Heal th Financia	al Systems	PUTNAM COUNTY HO	SPI TAL	In Lie	u of Form CMS-2552-10
	required by Law (42 USC 1395 since the beginning of the co	J			FORM APPROVED OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX C SUMMARY	OST REPORT CERTIFICATION	Provider CCN: 1513	Peri od: From 01/01/2015 To 12/31/2015	
PART I - COST	REPORT STATUS				
Provi der use only	1. [ X ] Electronically filed 2. [ ] Manually submitted co 3. [ O ] If this is an amended 4. [ F ] Medicare Utilization.	ost report I report enter the number of	f times the provide for low.	Date: 3/30/20	r
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened		this Provider CCN		

PART II - CERTIFICATION

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by PUTNAM COUNTY HOSPITAL (151333) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)	
	Officer or Administrator of Provider(s)
	• •
Ti tl	e
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	-34, 179	-160, 870	0	-1, 802	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	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	-13, 756	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
10.00	PPIM I	0		23, 021		0	10. 00
10. 01	FMC II	0		57, 453		0	10. 01
10.02	NPFH III	0		6, 816		0	10. 02
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
200.00	Total	0	-47, 935	-73, 580	0	-1, 802	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-MEDI CARE.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151333 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 3/30/2016 4:36 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 1542 SOUTH BLOOMINGTON ST 1.00 PO Box: 1.00 State: IN 2.00 City: GREENCASTLE Zip Code: 46135-County: PUTNAM 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 PUTNAM COUNTY HOSPITAL 151333 26900 12/31/2005 Ν 0 0 3.00 Hospi tal Subprovider - IPF 4.00 4.00 5.00 Subprovider - IRF 5 00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 PUTNAM COUNTY HOSPITAL 15Z333 26900 12/31/2005 N 0 N 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 10.00 Hospi tal -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospi tal -Based HHA 12.00 12.00 13.00 Separately Certified ASC 13.00 14.00 Hospi tal -Based Hospi ce 14.00 PPI M 15.00 Hospital-Based Health Clinic - RHC 158515 26900 02/23/2015 0 N 15.00 N 15.01 Hospital-Based Health Clinic - RHC FMC 158513 26900 02/25/2015 Ν 0 Ν 15.01 15.02 Hospital-Based Health Clinic - RHC NPFH 158514 26900 03/17/2015 O 15.02 1111 Hospital-Based Health Clinic - FQHC 16 00 16 00 17.00 Hospital-Based (CMHC) I 17.00 Hospital -Based (CORF) I 17.10 17.10 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 12/31/2015 01/01/2015 20 00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting Ν 22.01 Ν period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result 22.03 Ν Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or used in the prior cost reporting period? In column 2 "N" for no Out-of 0ther In-State In-State Out-of Medi cai d HMO days Medi cai d Medi cai d Medi cai d State State paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid 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, and other Medicaid days in column 6.

Heal th	Financial Systems PUTNA	M COUNTY HO	OSPI TAL			In Lieu	ı of For	m CMS-:	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		_	CCN: 151333	Peri od:		Workshe		
					From 01/0 To 12/3	31/2015			
		In-State	In-State	Out-of	Out-of	Medi ca	3/30/20 i d 0	)16 4:3 ther	6 pm
		Medi cai d	Medi cai d	State	State	HMO day	ys Med	di cai d	
		paid days	eligible unpaid	Medicaid paid days	Medicaid eligible			days	
			days	para days	unpai d				
05.00	lie iii	1.00	2.00	3. 00	4. 00	5. 00		5. 00	05.00
25. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state		C	0	0		0		25. 00
	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.								
						Rural S			
26. 00	Enter your standard geographic classification (not wa	age) status	at the bed	ginning of 1		00 2	2. (	JU	26. 00
	cost reporting period. Enter "1" for urban or "2" for	r rural.							
27. 00	Enter your standard geographic classification (not wareporting period. Enter in column 1, "1" for urban or				st	2			27. 00
	enter the effective date of the geographic reclassifi			эрг г саы с,					
35. 00	If this is a sole community hospital (SCH), enter the	e number of	periods SC	CH status ir	١	0			35. 00
	effect in the cost reporting period.				Begi n	ni ng:	Endi	ng:	
	<u> </u>					00	2. (	00	1
36. 00	Enter applicable beginning and ending dates of SCH sof periods in excess of one and enter subsequent date		script line	36 for numb	per				36. 00
37. 00	If this is a Medicare dependent hospital (MDH), enter		er of period	ds MDH statu	ıs	0			37. 00
20.00	is in effect in the cost reporting period.	o of MDU of	atua Ifili	no 27 i o					20.00
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38. 00
	enter subsequent dates.					40.			
						/N 00	Y/ 2. (		-
39. 00	Does this facility qualify for the inpatient hospital	l payment a	adjustment f	for low volu		V	N		39. 00
	hospitals in accordance with 42 CFR §412.101(b)(2)(ii) or "N" for no. Does the facility meet the mileage rea				S				
	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes				s)				
40. 00	Is this hospital subject to the HAC program reduction					V	N	I	40.00
	"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.			yes or "N" 1	or				
	Maria		,		,	V	XVIII		
	Prospective Payment System (PPS)-Capital					1. 00	2. 00	3.00	
45. 00	Does this facility qualify and receive Capital paymen	nt for disp	proporti onat	te share in	accordance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	ontion for	ovtraordi na	arv ci roumet	ancoc	N	N	N	46. 00
40.00	pursuant to 42 CFR §412.348(f)? If yes, complete Wks	t. L, Pt. I	II and Wkst	t. L-1, Pt.	I through	I IN	IN IN	I IN	40.00
47.00	Pt. III.								
	Is this a new hospital under 42 CFR §412.300 PPS capils the facility electing full federal capital paymen					l N N	N N	N N	47.00
	Teachi ng Hospi tal s								1 .0.00
56. 00	Is this a hospital involved in training residents in or "N" for no.	approved 0	GME programs	s? Enter "\	" for yes	N			56. 00
57. 00	If line 56 is yes, is this the first cost reporting	period duri	ng which re	esidents in	approved				57. 00
	GME programs trained at this facility? Enter "Y" for								
	is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "'								
	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II	l, if appli	cabl e.						
58. 00	If line 56 is yes, did this facility elect cost reiml defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ans' service	es as	N			58. 00
59. 00	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59. 00
60. 00	Are you claiming nursing school and/or allied health					N			60.00
	provider-operated criteria under §413.85? Enter "Y"	Y/N	IME	Direct GN		ME	Di rec	t GME	
61 00	Did your hospital receive FTE slots under ACA	1. 00	2. 00	3. 00	4.	0.00	5. (		61.00
01.00	section 5503? Enter "Y" for yes or "N" for no in					0.00		0.00	1 01.00
(1.04	column 1. (see instructions)		0.00		2 00				(1.05
61. 01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports		0. 00	, (	0. 00				61. 01
	ending and submitted before March 23, 2010. (see								
61. 02	instructions) Enter the current year total unweighted primary care		0. 00	,	0. 00				61. 02
01.02	FTE count (excluding OB/GYN, general surgery FTEs,		0.00	1 '	5. 00				01.02
	and primary care FTEs added under section 5503 of								
	ACA). (see instructions)	1 1		I	I				1

resident FIEs that trained in yo	ur hospital. Enter in	column 3 the ratio	1	I		1
of (column 1 divided by (column	1 + column 2)). (see	instructions)				
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
	-	_	FTĚs	FTEs in	(col. 3 + col.	
			Nonprovi der	Hospi tal	4))	
			Si te	·		
	1. 00	2. 00	3. 00	4. 00	5.00	

settings. Enter in column 2 the number of unweighted non-primary care

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151333 Peri od: Worksheet S-2 From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 3/30/2016 4:36 pm Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs (col. 3 + col FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col. Nonprovi der Hospi tal Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTES FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 0.000000 67.00 67.00 Enter in column 1, the program 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column

	4)). (see instructions)								
						1. 00	2. 00	3.00	
	Inpatient Psychiatric Facility P								
70. 00	Is this facility an Inpatient Ps		PF), or does it conta	ain an IPF subp	rovi der?	N			70. 00
	Enter "Y" for yes or "N" for no								
71. 00	If line 70 yes: Column 1: Did th							0	71. 00
	recent cost report filed on or b								
	42 CFR 412.424(d)(1)(iii)(c)) Co								
	program in accordance with 42 CF								
	Column 3: If column 2 is Y, indi	cate which program ye	ear began during this	cost reporting	j perioa.				
	(see instructions)	DDC							
75 00	Inpatient Rehabilitation Facilit		(LDE) on door it or	ntain an IDE		l N	1	1	75. 00
75.00	Is this facility an Inpatient Re subprovider? Enter "Y" for yes		y (TRF), OF does It Co	JIILAIII AII IKF		l IN			/5.00
76 00	If line 75 yes: Column 1: Did th		onroved GME teaching r	orogram in the	most			0	76. 00
70.00	recent cost reporting period end							"	70.00
	no. Column 2: Did this facility								
	CFR 412.424 (d)(1)(iii)(D)? Ente								
	indicate which program year bega								
MCRI F3	32 - 8. 6. 159. 0								

Health Financial Systems PUTNAM COUNTY	HOSPI TAL		. In Li€	eu of Form CM	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 151333	Period: From 01/01/2015	Worksheet S Part I	1-2
			To 12/31/2015		
	<u> </u>		'		
Long Term Care Hospital PPS				1.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers  85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)  86.00 Did this facility establish a new Other subprovider (excluded				N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  87.00 Is this hospital a "subclause (II)" LTCH classified under sec for yes or "N" for no.	tion 1886(d)	(1)(B)(iv)(I	l)? Enter "Y"	N	87. 00
Tot yes of A Tot Ho.			V	XIX	
Title V and XIX Services			1.00	2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospital	servi ces? E	nter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the			N	N	91. 00
full or in part? Enter "Y" for yes or "N" for no in the appli 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dua	l certificat			N	92. 00
instructions) Enter "Y" for yes or "N" for no in the applicable 93.00 Does this facility operate an ICF/IID facility for purposes on "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.	ınd "N" for n	o in the	N	N	94. 00
95.00   If line 94 is "Y", enter the reduction percentage in the appl 96.00   Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			O. 00 N	O. N	00 95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appl	icable colum	n.	0.00	0.	00 97.00
Rural Providers  105.00 Does this hospital qualify as a critical access hospital (CAH 106.00 of this facility qualifies as a CAH, has it elected the all-i		hod of payme	Y nt Y		105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see inst	ructions) If			107. 00
108.00 s this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee sche	dul e? See 4.	2 N		108. 00
	Physi cal	Occupati on		Respi rator	У
109.00 of this hospital qualifies as a CAH or a cost provider, are	1. 00 Y	2.00 Y	3. 00 Y	4.00 N	109. 00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	·				
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" f	Demonstrati for no.	on project (	410A Demo)for	N	110. 00
			1. 0	0 2.00 3.0	10
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no i	n column 1	If column 1 N		115 00
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 providers	If column 2 for long te	is "E", ente rm care (inc	rin column Ludes		115. 00
Pub.15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" f 117.00 s this facility legally-required to carry malpractice insura   no.	,		r"N" for Y		116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	cy? Enter 1	if the polic	y is 2		118. 00
		Premi ums	Losses	Insurance	
		1. 00	2.00	3.00	_

