283	
7. 00 05700 CT SCAN		0. 03464	45 310, 964	10, 773	57
3. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	58
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	59
D. 00 06000 LABORATORY		0. 1549		101, 305	
D. 01 06001 BLOOD LABORATORY		0.0000		0	60
1. 00 06400 I NTRAVENOUS THERAPY		0.0000		0	64
5. 00 06500 RESPI RATORY THERAPY		0. 43346		192, 159	
5. 00 06600 PHYSI CAL THERAPY		0. 35244		51, 486	66
7. 00 06700 OCCUPATI ONAL THERAPY		0. 2553		13, 060	
3. 00 06800 SPEECH PATHOLOGY		0. 30654		8, 098	
9. 00 06900 ELECTROCARDI OLOGY		0. 16034		4,070	
9. 01 06901 CARDI AC REHAB		0.66260		0	69
I. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		0	1
2. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0.0000		0	72
3. 00 07300 DRUGS CHARGED TO PATIENTS		0. 38130			
3. 01 07301 0NC0L0GY		0. 89968	87 1, 423	1, 280	73
		0.0000		2	00
3. 00 08800 RURAL HEALTH CLINIC		0.0000		0	88
8. 01 08801 RURAL HEALTH CLINIC II		0.0000		0	88
0.02 08802 RURAL HEALTH CLINIC III		0.0000		0	88
2. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	89
0. 00 09000 CLINIC		2.53072		0 527	90
00 00100 EMERGENCY		0. 44550		8, 537	91
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	00)	0. 59050		1 0(0 2(5	
00.00 Total (sum of lines 50 through 94 and 96 through			3, 401, 948	1, 068, 265	
11.00 Less PBP Clinic Laboratory Services-Program only	charges (Trne 61)		2 401 040		201
02.00 Net charges (line 200 minus line 201)		1	3, 401, 948		202

ealth Financial Systems PUTNAM COUNTY NPATIENT ANCILLARY SERVICE COST APPORTIONMENT PUTNAM COUNTY		CN: 15-1333	Peri od:	u of Form CMS-2 Worksheet D-3	
	li ovraci o	011. 10 1000	From 01/01/2017	WOLKSHEET D 5	
	Component	CCN: 15-Z333	To 12/31/2017	Date/Time Pre 5/29/2018 10:	
	Title	e XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	<u> </u>
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	-		
30. 00 03000 ADULTS & PEDIATRICS			0		30.0
31.00 03100 INTENSIVE CARE UNIT			0		31.0
1.00 04100 SUBPROVIDER - IRF			0		41.0
12.00 04200 SUBPROVI DER			0		42.0
13. 00 04300 NURSERY					43.0
ANCI LLARY SERVI CE COST CENTERS		0.4622	20 222	44.155	1 50 0
50. 00 05000 OPERATING ROOM		0. 49329			
51.00 O5100 RECOVERY ROOM		0. 4403		-	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000		-	1
53.00 05300 ANESTHESI OLOGY		0. 7231		-	
4. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 24862			
4. 01 05401 NUCLEAR MEDI CI NE-DI AGNOSTI C		0. 16236			
57.00 05700 CT SCAN		0. 03464		180	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		-	
9.00 05900 CARDI AC CATHETERI ZATI ON		0.0000		-	
0. 00 06000 LABORATORY		0. 1549			
0. 01 06001 BLOOD LABORATORY		0.0000		-	
4. 00 06400 I NTRAVENOUS THERAPY		0.00000		-	
5. 00 06500 RESPI RATORY THERAPY		0. 43346			
6.00 06600 PHYSI CAL THERAPY		0. 35244			
7.00 06700 OCCUPATI ONAL THERAPY		0. 2553			
8.00 06800 SPEECH PATHOLOGY		0. 30654			
9. 00 06900 ELECTROCARDI OLOGY		0. 16034			
9. 01 06901 CARDI AC REHAB		0.66260		-	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000		-	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.0000		-	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 38130			
3. 01 07301 ONCOLOGY		0. 89968	37 239	215	73.0
OUTPATIENT SERVICE COST CENTERS		1	1		4
8.00 08800 RURAL HEALTH CLINIC		0.0000		0	
8.01 08801 RURAL HEALTH CLINIC II		0.0000		0	
8. 02 08802 RURAL HEALTH CLINIC III		0.0000		0	
39. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER		0.00000		0	
0. 00 09000 CLINIC		2. 53072		0	
01.00 09100 EMERGENCY		0. 44556			
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 59050		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1) (3)		496, 183		
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)			496, 183		202.0

IPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1333	Peri od:	Worksheet D-3	;
			From 01/01/2017		
			To 12/31/2017	Date/Time Pre 5/29/2018 10:	parec 27 ar
	Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00	2.00	<u>col. 2)</u>	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
0. 00 03000 ADULTS & PEDI ATRI CS			15, 905		30.
. 00 03100 I NTENSI VE CARE UNI T			987		31.
. 00 04100 SUBPROVI DER – I RF			0		41.
2. 00 04200 SUBPROVI DER			0		42.
5. 00 04300 NURSERY			0		43.
ANCI LLARY SERVICE COST CENTERS					1 10.
0. 00 05000 OPERATING ROOM		0. 49329	96 17, 304	8, 536	50.
. 00 05100 RECOVERY ROOM		0. 4403	10 0	0	51.
. OO 05200 DELIVERY ROOM & LABOR ROOM		0.00000	0 00	0	52.
00 05300 ANESTHESI OLOGY		0. 7231	13 333	241	53.
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 24862	27 2, 881	716	54.
. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC		0. 16236	61 0	0	54.
7. 00 05700 CT SCAN		0. 03464	45 11, 131	386	57.
0. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000	0 00	0	58.
0. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000	0 00	0	59.
0. 00 06000 LABORATORY		0. 15491	19 14, 399	2, 231	60.
0. 01 06001 BLOOD LABORATORY		0.00000	0 00	0	60.
. 00 06400 I NTRAVENOUS THERAPY		0.00000	0 00	0	64.
0. 00 06500 RESPI RATORY THERAPY		0. 43346	68 2, 033	881	65.
0. 00 06600 PHYSI CAL THERAPY		0. 35244	49 3, 334	1, 175	66.
00 06700 OCCUPATI ONAL THERAPY		0. 25537	77 105	27	67.
00 06800 SPEECH PATHOLOGY		0. 30654	44 129	40	68.
0. 00 06900 ELECTROCARDI OLOGY		0. 16034	41 2, 333	374	69.
0. 01 06901 CARDI AC REHAB		0. 66260	0 80	0	69.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.0000	0 00	0	71.
2. 00 07200 I MPL. DEV. CHARGED TO PATIENT		0.0000	0 00	0	72.
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 38130	12, 140	4, 629	73.
01 07301 ONCOLOGY		0. 89968	37 1, 646	1, 481	73.
OUTPATIENT SERVICE COST CENTERS					
8. 00 08800 RURAL HEALTH CLINIC		0. 95793	30 0	0	88.
8. 01 08801 RURAL HEALTH CLINIC II		0. 93257	78 0	0	88.
8. 02 08802 RURAL HEALTH CLINIC III		1. 2485		0	88.
0. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
0. 00 09000 CLINIC		2. 53072	25 0	0	90.
. 00 09100 EMERGENCY		0. 44556	69 2, 359	1, 051	91.
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 59050	04 0	0	92.
0.00 Total (sum of lines 50 through 94 and 96 through 98)			70, 127	21, 768	200.
1.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.
2.00 Net charges (line 200 minus line 201)			70, 127		202.

CALCUL	Financial Systems PUTNAM COUNTY H ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1333	Period: From 01/01/2017	u of Form CMS-2 Worksheet E Part B	2332-10
			To 12/31/2017	Date/Time Pre 5/29/2018 10:	
		Title XVIII	Hospi tal	Cost	20 011
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		7, 689, 335 0	1
3.00	OPPS payments	(10115)		0	
4.00	Outlier payment (see instructions)			0	
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruc	ctions)		0 0. 000	
6.00	Line 2 times line 5			0.000	
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00 9.00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. I	V col 13 line 200		0	
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			7, 689, 335	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				1
	Ancillary service charges				12.00
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)	ne 69)		0	13.00 14.00
14.00	Customary charges			0	1 14.00
15.00	Aggregate amount actually collected from patients liable for p			0	
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(on a chargebasis	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	-)		0. 000000	17.00
	Total customary charges (see instructions)			0	
19.00	Excess of customary charges over reasonable cost (complete onl instructions)	y if line 18 exceeds I	ine 11) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds l	ine 18) (see	0	20.00
21 00	instructions) Lesser of cost or charges (see instructions)			7, 766, 228	21 00
	Interns and residents (see instructions)			7,700,220	•
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			56, 145	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for			3, 812, 053	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pinstructions)	olus the sum of lines 2	2 and 23] (see	3, 898, 030	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 898, 030 2, 788	•
	Subtotal (line 30 minus line 31)			3, 895, 242	
22 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)		0	33.00
	Composite rate ESRD (from Wkst. 1-5, line 11) Allowable bad debts (see instructions)			590, 836	
35.00	Adjusted reimbursable bad debts (see instructions)			384, 043	35.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)	ructions)		504, 799	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			4, 279, 285 0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39.50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39.50
	Demonstration payment adjustment amount before sequestration			0	
39.98	Partial or full credits received from manufacturers for replace	ced devices (see instru	ctions)	0	
40.00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 4, 279, 285	
	Sequestration adjustment (see instructions)			85, 586	
	Demonstration payment adjustment amount after sequestration			0	
	Interim payments			4, 481, 532	
42.00 43.00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2.	chapter 1,	-287, 833 0	
	§115. 2		· · ·		
00.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	5			0	•
91.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			-	92.00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2017 To 12/31/2017		pared:
			XVIII	Hospi tal	Cost	
		Inpati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2, 435, 04	40	4, 481, 532	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.00
3.00	amount based on subsequent revision of the interim rate					3.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	· · · · ·		!		
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. O´
3. 02				0	0	3.02
3.03				0	0	3.03
3.04				0	0	3.04
3. 05	Dura da la la Dura marte			0	0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.50
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.5
3.52				0	0	3.5
3.53				0	0	3.5
3.54				0	0	3.54
3.99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 435, 04	40	4, 481, 532	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVIDER			0	0	5.01
5.02				0	0	5.02
5.03	Dura da la la Dura marte			0	0	5.03
5.50	Provider to Program TENTATIVE TO PROGRAM			0	0	5.50
5.50	TENTATIVE TO PROGRAM			0	0	5.5
5. 52				0	0	5.5
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.9
-	5. 50-5. 98)					
5.00	Determined net settlement amount (balance due) based on					6.0
	the cost report. (1)					
5. 01	SETTLEMENT TO PROVIDER		100, 25		0	6.0
b. 02	SETTLEMENT TO PROGRAM		0 505 55	0	287, 833	6.0
7.00	Total Medicare program liability (see instructions)		2, 535, 29	21 Contractor	4, 193, 699 NPR Date	7.0
				Number	(Mo/Day/Yr)	
		C)	1.00	2.00	
		0				8.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2017		
		Component (CCN: 15-Z333	To 12/31/2017	Date/Time Pre 5/29/2018 10:	
		Title	XVIII	Swing Beds - SN		
		I npati en	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2,00	3, 00	4,00	
. 00	Total interim payments paid to provider		513, 44	2	0	1.0
. 00	Interim payments payable on individual bills, either			0	0	2.0
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~ ~	write "NONE" or enter a zero					
. 00	List separately each retroactive lump sum adjustment					3.0
	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				1	
. 01	ADJUSTMENTS TO PROVIDER			0	0	1 3.0
. 02				0	0	3.0
. 03				0	0	3.0
. 04				0	0	3.0
. 05				0	0	3.0
	Provider to Program					
. 50	ADJUSTMENTS TO PROGRAM			0	0	
. 51				0	0	
. 52				0	0	
. 53				0	0	
. 54 . 99	Subtatal (sum of lines 2.01.2.40 minus sum of lines			0		
. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.5
. 00	Total interim payments (sum of lines 1, 2, and 3.99)		513, 44	2	0	4.0
. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		010, 11		0	1.0
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					1
. 00	List separately each tentative settlement payment after					5.0
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
01	Program to Provider			0		
. 01 . 02	TENTATI VE TO PROVIDER			0	0	
. 02				0	0	
. 05	Provider to Program			0	0	
50	TENTATI VE TO PROGRAM			0	0	5.5
51				0	0	5.5
52				0	0	5. !
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
	5. 50-5. 98)					
. 00	Determined net settlement amount (balance due) based on					6.0
01	the cost report. (1)					
. 01 . 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		17 / 6	0	0	
02			17, 45 495, 98		0	
00	Total Medicare program liability (see instructions)		490, 98	Contractor	NPR Date	1.0
				Number	(Mo/Day/Yr)	
		0)	1.00	2.00	
00	Name of Contractor					8.0

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of	f Form CMS-2552-10
From 01/01/2017 Par To 12/31/2017 Dat 5/2	orksheet E-1 art II ate/Time Prepared: '29/2018 10:26 am
	Cost
	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	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2	3.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	4.00
5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200	5.00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20	6.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	7.00
8.00 Calculation of the HIT incentive payment (see instructions)	8.00
9.00 Sequestration adjustment amount (see instructions)	9.00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)	10.00
I NPATI ENT HOSPI TAL SERVICES UNDER THE I PPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions)	30.00
31.00 Other Adjustment (specify)	31.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	32.00

LOOL	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1333	Period: From 01/01/2017	Worksheet E-2	2
		Component CCN: 15-Z333	To 12/31/2017	Date/Time Pre 5/29/2018 10:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		350, 277	0	
00	Inpatient routine services - swing bed-NF (see instructions)		4/5 304		2
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	-	, 165, 701	0	3
0	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in:			0.00	4
00	Per diem cost for interns and residents not in approved teach instructions)	ing program (see		0.00	4
00	Program days		331	0	5
00	Interns and residents not in approved teaching program (see in	nstructions)	331	0	
00	Utilization review - physician compensation - SNF optional me		0	0	7
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		515, 978	0	
00	Primary payer payments (see instructions)		0	0	
00	Subtotal (line 8 minus line 9)		515, 978	0	10
00	Deductibles billed to program patients (exclude amounts appli)	cable to physician	0	0	11
	professional services)				
00	Subtotal (line 10 minus line 11)		515, 978	0	12
00	Coinsurance billed to program patients (from provider records)) (excl ude coi nsurance	9, 870	0	13
	for physician professional services)				
00	80% of Part B costs (line 12 x 80%)			0	
00	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	506, 108	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
50	Pioneer ACO demonstration payment adjustment (see instruction)				16
55	Rural community hospital demonstration project (§410A Demonst	ration) payment	0		16
99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	16
	Allowable bad debts (see instructions)		0	0	
01	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	
00	Total (see instructions)		506, 108	0	
	Sequestration adjustment (see instructions)		10, 122	0	
	Demonstration payment adjustment amount after sequestration)		0	0	19
00	Interim payments		513, 442	0	20
00	Tentative settlement (for contractor use only)		0	0	21
00	Balance due provider/program (line 19 minus lines 19.01, 20,	and 21)	-17, 456	0	22
00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	23
	chapter 1, §115.2				1
	Rural Community Hospital Demonstration Project (§410A Demonstr				1
). 00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no.				-
	Cost Reimbursement Medicare swing-bed SNF inpatient routine service costs (from)	West D_1 Pt II line			201
1.00	66 (title XVIII hospital))				201
2.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3. col. 3. li	ne		202
	200 (title XVIII swing-bed SNF))				
3. 00	Total (sum of lines 201 and 202)			I	203
. 00	Medicare swing-bed SNF discharges (see instructions)				204
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curr	ent 5-year demons	tration	
	period)				
	Medicare swing-bed SNF target amount				205
. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	<i>k</i>			206
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburg				
	Program reimbursement under the §410A Demonstration (see inst				207
3.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines	1		208
	and 3) Adjustment to Medicaro swing bod SNE PPS payments (see instru	ctions)			200
	Adjustment to Medicare swing-bed SNF PPS payments (see instru Reserved for future use				209 210
	Comparision of PPS versus Cost Reimbursement				210
					1

	Financial Systems PUTNAM COUNTY			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Period: From 01/01/2017	Worksheet E-3 Part V	
			To 12/31/2017		pared.
			10 12/01/2017	5/29/2018 10:	
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAR	PE PART A SERVICES - COS		1.00	
1.00	Inpatient services	E FART A SERVICES COS	T RETWOORSEWENT	2, 927, 392	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruct	ions)		0	2.00
3.00	Organ acqui si ti on	,		0	3.00
4.00	Subtotal (sum of lines 1 through 3)			2, 927, 392	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 956, 666	
	COMPUTATION OF LESSER OF COST OR CHARGES			· · · ·	1
	Reasonabl e charges				1
7.00	Routi ne servi ce charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9.00
10.00	Total reasonable charges			0	10.00
	Customary charges				
11.00	Aggregate amount actually collected from patients liable for			0	
12.00	Amounts that would have been realized from patients liable f	1 5	on a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13((e)			
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete o	only if line 14 exceeds l	ine 6) (see	0	15.00
	instructions)				
16.00	Excess of reasonable cost over customary charges (complete o	only if line 6 exceeds li	ne 14) (see	0	16.00
17.00	instructions)	structions)		0	17.00
17.00	Cost of physicians' services in a teaching hospital (see ins COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	17.00
18.00	Direct graduate medical education payments (from Worksheet E	-1 line 19)		0	18.00
19.00	Cost of covered services (sum of lines 6, 17 and 18)	-4, 11116 49)		2, 956, 666	
20.00	Deductibles (exclude professional component)			387, 956	
20.00	Excess reasonable cost (from Line 16)			307, 730	
22.00	Subtotal (line 19 minus line 20 and 21)			2, 568, 710	
23.00	Coi nsurance			329	
24.00	Subtotal (line 22 minus line 23)			2, 568, 381	
25.00	Allowable bad debts (exclude bad debts for professional serv	vices) (see instructions)		28,694	
26.00	Adjusted reimbursable bad debts (see instructions)			18, 651	
27.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		14, 735	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			2, 587, 032	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			2, 307, 032	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	
29.99	Demonstration payment adjustment amount before sequestration			0	29.99
30.00	Subtotal (see instructions)			2, 587, 032	
30.01	Sequestration adjustment (see instructions)			51, 741	
30.02	Demonstration payment adjustment amount after sequestration			0	30.02
31.00	Interim payments			2, 435, 040	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.	02, 31, and 32)		100, 251	33.00
34.00	Protested amounts (nonallowable cost report items) in accord		chapter 1,	0	34.00
	§115. 2		-		

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1333	Peri od:	Worksheet E-3	
			From 01/01/2017 To 12/31/2017	Part VII Date/Time Pre 5/29/2018 10:	
		Title XIX	Hospi tal	Cost	<u> </u>
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	ERVICES FOR TITLES V OR	XIX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES		44.475		
1.00	Inpatient hospital/SNF/NF services		41, 675	0	1.00
2.00 3.00	Medical and other services Organ acquisition (certified transplant centers only)		0	0	2.00
4.00	Subtotal (sum of lines 1, 2 and 3)		41, 675	0	4.00
5.00	Inpatient primary payer payments		41,075	0	5.00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		41, 675	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		16, 892		8.00
9.00	Ancillary service charges		70, 127	0	9.00
10.00 11.00	Organ acquisition charges, net of revenue Incentive from target amount computation	0		10.0	
12.00	Total reasonable charges (sum of lines 8 through 11)		87, 019	0	12.0
12.00	CUSTOMARY CHARGES		07,017	0	12.00
13.00	Amount actually collected from patients liable for payment for	or services on a charge	0	0	13.00
	basi s	5			
14.00	Amounts that would have been realized from patients liable for	on 0	0	14.00	
	a charge basis had such payment been made in accordance with				
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.00000	0.000000		
16.00	Total customary charges (see instructions)		87,019	0	
17.00	Excess of customary charges over reasonable cost (complete or line 4) (see instructions)	45, 344	0	17.0	
18.00	Excess of reasonable cost over customary charges (complete or	nlvifline 4 exceeds li	ne O	0	18.00
10.00	16) (see instructions)		0	0	10.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see ins		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line		41, 675	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	e completed for PPS prov			
22.00	Other than outlier payments		0	0	
23.00	Outlier payments		0	0	23.00
24.00 25.00	Program capital payments Capital exception payments (see instructions)		0		24.0
26.00	Routine and Ancillary service other pass through costs		0	0	26.0
27.00	Subtotal (sum of lines 22 through 26)		0	0	
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	
29.00	Titles V or XIX (sum of lines 21 and 27)		41, 675	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 0	6)	41, 675	0	
32.00	Deducti bl es		0	0	
33.00	Coinsurance		0	0	
34.00 35.00	Allowable bad debts (see instructions)		0	0	34.00 35.00
36.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 a	41, 675	0		
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		41, 075 O	0	
38.00	Subtotal (line 36 \pm line 37)	41, 675	0		
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	Ũ	39.0	
40.00	Total amount payable to the provider (sum of lines 38 and 39)	41, 675	0	40.0	
41.00	Interim payments		60, 478	0	41.0
42.00	Balance due provider/program (line 40 minus line 41)		-18, 803	0	
43.00	Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub 15-2,	0	0	43.0
	chapter 1, §115.2				1

	SHEET (If you are nonproprietary and do not maintain be accounting records, complete the General Fund column	Provider C		eriod: com 01/01/2017 0 12/31/2017	Worksheet G Date/Time Pre 5/29/2018 10:	parec 26 an
		General Fund	Specific Purpose Fund 2.00	Endowment Fund 3.00	Plant Fund	
С	URRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	20, 454, 470	0	0	0	1.0
00 T	emporary investments	0	0	0	0	2.0
00	lotes recei vabl e	0	0	0	0	3.0
00 A	ccounts receivable	11, 355, 445	0	0	0	4.
)ther receivable	2, 184, 602	0	0	0	5.
	Allowances for uncollectible notes and accounts receivable	-4, 749, 090		0	0	6.
	nventory	819, 966	0	0	0	7.
	Prepai d'expenses	285, 405		0	0	8.
	Other current assets	0	0	0	0	9.
	Due from other funds	0 250 700	0	0	0	10.
	Total current assets (sum of lines 1-10)	30, 350, 798	0	0	0	11.
	I XED ASSETS	150 2(4		0	0	1 1 2
	and improvements	159, 364	0	0	0	12.
	and improvements	329, 844 -252, 783	0	0	0	13. 14.
	Accumulated depreciation Buildings	32, 166, 110	0	0	0	14
	Accumulated depreciation	-21, 776, 644	0	0	0	16
	easehold improvements	-21, 770, 044	0	0	0	17
	Accumulated depreciation	0	0	0	0	18
	ixed equipment	0	0	0	0	19
	Accumulated depreciation	0	0	0	0	20
	Automobiles and trucks	0	0	0	0	20
	Accumulated depreciation	0	0	0	0	22
	lajor movable equipment	23, 096, 776	-	0	0	23
	Accumulated depreciation	-18, 978, 931	0	0	0	24
	li nor equi pment depreci able	0, 770, 701	0	0	0	25
	Accumulated depreciation	0	0	0	0	26
	IIT designated Assets	0	0	0	0	27
	Accumulated depreciation	0	0	0	0	28
	li nor equi pment-nondepreci abl e	0	0	0	0	29
	Total fixed assets (sum of lines 12-29)	14, 743, 736	-	0	0	30
	THER ASSETS					
	nvestments	349, 309	0	0	0	31
. 00 0	Deposits on Leases	0	0	0	0	32
. 00 0	Due from owners/officers	0	0	0	0	33
. 00 0)ther assets	244, 667	0	0	0	34
. 00 T	otal other assets (sum of lines 31-34)	593, 976	0	0	0	35
. 00 T	otal assets (sum of lines 11, 30, and 35)	45, 688, 510	0	0	0	36
С	URRENT LIABILITIES					
. 00 A	ccounts payable	3, 470, 599	0	0	0	37
. 00 5	Salaries, wages, and fees payable	103, 528	0	0	0	38
	Payroll taxes payable	103, 458	0	0	0	39
	lotes and Loans payable (short term)	3, 094, 133	0	0	0	
	Deferred income	0	0	0	0	
	Accelerated payments	0				42
	Due to other funds	0	0	0	0	
	Other current liabilities	469, 362		0	0	44
	otal current liabilities (sum of lines 37 thru 44)	7, 241, 080	0	0	0	45
	ONG TERM LIABILITIES			. 1		
	lortgage payable	0	0	0	0	46
	lotes payable	12, 708, 280		0	0	47
	Insecured Loans	0	0	0	0	48
	Other long term liabilities	10 700 000	0	0	0	
	otal long term liabilities (sum of lines 46 thru 49)	12, 708, 280		0	0	50
	Total liabilities (sum of lines 45 and 50)	19, 949, 360	0	0	0	51
	APITAL ACCOUNTS	25 720 150	1			1 5 2
	General fund balance	25, 739, 150	0			52 53
	Specific purpose fund		0	0		53
	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54
	Soverning body created - endowment fund balance - unrestricted			0		55
	Plant fund balance - invested in plant			0	0	50
	Plant fund balance - reserve for plant improvement,				0	57
	replacement, and expansion				0	⁰⁸
	otal fund balances (sum of lines 52 thru 58)	25, 739, 150	0	0	0	59
	otal liabilities and fund balances (sum of lines 51 and	45, 688, 510		0	0	60
	Star Frantitics and fund barances (Sum OF FILES ST dIU	-5,000,510	0	0	0	1 00