118. 02 Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  119. 000 Is this 150 of CM (11 hat qualifies for the Outpatient Hold Harmless provision in ACA N N N S3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.  121. 000 Bots this Facility practice at transplant center, enter the certification date in column 1 and termination date. If applicable, in column 2.  125. 000 Bots this Facility practice at transplant center, enter the certification date in column 1 and termination date. If applicable, in column 2.  127. 001 ft this is a Medicare certified Horer transplant center, enter the certification date in column 1 and termination date. If applicable, in column 2.  128. 001 ft this is a Medicare certified Horer transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  130. 001 ft this is a Medicare certified Horer transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  131. 001 ft this is a Medicare certified Horer transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  132. 001 ft this is a Medicare certified Horer transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  133. 001 ft this is a Medicare certified Horer transplant center, enter the certification date in column 1 and termination date, if applica					Part I	
18.02 Pre-mail practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  19.00 Po Not USE THIS LINE  19.00 Po Not USE Porter 'Y' For yes or 'W' For no.  19.00 Po Not					Doto/Timo D	roporod
18.00/Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? I free, submit supporting schedule listing cost centers and amounts contained therein.  19.000 No TUSE THIS LINE  20.00 Is this a SCH or FACH that qualifies for the Outpatient Hold Harmless provision in ACA N S121 and applicable amendments? (see instructions) Enter in column 1. "Y" for yes or "N" For No. 19.10 (No. 19.10				10 12/31/2015	3/30/2016 4	
18.02/Are mal practice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  19.00 DN NOT USE THIS LINE  20.00 Is this is a SKO in FACH that qualifies for the Outpatient Hold Harmless provision in ACA N S3121 and applicable amendments? (see instructions) Enter in column 1. "Y" for yes or "N" For No. S3121 and applicable amendments? (see instructions) Enter in column 1. "Y" for yes or "N" For No. "N S3121 and applicable amendments? (see instructions) Enter in column 2. "Y" for yes or "N" For No. "The past next yes and "N" for no. "The past next yes and "N" for no. "The past next yes and "N" for no. "The yes, enter certification date(s) (mm/dd/yyyy) below.  20.00 For this Tacility operate a transplant center? Enter "Y" for yes and "N" for no. "If yes, enter certification date(s) (mm/dd/yyyy) below.  21.00 For this is a Medicare certified Medicar transplant center, enter the certification date in column 1 and tremination date. If applicable, in column 2.  22.00 For this is a Medicare certified Jiver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  23.00 For this is a Medicare certified pancrass transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  24.00 For this is a Medicare certified pancrass transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  25.00 For this is a Medicare certified pancrass transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  26.00 For this is a Medicare certified pancrass transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  27.00 For this is a Medicare certified pancrass transplant center, enter the certificat				1.00	2.00	
Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.  19. 0000 NOT USC THIS LINE  20. 001s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with 1 200 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions)  21. 0001d this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. If high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no. If yes, enter certification dates (in modulum 1 and termination date, if applicable, in column?  25. 0000es this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification dates (in modulum 1 and termination date, if applicable, in column 2.  27. 001f this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  28. 001f this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30. 001f this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30. 001f this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30. 001f this is a Medicare certified light transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30. 001f this is a Medicare certified light transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  40. 001f this is a Medicare certified light transplant center, enter the certification date in column 1 and terminatio	practice premiums and paid losses reported in a cost co	enter other than	the		2.00	118. 0
19. 00 D0 NOT USE THIS LINE  20. 00 s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 1, "" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions)  Enter in column 2, "" for yes or "N" for no. "" for no. "N" for no. If yes, enter certification dare for years and the following patients? Enter "Y" for yes or "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below (mm/dd/ydyyy) below (mm/dd/ydyyy) b	trative and General? If yes, submit supporting schedul					
20.00  Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA S13121 and applicable amendments? (see instructions) Enter in column 1. "" for yes or "N" for no. Is this a rural hospital with 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA S13121 and applicable amendments? (see instructions)  Enter in column 2. "" for yes or "N" for no.  21.00Did this facility incur and report costs for high cost implantable devices charged to patients? Enter Y" for yes or "N" for no.  25.00Does this facility incur and report costs for high cost implantable devices charged to patients? Enter Y" for yes or "N" for no.  26.00Does this facility incur and report costs for high cost implantable devices charged to patients? Enter Y" for yes or "N" for no.  27.00If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  28.00If this is a Medicare certified there that the patient center, enter the certification date in column 1 and termination date, if applicable, in column 2.  29.00If this is a Medicare certified patient center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30.00If this is a Medicare certified diate, if applicable, in column 2.  30.00If this is a Medicare certified value, if applicable, in column 2.  30.00If this is a manual termination date, if applicable, in column 2.  31.00If this is a manual termination date, if applicable, in column 2.  31.00If this is an application to the manual termination date, if applicable in column 2.  31.00If this is an application to the manual termination date, if applicable in column 2.  31.00If this is an application to the manual termination date, if applicable in column 2.  31.00If this is a manual termination date, if applicable in column 2.  41.00Nate there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 107 Enter "Y" for yes or "N" for no in column 1. If y						119. 0
s3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 21. 00Did this facility operate a transplant center? Enter "Y" for yes or "N" for no. 15 battents? Enter "Y" for yes or "N" for no. 16 patients? Enter "Y" for yes or "N" for no. 17 yes, enter certification date(s) (mm/dd/yyyy) below.  25. 00Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. 16 yes, enter certification date(s) (mm/dd/yyyy) below.  27. 00If this is a Medicare certified the diney transplant center, enter the certification date in column 1 and termination date. If applicable, in column 2.  29. 00If this is a Sedicare certified liver transplant center, enter the certification date in column 1 and termination date. If applicable, in column 2.  29. 00If this is a Medicare certified ung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30. 00If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30. 00If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable in column 2.  31. 00If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable in column 2.  31. 00If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable in column 2.  32. 00If this is a Medicare certified of the transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  33. 00If this is a Medicare certified of the transplant center, enter the certification date in column 1 and termi		HarmLess provisio	on in ACA	N	N	120. 0
Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions)						1.20.0
Citter in column 2, "Y" for yes or "N" for no.						
21. 00 0 id this facility incur and report costs for high cost implantable devices charged to patients? Finter "Y" for yes or "N" for no. "P" for no. 17 months of the patients? Finter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  26. 00 0 this is a facility operate a transplant center? Enter "Y" for yes and "N" for no. If N yes, enter certification date(s) (mm/dd/yyyy) below.  26. 00 1 this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  27. 00 1 this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  28. 00 1 this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30. 00 1 this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  31. 00 1 this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  32. 00 1 this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  33. 00 1 this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  40. 00 1 this is a medicare certified other transplant center, enter the certification date in column 2.  41. 00 1 this is a medicare certified other transplant center, enter the certification date in column 2.  42. 00 1 this is a medicare certified other transplant center, enter the certification date in column 2.  43. 00 1 this is a medicare certified other transplant center, enter the certification date in column 2.  44. 00 1 this is a medicare certified other transplant center.  45. 00 1 this is a medicare certified other		s: (see instructi	oris)			
Transplant Center Information   Transplant center? Enter "Y" for yes and "N" for no. IF   N   yes, enter certification date(s) (mm/dd/yyyy) below.	s facility incur and report costs for high cost implan	table devices cha	arged to	Y		121. 0
25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.  26.00 If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  27.00 If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  28.00 If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  29.00 If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30.00 If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  31.00 If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  32.00 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  33.00 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  40.00 If this is an organ procurement organization (0PO), enter the 0PO number in column 1 and termination date, if applicable, in column 2.  40.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2. The home office contractor name and contractor number.  41.00 Name:  Contractor's Number:  42.00 Street:  43.00 If tosts for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is not used to the provide o						_
ves. enter certification date(s) (mm/dd/yyyy) below   2.00   fthis is a Medicare certification date, if applicable, in column 2.		yes and "N" for	no. If	N		125. 0
in column 1 and termination date, if applicable, in column 2.  28.00 if this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  28.00 if this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  29.00 if this is a Medicare certified ling transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30.00 if this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  31.00 if this is a Medicare certified into date, if applicable, in column 2.  32.00 if this is a Medicare certified into date, if applicable, in column 2.  33.00 if this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  33.00 if this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  34.00 if this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  34.00 if this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  34.00 if this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  35.00 if this is a Medicare certified is place transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  36.00 if this is a Medicare certified is place transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  37.00 if this is a Medicare certified is place transplant center, enter the certification date in column 1 and ter	ter certification date(s) (mm/dd/yyyy) below.					
27.00  If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  28.00  If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  29.00  If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30.00  If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  31.00  If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  32.00  If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  33.00  If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  34.00  If this is an organ procurement organization (PPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  40.00  If this is an organ procurement organization of PPO, enter the OPO number in column 1 and termination date, if applicable, in column 2.  40.00  If this is an organ procurement organization of PPO, enter the OPO number in column 1 and termination date, if applicable, in column 2.  40.00  If this is is an organ procurement organization of PPO, enter the OPO number in column 1 and termination date, if applicable, in column 2.  41.00  If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  42.00  If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and c		er the certificat	tion date			126. 0
28.00  f this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  29.00  f this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30.00  f this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  31.00  f this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  32.00  f this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  32.00  f this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  33.00  f this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  34.00  f this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  40.00  F this is an entermination date, if applicable, in column 2.  40.00  F this is an entermination date, if applicable, in column 2.  40.00  F centermination date, if applicable, in column 2.  41.00  Marchard organization or home office costs as defined in CMS Pub. 15-1, Name and address of the home office and enter the home office chain number. (see Instructions)  42.00  F this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  43.00  F costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. (see CMS Pub. 15-2, chapter 40, \$4020) If yes, enter the approval date (mm/dd/yyyy) in		r the certificati	on date			127. 0
in column 1 and termination date, if applicable, in column 2.  20.00  If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  30.00  If this is a Medicare certified applicable, in column 2.  31.00  If this is a Medicare certified applicable, in column 2.  31.00  If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  32.00  If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  33.00  If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  34.00  If this is an organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2.  40.00  Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  40.00  Are there any related organization or home office chain number. (see instructions)  41.00  Are claimed, enter in column 2 the home office chain number. (see instructions)  42.00  If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  42.00  Are provider based physicians' costs included in Worksheet A?  43.00  If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost report?  And the provider based physicians' costs included in Worksheet A?  44.00  Are the achieved a change in the statistical basis?						400 -
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30.00  If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  31.00  If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  32.00  If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  33.00  If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  44.00  If this is a morgan procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  40.00  And termination date, if applicable, in column 2.  41.1 Providers  40.00  Providers  Provid	is a Medicare certified lung transplant center, enter	the certification	on date in	n		129. 0
date in column 1 and termination date, if applicable, in column 2 31.00 If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2 32.00 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2 33.00 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2 34.00 If this is an organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2 40.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1.00  2.00  If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  41.00 Name:  (2.00 Street:  42.00 Street:  43.00 City:  State:  (2.10 Contractor's Name:  PO Box:  State:  (2.10 Contractor's Number:  At incourse of the provider based physicians' costs included in Worksheet A?  (3.10 Contractor's Name:  PO Box:  State:  (3.10 Contractor's Number:  At incourse of the provider based physicians' costs included in Worksheet A?  (4.00 Are provider based physicians' costs included in Worksheet A?  (5.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost report?  Enter "Y" for yes or "N" for no in column 2.  (4.00 Mas the cost allocation methodology changed from the previously filed cost report?  Enter "Y" for yes or "N" for no in column 2.  (4.00 Was there a change in the statistical basis? E						100.0
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32.00 If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  33.00 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  34.00 If this is an organ procurement organization (OPD), enter the OPO number in column 1 and termination date, if applicable, in column 2.  41. Providers  40.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "\" for yes or "\" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1.00   2.00   2.00   3.00    If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  41.00 Name:   Contractor's Name:	is a Medicare certified intestinal transplant center,	enter the certif	fication			131. 0
in column 1 and termination date, if applicable, in column 2.  33.00 If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.  34.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  All Providers  40.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1.00 2.00 3.00  If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  41.00 Name: Contractor's Name: PO Box: State:  2			on data			132. 0
in column 1 and termination date, if applicable, in column 2.  34.00 If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.  All Providers  40.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1.00 2.00   3.00   3.00    If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  41.00 Name:   Contractor's Name:   Contractor's Number: PO Box:   Zip Code:    42.00 Street:   PO Box:   Zip Code:    44.00 Are provider based physicians' costs included in Worksheet A?   Y  45.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  46.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2.  47.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.   N N N N N N N N N N N N N N N N N N	·	i the certificati	on date			132.0
34.00   f this is an organ procurement organization (0PO), enter the 0PO number in column 1 and termination date, if applicable, in column 2.  All Providers  40.00   Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)    1.00   2.00   3.00	is a Medicare certified other transplant center, enter	r the certificati	on date			133. 0
and termination date, if applicable, in column 2.  All Providers  40. 00 Are provider and enter the approval date (mm/dd/yyyy) in column 2.  All Providers  40. 00 Are a change in the statistical basis? Enter "Y" for yes or "N" for no.  All Providers  40. 00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1.00  2.00  3.00  If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  41.00 Name:  (Contractor's Name: PO Box: State:  Zip Code:  1.00  44.00 Are provider based physicians' costs included in Worksheet A?  45.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  46.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2.  47.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.  48.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.  48.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.  Are charter in column 1. In the column 1 is not column 2.  Are charter in column 2.  Are charter in column 2.  And the mame and address of the home office contractor number.		OPO number in co	aluma 1			134. 0
All Providers  40.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1.00  2.00  3.00  If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  41.00 Name:  Contractor's Name: P0 Box: State:  Zip Code:  1.00  44.00 Are provider based physicians' costs included in Worksheet A?  45.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  46.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 2.  47.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.  48.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.  N  N  1.00  47.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.  N  N		oro number in co	or uniir i			134.0
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)  1.00   2.00   3.00    If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.  41.00 Name:   Contractor's Name:   Contractor's Number:   42.00   Street:   P0 Box:   Zip Code:    43.00   City:   State:   Zip Code:    44.00   Are provider based physicians' costs included in Worksheet A?   Y    45.00   If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "V" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "V" for yes or "N" for no in column 2.  46.00   Has the cost allocation methodology changed from the previously filed cost report?   N    Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.  47.00   Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.   N    48.00   Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.   N    48.00   Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.   N    49.00   Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.   N    40.00   Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.   N    40.00   Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.   N    40.00   Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.   N    41.00   Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.   N    42.00   Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.   N    43.00   Was there a change in the order of allocati					_	<b>—</b>
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41.00 Name: 42.00 Street: 43.00 City:  State:  Zip Code:  1.00  44.00 Are provider based physicians' costs included in Worksheet A?  Y  1.00  45.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  46.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.  47.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.  N  N  N  N  N  N  N  N  N  N  N  N  N			143 the n	anie and address	or the	
43.00 City:    State:   Zip Code:	Contractor's Name:		Contracto	or's Number:		141. 0
44. 00 Are provider based physicians' costs included in Worksheet A?  1. 00  45. 00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  46. 00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.  1. 00  47. 00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.  N  N			7in Codo			142. 0 143. 0
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no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.  46.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.  1.00  47.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.  N  N  N	s for renal services are claimed on Wkst. A, line 74, a	are the costs for			2.00	145. 0
period? Enter "Y" for yes or "N" for no in column 2.  46.00 Has the cost allocation methodology changed from the previously filed cost report?  Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.  1.00  47.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.  N  N  N						
46.00 Has the cost allocation methodology changed from the previously filed cost report?  Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.  1.00  47.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.  N  N  N		or this cost repo	orting			
yes, enter the approval date (mm/dd/yyyy) in column 2.  1.00 47.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.  N 48.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.  N	cost allocation methodology changed from the previous	ly filed cost rep	oort?	N		146. 0
47.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.  N 48.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.  N		-2, chapter 40, §	§4020) If			
47.00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 48.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N	ter the approvar date (mm/dd/yyyy) fff Corumn 2.					
48.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						
					1	147. 0 148. 0
±7. Ovimas incre a cualide to the shiller realization increase. Filter 1 TOLVES OF N. TOLTIO.				no.	N N	149. 0
Part A Part B Title V Title X		Part A	Part B	Title V	Title XIX	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs	is facility contain a provider that qualifies for					
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
55.00 Hospi tal N N N N			N		N	155. C
56. 00 Subprovi der - I PF N N N		l l			1	156. 0
57.00 Subprovi der - I RF N N N N N N S58.00 SUBPROVI DER		N	N	N	l N	157. C
59. 00 SNF N N N	I DEN	N	N	N	N	159. 0
		IN I				
	ALTH AGENCY	N	N	N	N	160. 0
61. OD/GMEC N N N N N N N N N N N N N N N N N N N	ALTH AGENCY		N	N	N	160. 0 161. 0 161. 1

Health Financial Systems	PUTNAM CO	OUNTY HOSPITAL			In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA  Provider CCN: 151333   Period: From 01/01/2015   To 12/31/2015   Period: From 01/01/2015   Period: From 01/01/2							epared: 36 pm
						1.00	-
Multicampus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	s one or more campu	ises in di	ifferent (	CBSAs?	N	165. 00
, ,	Name	County	State	Zip Code	e CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5.00	1
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 166. 00
		1, 00	-				
Health Information Technology (HIT	) incentive in the Ame	arican Pecovery and	N Pai nyas	tment Act		1.00	
167.00 s this provider a meaningful user						Υ	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H	5 is "Y") and ís a mea	aningful user (line			er the	1	0168. 00
168.01 If this provider is a CAH and is n exception under §413.70(a)(6)(ii)?					rdshi p		168. 01
169.00 If this provider is a meaningful u transition factor. (see instruction	ser (line 167 is "Y")				enter the	0.0	0169. 00
				Е	egi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR b period respectively (mm/dd/yyyy)	eginning date and endi	ng date for the re	porting	0	1/01/2014	12/31/2014	170. 00
						1.00	-
171.00  f  ine 167 is "Y", does this prov	ider have any days for	individuals oprol	lad in so	action 10	76	1.00 N	171. 00
Medicare cost plans reported on Wk (see instructions)						l N	171.00