Heal th	Financial Systems	PUTNAM COUNTY	HOSPI TAL			In Lie	u of Form CM	S-2	552-10
STATE	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1333		d: 01/01/2017 12/31/2017	Worksheet (Date/Time F 5/29/2018 1	rep	
		General	Fund	Speci al	Purpos	e Fund	Endowment Fund		
		1.00	2.00	3.00		4.00	5.00	-	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		25, 739, 150 0 25, 739, 150 0 25, 739, 150	5.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0		5.00	0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
	sheet (line 11 minus line 18)	Endowment Fund	Pl ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0				10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

TATEM	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN:	15-1333		iod: m 01/01/2017 12/31/2017	Worksheet G-2 Parts I & II Date/Time Pre 5/29/2018 10:	epared:
	Cost Center Description	1		Inpati ent		Outpatient	Total	
				1.00		2.00	3.00	
	PART I - PATIENT REVENUES							
00	General Inpatient Routine Services			4 (50 5)			4 (50 54)	1 1 0
. 00				1, 652, 51	14		1, 652, 514	
. 00	SUBPROVIDER - IPF				~			2.00
. 00	SUBPROVIDER - IRF				0		0	
. 00 . 00	SUBPROVIDER Swing bed - SNF				0 0		C	
. 00	Swing bed - NF				0			
. 00	SKILLED NURSING FACILITY				U		L. L	7.0
. 00	NURSING FACILITY							8.0
. 00	OTHER LONG TERM CARE							9.0
0.00	Total general inpatient care services (sum of lines 1-9)			1, 652, 5 [.]	14		1, 652, 514	
0.00	Intensive Care Type Inpatient Hospital Services			1,002,0		I	1,002,011	
1.00	I NTENSI VE CARE UNI T			516, 20	64		516, 264	11.0
2.00	CORONARY CARE UNIT							12.0
3.00	BURN INTENSIVE CARE UNIT							13.0
4.00	SURGICAL INTENSIVE CARE UNIT							14.0
5.00	OTHER SPECIAL CARE (SPECIFY)							15.0
6.00	Total intensive care type inpatient hospital services (sum of	lines		516, 20	64		516, 264	16.0
	11-15)							
7.00	Total inpatient routine care services (sum of lines 10 and 16)		2, 168, 7			2, 168, 778	
8.00	Ancillary services			6, 953, 84		63, 067, 551	70, 021, 395	
	Outpatient services			126, 94		10, 884, 898	11, 011, 846	
	RURAL HEALTH CLINIC				0	2, 276, 278	2, 276, 278	
0. 01	RURAL HEALTH CLINIC II				0	1, 894, 217	1, 894, 217	
	RURAL HEALTH CLINIC III				0	825, 574	825, 574	
1.00	FEDERALLY QUALIFIED HEALTH CENTER				0	0	C	
2.00	HOME HEALTH AGENCY							22.0
3.00	AMBULANCE SERVICES							23.0
4.00 4.10	CMHC CORF				0	0	C	24.0
4. 10 5. 00	AMBULATORY SURGICAL CENTER (D. P.)				0	0	L L	24.1
6.00	HOSPICE							26.0
7.00	PHYSICIAN PRIVATE OFFICES			874,08	80	12, 371, 416	13, 245, 505	
8.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst		10, 123, 65		91, 319, 934	101, 443, 593	
0.00	G-3, line 1)			107 1207 00		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1017 1107 070	2010
	PART II - OPERATING EXPENSES					I		
9.00	Operating expenses (per Wkst. A, column 3, line 200)					41, 624, 293		29.0
0. 00	ADD (SPECIFY)				0			30.0
1.00					0			31.0
2.00					0			32.0
3.00					0			33.0
4.00					0			34.0
5.00					0			35.0
	Total additions (sum of lines 30-35)					0		36.0
7.00	DEDUCT (SPECIFY)				0			37.0
8.00					0			38.0
9.00					0			39.0
0.00					0			40.0
1.00					0	-		41.0
2.00	Total deductions (sum of lines 37-41)	12) (+ C				0		42.0
3.00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	i∠)(transf	er			41, 624, 293		43.0

STATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1333 Period: From 01/01/2017 To 12/31/2017 Workshee Date/Tim 5/29/201 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 101.44 2.00 Less contractual allowances and discounts on patients' accounts 62,09 3.00 Net patient revenues (line 1 minus line 2) 40.0 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 41,62 5.00 Net income from service to patients (line 3 minus line 4) -2,27 OTHER INCOME -2,27 6.00 Contributions, donations, bequests, etc -2,27 7.00 Income from telephone and other miscellaneous communication services 9.00 9.00 Revenues from telephone and other miscellaneous communication services 10.0 10.00 Purchase discounts 10.0 11.00 Rebates and refunds of expenses 10.0 12.00 Parking lot receipts 13.00 13.00 Revenue from meals sold to employees and guests 14.00 15.00 Revenue from meals eof medical and surgical supplies to other than patients 16.00 16.00 Revenue from sale of medical erecords and abstracts 18.00 <th>G-3</th>	G-3
To 12/31/2017 Date/Tim 5/29/201 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 101, 44 2.00 Less contractual allowances and discounts on patients' accounts 62,09 3.00 Net patient revenues (line 1 minus line 2) 39, 34 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 41, 62 5.00 Net income from service to patients (line 3 minus line 4) -2, 27 OTHER INCOME -2, 27 6.00 Contributions, donations, bequests, etc -2, 27 7.00 Income from telephone and other miscellaneous communication services 9, 08 8.00 Revenue from telephone and other miscellaneous communication services 10, 00 9.00 Revenue from television and radio service 10, 00 10.00 Purchase discounts 10, 00 11.00 Revenue from television and radio service 10, 00 12.00 Parking lot receipts 13, 00 13.00 Revenue from rental of living quarters 10, 00 16.00 Revenue from sale of medical and surgical supplies to other than patients 10, 00 16.00 Revenue from sale of medical and surgical suppli	
5/29/201 1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28) 2.00 Less contractual allowances and discounts on patients' accounts 3.00 Net patient revenues (line 1 minus line 2) 4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 5.00 Net income from service to patients (line 3 minus line 4) 0THER INCOME -2, 27 0THER INCOME 0 6.00 Contributions, donations, bequests, etc 7.00 Income from investments 8.00 Revenues from telephone and other miscellaneous communication services 9.00 Revenue from television and radio service 10.00 Purchase discounts 11.00 Rebates and refunds of expenses 12.00 Parking lot receipts 13.00 Revenue from neals sold to employees and guests 15.00 Revenue from sel of meical and surgical supplies to other than patients 16.00 Revenue from sale of drugs to other than patients	Prepared
1.00Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)101, 442.00Less contractual allowances and discounts on patients' accounts62, 093.00Net patient revenues (line 1 minus line 2)39, 344.00Less total operating expenses (from Wkst. G-2, Part II, line 43)41, 625.00Net income from service to patients (line 3 minus line 4)-2, 270OTHER INCOME-2, 276.00Contributions, donations, bequests, etc-2, 277.00Income from investments-2, 278.00Revenue from telephone and other miscellaneous communication services-2, 279.00Revenue from television and radio service-2, 2710.00Purchase discounts-2, 2711.00Rebates and refunds of expenses-2, 2712.00Parking lot receipts	<u>10: 26 am</u>
1.00Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)101, 442.00Less contractual allowances and discounts on patients' accounts62, 093.00Net patient revenues (line 1 minus line 2)39, 344.00Less total operating expenses (from Wkst. G-2, Part II, line 43)41, 625.00Net income from service to patients (line 3 minus line 4)-2, 270OTHER INCOME-2, 276.00Contributions, donations, bequests, etc-2, 277.00Income from investments-2, 278.00Revenue from telephone and other miscellaneous communication services-2, 279.00Revenue from television and radio service-2, 2710.00Purchase discounts-2, 2711.00Rebates and refunds of expenses-2, 2712.00Parking lot receipts	
2.00Less contractual allowances and discounts on patients' accounts62,093.00Net patient revenues (line 1 minus line 2)39,344.00Less total operating expenses (from Wkst. G-2, Part II, line 43)41,625.00Net income from service to patients (line 3 minus line 4)-2,27OTHER INCOME600Contributions, donations, bequests, etc7.00Income from telephone and other miscellaneous communication services9.00Revenues from telephone and other miscellaneous communication services9.00Purchase discounts11.00Rebates and refunds of expenses12.00Parking lot receipts13.00Revenue from neals sold to employees and guests15.00Revenue from rental of living quarters16.00Revenue from sale of medical and surgical supplies to other than patients17.00Revenue from sale of drugs to other than patients	
3.00Net patient revenues (line 1 minus line 2)39,344.00Less total operating expenses (from Wkst. G-2, Part II, line 43)41,625.00Net income from service to patients (line 3 minus line 4)-2,27OTHER INCOME6.00Contributions, donations, bequests, etc7.00Income from investments8.00Revenues from telephone and other miscellaneous communication services9.00Revenue from television and radio service10.00Purchase discounts11.00Rebates and refunds of expenses12.00Parking lot receipts13.00Revenue from neals sold to employees and guests15.00Revenue from rental of living quarters16.00Revenue from sale of medical and surgical supplies to other than patients17.00Revenue from sale of drugs to other than patients	
4.00Less total operating expenses (from Wkst. G-2, Part II, line 43)41,625.00Net income from service to patients (line 3 minus line 4)-2,27OTHER INCOME6.00Contributions, donations, bequests, etc7.00Income from investments8.00Revenues from telephone and other miscellaneous communication services9.00Revenue from television and radio service10.00Purchase discounts11.00Rebates and refunds of expenses12.00Parking lot receipts13.00Revenue from meals sold to employees and guests15.00Revenue from rental of living quarters16.00Revenue from sale of medical and surgical supplies to other than patients17.00Revenue from sale of drugs to other than patients	
5.00 Net income from service to patients (line 3 minus line 4) -2,27 OTHER INCOME -2,27 6.00 Contributions, donations, bequests, etc -2,27 7.00 Income from investments -2,27 8.00 Revenues from telephone and other miscellaneous communication services -2,27 9.00 Revenue from television and radio service -2,27 10.00 Purchase discounts -2,27 11.00 Rebates and refunds of expenses -2,27 12.00 Parking lot receipts -2,27 13.00 Revenue from laundry and linen service -2,27 14.00 Revenue from meals sold to employees and guests -2,27 15.00 Revenue from sale of living quarters -2,27 16.00 Revenue from sale of medical and surgical supplies to other than patients -2,27 17.00 Revenue from sale of drugs to other than patients -2,27	
OTHER INCOME 6.00 Contributions, donations, bequests, etc 7.00 Income from investments 8.00 Revenues from telephone and other miscellaneous communication services 9.00 Revenue from television and radio service 10.00 Purchase discounts 11.00 Rebates and refunds of expenses 12.00 Parking lot receipts 13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients	
 6.00 Contributions, donations, bequests, etc 7.00 Income from investments 8.00 Revenues from tellephone and other miscellaneous communication services 9.00 Revenue from tellevision and radio service 10.00 Purchase discounts 11.00 Rebates and refunds of expenses 12.00 Parking lot receipts 13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	906 5.00
 7.00 Income from investments 8.00 Revenues from telephone and other miscellaneous communication services 9.00 Revenue from television and radio service 10.00 Purchase discounts 11.00 Rebates and refunds of expenses 12.00 Parking lot receipts 13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	
 8.00 Revenues from telephone and other miscellaneous communication services 9.00 Revenue from television and radio service 10.00 Purchase discounts 11.00 Rebates and refunds of expenses 12.00 Parking lot receipts 13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	0 6.00
 9.00 Revenue from television and radio service 10.00 Purchase discounts 11.00 Rebates and refunds of expenses 12.00 Parking lot receipts 13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	0 7.00
 10.00 Purchase discounts 11.00 Rebates and refunds of expenses 12.00 Parking lot receipts 13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	0 8.00
 11.00 Rebates and refunds of expenses 12.00 Parking lot receipts 13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	0 9.00
 12.00 Parking lot receipts 13.00 Revenue from laundry and linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	0 10.00
 13.00 Revenue from Laundry and Linen service 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of Living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	0 11.00
 14.00 Revenue from meals sold to employees and guests 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	0 12.00
 15.00 Revenue from rental of living quarters 16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients 	0 13.00
16.00 Revenue from sale of medical and surgical supplies to other than patients 17.00 Revenue from sale of drugs to other than patients	
17.00 Revenue from sale of drugs to other than patients	
	0 16.00
	0 18.00
19.00 Tuition (fees, sale of textbooks, uniforms, etc.)	0 19.00
20.00 Revenue from gifts, flowers, coffee shops, and canteen	0 20.00
21. 00 Rental of vending machines	0 21.00
22.00 Rental of hospital space	0 22.00
23.00 Governmental appropriations	0 22.00
24. 00 OTHER OPERATING AND NONOPERATING INC 8, 87	
25. 00 Total other income (sum of lines 6-24) 8, 87	
26. 00 Total (line 5 plus line 25) 6, 60	
27. 00 OTHER EXPENSES (SPECIFY)	0 27.00
28.00 Total other expenses (sum of line 27 and subscripts)	0 28.00
	486 29.00