	Financial Systems AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	PUTNAM COUNTY HOS STIONNAIRE			eri od:	eu of Form CMS- Worksheet S-2	
					rom 01/01/2015 o 12/31/2015	Date/Time Pro	
					Y/N	3/30/2016 4:3 Date	36 pm
	Constant Instantian Fator V for all VFC many	Futur N 6	-1.1. NO :		1. 00	2. 00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	oonses. Enter N for	all NO re	esponses. Enter	all dates in	tne	
00	<u>Provider Organization and Operation</u> Has the provider changed ownership immediatel				N		1.00
	reporting period? If yes, enter the date of	the change in column	2. (see	instructions) Y/N	Date	V/I	
				1.00	2. 00	3. 00	
00	Has the provider terminated participation in yes, enter in column 2 the date of termination voluntary or "I" for involuntary.			N			2.00
00	Is the provider involved in business transaction contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or relationships? (see instructions)	., chain home office d to the provider or l, or members of the	s, drug its board	N			3.00
				Y/N	Type	Date	
	Financial Data and Reports			1. 00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Co enter date availabl	mpiled,	Y	А	03/01/2017	4.00
00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total		from	l N			5. 00
	those on the filed financial statements? If				V (1)		
					Y/N 1. 00	Legal Oper. 2.00	
00	Approved Educational Activities Column 1: Are costs claimed for nursing scho	ool 2 Column 2: If v	ae ie th	ne provider is	N		6. 00
00	the legal operator of the program?	Joi : Corumii 2. Tr y	cs, 15 th	ie provider 13	IN .		0.00
00	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health programs'	grams approved and/o		I during the	N N		7. 00 8. 00
00	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents i		ate medic	cal education	N		9. 00
0. 00	program in the current cost report? If yes, s Was an approved Intern and Resident GME progr		ewed in t	he current	N		10.00
	cost reporting period? If yes, see instruction	ons.					
1. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		in an App	proved	N		11.00
						Y/N 1.00	
	Bad Debts Is the provider seeking reimbursement for bad	d dobts2 lf vos soo	instruct	Long		Υ	12. 00
3. 00	If line 12 is yes, did the provider's bad del period? If yes, submit copy.	ot collection policy	change d	luring this cos	t reporting	N N	13. 00
	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments w	aived? If	yes, see inst	ructi ons.	N	14.00
	Did total beds available change from the price	or cost reporting pe	riod? If	yes, see instr	uctions.	N	15. 00
		Description		Y/N Par	Tt A Date	Part B Y/N	
		0		1.00	2. 00	3. 00	
	PS&R Data Was the cost report prepared using the PS&R			Υ	03/17/2016	Υ	14 0
6. 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			Y	03/1//2016	Y	16. 00
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is			N		N	17. 00
. 00	yes, enter the paid-through date in columns 2 and 4. (see instructions)  If line 16 or 17 is yes, were adjustments			N		N	18.00
	made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see			N		N	19.00
0. 00	instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe			N		N	20.00

Health Financial Systems PUTNAM CORNOR HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE In Lieu of Form CMS-2552-10 PUTNAM COUNTY HOSPITAL Worksheet S-2 Part II Date/Time Prepared: 3/30/2016 4:36 pm Peri od: From 01/01/2015 To 12/31/2015 Provi der CCN: 151333 Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the provider's records? If yes, see 21. 00 Ν Ν

	provider 3 records: 11 yes, see					
	instructions.					
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT CHILDRENS HO	SPI TALS)			
	Capital Related Cost					
	Have assets been relifed for Medicare purpose				N	22. 00
23.00	Have changes occurred in the Medicare depreci	ation expense due to appraisa	Is made during	g the cost	N	23. 00
	reporting period? If yes, see instructions.					
24.00	Were new leases and/or amendments to existing	g leases entered into during t	his cost repo	rting period?	Υ	24. 00
	If yes, see instructions					
25.00	Have there been new capitalized leases entere	ed into during the cost report	ing period? In	f yes, see	Υ	25. 00
	i nstructi ons.					
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during the cost reportin	g period? If	yes, see	N	26. 00
	i nstructi ons.				ı	
27.00	Has the provider's capitalization policy char	nged during the cost reporting	period? If ye	es, submit	N	27. 00
	copy.					
	Interest Expense					
28.00	Were new Loans, mortgage agreements or Letter	rs of credit entered into duri	ng the cost re	eporting	Υ	28. 00
	period? If yes, see instructions.				ı	
29.00	9.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund)					29. 00
	treated as a funded depreciation account? If		ı			
30.00	Has existing debt been replaced prior to its	scheduled maturity with new d	ebt? If yes,	see	N	30. 00
	i nstructi ons.				ı	
31.00	Has debt been recalled before scheduled matur	rity without issuance of new d	ebt? If yes, s	see	N	31. 00
	i nstructi ons.					
	Purchased Services					
32.00	Have changes or new agreements occurred in pa	atient care services furnished	through conti	ractual	N	32. 00
	arrangements with suppliers of services? If	yes, see instructions.			ı	
33.00	If line 32 is yes, were the requirements of 9	Sec. 2135.2 applied pertaining	to competitiv	ve bidding? If		33. 00
	no, see instructions.					
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facili	ty under an arrangement with	provi der-base	d physi ci ans?	Υ	34.00
	If yes, see instructions.				ı	
35.00	If line 34 is yes, were there new agreements	or amended existing agreement	s with the pro	ovi der-based	N	35. 00
	physicians during the cost reporting period?	If yes, see instructions.				
				Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost re	eport?		N		36.00
	If line 36 is yes, has a home office cost sta		ome office?		i	37. 00
	If yes, see instructions.				i	
20 00	If line 24 is yes was the fiscal year and	of the home office different f	rom that of		1	20 00

	1. 00	2. 00	
Home Office Costs			
36.00 Were home office costs claimed on the cost report?	N		36. 00
37.00   If line 36 is yes, has a home office cost statement been prepared by the home offi	ce?		37. 00
If yes, see instructions.			
38.00   If line 36 is yes , was the fiscal year end of the home office different from that of			38. 00
the provider? If yes, enter in column 2 the fiscal year end of the home office.			
39.00   If line 36 is yes, did the provider render services to other chain components? If	yes,		39. 00
see instructions.			
40.00   If line 36 is yes, did the provider render services to the home office? If yes,	see		40. 00
instructions.			
1.00		2.00	

	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position	TI NA	SEVERS	41.00
	held by the cost report preparer in columns 1, 2, and 3,			
	respecti vel y.			
42.00	Enter the employer/company name of the cost report	BLUE & CO., LLC		42.00
	preparer.			
43.00	Enter the telephone number and email address of the cost	317-713-7946	TSEVERS@BLUEANDCO. COM	43.00
	report preparer in columns 1 and 2, respectively.			

Health Financial Systems	PUTNAM COUNT	Y HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der CCN: 151333	From 01/01/2015	Worksheet S-2 Part II Date/Time Pre 3/30/2016 4:3	pared:
	Part B				
	Date				
	4.00				
PS&R Data					
16.00 Was the cost report prepared using the PS&R	03/17/2016				16. 00

		Part B		 •
		Date		
		4. 00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R	03/17/2016		16. 00
	Report only? If either column 1 or 3 is yes,			
	enter the paid-through date of the PS&R			
	Report used in columns 2 and 4 (see			
	instructions)			
17. 00	Was the cost report prepared using the PS&R			17. 00
	Report for totals and the provider's records			
	for allocation? If either column 1 or 3 is			
	yes, enter the paid-through date in columns			
10.00	2 and 4. (see instructions)			10.00
18. 00	J			18. 00
	made to PS&R Report data for additional claims that have been billed but are not			
	included on the PS&R Report used to file			
	this cost report? If yes, see instructions.			
19. 00	If line 16 or 17 is yes, were adjustments			19. 00
17.00	made to PS&R Report data for corrections of			19.00
	other PS&R Report information? If yes, see			
	instructions.			
20.00	If line 16 or 17 is yes, were adjustments			20.00
	made to PS&R Report data for Other? Describe			
	the other adjustments:			
21.00	Was the cost report prepared only using the			21. 00
	provider's records? If yes, see			
	instructions.			
	T		3. 00	
	Cost Report Preparer Contact Information		humann	
41.00	Enter the first name, last name and the title		MANAGER	41. 00
	held by the cost report preparer in columns	ı, ∠, and 3,		
42.00	respectively.	anant		42.00
42.00	Enter the employer/company name of the cost i	epor t		42. 00
42 00	preparer. Enter the telephone number and email address	of the cost		43. 00
43.00	report preparer in columns 1 and 2, respective			43.00
	preport preparer in corumns rand 2, respective	∕⊂ıy.		1

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Health Financial Systems PUTNAI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 151333

						10	12/31/2015	3/30/2016 4:30	
								I/P Days / 0/P	<b>У</b> РШ
								Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	
		Line Number			Avai I abl e				
		1.00		2. 00	3.00		4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		19	6, 93	35	37, 032. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2. 00
3.00	HMO IPF Subprovider								3. 00
4.00	HMO IRF Subprovider								4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF							0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					_		0	6. 00
7. 00	Total Adults and Peds. (exclude observation			19	6, 93	35	37, 032. 00	0	7. 00
0.00	beds) (see instructions)	21 00		,	0.10		10 1/0 00	0	0.00
8.00	INTENSIVE CARE UNIT	31. 00		6	2, 19	10	12, 168. 00	0	8. 00
9.00	CORONARY CARE UNIT								9.00
10. 00 11. 00	BURN INTENSIVE CARE UNIT								10. 00 11. 00
12.00	SURGICAL INTENSIVE CARE UNIT								11.00
13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43. 00						0	13. 00
14. 00	Total (see instructions)	43.00		25	9, 12	25	49, 200. 00	0	14. 00
15. 00	CAH visits			25	7, 12	23	49, 200. 00	0	15. 00
16. 00	SUBPROVI DER - I PF							O	16. 00
17. 00	SUBPROVI DER - I RF	41. 00		0		0		0	17. 00
18. 00	SUBPROVI DER	42. 00		0		0		0	18. 00
19. 00	SKILLED NURSING FACILITY	12.00		ū				Ĭ	19. 00
20. 00	NURSING FACILITY								20. 00
21. 00	OTHER LONG TERM CARE								21. 00
22. 00	HOME HEALTH AGENCY								22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)								23.00
24.00	HOSPI CE								24.00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25.00	CMHC - CMHC								25.00
25. 10	CMHC - CORF	99. 10						0	25. 10
26. 00	PPIM	88. 00						0	26.00
26. 01	FMC	88. 01						0	26. 01
26. 02	NPFH	88. 02						0	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	26. 25
27. 00	Total (sum of lines 14-26)			25					27. 00
28. 00	Observation Bed Days							0	28. 00
29. 00	Ambul ance Tri ps								29. 00
30. 00	Employee discount days (see instruction)								30. 00
31.00	Employee discount days - IRF			_					31. 00
32. 00	Labor & delivery days (see instructions)			0		0			32. 00
32. 01	Total ancillary labor & delivery room								32. 01
22 00	outpatient days (see instructions)								33. 00
33. 00	LTCH non-covered days				l	- 1			33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Labor & delivery days (see instructions)

Total ancillary labor & delivery room

outpatient days (see instructions)

LTCH non-covered days

Provider CCN: 151333 | Period: | Worksheet S-3 | From 01/01/2015 | Part I

0

0

32.00

32.01

33.00

12/31/2015 Date/Time Prepared: 3/30/2016 4:36 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 6.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 897 32 1, 533 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 13 3.00 HMO IPF Subprovider 0 0 3.00 HMO IRF Subprovider 4.00 4.00 Hospital Adults & Peds. Swing Bed SNF 487 0 5.00 5.00 560 Hospital Adults & Peds. Swing Bed NF 6.00 C 21 6.00 7.00 Total Adults and Peds. (exclude observation 1, 384 32 2, 114 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 176 385 8.00 CORONARY CARE UNIT 9.00 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 14.00 Total (see instructions) 1,560 32 2, 499 0.00 246.21 14.00 CAH visits 15.00 0 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 0.00 17.00 0 C 0 0.00 17.00 18.00 SUBPROVI DER 0 0 0.00 0.00 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 24 00 HOSPICE (non-distinct part) 24. 10 0 0 0 24.10 CMHC - CMHC 25.00 25.00 25. 10 CMHC - CORF 0 0.00 0.00 25. 10 475 6, 587 26.00 PPI M 0 0.00 3.11 26.00 26.01 FMC 722 0 6, 469 0.00 2.46 26.01 26.02 180 2,009 0.00 1.71 26.02 FEDERALLY QUALIFIED HEALTH CENTER 0 0.00 0.00 26, 25 26, 25 0 0 253.49 27 00 Total (sum of lines 14-26) 0.00 27 00 28. 00 Observation Bed Days 1, 123 28.00 29.00 Ambul ance Trips 29.00 0 Employee discount days (see instruction) 30.00 0 30.00 31.00 Employee discount days - IRF 0 31.00

0

32.00

32.01

33.00

Health Financial Systems PUTNAI HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 151333

					3 12/31/2013	3/30/2016 4: 3	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	349	13	673	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			0	0		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	C	349	13	673	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF	0. 00	C		0	0	17. 00
18. 00	SUBPROVI DER	0. 00	C	0	0	0	18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0.00					25. 00
25. 10	CMHC - CORF PPIM	0.00					25. 10 26. 00
26. 00 26. 01	FMC	0.00					26. 00 26. 01
	NPFH	0.00					
26. 02		0.00					26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00 0. 00					26. 25 27. 00
27. 00	Total (sum of lines 14-26)	0.00					
28. 00	Observation Bed Days						28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33 00	outpatient days (see instructions) LTCH non-covered days						33. 00
33.00	LIGH HOH-COVELEG Gays	I		1	ا		33.00