	Financial Systems	PUTNAM COUNT			_		u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333		eriod:	Worksheet M-1	
			Component	CCN: 15-8515		rom 01/01/2017 5 12/31/2017	Date/Time Pre 5/29/2018 10:	
						RHC I	Cost	
		Compensati on	Other Costs	Total (col.	1	Recl assi 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	440, 052	0			0	440, 052	1.00
2.00	Physician Assistant	0	0		0	0	0	2.00
3.00	Nurse Practitioner	179, 965	0			0	179, 965	3.00
4.00	Visiting Nurse	0	0		0	0	0	4.00
5.00	Other Nurse	0	0		0	0	0	5.00
6.00	Clinical Psychologist	0	0		0	0	0	6.00
7.00	Clinical Social Worker	0	0		0	0	0	7.00
8.00	Laboratory Techni ci an	0	0		0	0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	620, 017	0	620, 0	17	0	620, 017	10.00
11.00	Physician Services Under Agreement	0	0		0	0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0	0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	0	14.00
15.00	Medical Supplies	0	0		0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	0	18.00
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	0	21.00
22.00	Total Cost of Health Care Services (sum of	620, 017	0	620, 0	17	0	620, 017	
	lines 10, 14, and 21)		-			-		
	COSTS OTHER THAN RHC/FQHC SERVICES							
23.00	Pharmacy	0	0		0	0	0	23.00
24.00	Dental	0	0		0	0	0	24.00
25.00	Optometry	0	0		0	0	0	25.00
25.01	Tel eheal th	0	0		0	0	0	25.01
25.02	Chronic Care Management	0	0		0	0	0	25.02
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs	-	-		-	-	-	27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27)	-	-		-	-	-	
	FACILITY OVERHEAD							
29.00	Facility Costs	0	0		0	0	0	29.00
30.00	Administrative Costs	383, 318	317, 285			-113, 904	586, 699	30.00
31.00	Total Facility Overhead (sum of lines 29 and	383, 318	317, 285			-113, 904	586, 699	31.00
	30)	,					,	
32.00	Total facility costs (sum of lines 22, 28	1, 003, 335	317, 285	1, 320, 6	20	-113, 904	1, 206, 716	32.00
JZ. 00								

	Financial Systems	PUINAM COUNT				u of Form CMS-	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333	Period: From 01/01/2017	Worksheet M-	1
			Component	CCN: 15-8515	To 12/31/2017	Date/Time Pro 5/29/2018 10	
					RHC I	Cost	
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
		6.00	col. 6) 7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
1.00	Physi ci an	0	440, 052				1.00
2.00	Physician Assistant	0					2.00
3.00	Nurse Practitioner	0	179, 965				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	-				9.00
10.00	Subtotal (sum of lines 1 through 9)	0	620, 017				10.0
11.00	Physician Services Under Agreement	0					11.0
12.00	Physician Supervision Under Agreement	0	0				12.0
	Other Costs Under Agreement	0	0				13.0
	Subtotal (sum of lines 11 through 13)	0	-				14.0
	Medical Supplies	0	0				15.0
	Transportation (Health Care Staff)	0	-				16.0
	Depreciation-Medical Equipment	0	0				17.0
	Professional Liability Insurance Other Health Care Costs	0	-				19.00
	Allowable GME Costs	0	0				20.00
	Subtotal (sum of lines 15 through 20)	0	0				21.00
22.00	Total Cost of Health Care Services (sum of	0	-				22.00
221 00	lines 10, 14, and 21)	0	020,011				
	COSTS OTHER THAN RHC/FOHC SERVICES		I	1			
23.00	Pharmacy	0	0				23.00
24.00	Dental	0	0				24.0
25.00	Optometry	0	0				25.0
25.01	Tel eheal th	0	0				25.0
	Chronic Care Management	0	0				25.0
	All other nonreimbursable costs	0	0				26.0
27.00	Nonallowable GME costs						27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.00
	through 27) FACILITY OVERHEAD			1			-
29.00	Facility Costs	0	0				29.00
30.00	Administrative Costs	0					30.0
31.00	Total Facility Overhead (sum of lines 29 and	0					31.0
	30)	0					
32.00	Total facility costs (sum of lines 22, 28	0	1, 206, 716				32.00
	and 31)						

	Financial Systems	PUTNAM COUNT			D 1 1	In Lie	u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333	Period:	/01/2017	Worksheet M-1	
			Component	CCN: 15-8513		/31/2017	Date/Time Pre 5/29/2018 10:	
					RHO		Cost	
		Compensation	Other Costs	Total (col.				
				+ col. 2)	i	ons	Trial Balance	
							(col. 3 +	
		1.00		2.00			<u>col. 4)</u>	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4	. 00	5.00	
1.00	Physician	224, 305	0	224, 3	05	0	224, 305	1.00
2.00	Physician Assistant	294, 481	0			0		2.00
3.00	Nurse Practitioner	2 94, 401	0	, .	0	0	,	3.00
4.00	Visiting Nurse	0	0		0	0	-	
4.00 5.00	Other Nurse	0	0		0	0		
6.00	Clinical Psychologist	0	0		0	0	-	
	Clinical Social Worker	0	0		0	0		
7.00		0	0		Ŭ	0	-	
8.00	Laboratory Technician	0	0		0	0	0	
9.00	Other Facility Health Care Staff Costs	0	0		0	0	-	
10.00	Subtotal (sum of lines 1 through 9)	518, 786	0			0	010/100	
11.00	Physician Services Under Agreement	0	0		0	0		
12.00	Physician Supervision Under Agreement	0	0		0	0	, o	12.00
13.00	Other Costs Under Agreement	0	0		0	0	-	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	-	
15.00	Medical Supplies	0	0		0	0	0	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	-	
17.00	Depreciation-Medical Equipment	0	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	0	21.00
22.00	Total Cost of Health Care Services (sum of	518, 786	0	518, 7	86	0	518, 786	22.00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES			1	-		-	
23.00	Pharmacy	0	0		0	0	-	
24.00	Dental	0	0		0	0		24.00
25.00	Optometry	0	0		0	0	-	
25.01	Tel eheal th	0	0		0	0	0	
25.02	Chronic Care Management	0	0		0	0	-	
26.00	All other nonreimbursable costs	0	0		0	0	0	26.00
27.00	Nonallowable GME costs							27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	0	28.00
	through 27)							
	FACILITY OVERHEAD			1	-		1	
29.00	Facility Costs	0	0		0	0		
30.00	Administrative Costs	381, 569	325, 447			-88, 849		
31.00	Total Facility Overhead (sum of lines 29 and	381, 569	325, 447	707, 0	16	-88, 849	618, 167	31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	900, 355	325, 447	1, 225, 8	02	-88, 849	1, 136, 953	32.00
	and 31)			1			1	1

	Financial Systems	PUTNAW COUNT	PUTNAM COUNTY HOSPITAL Provi der CCN: 15-1333			u of Form CMS-	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333	Period: From 01/01/2017	Worksheet M-	1
			Component	CCN: 15-8513	To 12/31/2017	Date/Time Pr	
					RHC II	5/29/2018 10 Cost	20 811
		Adjustments	Net Expenses			031	
		naj astinorres	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6.00	7.00				
	FACILITY HEALTH CARE STAFF COSTS						
. 00	Physi ci an	0					1.0
2.00	Physician Assistant	0					2.0
. 00	Nurse Practitioner	0	-				3.0
1.00	Visiting Nurse	0	0				4.0
. 00	Other Nurse	0	0				5.0
. 00	Clinical Psychologist	0	-				6.0
. 00	Clinical Social Worker	0	0				7.
. 00	Laboratory Technician	0	0				8.
. 00	Other Facility Health Care Staff Costs	0	-				9.
0.00	Subtotal (sum of lines 1 through 9)	0					10.
1.00 2.00	Physician Services Under Agreement Physician Supervision Under Agreement	0	0				11.
	Other Costs Under Agreement	0	0				13.
	Subtotal (sum of lines 11 through 13)	0	-				14.
	Medical Supplies	0					14.
	Transportation (Health Care Staff)	0	0				16.
	Depreciation-Medical Equipment	0					17.
	Professional Liability Insurance	0	-				18.
	Other Health Care Costs	0	-				19.
	Allowable GME Costs	0					20.
	Subtotal (sum of lines 15 through 20)	0	0				21.
	Total Cost of Health Care Services (sum of	0	518, 786				22.
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
3.00	Pharmacy	0	0				23.
4.00	Dental	0	0				24.
	Optometry	0	-				25.
	Tel eheal th	0					25.
	Chronic Care Management	0	-				25.
	All other nonreimbursable costs	0	0				26.
7.00	Nonallowable GME costs						27.
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.
	through 27)						_
0 00	FACILITY OVERHEAD						
	Facility Costs	0	-				29.
0.00	Administrative Costs	-2, 500					30.
31.00	Total Facility Overhead (sum of lines 29 and	-2, 500	615, 667				31.
32.00	30) Total facility costs (sum of lines 22, 28	-2, 500	1, 134, 453				32.0
	TIVEN TACITLY CUSES (SUII UT TITLES ZZ, ZÖ	-2,000	I I, IS4, 453	1			1 32.1