. 00   Ci	L-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIFICAL DATA  Iinic Address and Identification  Street  City, State, ZIP Code, County  FOHCS ONLY: Designation - Enter "R" for rural ource of Federal Funds	GR	Componen			Date/Time Pre 3/30/2016 4:3 Cost  OO  NGTON ST., STE  ZIP Code	epared: 36 pm
. 00 S	City, State, ZIP Code, County  FQHCs ONLY: Designation - Enter "R" for rural	•	1.		1. 1542 S. BLOOMI 1200 State	OO NGTON ST., STE	
. 00 S . 00 C . 00 F . 00 G . 00 G . 00 M . 00 H . 00 H	City, State, ZIP Code, County  FQHCs ONLY: Designation - Enter "R" for rural	•	1.		1. 1542 S. BLOOMI 1200 State	NGTON ST., STE	1.0
. 00 S	City, State, ZIP Code, County  FQHCs ONLY: Designation - Enter "R" for rural	•	1.		1542 S. BLOOMI 1200 State	NGTON ST., STE	1.0
. 00 S . 00 C . 00 F . 00 G . 00 G . 00 M . 00 H . 00 H	City, State, ZIP Code, County  FQHCs ONLY: Designation - Enter "R" for rural	•	1.		1200 State	ZIP Code	1.0
. 00 F0	FQHCs ONLY: Designation - Enter "R" for rural	•	1.				
. 00 F0	FQHCs ONLY: Designation - Enter "R" for rural	•		00	2. 00		_
. 00 F0	FQHCs ONLY: Designation - Enter "R" for rural	•	EENCASTLE		LN	3. 00 46135	2.0
Sc . 00 Cc . 00 Mi . 00 He	<u> </u>	or "U" for urba				40135	2.0
Sc . 00 Cc . 00 Mi	<u> </u>	or "U" for urba				1. 00	
. 00 Co . 00 Mi . 00 He	ource of Federal Funds		in			0	3. (
. 00 Co . 00 Mi . 00 He	ource of Federal Funds				Grant Award	Date	
. 00 Co . 00 Mi . 00 He					1. 00	2. 00	+
00 Mi	Community Health Center (Section 330(d), PHS	Act)			0		4.0
1	Migrant Health Center (Section 329(d), PHS Ac				0	,	5.
00 A	Health Services for the Homeless (Section 340	O(d), PHS Act)			0	1	6.
- l.	Appalachian Regional Commission				0	1	7.
	Look-Alikes				0	l .	8.
. 00 0	OTHER (SPECIFY)				0		9.
					1. 00	2. 00	
no	Does this facility operate as other than an R no in column 1. If yes, indicate number of ot subscripts of line 11 the type of other opera	her operations i	n column 2.	(Enter in	N	0	10.
		Sunda	у	Mo	onday	Tuesday	
		from	to	from	to	from	
le.		1. 00	2. 00	3.00	4. 00	5. 00	-
1. 00 CI	acility hours of operations (1)			07: 00	17: 00	07: 00	11.
1.00  01	7.1111.0			07.00	17.00	07.00	
					1. 00	2. 00	
3. 00   I : 30 ni	Have you received an approval for an exception is this a consolidated cost report as defined as 80.8? Enter "Y" for yes or "N" for no in columnumber of providers included in this report.	lin CMS Pub. 100 umn 1. If yes, en	)-04, chapter iter in colur	9, section nn 2 the	N N	0	12.
1				Provi	der name	CCN number	
				1	1.00	2. 00	
4. 00   Pi	Provider name, CCN number	V /N1	V	VVIII	VIV	Total Vi -i d	14.
		Y/N 1.00	2. 00	3. 00	XI X 4. 00	Total Visits 5.00	
GI cc 4 I i X	Have you provided all or substantially all SME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and I the number of program visits performed by ntern & Residents for titles V, XVIII, and (IX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	1.00	2.00	3.00	4.00	3.00	15. (
				inty			
00	712 0 1 2			00			
. 00   Ci	City, State, ZIP Code, County		TNAM	oeday	Thur	ceday	2.
		Tuesday to	Wedn from	esday to	from	rsday to	
		6. 00	7. 00	8. 00	9. 00	10.00	
	acility hours of operations (1)						

Health Financial Systems	PUTNAM COUNT	TY HOSPI TAL	In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FLED HEALTH CEN	TER Provi der	CCN: 151333	Peri od:	Worksheet S-8	
STATISTICAL DATA		Componen	t CCN: 158515	From 01/01/2015 To 12/31/2015		
				Rural Health	Cost	
				Clinic (RHC) I		
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 Cl i ni c	07: 00	17: 00				11. 00

	Financial Systems TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	PUTNAM COUNTY		CCN: 151333	Peri od:	worksheet S-	
	TI CAL DATA	TED HEALTH GENTE		it CCN: 158513	From 01/01/2015		epared:
					Rural Health Clinic (RHC) II	Cost	оо рііі
					1.	00	
	Clinic Address and Identification						
. 00	Street				51 E. MARKET S		1. (
				i ty	State	ZIP Code	
	T			. 00	2. 00	3. 00	
2. 00	City, State, ZIP Code, County	<u> C</u>	LOVERDALE		IN	46120	2.0
						4 00	
	FOLIO ONLY D : 11 F I HDH C					1. 00	
. 00	FQHCs ONLY: Designation - Enter "R" for rura	or "U" for urb	an		C+ A		3.0
					Grant Award	Date	
	Course of Fodous L Funds				1. 00	2. 00	
	Source of Federal Funds	A a + \					١,,
. 00	Community Health Center (Section 330(d), PHS				0	•	4. C
6. 00 6. 00	Migrant Health Center (Section 329(d), PHS A Health Services for the Homeless (Section 34)				0		6. (
. 00	Appal achi an Regional Commission	U(u), PH3 ACI)			0		7. (
3. 00	Look-Alikes				0		8. 0
00	OTHER (SPECIFY)				0	l .	9. (
r. 00	OTTLER (SPECITY)				0		7. (
					1. 00	2. 00	
0. 00	Does this facility operate as other than an	RHC or FOHC? Ent	er "Y" for v	es or "N" for			10.0
0.00	no in column 1. If yes, indicate number of o subscripts of line 11 the type of other opera	ther operations	in column 2.	(Enter in		,	10. (
	Subscripts of Time II the type of other open	Sund			londay	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4. 00	5. 00	
	Facility hours of operations (1)	1.00		1 2.22		3.00	
11.00	Clinic			08: 00	18: 00	08: 00	T 11. 0
					1. 00	2. 00	
12. 00 13. 00	Have you received an approval for an exception is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in column in the control of the control	d in CMS Pub. 10 umn 1. If yes, e	00-04, chapte enter in colu	r 9, section mn 2 the	N N	(	12.0
	number of providers included in this report. numbers below.	LIST the names	or arr provi	uers and			
	Tridiliber's berow.			Provi	ider name	CCN number	
					1. 00	2. 00	
4. 00	Provider name, CCN number				, <u></u>		14. C
		Y/N	V	XVIII	XIX	Total Visits	
		1.00	2.00	3.00	4. 00	5. 00	
15. 00	Have you provided all or substantially all						15. 0
	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)						
				unty			
000	0: + 0+-+- 710 0-4- 0			. 00			
2. 00	City, State, ZIP Code, County		UTNAM	anday.	T1	anday.	2.0
		Tuesday		nesday T + a		sday	
		to	from	to	from	to	
	Eacility hours of operations (1)	6.00	7. 00	8. 00	9. 00	10.00	
11 00	Facility hours of operations (1)	18: 00 0	8: 00	18: 00	08: 00	18: 00	11 0
11.00	TOT THE C	pro. 00  0	0.00	110.00	JUG. UU	110.00	11.0

Health Financial Systems	PUTNAM COUNTY HOSPITAL In Lieu						
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FIED HEALTH CEN	ITER	Provi der	CCN: 151333	Peri od: From 01/01/2015	Worksheet S-8	
STATISTICAL DATA			Component	CCN: 158513	To 12/31/2015		
					Rural Health	Cost	-
					Clinic (RHC) II		
	Fri	day		Sa	turday		
	from		to	from	to		
	11. 00	1 '	12. 00	13.00	14. 00		
Facility hours of operations (1)							
11. 00 Clinic	08: 00	18: 00	ı				11. 00

Component CCN: 158514   Tom 01/01/2015   Date/Time If 3/30/2016   Rural Heal th Clinic (RHC) III   Cos		Financial Systems TAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	PUTNAM COUNTY		CCN: 151333	Peri od:	worksheet S-	
Clinic Address and Identification			TED HEALTH CENTE			From 01/01/2015	Date/Time Pr	epared
1.00							Cost	
Street				·				
City   State   ZiP Code   County   BAINBRIDGE   1.00   2.00   3.00   3.00   3.00   5.00   FORTH   The provider special provider and provided in this report. List the names of all providers and provider for this provider.   Purple   Purple		Clinic Address and Identification						
1.00   2.00   3.00   1   1.00   2.00   3.00   1   1.00   2.00   1   1.00   2.00   1   1.00   2.00   1   1.00   2.00   1   1.00   2.00   1   1.00   2.00   1   1.00   2.00   1.00   2.0	. 00	Street				440 E. PAT RAD	Y WAY	1.
County   RAINBRIDGE   IN   6105								
1.00   Formal   For					. 00			
Community Heal th Center (Section 330(d) PHS Act)	. 00	City, State, ZIP Code, County	B	AI NBRI DGE		IN	46105	2.
Community Heal th Center (Section 330(d) PHS Act)							1.00	
Source of Federal Funds	-00	FOLICE ONLY Designation Fator UDII for any	l "II"					0 3.
Source of Federal Funds	. 00	FUNCS UNLY: Designation - Enter R for rura	i or u for urb	an		Cront Award		0 3.
Source of Federal Funds								
Community Heal th Center (Section 330(d), PHS Act)   0   0   0   0   0   0   0   0   0		Source of Endoral Funds				1.00	2.00	
Migrant Heal th Center (Section 329(d), PHS Act)   0   0   0   0   0   0   0   0   0	00		Act)			0		4.
No   Heal th Services for the Homeless (Section 340(d), PHS Act)   0   0   0   0   0   0   0   0   0							•	5.
Appal achian Regional Commission   0   0   0   0   0   0   0   0   0						0		6.
Look-Alikes			o(u) / 11.0 / 101)			o o		7.
1.00   2.00						0		8.
1.00   2.00						0		9.
Does this facility operate as other than an RHC or FOHC? Enter "Y" for 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.)    Sunday								
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.)						1. 00	2.00	
Sunday   Monday   Tuesday   From   to   Facility hours of operations (1)	0. 00	no in column 1. If yes, indicate number of o	ther operations	in column 2.	(Enter in	N		0 10.
From to from 1.00 2.00 3.00 4.00 5.00		Subscripts of time if the type of other opera				londov	Tuecday	
1.00   2.00   3.00   4.00   5.00								
Facility hours of operations (1)								
1.00   Clinic		Facility hours of operations (1)	1.00	2.00	3.00	4.00	3.00	
2.00 Have you received an approval for an exception to the productivity standard?  3.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.    Provider name	1. 00				08: 00	17: 00	08: 00	11.
Have you received an approval for an exception to the productivity standard?   Solution   Solutio		1	Y Y					
3.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below.    Provider name   CCN number   1.00   2.00						1. 00	2.00	
Provider name   CCN number   1.00   2.00		Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. 10 umn 1. If yes, e	0-04, chapte nter in colu	r 9, section mn 2 the			12. 0 13.
4.00   Provider name, CCN number					Prov	ider name	CCN number	
Y/N   V   XVIII   XIX   Total Visit						1. 00	2.00	
1.00 2.00 3.00 4.00 5.00    Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)    County	4. 00	Provider name, CCN number						14.
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)    County   4.00					_		Total Visits	
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)  County 4.00  PUTNAM  Tuesday  to from to from to 6.00 7.00 8.00 9.00 10.00  Facility hours of operations (1)	F 60	In	1.00	2.00	3.00	4. 00	5. 00	
County   4.00     City, State, ZIP Code, County   PUTNAM   Tuesday   Thursday   to from to from to 6.00   7.00   8.00   9.00   10.00     Facility hours of operations (1)	5. 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.						15.
A.00				Co	unty			
City, State, ZIP Code, County   PUTNAM   Tuesday   Wednesday   Thursday   to   from   f								
	. 00	City, State, ZIP Code, County	P		-			2.
					nesday	Thur	sday	
Facility hours of operations (1)								
			6.00		8.00		10.00	
1. 00   Clinic   17: 00   08: 00   17: 00   08: 00   17: 00	_							
	1. 00	Cl i ni c	17: 00  0	8: 00	17: 00	08: 00	17: 00	11.

Health Financial Systems	PUTNAM COUNT	TY HOSPI TAL	In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RURAL HEALTH CLINIC/FEDERALLY QUALIF	FLED HEALTH CEN	TER Provi der	CCN: 151333	Peri od:	Worksheet S-8	1
STATISTICAL DATA		Componen	t CCN: 158514	From 01/01/2015 To 12/31/2015		
				Rural Health	Cost	•
				Clinic (RHC) III		
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 Cl i ni c	08: 00	17: 00				11. 00

Heal th	Financial Systems PUTNAM COUNTY HO	SPI TAI		In lie	u of Form CMS-2	2552-10	
	AL UNCOMPENSATED AND INDIGENT CARE DATA	_	CCN: 151333	Peri od:	Worksheet S-10		
				From 01/01/2015 To 12/31/2015	Date/Time Prep 3/30/2016 4:30		
					1. 00		
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	vided by li	ne 202 columi	า 8)	0. 372734	1. 00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				68, 453	2. 00	
3.00	Did you receive DSH or supplemental payments from Medicaid?					3. 00 4. 00	
4.00							
5.00	If line 4 is "no", then enter DSH or supplemental payments from	n Medicaid			0	5. 00	
6.00	Medi cai d charges				172, 732		
7.00	Medicaid cost (line 1 times line 6)	64, 383	7. 00 8. 00				
8. 00	< zero then enter zero)						
	State Children's Health Insurance Program (SCHIP) (see instruct	tions for e	ach line)				
9.00	Net revenue from stand-alone SCHIP				0		
10.00					0	10.00	
11. 00	Stand-alone SCHIP cost (line 1 times line 10)	(1: 11	: 1: O	:6	0		
12. 00	Difference between net revenue and costs for stand-alone SCHIP enter zero)				0	12. 00	
	Other state or local government indigent care program (see inst						
13. 00	Net revenue from state or local indigent care program (Not incl		0	13. 00 14. 00			
14. 00	OD   Charges for patients covered under state or local indigent care program (Not included in lines 6 or   10)						
15. 00	State or local indigent care program cost (line 1 times line 14	,			0	15. 00 16. 00	
16. 00	00 Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)						
	Uncompensated care (see instructions for each line)						
17. 00	Private grants, donations, or endowment income restricted to fu	9	,			17. 00	
18. 00	Government grants, appropriations or transfers for support of h				0		
19. 00	Total unreimbursed cost for Medicaid, SCHIP and state and local 8, 12 and 16)	al indigent	care progra	ns (sum of lines	0	19. 00	
			Uni nsured	Insured	Total (col. 1		
			patients	pati ents	+ col . 2)		
00.00	T	( ) ( ) ( )	1.00	2. 00	3. 00	00.00	
20. 00	Total initial obligation of patients approved for charity care		1, 217, 7	98 0	1, 217, 798	20. 00	
21. 00	charges excluding non-reimbursable cost centers) for the entire Cost of initial obligation of patients approved for charity can		453, 9	15 0	453, 915	21. 00	
22.00	times line 20)			0		22.00	
22. 00 23. 00	Partial payment by patients approved for charity care Cost of charity care (line 21 minus line 22)		453, 9	0	0 453, 915		
24. 00	Does the amount in line 20 column 2 include charges for patient	t days boyo	nd a Longth	of stay limit	1. 00	24. 00	
24.00	imposed on patients covered by Medicaid or other indigent care		ilu a religiti (	or Stay IIIII t		24.00	
25 00	.00  If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit  0						
26. 00							
27. 00	Medicare bad debts for the entire hospital complex (see instruc				360, 997		
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (li		s line 27)		-360, 997		
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp			28)	-134, 556		
30. 00		,		,	319, 359		
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			319, 359		
		•			. '	-	

	Financial Systems	PUTNAM COUNTY		CON 151222   5		u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IF EXPENSES	Provi der	F	Period: From 01/01/2015	Worksheet A	
				[1	o 12/31/2015	Date/Time Pre 3/30/2016 4:3	
	Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	<u>Б</u>
				+ col. 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	GENERAL SERVICE COST CENTERS		2 004 510	2 004 510	210 021	2 124 240	1 00
1. 00 4. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT	25, 213	2, 804, 518 3, 919, 400	2, 804, 518 3, 944, 613		3, 124, 349 3, 961, 153	1. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	2, 343, 648	2, 623, 599	4, 967, 247		4, 877, 112	5. 00
7. 00	00700 OPERATION OF PLANT	246, 823	1, 006, 238			1, 292, 906	1
8. 00 9. 00	O0800   LAUNDRY & LINEN SERVICE   O0900   HOUSEKEEPING	28, 499	86, 668			115, 167	8. 00 9. 00
10.00	01000 DI ETARY	307, 907 292, 458	95, 539 323, 500	403, 44 <i>6</i> 615, 958		403, 446 179, 535	1
11. 00	01100 CAFETERI A	0	0	(			1
13. 00	01300 NURSING ADMINISTRATION	66, 002	235, 587	301, 589		301, 589	1
16. 00 17. 00	01600   MEDICAL RECORDS & LIBRARY   01700   SOCIAL SERVICE	366, 818	148, 629	515, 447	0	515, 447 0	16. 00 17. 00
17. 00	01701 UTI LI ZATI ON REVI EW	101, 903	4, 456	106, 359		_	ł
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	918, 473	42, 723			961, 456	
31. 00 41. 00	03100   INTENSIVE CARE UNIT   04100   SUBPROVIDER -   RF	753, 974 0	46, 776 0	800, 750	398	801, 148 0	ı
42. 00	04200 SUBPROVI DER	O	O		o o	Ö	42.00
43.00	04300 NURSERY	0	0	(	0	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	449, 517	534, 758	984, 275	-8, 758	975, 517	50.00
51. 00	05100 RECOVERY ROOM	65, 063	6, 714	71, 777		71, 777	l
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	-	0	52. 00
53. 00	05300 ANESTHESI OLOGY	563, 640	98, 215	661, 855		661, 855	
54. 00 54. 01	05400  RADI OLOGY-DI AGNOSTI C   05401  NUCLEAR   MEDI CI NE-DI AGNOSTI C	682, 241	244, 455 143, 058	926, 696 143, 058		927, 981 143, 058	•
57. 00	05700 CT SCAN	155, 507	138, 969			294, 476	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	0	0	58. 00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	644, 116	0 1, 311, 758	1, 955, 87 <sup>4</sup>	0	0 1, 955, 874	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	044, 110	1, 311, 730	1, 755, 675		1, 755, 674	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	334, 743	106, 170			441, 582	1
66. 00 67. 00	06600  PHYSI CAL THERAPY   06700  OCCUPATI ONAL THERAPY	0	477, 808 116, 011	477, 808 116, 011		478, 246 116, 011	1
68. 00	06800 SPEECH PATHOLOGY	0	24, 814			24, 814	1
69. 00	06900 ELECTROCARDI OLOGY	65, 060	70, 958			136, 018	1
69. 01 71. 00	06901   CARDI AC REHAB   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	111, 259	7, 888 12, 011	119, 147 12, 011		119, 147 0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	12, 01		_	ł
73. 00	07300 DRUGS CHARGED TO PATIENTS	107, 315	1, 381, 440				ı
73. 01	07301   ONCOLOGY   OUTPATIENT SERVICE COST CENTERS	283, 515	2, 254, 385	2, 537, 900	-1, 883, 418	654, 482	73. 01
88. 00	08800 PPIM	0	0	(	969, 751	969, 751	88. 00
88. 01	08801 FMC	0	0	(	812, 385	812, 385	88. 01
88. 02		0	0	(	415, 256		
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0 1, 472	1, 472	0	0 1, 472	
91. 00	09100 EMERGENCY	1, 636, 775	902, 276				1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
00 10	OTHER REIMBURSABLE COST CENTERS  09910 CORF	0	0	(	0	0	99. 10
99. 10	SPECIAL PURPOSE COST CENTERS	l ol	U		)  0	0	99.10
	10900 PANCREAS ACQUISITION	0	0	(	0		109. 00
	11000 INTESTINAL ACQUISITION	0	0	(	0		110.00
	11100  SLET ACQUISITION  11300  NTEREST EXPENSE	0	0	(			111. 00 113. 00
	11400 UTI LI ZATI ON REVI EW-SNF	0	0		o o		114. 00
118.00		10, 550, 469	19, 170, 793	29, 721, 262	2, 483, 473	32, 204, 735	118. 00
100 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0			0	190. 00
190.00	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 798, 829	1, 064, 718	4, 863, 547	-2, 483, 473		
193.00	19300 NONPALD WORKERS	0	0		0	0	193. 00
	19301 DME	0	0	(	0		193. 01
	19302 LACTATION CONSULTING  19303 DIABETIC COUNSELING	0	0	(			193. 02 193. 03
194.00	07950 VACANT SPACE	j ő	0		o o	0	194. 00
	07951 BOARD OF HEALTH	0	0	(	0		194. 01
194. 02 200. 00	07952 PUTNAM/HENRY PRENATAL TOTAL (SUM OF LINES 118-199)	10, 566 14, 359, 864	578 20, 236, 089				194. 02
_00.00	1.5 (55 5) EINES 110 177)	. 1, 557, 554	20, 200, 007	1 31, 373, 730	٠, ٥	1 01,070,700	,_55. 00

Provi der CCN: 151333

Peri od: From 01/01/2015 To 12/31/2015 Worksheet A Date/Time Prepared: 3/30/2016 4:36 pm

					3/30/2016 4: 36 pm
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS		T		
1. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	-406, 568			1. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-4, 003		•	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-782, 969		1	5. 00
7. 00	00700 OPERATION OF PLANT	-3, 110		1	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0		•	8. 00
9.00	00900 HOUSEKEEPI NG	0			9. 00
10. 00		-1, 481	178, 054		10.00
11. 00	01100 CAFETERI A	-60, 865	375, 558		11.00
13.00	01300 NURSING ADMINISTRATION	0	301, 589		13.00
16.00	01600 MEDICAL RECORDS & LIBRARY	-203	515, 244		16.00
17. 00	01700 SOCIAL SERVICE	0	0		17. 00
17. 01	01701 UTILIZATION REVIEW	0	106, 359		17. 01
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00		0	961, 456		30.00
31.00	03100 INTENSIVE CARE UNIT	0		•	31.00
41. 00		0	1	1	41.00
42. 00		0	ł c		42. 00
43. 00	•	0	Ö	1	43. 00
	ANCILLARY SERVICE COST CENTERS		-	I	13, 33
50. 00		-130	975, 387		50.00
51. 00	l l	0		•	51.00
52. 00	l l	0		1	52. 00
53. 00	•	-484, 767	177, 088	1	53. 00
54. 00	•	-2, 706			54. 00
54. 00	05401 NUCLEAR MEDICINE-DIAGNOSTIC	-2,700	1	•	54. 01
57. 00		0	294, 476	•	57. 00
58. 00		0	294, 470	1	58. 00
		_	1		l l
59. 00		0			59.00
60.00		0		1	60.00
60. 01	06001 BLOOD LABORATORY	0	· -	1	60. 01
64. 00		0			64. 00
65. 00		0	,	•	65. 00
66. 00		0	478, 246		66. 00
67. 00		0	116, 011		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	24, 814		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	136, 018		69. 00
69. 01	06901 CARDI AC REHAB	0	119, 147		69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	16, 519		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-90, 124	3, 282, 830		73. 00
73. 01		-350, 549		•	73. 01
	OUTPATIENT SERVICE COST CENTERS			1	
88. 00		0	969, 751		88. 00
88. 01		0	812, 385		88. 01
88. 02		0		•	88. 02
89. 00	l l	0		1	89. 00
90. 00		0		1	90.00
	09100 EMERGENCY	-987, 906		•	91.00
92. 00	l l	707, 700	1, 551, 504		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
00 10	09910 CORF	0	0		99. 10
77. 10	SPECIAL PURPOSE COST CENTERS				77. 10
100 0	0 10900 PANCREAS ACQUISITION	0	0		109. 00
				1	l l
	0 11000 I NTESTI NAL ACQUI SI TI ON	0			110.00
	0 11100 I SLET ACQUI SI TI ON	0	· -		111.00
	0 11300 I NTEREST EXPENSE	0			113. 00
	0 11400 UTI LI ZATI ON REVI EW-SNF	0			114. 00
118. 0	,	-3, 175, 381	29, 029, 354		118. 00
	NONREI MBURSABLE COST CENTERS				
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	1	190. 00
	0 19200 PHYSICIANS' PRIVATE OFFICES	0	2, 380, 074		192. 00
193. 0	0 19300 NONPALD WORKERS	0	0		193. 00
193. 0	1 19301 DME	0	0		193. 01
193. 0	2 19302 LACTATION CONSULTING	0	0		193. 02
	3 19303 DI ABETI C COUNSELI NG	0	0		193. 03
	007950 VACANT SPACE	0	0		194. 00
	1 07951 BOARD OF HEALTH	0	l		194. 01
	207952 PUTNAM/HENRY PRENATAL	0	11, 144		194. 02
200. 0		-3, 175, 381	1	•	200. 00
,	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		,	1	1=33.00

Provi der CCN: 151333 | Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: | 3/30/2016 4: 36 pm

					6 4:36 pm
		Increases		·	·
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4.00	5. 00	
	A - FMC RECLASS				
1.00	FMC	<u>88.</u> 01	<u>624, 3</u> 69	248, 408	1. 00
	TOTALS		624, 369	248, 408	
	B - PPIM RECLASS				
1.00	PPIM		79 <u>2, 4</u> 54	<u>262, 4</u> 15	1.00
	TOTALS		792, 454	262, 415	
	C - NPFH RECLASS				
1. 00	NPFH	8802	31 <u>3, 5</u> 38	124, 125	1. 00
	TOTALS		313, 538	124, 125	
	D - CLINIC RECLASS				
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	212, 112	1. 00
	FIXT	5.00			
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	920	2. 00
3.00	OPERATION OF PLANT	7. 00	0	39, 845	3. 00
4.00		0.00	0	0	4.00
7.00		0.00	0	0	7. 00
10.00		0.00	0	0	10.00
13. 00	TOTAL C	0.00			13. 00
	TOTALS		0	252, 877	
1.00	E - PHYS PRACT LABOR DIST  ADMINISTRATIVE & GENERAL	5.00	24, 999	0	1. 00
1.00	TOTALS		2 <u>4, 999</u> 24, 999	0	1.00
	F - CAFETERIA RECLASS		24, 777	U	
1.00	CAFETERI A	11. 00	207, 214	229, 209	1.00
1.00	TOTALS		207, 214	229, 209	1.00
	G - EMPLOYEE PROMOTIONS		207, 2.1.	227,207	
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	16, 540	1.00
	TOTALS			16, 540	
	H - INSURANCE RECLASS			.,	
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	99, 514	1.00
	FIXT				
	TOTALS		0	99, 514	
	I - DRUG RECLASS				
1.00	DRUGS CHARGED TO PATIENTS	7300	0	<u>1, 883, 4</u> 61	1. 00
	TOTALS		0	1, 883, 461	
	J - PPO DEPRECIATION				
1. 00	NEW CAP REL COSTS-BLDG &	1. 00	0	8, 205	1. 00
	FIXT				
2.00		0.00	0	0	2. 00
3. 00		0.00	0	0	3. 00
4.00		0.00		0	4. 00
	TOTALS		0	8, 205	
1 00	K - IMPLANTABLE DEVICES IMPL. DEV. CHARGED TO	72.00	ما	1/ F10	1 00
1. 00	PATIENT	72.00	0	16, 519	1. 00
	TOTALS	+		<sub>16, 519</sub>	
	L - MED SUPPLY RECLASS		<u> </u>	10, 517	
1.00	ADULTS & PEDIATRICS	30.00	0	260	1. 00
2.00	INTENSIVE CARE UNIT	31. 00	0	398	2. 00
3.00	OPERATING ROOM	50.00	0	7, 761	3. 00
4. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 285	4. 00
5.00	RESPIRATORY THERAPY	65. 00	0	669	5. 00
6.00	PHYSICAL THERAPY	66.00	0	438	6. 00
7. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	738	7. 00
8. 00	ONCOLOGY	73. 00	0	43	8. 00
9. 00	EMERGENCY	91.00	0	419	9. 00
7. 00	TOTALS			12, 011	7.00
500 00	Grand Total: Increases		1, 962, 574	3, 153, 284	500. 00
550.00	1 10 (01)	l l	.,	5, .55, 254	1 555. 55

| Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Provider CCN: 151333

					10	3/30/2016	4: 36 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - FMC RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	624, 369	248, 408	0		1. 00
	TOTALS		624, 369	248, 408			
	B - PPIM RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	792, 454	262, 415	0		1. 00
	TOTALS	<sub>_</sub> _	792, 454	262, 415			İ
	C - NPFH RECLASS	•			,		
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	313, 538	124, 125	0		1. 00
	TOTALS		313, 538	124, 125			i
	D - CLINIC RECLASS	<u> </u>		., .	I		
1.00	PPIM	88. 00	0	83, 966	10		1. 00
2.00	FMC	88. 01	ol	56, 321			2. 00
3.00	NPFH	88. 02	o	21, 755			3. 00
4. 00	PHYSICIANS' PRIVATE OFFICES	192.00	Ö	90, 835			4. 00
7. 00	THISTOTANS THE WATE STATES	0.00	0	70, 000			7. 00
10. 00		0.00	0	0			10.00
13. 00		0.00	0	0	10		13. 00
13.00	TOTALS — — — — +	— — <del>0.</del> 00		<u></u>			13.00
	E - PHYS PRACT LABOR DIST		U <sub>I</sub>	232, 677			
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	24, 999	0	0		1.00
1.00	TOTALS		24, 999	0			1.00
			24, 999	0			
1 00	F - CAFETERI A RECLASS	10.00	207 214	220, 200			1 00
1.00	DI ETARY	1000	207, 214	229, 209			1. 00
	TOTALS		207, 214	229, 209			
4 00	G - EMPLOYEE PROMOTIONS	5 00		47.540			4 00
1.00	ADMI NI STRATI VE & GENERAL		0	1 <u>6, 5</u> 40			1. 00
	TOTALS		0	16, 540			
	H - INSURANCE RECLASS	- aal	ما	00.544	1.0		
1.00	ADMI NI STRATI VE & GENERAL		0	99, 514			1. 00
	TOTALS		0	99, 514			
	I - DRUG RECLASS						
1.00	ONCOLOGY	<u>73.</u> 01	•	<u>1, 883, 4</u> 61			1. 00
	TOTALS		0	1, 883, 461			
	J - PPO DEPRECIATION				T		
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	2, 330			1. 00
2.00	PPIM	88. 00	0	1, 152			2. 00
3.00	FMC	88. 01	0	4, 071			3. 00
4.00	NPFH	8802	•	652			4. 00
	TOTALS		0	8, 205			
	K - IMPLANTABLE DEVICES						
1.00	OPERATI NG ROOM	5000	0	1 <u>6, 5</u> 19			1. 00
	TOTALS		0	16, 519			
	L - MED SUPPLY RECLASS						
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	12, 011	0		1. 00
	PATI ENTS						
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3. 00
4.00		0.00	o	0	O		4. 00
5.00		0.00	ol	0	0		5. 00
6.00		0.00	О	0	O		6. 00
7.00		0.00	O	0			7. 00
8. 00		0.00	ol	0			8. 00
9. 00		0.00	ol	0	o		9. 00
	TOTALS — — — —	— — <del></del>	— — — —	1 <u></u> 11	— — <u> </u>		1.00
			( )	12.011			