	Financial Systems	PUTNAM COUNT				u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1333	Peri od:	Worksheet M-1	
			Component	CCN: 15-8514	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 10:	
					RHC III	Cost	
		Compensati on	Other Costs	Total (col.	1 Recl assi 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	45, 798	0				1.00
2.00	Physician Assistant	0	0		0 0	-	2.00
3.00	Nurse Practitioner	292, 854	0			,	•
4.00	Visiting Nurse	0	0		0 0		•
5.00	Other Nurse	0	0		0 0	Ŭ	
6.00	Clinical Psychologist	0	0		0 0	-	
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Technician	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0 0	-	
10.00	Subtotal (sum of lines 1 through 9)	338, 652	0			000,002	•
11.00	Physician Services Under Agreement	0	0		0 0		
12.00	Physician Supervision Under Agreement	0	0		0 0		12.00
13.00	Other Costs Under Agreement	0	0		0 0	-	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0 0	-	•
15.00	Medical Supplies	0	0		0 0		
16.00	Transportation (Health Care Staff)	0	0		0 0	-	
17.00	Depreciation-Medical Equipment	0	0		0 0	0	
	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	
20.00	Allowable GME Costs		0				20.00
21.00	Subtotal (sum of lines 15 through 20)	000 (50	0	000 (0 0	0	
22.00	Total Cost of Health Care Services (sum of	338, 652	0	338, 6	52 C	338, 652	22.00
	l i nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.00
23.00	Dental	0	0			-	23.00
24.00	Optometry	0	0				
25.00	Tel eheal th	0	0			0	
25.01	Chronic Care Management	0	0				
26.02	All other nonreimbursable costs	0	0			0	
28.00	Nonallowable GME costs	0	0		0 0	0	27.00
27.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	
20.00	through 27)	0	0		0 0	0	20.00
	FACILITY OVERHEAD						
29.00	Facility Costs	0	0		0 0	0	29.00
30.00	Admini strati ve Costs	188, 328	176, 102				•
31.00	Total Facility Overhead (sum of lines 29 and	188, 328	176, 102				•
51.00	30)	100, 520	170, 102	304, 4	-2,131	521,075	
32.00	Total facility costs (sum of lines 22, 28	526, 980	176, 102	703, 0	-42, 737	660, 345	32.00
JZ. UU							1 22.00

2.00 Physician Assistant 0 0 2.0 3.00 Nurse Practitioner 0 292,854 3.0 4.00 Visiting Nurse 0 0 4.0 5.00 Other Nurse 0 0 5.0 6.00 Clinical Social Worker 0 0 6.0 7.00 Operatory Technician 0 0 8.0 8.00 Laboratory Technician 0 0 8.0 9.00 Other Facility Health Care Staff Costs 0 0 8.0 9.00 Other Services Under Agreement 0 0 11.0 12.00 Physician Supervision Under Agreement 0 0 13.0 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.0 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.0 15.00 Merasportation (Health Care Staff) 0 0 14.0 10.00 Uther Medical Equipment 0 0 14.0	Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu	u of Form CMS-	2552-10
Adjustments Net Expenses for Adjustments Net Expenses for Adjusth	ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider (CCN: 15-1333		Worksheet M-7	1
Adjustments Net Expenses for Al location (col. 5 + col. 6) Net Expenses for Al location (col. 5 + col. 6) Image: Col. 11 Adjustments Col. 11 Adjustments 1.00 Physician (col. 6) Physician (col. 6) 1.00 1.00 0.00 Physician (col. 6) 0 45,798 1.00 0.00 Nurse Practitioner 0 292,854 3.00 0.00 Other Nurse 0 0 4.00 0.00 Clinical Social Worker 0 0 4.00 0.00 Clinical Social Worker 0 0 4.00 0.00 Other Facility Health Care Staff Costs 0 0 4.00 0.00 Other Casts Under Agreement 0 0 11.00 11.00 11.00 Physician Supervision Under Agreement 0 0 13.00 13.00 11.00 Medical Supplies 0 0 11.00 13.00 11.00 Supplication Supervision Under Agreement 0 0 13.00 13.00 11.00 Supplicatin Supervision Under Agreeme				Component	CCN: 15-8514			
Adjustments Net Expenses N (1) Costion (col. 5) + col. 6) Net Expenses (col. 6) 1.00 Physician 0 45,798 1.0 2.00 Physician Assistant 0 45,798 2.0 0.00 Nurse Practitioner 0 292,854 3.0 0.00 Visiting Nurse 0 0 0 4.0 0.00 Clinical Social Worker 0 0 0 6.00 292,854 3.0 0.00 Clinical Social Worker 0 0 0 6.0 7.0 0.01 Clinical Social Worker 0 0 0 6.0 7.0 0.00 Cher Facility Health Care Staff Costs 0 0 0 7.0 10.00 Subtotal (sun of lines 1 through 9) 0 338,652 10.0 10.0 11.00 Physician Services Under Agreement 0 0 11.0 11.0 12.00 Dhysician Supervision Under Agreement 0 0 11.0 11.0 13.00 Dhore						RHC III		20 411
All caction All caction All caction (col. 5 + col. 6) (col. 5) (col. 5) (col. 5) (col. 5) (col. 6) 7.00 1.00 Physician Assistant 0 0.00 Newse Practitioner 292,854 0.00 Clinical Social Worker 0 0.00 Clinical Social Worker 0 0.00 Clinical Social Worker 0 0.00 Laboratory Technician 0 0.00 Subtotal (sum of Lines 1 through 9) 338,652 11.00 Physician Services Under Agreement 0 0.01 Other Cast Under Agreement 0 0.01 Other Cast Under Agreement 0 0.01 Other Cast Under Agreement 0 0.02 Other Cast Under Agreement 0 0.03 Other Cast Under Agreement 0 0.03 Other Cast Under Agreement 0 0.03 Other Cast Under Agreement 0 0.04 Other Cast Under Agreement 0			Adjustments	Net Expenses				
Image: constraint of the second sec			5	for				
Col. 6) Col. 6) 1.00 Physician 0 45,798 2.00 Physician 0 0 45,798 2.00 Physician Assistant 0 0 0 200 3.00 Nurse Practitioner 0 292,854 3.0 3.00 Nurse Practitioner 0 0 4.0 3.00 Nurse Practitioner 0 0 4.0 3.00 Nurse Practitioner 0 0 4.0 3.00 Clinical Social Worker 0 0 6.00 7.0 6.00 Laboratory Technician 0 0 338,652 10.0 9.0 11.00 Physician Sorpresent dunder Agreement 0 0 11.0				Allocation				
6.00 7.00 FACILITY HEALTH CARE STAFF COSTS 1.00 1.00 Physician Assistant 0 45,798 2.00 Physician Assistant 0 0 202,854 3.00 0.00 Virse Practitioner 0 0 0 4.00 0.00 Other Nurse 0 0 0 4.00 0.00 Clinical Social Worker 0 0 0 6.00 0.00 Subtotal (sum of lines 1 through 9) 0 338,652 10.00 11.00 10.00 Subtotal (sum of lines 11 through 13) 0 0 12.00 13.00 14.00 13.00 14.00								
FACILITY HEALTH CARE STAFF COSTS 0 45,798 0 0 200 Physician Assistant 0 45,798 0 200 200 Physician Assistant 0 45,798 300 300 300 Nurse Practitioner 0 200 200 60 300								
1.00 Physician 0 45,798 1.0 2.00 Physician Assistant 0 0 0 3.00 Nurse Practitioner 0 292,854 3.0 4.00 Visiting Nurse 0 0 4.0 5.00 Other Nurse 0 0 4.0 6.00 Clinical Social Worker 0 0 6.0 7.00 Clinical Social Worker 0 0 7.0 8.00 Laboratory Technician 0 0 9.0 9.00 Other Facility Health Care Staff Costs 0 0 10.0 10.00 Physician Supervision Under Agreement 0 0 11.0 11.00 Physician Supervision Under Agreement 0 0 13.0 11.00 Physician Supervision Under Agreement 0 0 13.0 12.00 Physician Supervision Under Agreement 0 0 14.0 13.00 Other Costs Under Agreement 0 0 14.0 15			6.00	7.00				
2.00 Physician Assistant 0 0 2.0 3.00 Nurse Practitioner 0 292,854 3.0 3.00 Other 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 Technician 0 0 8.0 9.00 Other Facility Heal th Care Staff Costs 0 0 8.0 9.00 Other Costs Under Agreement 0 0 11.00 10.00 Subtotal (sum of lines 11 through 9) 0 338,652 10.00 11.00 Physician Supervision Under Agreement 0 0 12.0 11.00 Subtotal (sum of lines 11 through 13) 0 0 14.0 12.00 Physician Supervision Under Agreement 0 0 14.0 12.00 Medical Supplies 0 0 14.0					-1			
3.00 Nurse Practitioner 0 292,854 3.0 4.00 Visiting Nurse 0 0 4.0 5.00 Other Nurse 0 0 0 4.0 6.00 Clinical Social Worker 0 0 0 7.0 7.00 Clinical Social Worker 0 0 0 7.0 8.00 Laboratory Technician 0 0 0 0 7.0 9.00 Other Facility Health Care Staff Costs 0 0 0 9.0 10.00 Physician Scruces Under Agreement 0 0 0 11.0 12.00 Physician Scruces Under Agreement 0 0 11.0 11.0 13.00 Other Costs Under Agreement 0 0 13.0 14.0 Subtotal (sum of lines 11 through 13) 0 0 14.0 Subtotal (sum of lines 11 through 13) 0 0 15.0 16.0 17.0 18.0 16.0 17.0 18.0 18.0 19.0 19.0 18.0 </td <td></td> <td></td> <td></td> <td></td> <td>1</td> <td></td> <td></td> <td>1.00</td>					1			1.00
4.00 Visiting Nurse 0 0 0 5.00 Other Nurse 0 0 0 6.00 Clinical Psychologist 0 0 0 7.00 Clinical Social Worker 0 0 0 8.00 Laboratory Technician 0 0 0 9.00 Other Facility Health Care Staff Costs 0 0 0 10.00 Subtotal (sum of lines 1 through 9) 0 338,652 10.0 11.00 Physician Services Under Agreement 0 0 11.0 12.00 Physician Supervision Under Agreement 0 0 13.0 13.00 Other Costs Under Agreement 0 0 13.0 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.0 15.00 Medical Supplies 0 0 14.0 16.00 Transportation (Health Care Staff) 0 0 14.0 17.00 Depreciation-Medical Equipment 0 0 16.0 17.00 Subtotal (sum of lines 15 through 20) 0 0 22.0 <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td>					-			
5.00 Other Marse 0 0 5.0 6.00 Clinical Psychologist 0 0 6.0 7.00 Clinical Social Worker 0 0 7.0 8.00 Laboratory Technician 0 0 7.0 9.00 Other Facility Health Care Staff Costs 0 0 9.0 11.00 Physician Supervision Under Agreement 0 0 11.0 12.00 Physician Supervision Under Agreement 0 0 11.0 13.00 Other Costs Under Agreement 0 0 13.0 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.0 15.00 Medical Supplies 0 0 15.0 16.00 Transportation (Heal th Care Staff) 0 0 16.0 17.00 Depreciation-Medical Equipment 0 0 17.0 18.00 Professional Liability Insurance 0 0 20.0 20.00 Allowable GME Costs 0 0 20.0								1
6.00 Ci inical Psychologist 0 0 6.00 Ci inical Social Worker 0 0 7.00 Ci inical Social Worker 0 0 7.00 Ci inical Social Worker 0 0 0 0 7.00 Social Worker 0		5	-					
7.00 Clinical Social Worker 0 0 7.00 8.00 Laboratory Technician 0 0 0 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 8.00 9.00 0 ther Facility Health Care Staff Costs 0 0 9.00 010.00 Physician Supervision Under Agreement 0 0 0 11.00 Physician Supervision Under Agreement 0 0 13.00 0 13.00 0 13.00 0 13.00 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.00			0					
8.00 Laboratory Technician 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) 0 338,652 10.0 11.00 Physician Services Under Agreement 0 0 11.0 12.00 Physician Supervision Under Agreement 0 0 12.0 13.00 Other Costs Under Agreement 0 0 13.0 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.0 15.00 Medical Supplies 0 0 15.0 16.00 Transportation (Heal th Care Staff) 0 0 15.0 16.00 Professional Liability Insurance 0 0 17.0 19.00 Other Heal th Care Costs 0 0 20.0 21.00 Subtotal (sum of lines 15 through 20) 0 0 21.0 22.00 Pharmacy 0 0 23.0 24.0 25.01 Teleheal th 0 <td></td> <td></td> <td>-</td> <td></td> <td>-</td> <td></td> <td></td> <td>1</td>			-		-			1
9.00 Other FacI lity Health Care Staff Costs 0 0 9.0 10.00 Subtotal (sum of lines 1 through 9) 0 338, 652 10.0 11.00 Physician Services Under Agreement 0 0 11.0 12.00 Physician Supervision Under Agreement 0 0 12.0 13.00 Other Costs Under Agreement 0 0 13.0 14.00 Subtotal (sum of lines 11 through 13) 0 0 14.0 15.00 Medical Supplies 0 0 16.0 15.0 16.00 Transportation (Health Care Staff) 0 0 16.0 17.0 17.00 Depreciation-Medical Equipment 0 0 17.0 17.0 18.00 Professional Liabili ity Insurance 0 0 20.0 20.0 21.0 21.0 21.0 22.0 10.00 Subtotal (sum of lines 15 through 20) 0 0 22.0 21.0 22.0 21.0 22.0 21.0 22.0 21.0 22.0 21.0<			0					
10.00 Subtotal (sum of lines 1 through 9) 0 338, 652 10.0 11.00 Physician Services Under Agreement 0 0 11.0 12.00 Physician Services Under Agreement 0 0 12.0 13.00 Other Costs Under Agreement 0 0 13.0 14.00 Subtotal (sum of lines 11 through 13) 0 0 13.0 14.00 Subtotal (supplies 0 0 14.0 15.00 Medical Supplies 0 0 14.0 16.00 Transportation (Heal th Care Staff) 0 0 16.0 17.00 Depreciation-Medical Equipment 0 0 17.0 18.00 Professional Liability Insurance 0 0 18.0 19.00 Other Heal th Care Staff) 0 0 21.0 10.10 subtotal (sum of lines 15 through 20) 0 0 0 21.0 22.00 Pharmacy 0 0 0 23.0 23.00 Pharmacy 0 0 24.0 24.00 25.0 25.00 Optometry </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
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12.00 Physician Supervision Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 13.00 Other Costs Under Agreement 0 0 14.00 Subtotal (sum of lines 11 through 13) 0 0 15.00 Medical Supplies 0 0 16.00 Transportation (Health Care Staff) 0 0 17.00 Depreciation-Medical Equipment 0 0 18.00 Professional Liability Insurance 0 0 19.00 Other Health Care Costs 0 0 21.00 Subtotal (sum of lines 15 through 20) 0 0 22.00 Total Cost of Health Care Services (sum of 0 338, 652 21.0 23.00 Pharmacy 0 0 23.0 24.00 Dental 0 0 25.0 25.01 Telehealth 0 0 25.0 25.02 Chronic Care Management 0 0 25.0 26.00 Jotal Wable GME costs 0 0 26.0 27.00 Nonal Iowable GME costs			-					
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19.00 Other Health Care Costs 0 0 19.00 20.00 Allowable GME Costs 0 0 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 0 338,652 22.00 23.00 Pharmacy 0 0 24.00 24.00 25.00 Optometry 0 0 25.00 25.01 25.01 Telehalth 0 0 25.02 26.00 All other nonreimbursable costs 0 0 25.02 27.00 Nonallowable GME costs 0 0 26.00 27.00 Nonallowable GME costs 0 0 26.00 27.00 Nonallowable GME costs 0 0 28.0 27.00 Nonallowable GME costs 0 0 28.0 27.00 Racillity Costs 0 0 28.0 29.00 Facility Costs 0 321,693 30.0 31.00 Total Facility Overhead (sum of lines 29 and 30) 321,693 31.0 </td <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td> <td>18.00</td>			-					18.00
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22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 23.00 338,652 22.00 COSTS OTHER THAN RHC/FOHC SERVICES 0 0 23.00 24.00 24.00 25.00 Optometry 0 0 25.00 25.01 Telehealth 0 0 25.02 25.01 Telehealth 0 0 0 25.02 25.02 Chronic Care Management 0 0 25.02 26.00 All other nonreimbursable costs 0 0 0 25.02 26.00 27.00 Nonal lowable GME costs 0 0 0 27.02 27.02 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 27.02 28.00 29.00 Facility Costs 0 0 321,693 30.02 31.00 30.00 Administrative Costs 0 321,693 321,693 31.00 321,693 31.00			0					21.00
lines 10, 14, and 21) O O COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 23.00 24.00 Dental 0 0 0 24.00 24.00 25.00 Optometry 0 0 0 25.01 Teleheal th 0 0 25.02 Chronic Care Management 0 0 0 25.02 25.00 0 0 0 25.02 25.00 0 0 0 25.02 25.00 25.02 Chronic Care Management 0 0 0 25.02 26.00 27.00 28.00 26.00 27.00 28.00 26.00 27.00 28.00 26.00 27.00 28.00 27.00 28.00 28.00 27.00 28.00 28.00 27.00 28.00			0	338, 65	2			22.00
COSTS OTHER THAN RHC/FOHC SERVICES 0 0 0 23.00 Pharmacy 0 0 0 23.00 24.00 Dental 0 0 0 0 24.00 24.00 Dental 0 0 0 0 0 24.00 25.01 25.01 0 0 0 0 0 0 25.01 25.01 25.01 25.02 Chronic Care Management 0 0 0 0 25.02 25.02 26.00 25.02 26.02 27.02 28.02 2								
24.00 Dental 0 0 0 24.00 25.00 Optometry 0 0 0 25.00 25.01 Teleheal th 0 0 0 25.00 25.02 Chronic Care Management 0 0 0 25.00 26.00 All other nonreimbursable costs 0 0 26.00 26.00 26.00 Nonal lowable GME costs 0 0 27.00 28.00 70.00 28.00 7.00 Nonal lowable Costs (sum of lines 23 0 0 0 28.00 7.01 VerkHEAD 29.00 Facility Costs 0 0 28.00 29.00 Facility Costs 0 321, 693 30.00 30.00 30.01 31.00 321, 693 30.01 31.00 31.00 321, 693 31.00 321, 693 31.00 321, 693 31.00 31.00 30.01 31.00 321, 693 31.00 31.00 321, 693 31.00 31.00 321, 693 31.00 31.00 321, 693 31.00 31.00 321, 693 31.00					•			
25.00 Optometry 0 0 25.01 25.01 Teleheal th 0 0 25.02 25.02 Chronic Care Management 0 0 25.02 26.00 All other nonreimbursable costs 0 0 25.02 26.00 All other nonreimbursable costs 0 0 26.02 27.00 Nonallowable GME costs 0 0 26.02 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.02 FACILITY OVERHEAD Facility Costs 0 0 321, 693 30.02 29.00 Facility Overhead (sum of lines 29 and 30) 0 321, 693 31.02 31.02	23.00	Pharmacy	0	()			23.00
25.01 Telehealth 0 0 25.02 25.02 Chronic Care Management 0 0 0 26.00 All other nonreimbursable costs 0 0 26.00 27.00 Nonallowable GME costs 0 0 26.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 28.00 4 Through 27) FACILITY OVERHEAD 29.00 321,693 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 0 321,693 31.00 31.00	24.00	Dental	0	(D			24.00
25.02Chronic Care Management0025.0226.00All other nonreimbursable costs0026.0027.00Nonal Iowable GME costs0026.0028.00Total Nonreimbursable Costs (sum of lines 230028.00FACILITY OVERHEAD29.00Facility Costs0030.00Administrative Costs0321,69330.0031.00Total Facility Overhead (sum of lines 29 and 30)0321,69331.00	25.00	Optometry	0	(D			25.00
26.00All other nonreimbursable costs0026.0027.00Nonal I owable GME costs27.0028.0028.00Total Nonreimbursable Costs (sum of Lines 230040006728.007FACI LI TY OVERHEAD29.007728.0170070070321,69331.000321,69330.0030321,69330.00321,69330.00321,693	25.01	Tel eheal th	0	(D			25.01
27.00 28.00Nonal I owable GME costs Total Nonreimbursable Costs (sum of lines 23 through 27)0028.00FACILITY OVERHEAD29.00Facility Costs0030.00Administrative Costs0321,69331.00Total Facility Overhead (sum of lines 29 and 30)0321,693	25.02		0	(D			25.02
28.00Total Nonreimbursable Costs (sum of lines 23 of through 27)0028.00FACILITY OVERHEAD29.00Facility Costs0029.0030.00Administrative Costs0321,69330.0031.00Total Facility Overhead (sum of lines 29 and 30)0321,69331.00	26.00	All other nonreimbursable costs	0	(D			26.00
through 27)FACILITY OVERHEAD29.00Facility Costs0030.00Administrative Costs0321,69331.00Total Facility Overhead (sum of lines 29 and 0)321,69331.00								27.00
FACILITY OVERHEAD 0 0 29.00 Facility Costs 0 0 29.00 30.00 Administrative Costs 0 31.00 321,693 30.00 321,693 31.00 30.00 31.00 30.00 321,693 31.00 31.00 30.00 31.00 31.00 30.00 31.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00 31.00 30.00	28.00		0	(D			28.00
29.00 Facility Costs 0 0 29.0 30.00 Administrative Costs 0 321,693 30.0 30.0 31.00 Total Facility Overhead (sum of lines 29 and 30) 0 321,693 31.00 31.00								
30.00 Administrative Costs 0 321,693 30.0 31.00 Total Facility Overhead (sum of lines 29 and 30) 0 321,693 31.00					-1			
31.00 Total Facility Overhead (sum of lines 29 and 30) 0 321,693 31.00 31.00			-		-			29.00
30)					1			30.00
	31.00	3	0	321, 693	3			31.00
	22.02	· ·	~		_			22.00
	32.00	3	0	660, 34				32.00
and 31)				I	1			I

leal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/F	QHC SERVICES	Provider C		Period: From 01/01/2017	Worksheet M-2	
			Component		To 12/31/2017	Date/Time Pre 5/29/2018 10:	
					RHC I	Cost	
		Number of FTE	Total Visits	Producti vi ty	Minimum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions		1				
1. 00	Physi ci an	2.00		4, 200			1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	0. 93		2, 100			3.00
4.00	Subtotal (sum of lines 1 through 3)	2.93			10, 353	10, 353	
5.00	Visiting Nurse	0.00				0	5.00
5.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC	0.00	0			0	7.02
8.00	only) Total FTEs and Visits (sum of lines 4	2.93	10, 124			10, 353	8.00
0.00	through 7)	2170				10,000	
9.00	Physician Services Under Agreements		0			0	9.00
			-				
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICAE	BLE TO HOSPI TAL-BASI	ED RHC/FQHC SEI	RVICES			
10.00	Total costs of health care services (fro	om Wkst. M-1, col.	7, line 22)			620, 017	10.00
11.00	Total nonreimbursable costs (from Wkst.	M-1, col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead	d) (sum of lines 10	and 11)			620, 017	12.00
13.00	Ratio of hospital -based RHC/FQHC service	es (line 10 divided	by line 12)			1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead	- (from Worksheet.	M-1, col. 7, li	ine 31)		586, 699	14.00
15.00	Parent provider overhead allocated to fa	acility (see instru	ctions)	-		973, 799	15.00
16.00	Total overhead (sum of lines 14 and 15)	.	•			1, 560, 498	16.00
17.00	Allowable GME overhead (see instructions	5)				0	17.00
18.00	Enter the amount from line 16					1, 560, 498	18.00
19.00	Overhead applicable to hospital-based R	HC/FQHC services (I	ine 13 x line '	18)		1, 560, 498	19.00
	Total allowable cost of hospital-based I					2, 180, 515	