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 151333 Peri od:	Worksheet A-7		

Peri od: From 01/01/2015 | Part I To 12/31/2015 | Date/Time Prepared: 3/30/2016 4:36 pm Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 159, 364 0 1.00 2.00 298, 404 0 Land Improvements 0 2.00 0 3.00 Buildings and Fixtures 28, 946, 880 129, 898 129, 898 3.00 0 Building Improvements 4.00 0 4.00 5.00 Fixed Equipment 0 5.00 6.00 Movable Equipment 20, 070, 624 1, 209, 392 0 0 0 1, 209, 392 0 6.00 7.00 HIT designated Assets 7.00 0 8.00 Subtotal (sum of lines 1-7) 49, 475, 272 1, 339, 290 1, 339, 290 0 8.00 9.00 Reconciling Items 771, 086 0 479, 087 9.00 Total (line 8 minus line 9) 48, 7<u>04, 186</u> <u>1, 339, 29</u>0 -479, 087 10.00 1, 339, 290 O 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 159, 364 1.00 2.00 Land Improvements 298, 404 0 2.00 3.00 Buildings and Fixtures 29, 076, 778 0 3.00 0) 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 0 5.00 6.00 Movable Equipment 21, 280, 016 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 0 8.00 50, 814, 562 8.00 9.00 Reconciling Items 291, 999 9.00

50, 522, 563

10.00

10.00 Total (line 8 minus line 9)

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lieu of Form CMS-2552-10			
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151333	Peri od: From 01/01/2015 To 12/31/2015		pared:	
			SL	JMMARY OF CAP	I TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10.00	11. 00	12. 00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	2, 804, 518	0		0	0	1. 00	
3.00	Total (sum of lines 1-2)	2, 804, 518	0		0 0	0	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1) (sum					
		Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	2, 804, 518				1. 00	
3. 00	Total (sum of lines 1-2)	0	2, 804, 518				3. 00	

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015	Part III Date/Time Prep	pared:
						3/30/2016 4: 3	
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	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 CE			1			
1.00	NEW CAP REL COSTS-BLDG & FIXT	29, 076, 788		29, 076, 78			1. 00
3.00	Total (sum of lines 1-2)	29, 076, 788		29, 076, 78	_		3. 00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL							
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DADT III DECONOLILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE	INTERS		1	0 2 407 (/7	212 112	1 00
1. 00 3. 00	NEW CAP REL COSTS-BLDG & FIXT Total (sum of lines 1-2)	0	0		0 2, 487, 667 0 2, 487, 667		1. 00 3. 00
3.00	Total (sull of Titles 1-2)	U	<u> </u>	L JMMARY OF CAPI		212, 112	3.00
			30	DIVINIANCE OF CALL	IAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		44.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COCTO OF	11. 00	12.00	13. 00	14. 00	15. 00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE		00 514	1		2 717 701	1 00
1. 00 3. 00	NEW CAP REL COSTS-BLDG & FIXT Total (sum of lines 1-2)	-81, 512			0 0 0	2, 717, 781	1.00
3.00	Tiotal (Suill of Titles 1-2)	-81, 512	99, 514	1	u <sub>l</sub> u	2, 717, 781	3.00

Provi der CCN: 151333 | Peri od: | Workshee

		To 12/31/2015					
				Expense Classification on		3/30/2016 4: 30	o pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		0	NEW CAP REL COSTS-BLDG &	1. 00	0	1. 00
2.00	2) Investment income - CAP REL		0	*** Cost Center Deleted ***	2. 00	0	2. 00
3.00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
4.00	(chapter 2) Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	О	7. 00
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -1, 822, 320		0. 00	0 0	
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13.00	Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee and others		0		0. 00 0. 00	0	14. 00 15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0. 00	0	16. 00
17. 00	patients Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0. 00	0	21. 00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	O	22. 00
23. 00	therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review –		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - NEW CAP REL COSTS-BLDG & FLXT			NEW CAP REL COSTS-BLDG & FIXT	1. 00	0	
27. 00	COSTS-MVBLE EQUIP			*** Cost Center Deleted ***	2. 00	0	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
30. 99	limitation (chapter 14) Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32. 00	limitation (chapter 14)		0		0. 00	0	32. 00
	Depreciation and Interest	В					33. 00
აა. UU ———	DI SCOUNTS	l p	-3, 308	ADMINISTRATIVE & GENERAL	5. 00	o <sub>l</sub>	

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 151333 Peri od: Worksheet A-8 From 01/01/2015 | Worksheet A-8 | To 12/31/2015 | Date/Time Prepared:

					0 12/31/2013	3/30/2016 4:3	
				Expense Classification on	Worksheet A	07 007 2010 1: 0	O PIII
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	<b>'</b>	1.00	2. 00	3.00	4. 00	5. 00	
33. 01	VENDOR REBATE/REFUND	В	-13, 182	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	PHARMACY REBATE	В		DRUGS CHARGED TO PATIENTS	73. 00	0	33. 02
33. 03	SI LVER RECOVERY	В	· ·	RADI OLOGY-DI AGNOSTI C	54. 00	0	33. 03
33. 04	MEDICAL RECORDS FEES	B	· ·	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 04
33. 05	VENDING MACHINES	B		DI ETARY	10. 00	· -	33. 05
33. 06	CAFETERI A SALES	B	· ·	CAFETERI A	11. 00	l e	33. 06
33. 07	OTHER MISC INCOME	B	· ·	ADMINISTRATIVE & GENERAL	5. 00		33. 07
33. 08	NONALLOWABLE INTEREST EXPENSE	A		NEW CAP REL COSTS-BLDG &	1. 00	l	33. 08
33.00	NONALLOWABLE THTEREST EXPENSE	A	-11, 303	FLXT	1.00	''	33.00
33. 09	INVESTMENT INCOME	В	_/ 1/0	NEW CAP REL COSTS-BLDG &	1. 00	11	33. 09
33.07	TIVESTMENT TIVESME		-4, 147	FLXT	1.00	''	33.07
33. 10	LOBBYING OFFSET	A	5.45	ADMINISTRATIVE & GENERAL	5. 00	0	33. 10
33. 10	ADVERTSING OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	l	33. 10
33. 11	COMMUNITY RELATIONS OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	l e	33. 11
33. 12	1	1	· ·	la contraction of the contractio			33. 12
	COMMUNITY RELATIONS OFFSET	A	· ·	EMPLOYEE BENEFITS DEPARTMENT	4.00	l	
33. 14	TELEPHONE WAGES	A		ADMI NI STRATI VE & GENERAL	5. 00	0	33. 14
33. 15	TELEPHONE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 15
33. 16	TELEPHONE OTHER	A		ADMI NI STRATI VE & GENERAL	5. 00	0	33. 16
33. 17	TELEVISION OFFSET	A		OPERATION OF PLANT	7. 00	0	33. 17
33. 18	PHYSICIAN RECRUITMENT	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 18
33. 19	HAF EXPENSE	Α	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
33. 20	MI SC REVENUE-CBO	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 21	ADVERTISING OFFSET	A		ONCOLOGY	73. 01	0	33. 21
33. 22	EHR DEPRECIATION	A	-325, 056	NEW CAP REL COSTS-BLDG &	1. 00	9	33. 22
				FLXT			
33. 23	ADVERTISING EXPENSE	A	-130	OPERATING ROOM	50. 00	0	
33. 24			0		0. 00	0	33. 24
33. 25	PHARMACY MISC REV	В	-662	DRUGS CHARGED TO PATIENTS	73. 00	0	33. 25
33. 26			0		0. 00	0	33. 26
33. 27			0		0.00	0	33. 27
33. 28			0		0.00	0	33. 28
33. 29			0		0.00	0	33. 29
33. 30	340B OFFSET	В	-50, 566	DRUGS CHARGED TO PATIENTS	73.00	0	33. 30
33. 31	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 31
	(3)						
33. 32	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 32
	(3)						
33. 33	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 33
	(3)						
33. 34	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 34
	(3)						
33. 35	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 35
	(3)						
50.00	TOTAL (sum of lines 1 thru 49)		-3, 175, 381				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
	-						

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

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

B. Amount Received - if cost cannot be determined.

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

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

						'	0 12/31/2013	3/30/2016 4:3	
	Wkst. A Line #	Cost Center/Physician	Total	Professi ona	al	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	1, 155, 637	987, 9	906	167, 731	0	0	1. 00
2.00	60.00	LABORATORY	10, 000		0	10, 000	0	0	2. 00
3.00	73. 01	ONCOLOGY	349, 647	349, 6	647	0	0	0	3. 00
4.00	53. 00	ANESTHESI OLOGY	604, 460	484, 7	767	119, 693	0	0	4. 00
5.00	0. 00		0		0	0	0	0	5. 00
6.00	0.00		0		0	0	0	0	6. 00
7.00	0.00		0		0	0	0	0	7. 00
8.00	0.00		0		0	0	0	0	8. 00
9. 00	0.00		0		0	0	0	0	9. 00
10.00	0. 00		0		0	0	0	0	10.00
200.00			2, 119, 744	1, 822, 3	320	297, 424		0	1
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of	Provi der	Physician Cost	
		I denti fi er				Memberships &	Component	of Malpractice	
				Limit		Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00	2.00	8. 00	9.00		12. 00	13.00	14.00	
1.00	91. 00	EMERGENCY	0		0	0	0	0	1. 00
2.00	60.00	LABORATORY	0		0	0	0	0	2. 00
3.00	73. 01	ONCOLOGY	0		0	0	0	0	3. 00
4.00	53. 00	ANESTHESI OLOGY	0		0	0	0	0	4. 00
5.00	0.00		0		0	0	0	0	5. 00
6.00	0.00		0		0	0	0	0	6. 00
7.00	0.00		0		0	0	0	0	7. 00
8.00	0.00		0		0	0	0	0	8. 00
9.00	0.00		0		0	0	0	0	9. 00
10.00	0.00		0		0	0	0	0	10.00
200.00			0		0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RC	CE	RCE	Adjustment		
		Identi fi er	Component	Limit		Di sal I owance			
			Share of col.						
			14						
	1. 00	2. 00	15. 00	16. 00		17. 00	18. 00		
1.00		EMERGENCY	0		0	0	987, 906		1. 00
2.00		LABORATORY	0		0	0	0		2. 00
3.00		ONCOLOGY	0		0	0	349, 647		3. 00
4.00	53. 00	ANESTHESI OLOGY	0		0	0	484, 767		4. 00
5.00	0.00		0		0	0	0		5. 00
6.00	0.00		0		0	0	0		6. 00
7.00	0.00		0		0	0	0		7. 00
8.00	0. 00		0		0	0	0		8. 00
9.00	0.00		0		0	0	0		9. 00
10.00	0.00		0		0	0	0		10.00
200.00			0		0	0	1, 822, 320		200. 00

REASON	Financial Systems  IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	PUTNAM COUNTY HO FURNI SHED BY	SPI TAL Provi der C		Period: From 01/01/2015		-3
					To 12/31/2015	3/30/2016 4: 3	
					Physical Therapy	Cost	
						1. 00	
1.00	PART I - GENERAL INFORMATION  Total number of weeks worked (excluding aides	s) (see instruction	s)			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 supervisions of unduplicated days in which therapy	assistant was on p				292 253	3. 00 4. 00
5. 00	nor therapist was on provider site (see inst Number of unduplicated offsite visits - super		ts (see ins	tructions)		o	5. 00
6. 00	Number of unduplicated offsite visits - there assistant and on which supervisor and/or them	apy assistants (ind	lude only v	isits made b		0	6. 00
7. 00	instructions) Standard travel expense rate					0.00	7. 00
8. 00	Optional travel expense rate per mile					0.00	8. 00
		Supervi sors Th	erapists 2.00	Assi stants 3.00	Ai des 4. 00	Trai nees 5.00	
9.00	Total hours worked	0.00	3, 499. 00	2, 147. C		0.00	9. 00
	AHSEA (see instructions) Standard travel allowance (columns 1 and 2,	0. 00 39. 26	78. 52 39. 26	58. 8 29. 4		0.00	10. 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	0		О		12. 00
	Number of travel hours (offsite) Number of miles driven (provider site)	0	0		0		12. 01 13. 00
	Number of miles driven (provider site)	0	0		0		13. 00
						1. 00	
	Part II - SALARY EQUIVALENCY COMPUTATION					1.00	
14. 00 15. 00	Supervisors (column 1, line 9 times column 1, Therapists (column 2, line 9 times column 2,					0 274, 741	14. 00 15. 00
16. 00	Assistants (column 3, line 9 times column 3,	line10)				126, 437	16. 00
17. 00	Subtotal allowance amount (sum of lines 14 allothers)	nd 15 for respirato	ry therapy	or lines 14-	16 for all	401, 178	17. 00
	Aides (column 4, line 9 times column 4, line					0	18.00
19. 00 20. 00	Trainees (column 5, line 9 times column 5, li Total allowance amount (sum of lines 17–19 fo		apy or line:	s 17 and 18	for all others)	0 401, 178	19. 00 20. 00
	If the sum of columns 1 and 2 for respiratory						
	occupational therapy, line 9, is greater than the amount from line 20. Otherwise complete	lines 21-23.				11 ne 23	
21. 00	Weighted average rate excluding aides and traffor respiratory therapy or columns 1 thru 3,			of columns	1 and 2, line 9	0. 00	21. 00
	Weighted allowance excluding aides and traine						22. 00
23. 00	Total salary equivalency (see instructions) PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVEL EX	PENSE COMPU	TATION - PRO	VIDER SLTE	401, 178	23. 00
	Standard Travel Allowance						
24. 00 25. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					11, 464 7, 451	24. 00 25. 00
26. 00	Subtotal (line 24 for respiratory therapy or				1.4.6	18, 915	26. 00
27. 00	Standard travel expense (line 7 times line 3 others)	for respiratory tr	erapy or su	m of lines 3	and 4 for all	0	27. 00
28. 00	Total standard travel allowance and standard 27)	travel expense at	the provide	r site (sum	of lines 26 and	18, 915	28. 00
	Optional Travel Allowance and Optional Travel	Expense					
29. 00 30. 00	Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3,		line 12 )			0	29. 00 30. 00
31. 00	Subtotal (line 29 for respiratory therapy or		d 30 for al	l others)		ő	31. 00
32. 00	Optional travel expense (line 8 times columns columns 1-3, line 13 for all others)	s 1 and 2, line 13	for respira	tory therapy	or sum of	0	32. 00
33. 00	Standard travel allowance and standard travel					18, 915	33. 00
34. 00 35. 00	Optional travel allowance and standard travel Optional travel allowance and optional travel					0	34. 00 35. 00
55. 55	Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA				ICES OUTSIDE PRO		55.50
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	37. 00
38. 00 39. 00	Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur	m of lines 5 and 6)				0	38. 00 39. 00
	Optional Travel Allowance and Optional Travel	Expense					
40.00	Therapists (sum of columns 1 and 2, line 12.0		ııne 10)			0	40.00

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

Total Travel Allowance and Travel Expense - Offsite Services; Complete one of the following three lines 44, 45, or 46, as appropriate.