Health Financial Systems		PUTNAM COUNT	TY HOSPI TAL		In Lie	u of Form CMS-2	2552-1
ALLOCATION OF OVERHEAD T	0 HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period: From 01/01/2017	Worksheet M-2	
			Component		o 12/31/2017		
					RHC II	Cost	
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
VISITS AND PRODUCT	TIVITY						
Posi ti ons				_			
.00 Physi ci an		1.00		4, 200	4, 200		1.0
2.00 Physician Assista	nt	2.95	6, 544	2, 100	6, 195		2.0
8.00 Nurse Practitione	r	0.00		2, 100	0 0		3.0
.00 Subtotal (sum of I	ines 1 through 3)	3.95	8, 511		10, 395	10, 395	4.C
.00 Visiting Nurse		0.00	0			0	5.0
.00 Clinical Psycholog	gist	0.00	0			0	6.0
.00 Clinical Social We	orker	0.00	0			0	7.0
7.01 Medical Nutrition	Therapist (FQHC only)	0.00	0			0	7.0
7.02 Diabetes Self Mana	agement Training (FQHC	0.00	0			0	7.0
onl y)							
	sits (sum of lines 4	3.95	8, 511			10, 395	8.0
through 7)							
9.00 Physician Services	s Under Agreements		0			0	9.0
						1.00	
DETERMINATION OF A	ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BAS	ED RHC/FOHC SE	RVLCES		1.00	
0.00 Total costs of hea	alth care services (from	Wkst. M-1, col.	7, line 22)			518, 786	10. c
	able costs (from Wkst. M-						11.0
	ces (excluding overhead)					518, 786	12.0
	-based RHC/FQHC services					1.000000	
	sed RHC/FQHC overhead - (ine 31)		615, 667	
	verhead allocated to faci					632, 052	
	um of lines 14 and 15)		,			1, 247, 719	
	rhead (see instructions)					0	
8.00 Enter the amount						1, 247, 719	18.0
	e to hospital-based RHC/	FQHC services (I	ine 13 x line	18)		1, 247, 719	
	act of bocnital bacad DUC					1 744 505	

20.00 Total allowable cost of hospital -based RHC/FQHC services (sum of lines 10 and 19) 1,766,505 20.00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQ	IC SERVI CES	Provider C		Period: From 01/01/2017	Worksheet M-2	
			Component	CCN: 15-8514	To 12/31/2017	Date/Time Pre 5/29/2018 10:	
					RHC III	Cost	
		Number of FTE	Total Visits	Producti vi ty	Mi ni mum	Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Positions		1				
1.00	Physi ci an	0. 20		4, 20			1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	2.79					3.00
4.00	Subtotal (sum of lines 1 through 3)	2.99			6, 699	6, 699	4.00
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	7.00
7.01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.01
7.02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
8.00	Total FTEs and Visits (sum of lines 4	2.99	3, 438			6, 699	8.00
	through 7)						
9.00	Physician Services Under Agreements		0			0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABL	E TO HOSPITAL-BAS	ED RHC/FOHC SE	RVLCES		1100	
10.00	Total costs of health care services (from	Wkst. M-1, col.	7, line 22)			338, 652	10.00
11.00	Total nonreimbursable costs (from Wkst. M	-1, col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead)	(sum of lines 10	and 11)			338, 652	12.00
13.00	Ratio of hospital-based RHC/FQHC services					1.000000	
14.00	Total hospital-based RHC/FQHC overhead -			ne 31)		321, 693	14.OC
15.00	Parent provider overhead allocated to fac			-		370, 446	15.00
16.00	Total overhead (sum of lines 14 and 15)	J .				692, 139	16.00
17.00	Allowable GME overhead (see instructions)					0	17.OC
18.00	Enter the amount from line 16					692, 139	18.00
19.00	Overhead applicable to hospital-based RHC	/FQHC services (I	ine 13 x line	18)		692, 139	19.00
20 00	Total allowable cost of hospital-based RH	C/FQHC services (sum of lines 1) and 19)		1, 030, 791	20 00

alth Financial Systems PUTNAM COUNTY ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FOHC	HOSPITAL	Peri od:	u of Form CMS-2	
ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC ERVICES	Provider CCN: 15-1333	From 01/01/2017	Worksheet M-3	
	Component CCN: 15-8515	To 12/31/2017	Date/Time Pre	
	T	DUO I	5/29/2018 10:	27 ar
	Title XVIII	RHC I	Cost	
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1100	
.00 Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		2, 180, 515	1.0
.00 Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		209, 922	2.
.00 Total allowable cost excluding vaccine (line 1 minus line 2)			1, 970, 593	
.00 Total Visits (from Wkst. M-2, column 5, line 8)			10, 353	
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
.00 Total adjusted visits (line 4 plus line 5)			10, 353	6. 7.
.00 Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	190.34	/.
		carcuration		
		Prior to Jan.	On or After	
		1 (Rate	Jan. 1 (Rate	
		Period 1)	Period 2)	
		1.00	2.00	-
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20).6 or your contractor)	82.30	82.30	
.00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		190. 34	190. 34	9.
0.00 Program covered visits excluding mental health services (from	contractor records)	0	1, 257	1 10.
1.00 Program cost excluding costs for mental health services (line		0	239, 257	
2.00 Program covered visits for mental health services (from contr		0	207,207	
3.00 Program covered cost from mental health services (line 9 x li	-	0	0	
4.00 Limit adjustment for mental health services (see instructions	-	0	0	14.
5.00 Graduate Medical Education Pass Through Cost (see instruction	าร)			15.
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	239, 257	
6.01 Total program charges (see instructions)(from contractor's re	· ·		234, 553	
6.02 Total program preventive charges (see instructions)(from prov			14, 589	
6.03 Total program preventive costs ((line 16.02/line 16.01) times 6.04 Total Program non-preventive costs ((line 16 minus lines 16.0	-		14, 882	
6.04 Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	JS and 18) trilles . 80)		166, 957	10.
6. 05 Total program cost (see instructions)		0	181, 839	16.
7.00 Primary payer amounts			0	
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		15, 679	18.
records)				
9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		43, 761	19.
records)			101 000	
0.00 Net Medicare cost excluding vaccines (see instructions)	M 4 Line 1()		181, 839	
1.00 Program cost of vaccines and their administration (from Wkst. 2.00 Total reimbursable Program cost (line 20 plus line 21)	M-4, ITTIE 10)		20, 267 202, 106	
3.00 Allowable bad debts (see instructions)			202, 100	23.
3.01 Adjusted reimbursable bad debts (see instructions)			0	23.
4.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24.
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25.
5.50 Pioneer ACO demonstration payment adjustment (see instruction	is)		0	
5.99 Demonstration payment adjustment amount before sequestration			0	
6.00 Net reimbursable amount (see instructions)			202, 106	
6.01 Sequestration adjustment (see instructions)			4, 042	
 6.02 Demonstration payment adjustment amount after sequestration 7.00 Interim payments 			0 137, 704	
8.00 Tentative settlement (for contractor use only)			137, 704	27.
9.00 Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		60, 360	
0.00 Protested amounts (nonallowable cost report items) in accorda			00,000	
chapter I, §115.2			-	1

	Financial Systems PUTNAM COUNTY H ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Period:	u of Form CMS-2	
SERVI C		Component CCN: 15-1333	From 01/01/2017 To 12/31/2017	Worksheet M-3 Date/Time Pre	
			10 12/31/2017	5/29/2018 10:	
		Title XVIII	RHC II	Cost	
			-	1.00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		1, 766, 505	1 1.
. 00	Cost of vaccines and their administration (from Wkst. M-4, li	· · · · · ·		88, 750	
. 00	Total allowable cost excluding vaccine (line 1 minus line 2)			1, 677, 755	3.
. 00	Total Visits (from Wkst. M-2, column 5, line 8)			10, 395	
. 00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
. 00	Total adjusted visits (line 4 plus line 5)			10, 395	
. 00	Adjusted cost per visit (line 3 divided by line 6)		Calculation	161.40	7.
			carcuration		
			Prior to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Period 1) 1.00	Period 2) 2.00	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20) 6 or your contractor)	82.30	82.30	8.
. 00	Rate for Program covered visits (see instructions)		161.40	161.40	
	CALCULATION OF SETTLEMENT				
0.00	Program covered visits excluding mental health services (from	contractor records)	0	2, 133	10
1.00	Program cost excluding costs for mental health services (line	e 9 x line 10)	0	344, 266	11
2.00	Program covered visits for mental health services (from contr	<i>,</i>	0	0	12
3.00	Program covered cost from mental health services (line 9 x li		0	0	
4.00	Limit adjustment for mental health services (see instructions		0	0	
5.00 6.00	Graduate Medical Education Pass Through Cost (see instruction Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	244 244	15
6.00	Total program charges (see instructions)(from contractor's re		0	344, 266 372, 419	
6. 02	Total program preventive charges (see instructions)(from prov			44, 951	
6.03	Total program preventive costs ((line 16.02/line 16.01) times			41, 553	
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.0			201, 978	
	(Titles V and XIX see instructions.)				
6. 05	Total program cost (see instructions)		0	243, 531	
7.00	Primary payer amounts			0	
8.00	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		50, 240	18
9.00	Beneficiary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		58, 946	19.
. 00	records)			00, 710	
0. 00	Net Medicare cost excluding vaccines (see instructions)			243, 531	20
1.00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		34, 358	21
2.00	Total reimbursable Program cost (line 20 plus line 21)			277, 889	
3.00	Allowable bad debts (see instructions)			0	23
3.01	Adjusted reimbursable bad debts (see instructions)			0	23
4.00 5.00	Allowable bad debts for dual eligible beneficiaries (see inst OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	ructions)		0	24 25
5.50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	
5.99	Demonstration payment adjustment amount before sequestration			0	
6.00	Net reimbursable amount (see instructions)			277, 889	
6. 01	Sequestration adjustment (see instructions)			5, 558	
6. 02	Demonstration payment adjustment amount after sequestration			0	26
7.00	Interim payments			238, 818	
8.00	Tentative settlement (for contractor use only)			0	28.
	Balance due component/program (line 26 minus lines 26.01, 26.	02, 27, and 28)		33, 513	29.
29.00 30.00	Protested amounts (nonallowable cost report items) in accorda			0	30.

alth Financial Systems PUTNAM COUNTY H	OSPITAL Provider CON: 15 1222	Period:	u of Form CMS-2 Worksheet M-3	
RUCCES	Provider CCN: 15-1333	From 01/01/2017	worksneet M-3	
	Component CCN: 15-8514	To 12/31/2017	Date/Time Pre	
	Title XVIII	RHC III	5/29/2018 10: Cost	27 a
			0031	
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1 020 701	1 1
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from 00 Cost of vaccines and their administration (from Wkst. M-4, lin	· · · · · ·		1, 030, 791 36, 385	1. 2.
00 Total allowable cost excluding vaccine (line 1 minus line 2)	lie 13)		994, 406	3.
00 Total Visits (from Wkst. M-2, column 5, line 8)			6, 699	4.
00 Physicians visits under agreement (from Wkst. M-2, column 5, I	line 9)		0	5.
00 Total adjusted visits (line 4 plus line 5)			6, 699	6.
00 Adjusted cost per visit (line 3 divided by line 6)			148.44	7.
		Calculation	of Limit (1)	
		Prior to Jan.	On or After	
		1 (Rate	Jan. 1 (Rate	
		Period 1)	Period 2)	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	1.00	2.00	8.
00 Rate for Program covered visits (see instructions)	. S Si your contractor)	148.44	148.44	9
CALCULATION OF SETTLEMENT		110111	110111	
0.00 Program covered visits excluding mental health services (from	contractor records)	0	484	10
.00 Program cost excluding costs for mental health services (line		0	71, 845	11
2.00 Program covered visits for mental health services (from contra		0	0	12
8.00 Program covered cost from mental health services (line 9 x lin	-	0	0	13
1.00 Limit adjustment for mental health services (see instructions)		0	0	14
5.00 Graduate Medical Education Pass Through Cost (see instructions 5.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	71, 845	15 16
b. 01 Total program charges (see instructions)(from contractor's real		0	79,897	
5.02 Total program preventive charges (see instructions)(from provi	-		9, 350	
0.03 Total program preventive costs ((line 16.02/line 16.01) times			8, 408	
0.04 Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		44, 017	16
(Titles V and XIX see instructions.)				
o. 05 Total program cost (see instructions)		0	52, 425	
7.00 Primary payer amounts	(6		0	
8.00 Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		8, 416	18
0.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		14, 296	19
records)			11/2/0	
0.00 Net Medicare cost excluding vaccines (see instructions)			52, 425	20
.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		2, 146	
2.00 Total reimbursable Program cost (line 20 plus line 21)			54, 571	22
8.00 Allowable bad debts (see instructions)			0	23
8.01 Adjusted reimbursable bad debts (see instructions) 9.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	23
1.00 Allowable bad debts for dual eligible beneficiaries (see inst 5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	24
5.50 Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
5.99 Demonstration payment adjustment amount before sequestration	·		0	
0.00 Net reimbursable amount (see instructions)			54, 571	
0.01 Sequestration adjustment (see instructions)			1, 091	26
0.02 Demonstration payment adjustment amount after sequestration			0	
7.00 Interim payments			48, 063	
8.00 Tentative settlement (for contractor use only)	22 27 and 20)		0	28
0.00 Balance due component/program (line 26 minus lines 26.01, 26.0 0.00 Protested amounts (nonallowable cost report items) in accorda			5, 417	
	ILE WILLIUWS PUD. 15-11		0	30

Heal th	Financial Systems PUTNAM COUNTY I	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1333	Period:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-8515	From 01/01/2017 To 12/31/2017		
		Title XVIII	RHC I	Cost	
			Pneumococcal	I nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		620, 017		
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				
3.00	Pneumococcal and influenza vaccine health care staff cost (li		8, 194		3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f		37, 932		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		46, 126		
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	neet M-1, col. 7, line 22	· · ·		
7.00	Total overhead (from Wkst. M-2, line 19)		1, 560, 498		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	otal direct cost (line 5	0. 074395	0. 021877	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	116, 093	34, 139	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	162, 219	47, 703	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	s (from your records)	431	390	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	376.38	122.32	12.00
13.00	Number of pneumococcal and influenza vaccine injections admir beneficiaries	nistered to Program	9	138	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration	3, 387	16, 880	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3			209, 922	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		20, 267	16. 00

Heal th	Financial Systems PUTNAM COUNTY I	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA		Peri od:	Worksheet M-4	
VACCIN	E COST	Component CCN: 15-8513	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 10:	
		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)		518, 786		
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	2, 369		3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f		13, 378		
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		15, 747		
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	neet M-1, col. 7, line 22			
7.00	Total overhead (from Wkst. M-2, line 19)		1, 247, 719		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	otal direct cost (line 5	0. 030354	0. 019887	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	37, 873	24, 813	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	53, 620	35, 130	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	s (from your records)	152	329	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	352.76	106. 78	12.00
13.00	Number of pneumococcal and influenza vaccine injections admir beneficiaries	nistered to Program	19	259	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (t (line 12 x line 13)	heir) administration:	6, 702	27, 656	14.00
15.00	Total cost of pneumococcal and influenza vaccine and its (the of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3			88, 750	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)			34, 358	16.00

Heal th	Financial Systems PUTNAM COUNTY I	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF HOSPITAL-BASED RHC/FQHC PNEUMOCOCCAL AND INFLUENZA		Peri od:	Worksheet M-4	
VACCIN	IE COST	Component CCN: 15-8514	From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 10:	
		Title XVIII	RHC III	Cost	
			Pneumococcal	l nfl uenza	
			1.00	2.00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		338, 652		
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot				
3.00	Pneumococcal and influenza vaccine health care staff cost (li	,	1, 212	,	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f		7, 833	,	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu		9, 045	,	
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	neet M-1, col. 7, line 22			
7.00	Total overhead (from Wkst. M-2, line 19)		692, 139		
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to divided by line 6)	otal direct cost (line 5	0. 026709	0. 008590	8.00
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	18, 486	5, 945	9.00
10.00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	27, 531	8, 854	10.00
11.00	Total number of pneumococcal and influenza vaccine injections	s (from your records)	89	99	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	10/line 11)	309.34	89.43	12.00
13.00	Number of pneumococcal and influenza vaccine injections admir beneficiaries	nistered to Program	0	24	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (1 (line $12 \times 100 \text{ km})$	their) administration	0	2, 146	14.00
15.00				36, 385	15.00
16.00	Total Program cost of pneumococcal and influenza vaccine and administration (sum of cols. 1 and 2, line 14) (transfer this line 21)	its (their)		2, 146	16.00

Health Financial Systems	PUTNAM COUN	TY HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/F	OHC PROVIDER FOR	Provider CCN: 15-1333	Peri od:	Worksheet M-5	
SERVICES RENDERED TO PROGRAM BENEFICIARIES			From 01/01/2017		
		Component CCN: 15-8515	To 12/31/2017	Date/Time Prep 5/29/2018 10:2	
			RHC I	Cost	27 0111
				T B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00 Total interim payments paid to hospita	al-based RHC/FQHC	· · · · · · · · · · · · · · · · · · ·		137, 704	1.00
2.00 Interim payments payable on individual		tted or to be submitted to		0	2.00
the contractor for services rendered i					
"NONE" or enter a zero					
3.00 List separately each retroactive lump	sum adjustment amour	nt based on subsequent			3.00
revision of the interim rate for the o	cost reporting period	d. Also show date of each			
payment. If none, write "NONE" or ente	er a zero. (1)				
Program to Provider				_	
3. 01				0	3.01
3. 02				0	3.02
3. 03				0	3.03
3. 04				0	3.04
3. 05				0	3.05
Provider to Program					
3. 50				0	3.50
3. 51				0	3.51
3. 52				0	3.52
3. 53				0	3.53
3. 54				0	3.54
3.99 Subtotal (sum of lines 3.01-3.49 minus	sum of lines 3.50-3	3. 98)		0	3.99
4.00 Total interim payments (sum of lines '	, 2, and 3.99) (trar	nsfer to Worksheet M-3, lin	e	137, 704	4. OC
27)					
TO BE COMPLETED BY CONTRACTOR			- 1		
5.00 List separately each tentative settler		esk review. Also show date	of		5.OC
each payment. If none, write "NONE" or	r enter a zero. (1)				
Program to Provider					F 01
5. 01				0	5.01
5.02				0	5.02
5.03				0	5.03
Provider to Program				0	E EC
5.50				0	5.50 5.51
5. 51 5. 52				0	5.51
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus	sum of Linos E EO E	5 09)		0	5.52 5.99
6.00 Determined net settlement amount (bala				0	5.99 6.00
6.01 SETTLEMENT TO PROVIDER	nce uue, baseu un ti			60, 360	6.00
6.02 SETTLEMENT TO PROVIDER				00, 300 0	6.01
7.00 Total Medicare program liability (see	instructions)			0 198, 064	6.0∠ 7.00
7.00 TOTAL MEDICALE PROGRAM HADITLY (See	nisti ucti UNS)		Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1, 00	2.00	
			1.00	2.00	

ealth Financial Systems PUTNAM COUNT	Y HOSPI TAL	In Lie	eu of Form CMS-2	2552-1
NALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provider CCN: 15-1333	Peri od:	Worksheet M-5	
ERVICES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8513	From 01/01/2017 To 12/31/2017		
		RHC II	Cost	_ , diii
			rt B	
		mm/dd/yyyy	Amount	
		1.00	2.00	
 .00 Total interim payments paid to hospital-based RHC/FQHC .00 Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting "NONE" or enter a zero 			238, 818 0	1.00 2.00
.00 List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3.00
Program to Provider				
. 01			0	3.01
. 02			0	3.02
. 03			0	3.0
. 04 . 05			0	3.0 3.0
Provider to Program			0	3.0
. 50			0	3.5
. 51			0	3.5
. 52			0	3.5
. 53			0	3.5
. 54			0	3.5
.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.			0	3.9
.00 Total interim payments (sum of lines 1, 2, and 3.99) (trans	sfer to Worksheet M-3, line	e	238, 818	4.0
27) TO BE COMPLETED BY CONTRACTOR				
.00 List separately each tentative settlement payment after des	sk review. Also show date (of		5.0
each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				01.0
. 01			0	5.0
. 02			0	5.0
. 03			0	5.C
Provider to Program				
. 50			0	5.5
. 51			0	5.5
.52 .99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	08)		0	5.5 5.9
. 00 Determined net settlement amount (balance due) based on the			0	5.9 6.0
.00 SETTLEMENT TO PROVIDER			33, 513	6.0
. 02 SETTLEMENT TO PROGRAM			00,010	6.0
.00 Total Medicare program liability (see instructions)			272, 331	7.0
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	
	0	1.00	2.00	
.00 Name of Contractor				8.0

Health Financial Systems PU	Systems PUTNAM COUNTY HOSPITAL		In Lieu of Form CMS-2552-10		
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDE	R FOR Provider CCN: 15-13	33 Period:	Worksheet M-5		
SERVICES RENDERED TO PROGRAM BENEFICIARIES		From 01/01/201			
	Component CCN: 15-8	514 To 12/31/201		pared:	
		RHC III	5/29/2018 10:	27 am	
			rt B		
		mm/dd/yyyy	Amount		
		1.00	2.00		
1.00 Total interim payments paid to hospital-based RH	C/EOHC	1.00	48,063	1.00	
2.00 Interim payments payable on individual bills, ei		d to	40,000	2.00	
the contractor for services rendered in the cost			0	2.00	
"NONE" or enter a zero	i opoi ti ng poi roai i i nono, in i				
3.00 List separately each retroactive lump sum adjust	ent amount based on subsequent			3.00	
revision of the interim rate for the cost report		ch			
payment. If none, write "NONE" or enter a zero.					
Program to Provider				1	
3.01			0	3.01	
3.02			0	3.02	
3.03			0	3.03	
3.04			0	3.04	
3. 05			0	3.05	
Provider to Program				1	
3.50			0	3.50	
3. 51			0	3.51	
3. 52			0	3.52	
3. 53			0	3.53	
3. 54			0	3.54	
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lin	es 3.50-3.98)		0	3.99	
4.00 Total interim payments (sum of lines 1, 2, and 3	99) (transfer to Worksheet M-3,	line	48, 063	4.00	
27)					
TO BE COMPLETED BY CONTRACTOR		1	-		
5.00 List separately each tentative settlement payment		ate of		5.00	
each payment. If none, write "NONE" or enter a z	ero. (1)				
Program to Provider			-		
5.01			0	5.01	
5.02			0		
5.03			0	5.03	
Provider to Program					
5. 50			0		
5. 51			-		
5.52			0		
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 6.00 Determined net settlement amount (balance due) b			0	5.99	
6.00 Determined net settlement amount (balance due) ba	ised on the cost report. (1)		E 117		
6.02 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM			5, 417		
7.00 Total Medicare program liability (see instruction			53, 480		
7.00 Trotal medicare program traditity (see fistruction		Contractor	NPR Date	7.00	
		Number	(Mo/Day/Yr)		
	0	1.00	2.00		
	0	1.00	2.00		