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

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

0 41.00

0 44.00 0 45.00

0 42.00

0 43.00

41.00 Assistants (column 3, line 12.01 times column 3, line 10)

Subtotal (sum of lines 40 and 41)

Hoal th	Financial Systems	PUTNAM COUNTY	HUSDI TVI		Inlie	eu of Form CMS-2	2552_10
REASON	ABLE COST DETERMINATION FOR THERAPY SERVICES I			CCN: 151333	Peri od: From 01/01/2015 To 12/31/2015	Worksheet A-8 Parts I-VI	-3 pared:
					Physical Therapy	Cost	
						1. 00	
46. 00	Optional travel allowance and optional travel						46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	DART W. OVERTIME COMPUTATION	1. 00	2. 00	3. 00	4. 00	5. 00	
47. 00	PART V - OVERTIME COMPUTATION  Overtime hours worked during reporting	0. 00	0.00	0. 0	0.00	0.00	47.00
47.00	period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each	0.00	0.00	0.0	0.00	0.00	47. 00
	column of line 56)						
48. 00	Overtime rate (see instructions)	0. 00	0.00				48. 00
49. 00	Total overtime (including base and overtime	0. 00	0. 00	0. (	0.00		49. 00
	allowance) (multiply line 47 times line 48)						
EO 00	CALCULATION OF LIMIT	0.00	0.00	0.0	0.00	0.00	FO 00
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0. 00	0.00	0.0	0. 00	0.00	50.00
51. 00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions)	0. 00	0.00	0. (	0.00	0.00	51. 00
	DETERMINATION OF OVERTIME ALLOWANCE						
52. 00	Adjusted hourly salary equivalency amount (see instructions)	78. 52	58. 89	0. (	0.00		52. 00
53. 00	Overtime cost limitation (line 51 times line 52)	0	0		0 0		53. 00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply	0	0		0 0		55. 00
56. 00	line 47 times line 52) Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5	0	0		0 0	0	56. 00
	the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3						
	for all others.)					4 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EVCESS COST	AD IIICTMENT			1.00	
57 OO	Salary equivalency amount (from line 23)	IND EXCESS COST	ADJUSTNIENT			401, 178	57. 00
	Travel allowance and expense - provider site	(from lines 33	34 or 35))			18, 915	
59. 00	Travel allowance and expense - Offsite service			)		0	1
60.00	Overtime allowance (from column 5, line 56)	700 (110 111100	,	,		Ö	
61. 00						Ō	
	Supplies (see instructions)					0	1
	Total allowance (sum of lines 57-62)					420, 093	63.00
64.00	Total cost of outside supplier services (from	your records)				405, 568	64. 00
65.00	Excess over limitation (line 64 minus line 63	3 - if negative,	enter zero)			0	65. 00
	LINE 33 CALCULATION						1
100.00	Line 26 = line 24 for respiratory therapy or	sum of lines 24	and 25 for a	II others		18, 915	100. 00
100.01	Line 27 = line 7 times line 3 for respiratory	therapy or sum	of lines 3 a	nd 4 for all	others	0	100. 01
100. 02	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					18, 915	100. 02
101.00	Line 27 = line 7 times line 3 for respiratory	therapy or sum	of lines 3 a	nd 4 for all	others	0	101. 00
	Line 31 = line 29 for respiratory therapy or						101. 01
	Line 34 = sum of lines 27 and 31					l	101. 02
102. 00	LINE 35 CALCULATION Line 31 = line 29 for respiratory therapy or	sum of lines 29	and 30 for a	II others		0	102. 00
	Line 32 = line 8 times columns 1 and 2, line 13 for all others				umns 1-3, line		102. 01
102. 02	Line 35 = sum of lines 31 and 32					0	102. 02

	IABLE COST DETERMINATION FOR THERAPY SERVICES DE SUPPLIERS	FUKNI SHED BY	Provi der (	1	Period: From 01/01/2015 Fo 12/31/2015		pared:	
					Occupati onal Therapy	Cost		
						1.00		
	PART I - GENERAL INFORMATION							
00 00	Total number of weeks worked (excluding aides Line 1 multiplied by 15 hours per week	s) (see instruc	tions)			52 780	1. 0 2. 0	
00	Number of unduplicated days in which supervis	sor or therapis	t was on provid	der site (see	instructions)	244	3.0	
00	Number of unduplicated days in which therapy					0	4. C	
	nor therapist was on provider site (see inst							
00	Number of unduplicated offsite visits - super				, +horon,,	0	5.0	
00	Number of unduplicated offsite visits - thera assistant and on which supervisor and/or the					١	6. (	
	instructions)	.,	,		(			
00	Standard travel expense rate					0.00		
00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8. 0	
		1. 00	2. 00	3. 00	4. 00	5. 00		
00	Total hours worked	0. 00	1, 748. 00	0.00		0.00		
. 00	AHSEA (see instructions)	0.00	74. 44	0.00		0.00		
. 00	Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3,	37. 22	37. 22	0.00	]		11.0	
	one-half of column 3, line 10)							
. 00	Number of travel hours (provider site)	0	0	(	1		12.0	
. 01	Number of travel hours (offsite)	0	0				12.0	
. 00	Number of miles driven (provider site) Number of miles driven (offsite)	0	0				13. ( 13. (	
		-1						
	D					1.00		
. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				0	14. (	
. 00	Therapists (column 2, line 9 times column 2,					130, 121		
. 00	Assistants (column 3, line 9 times column 3,	line10)				0	16. (	
. 00	Subtotal allowance amount (sum of lines 14 au	nd 15 for respi	ratory therapy	or lines 14-1	l6 for all	130, 121	17. (	
. 00	others) Aides (column 4, line 9 times column 4, line	10)				ol	18. (	
. 00	1 · · · · · · · · · · · · · · · · · · ·					Ö	19. (	
. 00	Total allowance amount (sum of lines 17-19 for					130, 121	20.0	
	If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech path occupational therapy, line 9, is greater than line 2, make no entries on lines 21 and 22 and enter on							
	the amount from line 20. Otherwise complete lines 21-23.							
. 00	Weighted average rate excluding aides and tra			n of columns 1	l and 2, line 9	0.00	21. (	
. 00	for respiratory therapy or columns 1 thru 3, Weighted allowance excluding aides and trained					o	22. (	
. 00	Total salary equivalency (see instructions)	ees (Title 2 till	les Title 21)			130, 121		
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW	VANCE AND TRAVE	L EXPENSE COMPL	JTATION - PROV	/IDER SITE			
00	Standard Travel Allowance					0.000		
. 00	Therapists (line 3 times column 2, line 11) Assistants (line 4 times column 3, line 11)					9, 082		
. 00	Subtotal (line 24 for respiratory therapy or	sum of lines 2	4 and 25 for al	l others)		9, 082		
. 00	Standard travel expense (line 7 times line 3				and 4 for all	0	27. (	
	others)	<b>*</b> 1		: +- /	. E. I.: 2/I	0.000	20.0	
. 00	Total standard travel allowance and standard 27)	travei expense	at the provide	er site (sum o	or lines 26 and	9, 082	28. 0	
	Optional Travel Allowance and Optional Travel	Expense						
. 00	Therapists (column 2, line 10 times the sum of		d 2, line 12 )			0		
. 00	Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or		0 and 20 for al	l others)		0	30. ( 31. (	
. 00	Optional travel expense (line 8 times columns				or sum of	0	32. (	
	columns 1-3, line 13 for all others)			ypy				
	Standard travel allowance and standard travel			. 04)		9, 082		
. 00	Optional travel allowance and standard travel expense (sum of lines 27 and 31)						34. ( 35. (	
. 00	1 .	O Optional travel allowance and optional travel expense (sum of lines 31 and 32)  Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWANCE AND TRAVEL EXPENSE COMPUTATION - SERVICES OUTSIDE PROV						
	Optional travel allowance and optional travel							
. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense							
. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11)							
. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)					0	37. (	
. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37)	ANCE AND TRAVEL					37. ( 38. (	
. 00 . 00 . 00 . 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11)	NCE AND TRAVEL				0	37. ( 38. (	
0. 00 0. 00 0. 00 0. 00 0. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sur Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.0	n of lines 5 an Expense Of times column	d 6)			0 0 0	38. 0 39. 0 40. 0	
0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times columns)	n of lines 5 an Expense Of times column	d 6)			0 0	37. ( 38. ( 39. ( 40. ( 41. (	
	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times column Subtotal (sum of lines 40 and 41)	m of lines 5 an Expense Of times column 1, line 10)	d 6)			0 0 0	37. 38. 39. 40. 41. 42.	
0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOW/Standard Travel Expense Therapists (line 5 times column 2, line 11) Assistants (line 6 times column 3, line 11) Subtotal (sum of lines 36 and 37) Standard travel expense (line 7 times the sum Optional Travel Allowance and Optional Travel Therapists (sum of columns 1 and 2, line 12.04 Assistants (column 3, line 12.01 times columns)	n of lines 5 an Expense D1 times column 1 3, line 10) n of columns 1-	d 6) 2, line 10) 3, line 13.01)	e of the follo	owing three line	0 0 0 0 0 0	37. 38. 39. 40. 41. 42.	

	ABLE COST DETERMINATION FOR THERAPY SERVICES F E SUPPLIERS	FURNI SHED BY	Provi der	CCN: 151333	Period: From 01/01/2015 To 12/31/2015 Occupational	Worksheet A-8 Parts I-VI Date/Time Pre 3/30/2016 4:3	pared:
					Therapy	0031	
						1. 00	
5. 00	Optional travel allowance and standard travel	expense (sum	of lines 39 an	nd 42 - see i	nstructions)	0	45. 00
6. 00	Optional travel allowance and optional travel		of lines 42 an	nd 43 - see i	nstructions)	0	46. 00
		Therapi sts	Assi stants	Ai des	Trai nees	Total	
	PART V - OVERTIME COMPUTATION	1.00	2. 00	3.00	4. 00	5. 00	
7. 00	Overtime hours worked during reporting	0. 00	0.00	0.	0.00	0.00	47. 0
	period (if column 5, line 47, is zero or						
	equal to or greater than 2,080, do not						
	complete lines 48-55 and enter zero in each column of line 56)						
8. 00	Overtime rate (see instructions)	0. 00	0. 00	0.	0. 00		48. 0
9. 00	Total overtime (including base and overtime	0. 00	0. 00	1			49. 0
	allowance) (multiply line 47 times line 48)						
0 00	CALCULATION OF LIMIT	0.00	0.00	0.1	0.00	0.00	50. 0
0. 00	Percentage of overtime hours by category (divide the hours in each column on line 47	0. 00	0.00	0.1	0.00	0. 00	50.0
	by the total overtime worked - column 5,						
	line 47)						
1. 00	Allocation of provider's standard work year	0. 00	0. 00	0. (	0.00	0.00	51.0
	for one full-time employee times the percentages on line 50) (see instructions)						
	DETERMINATION OF OVERTIME ALLOWANCE			1			
	Adjusted hourly salary equivalency amount	74. 44	0. 00	0. (	0. 00		52.0
	(see instructions)						
3. 00	Overtime cost limitation (line 51 times line 52)	0	0	1	0 0		53. 0
4. 00	Maximum overtime cost (enter the lesser of	О	0	,	0 0		54. 0
	line 49 or line 53)						
5. 00	Portion of overtime already included in	0	0	1	0 0		55.0
	hourly computation at the AHSEA (multiply line 47 times line 52)						
6. 00	Overtime allowance (line 54 minus line 55 -	o	0	,	0 0	0	56.0
	if negative enter zero) (Enter in column 5						
	the sum of columns 1, 3, and 4 for						
	respiratory therapy and columns 1 through 3 for all others.)						
	Tot all others.)						
						1. 00	
	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			400 404	
7. 00 8. 00	Salary equivalency amount (from line 23) Travel allowance and expense - provider site	(from lines 33	34 or 35))			130, 121 9, 082	57. C
9. 00	Travel allowance and expense - Offsite service	•		)		0	59.0
0. 00	Overtime allowance (from column 5, line 56)	•				0	60.0
	Equipment cost (see instructions)					0	
2.00	Supplies (see instructions)					120, 202	1
3.00 1.00	Total allowance (sum of lines 57-62) Total cost of outside supplier services (from	vour records)				139, 203 116, 011	
	Excess over limitation (line 64 minus line 63	-	enter zero)			0	1
	LINE 33 CALCULATION	, ,	,				
00.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others						9, 082	
	Line 27 = line 7 times line 3 for respiratory	therapy or su	m of lines 3 a	ind 4 for all	others	9, 082	100.0
JU. UZ	Line 33 = line 28 = sum of lines 26 and 27 LINE 34 CALCULATION					9,002	1100. 0
01. 00	Line 27 = line 7 times line 3 for respiratory	therapy or su	m of lines 3 a	nd 4 for all	others	0	101. C
01. 01	Line 31 = line 29 for respiratory therapy or					0	101. C
1. 02	Line 34 = sum of lines 27 and 31					0	101. C
12 00	Line 35 CALCULATION	cum of li o	0 and 20 f	II other-		^	102 2
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				ımns 1_3 line		102. C
)2 N1			tory therapy C	, Juni Di COll	annio i o, lillo		1102.
2. 01	13 for all others		3 13		·		

	Financial Systems ABLE COST DETERMINATION FOR THERAPY SERVICES	PUTNAM COUNTY FURNISHED BY		CCN: 151333	In Lie	u of Form CMS-2 Worksheet A-8-	
REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS  Provider CCN: 151333   Period: From 01/01/2015   To 12/31/2015						Parts I-VI	pared:
					Speech Pathology		o piii
						1. 00	
	PART I - GENERAL INFORMATION					1.00	
. 00 . 00 . 00 . 00	Total number of weeks worked (excluding aides) (see instructions) Line 1 multiplied by 15 hours per week Number of unduplicated days in which supervisor or therapist was on provider site (see instructions) Number of unduplicated days in which therapy assistant was on provider site but neither supervisor					52 780 136 0	1. 0 2. 0 3. 0 4. 0
00	nor therapist was on provider site (see instructions)  Number of unduplicated offsite visits - supervisors or therapists (see instructions)  Number of unduplicated offsite visits - therapy assistants (include only visits made by therapy assistant and on which supervisor and/or therapist was not present during the visit(s)) (see instructions)					0	5. 0 6. 0
. 00	Standard travel expense rate					0. 00	1
3. 00	Optional travel expense rate per mile	Supervi sors	Therapi sts	Assi stants	Ai des	0.00 Trai nees	8. 00
		1. 00	2.00	3. 00	4. 00	5. 00	
1. 00	Total hours worked AHSEA (see instructions) Standard travel allowance (columns 1 and 2, one-half of column 2, line 10; column 3, one-half of column 3, line 10)	0. 00 0. 00 35. 77	525. 00 71. 54 35. 77	0. ( 0. ( 0. (	0. 00		9. 00 10. 00 11. 00
2. 01 3. 00	Number of travel hours (provider site) Number of travel hours (offsite) Number of miles driven (provider site)	0 0	0		0 0		12. 0 12. 0 13. 0
3. 01	Number of miles driven (offsite)	0	0		0		13. 0
	D. J. J. J. CALADY FOULVALENCY COMPUTATION					1. 00	
4. 00	Part II - SALARY EQUIVALENCY COMPUTATION Supervisors (column 1, line 9 times column 1,	line 10)				0	l l 14. 0
5. 00 6. 00 7. 00	Therapists (column 2, line 9 times column 2, line 10) Assistants (column 3, line 9 times column 3, line10) Subtotal allowance amount (sum of lines 14 and 15 for respiratory therapy or lines 14-16 for all					37, 559 0 37, 559	15. 0 16. 0
	others) Aides (column 4, line 9 times column 4, line 10) Trainees (column 5, line 9 times column 5, line 10) Total allowance amount (sum of lines 17–19 for respiratory therapy or lines 17 and 18 for all others) If the sum of columns 1 and 2 for respiratory therapy or columns 1-3 for physical therapy, speech patl						18. 0 19. 0 20. 0
	occupational therapy, line 9, is greater than		o entries on	lines 21 and	22 and enter on	line 23	
1. 00	the amount from line 20. Otherwise complete lines 21-23.  Weighted average rate excluding aides and trainees (line 17 divided by sum of columns 1 and 2, line 9 for respiratory therapy or columns 1 thru 3, line 9 for all others)						21.0
	Weighted allowance excluding aides and traine Total salary equivalency (see instructions)					55, 801 55, 801	
	PART III - STANDARD AND OPTIONAL TRAVEL ALLOW Standard Travel Allowance	VANCE AND TRAVEL	EXPENSE COMP	UIAIION - PRO	OVI DER SITE		
	Therapists (line 3 times column 2, line 11)						
	Assistants (line 4 times column 3, line 11)					4, 865 0	
5. 00 6. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or Standard travel expense (line 7 times line 3			,	3 and 4 for all		25. 0 26. 0
5. 00 6. 00 7. 00	Assistants (line 4 times column 3, line 11) Subtotal (line 24 for respiratory therapy or	for respiratory	therapy or s	um of lines 3		0 4, 865	25. 0 26. 0 27. 0
5. 00 6. 00 7. 00 8. 00	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 Travel	for respiratory travel expense Expense	therapy or s	um of lines 3		0 4, 865 0 4, 865	25. 00 26. 00 27. 00 28. 00
5. 00 6. 00 7. 00 8. 00 9. 00	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)	for respiratory travel expense  Expense of columns 1 and	therapy or s	um of lines 3		0 4, 865 0	25. 00 26. 00 27. 00 28. 00
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00	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 Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns)	travel expense  Expense of columns 1 and line 12) sum of lines 29	therapy or s at the provid  2, line 12) and 30 for a	um of lines 3 er site (sum	of lines 26 and	0 4, 865 0 4, 865	25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00	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 Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel	travel expense  Expense  Of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line	therapy or s at the provid  2, line 12) and 30 for a 13 for respir. 28)	um of lines 3 er site (sum  II others) atory therapy	of lines 26 and	0 4, 865 0 4, 865 0 0 0 0 0 4, 865	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00
5. 00 6. 00 7. 00 8. 00 9. 00 0. 00 1. 00 2. 00 3. 00 4. 00	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 Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	travel expense  Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of expense (sum o	therapy or s at the provid  2, line 12) and 30 for a 13 for respir  28) f lines 27 an f lines 31 an	um of lines 3 er site (sum  II others) atory therapy d 31) d 32)	of lines 26 and	0 4, 865 0 4, 865 0 0 0 0 4, 865 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
25. 00 27. 00 28. 00 29. 00 0. 00 11. 00 12. 00 44. 00 45. 00	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 Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense	travel expense  Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of expense (sum o	therapy or s at the provid  2, line 12) and 30 for a 13 for respir  28) f lines 27 an f lines 31 an	um of lines 3 er site (sum  II others) atory therapy d 31) d 32)	of lines 26 and	0 4, 865 0 4, 865 0 0 0 4, 865 0 0 0 0 0 0 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00 35. 00
24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 34. 00 35. 00	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 Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA	travel expense  Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of expense (sum o	therapy or s at the provid  2, line 12) and 30 for a 13 for respir  28) f lines 27 an f lines 31 an	um of lines 3 er site (sum  II others) atory therapy d 31) d 32)	of lines 26 and	0 4, 865 0 4, 865 0 0 0 0 4, 865 0	25. 00 26. 00 27. 00 28. 00 30. 00 31. 00 32. 00 33. 00 34. 00
5. 00 6. 00 7. 00 8. 00 9. 00 1. 00 2. 00 4. 00 5. 00	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 Travel Therapists (column 2, line 10 times the sum of Assistants (column 3, line 10 times column 3, Subtotal (line 29 for respiratory therapy or Optional travel expense (line 8 times columns columns 1-3, line 13 for all others) Standard travel allowance and standard travel Optional travel allowance and standard travel Optional travel allowance and optional travel Part IV - STANDARD AND OPTIONAL TRAVEL ALLOWA Standard Travel Expense Therapists (line 5 times column 2, line 11)	for respiratory travel expense  Expense of columns 1 and line 12) sum of lines 29 s 1 and 2, line expense (line expense (sum of expense (sum o	therapy or s at the provid  2, line 12) and 30 for a 13 for respir. 28) f lines 27 and f lines 31 and EXPENSE COMPU	um of lines 3 er site (sum  II others) atory therapy d 31) d 32)	of lines 26 and	0 4, 865 0 4, 865 0 0 4, 865 0 0 0 0 0 0 0 0 0	25. (26. (27. (27. (27. (27. (27. (27. (27. (27

0 40.00 41.00

0

0 42.00

0 43.00

Optional Travel Allowance and Optional Travel Expense
Therapists (sum of columns 1 and 2, line 12.01 times column 2, line 10)

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

41.00 Assistants (column 3, line 12.01 times column 3, line 10)

Subtotal (sum of lines 40 and 41)

40.00

42.00

43.00

Heal th	Financial Systems	PUTNAM COUNTY	HOSPI TAI		In lie	eu of Form CMS-2	2552_10
REASON	IABLE COST DETERMINATION FOR THERAPY SERVICES IN			CCN: 151333	Peri od: From 01/01/2015 To 12/31/2015	Worksheet A-8 Parts I-VI	-3 pared:
					Speech Pathology		
						1. 00	
46. 00	Optional travel allowance and optional travel						46. 00
		Therapists 1.00	Assi stants 2.00	Ai des 3.00	Trai nees 4.00	Total 5.00	
	PART V - OVERTIME COMPUTATION	1.00	2.00	3.00	4.00	3.00	
47. 00	Overtime hours worked during reporting period (if column 5, line 47, is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)	0. 00	0. 00	0. (	0.00	0.00	47. 00
48.00	Overtime rate (see instructions)	0. 00	0.00	0.0	0.00		48. 00
49. 00	Total overtime (including base and overtime allowance) (multiply line 47 times line 48) CALCULATION OF LIMIT	0. 00	0. 00	0.0	0.00		49. 00
50.00	Percentage of overtime hours by category (divide the hours in each column on line 47 by the total overtime worked - column 5, line 47)	0.00	0.00	0.0	0.00	0.00	50. 00
51.00	Allocation of provider's standard work year for one full-time employee times the percentages on line 50) (see instructions) DETERMINATION OF OVERTIME ALLOWANCE	0. 00	0.00	0.0	0.00	0.00	51.00
52. 00		71. 54	0.00	0.0	0.00		52. 00
53. 00	(see instructions) Overtime cost limitation (line 51 times line	0	0		0 0		53. 00
54. 00	Maximum overtime cost (enter the lesser of line 49 or line 53)	0	0		0 0		54. 00
55. 00	Portion of overtime already included in hourly computation at the AHSEA (multiply line 47 times line 52)	0	0		0 0		55. 00
56. 00	Overtime allowance (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)	0	0		0 0	0	56. 00
						1.00	
F7 00	Part VI - COMPUTATION OF THERAPY LIMITATION A	ND EXCESS COST	ADJUSTMENT			55.004	-7 00
58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00	Supplies (see instructions) Total allowance (sum of lines 57-62)	ces (from lines	44, 45, or 46	)		55, 801 4, 865 0 0 0 0 60, 666 24, 755	58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00
100.01	100.00 Line 26 = line 24 for respiratory therapy or sum of lines 24 and 25 for all others 100.01 Line 27 = line 7 times line 3 for respiratory therapy or sum of lines 3 and 4 for all others 100.02 Line 33 = line 28 = sum of lines 26 and 27						100. 00 100. 01 100. 02
101. 01	LINE 34 CALCULATION Line 27 = line 7 times line 3 for respiratory Line 31 = line 29 for respiratory therapy or Line 34 = sum of lines 27 and 31 LINE 35 CALCULATION				others	0	101. 00 101. 01 101. 02
	Line 31 = line 29 for respiratory therapy or Line 32 = line 8 times columns 1 and 2, line				umns 1-3, line		102. 00 102. 01
102. 02	13 for all others Line 35 = sum of lines 31 and 32					0	102. 02

| In Lieu of Form CMS-2552-10 | Provider CCN: 151333 | Period: | Worksheet B | From 01/01/2015 | Part I | To 1/03/2015 | Part I | Propagate | Part I | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

					Fi To	com 01/01/2015 0 12/31/2015	Part I Date/Time Prep 3/30/2016 4:30	
		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	CAPITAL RELATED COSTS NEW BLDG & FIXT	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMI NI STRATI VE & GENERAL	<i>5</i> piii
			col. 7) 0	1.00	4.00	4A	5. 00	
1 00		AL SERVICE COST CENTERS						1 00
1. 00 4. 00		NEW CAP REL COSTS-BLDG & FIXT EMPLOYEE BENEFITS DEPARTMENT	2, 717, 781 3, 957, 150	2, 717, 781 0				1. 00 4. 00
5.00	00500	ADMINISTRATIVE & GENERAL	4, 094, 143	369, 022	653, 876	5, 117, 041	5, 117, 041	5. 00
7. 00 8. 00		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	1, 289, 796 115, 167	180, 416 18, 154		1, 538, 349 141, 188	299, 267 27, 466	7. 00 8. 00
9. 00	1	HOUSEKEEPI NG	403, 446			503, 538	97, 957	9. 00
10.00	1	DIETARY	178, 054	78, 284		279, 870	54, 445	10.00
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	375, 558 301, 589			475, 836 334, 660	92, 568 65, 104	11. 00 13. 00
16. 00	01600	MEDICAL RECORDS & LIBRARY	515, 244	112, 256	101, 262	728, 762	141, 772	16. 00
17. 00 17. 01		SOCIAL SERVICE UTILIZATION REVIEW	0 106, 359	0 3, 625	1	0 138, 115	0 26, 869	17. 00 17. 01
17.01	I NPAT	ENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	961, 456 801, 148			1, 449, 427 1, 085, 583	281, 969 211, 187	30. 00 31. 00
41. 00	1	SUBPROVI DER - I RF	0	0 70, 247		1, 085, 585	211, 187	41. 00
42. 00	1	SUBPROVI DER	0	0		0	0	42.00
43. 00		NURSERY LARY SERVICE COST CENTERS	0	0	0	0	0	43. 00
50. 00	05000	OPERATING ROOM	975, 387			1, 350, 148	262, 655	50. 00
51. 00 52. 00		RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	71, 777	61, 633		151, 371 0	29, 447 0	51. 00 52. 00
53. 00		ANESTHESI OLOGY	177, 088			332, 684	64, 720	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	925, 275			1, 197, 911	233, 039	54.00
54. 01 57. 00		NUCLEAR MEDICINE-DIAGNOSTIC CT SCAN	143, 058 294, 476			146, 818 372, 853	28, 562 72, 534	54. 01 57. 00
58. 00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0 1, 955, 874	0 66, 387	_	0 2, 200, 072	0 427, 998	59. 00 60. 00
60. 01	06001	BLOOD LABORATORY	0	0		0	0	60. 01
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0 441, 582	0 18, 342	0 92, 407	0 552, 331	0 107, 449	64. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	478, 246			564, 587	107, 449	66. 00
67. 00		OCCUPATI ONAL THERAPY	116, 011	0		116, 011	22, 569	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	24, 814 136, 018		1	24, 814 156, 664	4, 827 30, 477	68. 00 69. 00
69. 01	06901	CARDI AC REHAB	119, 147	19, 417	30, 714	169, 278	32, 931	69. 01
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENT	0 16, 519	0		0 16, 519	0 3, 214	71. 00 72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS	3, 282, 830		-	3, 333, 295	648, 453	73. 00
73. 01		ONCOLOGY	303, 933	130, 921	78, 266	513, 120	99, 821	73. 01
88. 00	08800	TIENT SERVICE COST CENTERS PPIM	969, 751	33, 113	218, 761	1, 221, 625	237, 652	88. 00
88. 01	08801		812, 385			1, 040, 578	202, 432	
88. 02 89. 00	08802	NPFH  FEDERALLY QUALIFIED HEALTH CENTER	415, 256 0			528, 719 0	102, 856 0	88. 02 89. 00
90.00	09000	CLINIC	1, 472	4, 351	0	5, 823	1, 133	90. 00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	1, 551, 564	161, 241	451, 840	2, 164, 645 0	421, 106	91. 00 92. 00
72.00		REI MBURSABLE COST CENTERS				0		72.00
99. 10	09910	CORF AL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
109.00		PANCREAS ACQUISITION	0	0	0	0	0	109. 00
		INTESTINAL ACQUISITION	0	1		0		110.00
		ISLET ACQUISITION INTEREST EXPENSE	0	0	0	0		111. 00 113. 00
114.00	11400	UTILIZATION REVIEW-SNF						114. 00
118. 00		SUBTOTALS (SUM OF LINES 1-117)  IMBURSABLE COST CENTERS	29, 029, 354	2, 207, 689	3, 390, 123	27, 952, 235	4, 442, 313	118. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 810	0	12, 810	2, 492	190. 00
		PHYSICIANS' PRIVATE OFFICES	2, 380, 074	433, 258	564, 110	3, 377, 442	657, 046	
193. 00 193. 01		NONPALD WORKERS DME	0	0		0		193. 00 193. 01
193. 02	19302	LACTATION CONSULTING	0	0	0	Ö	0	193. 02
		DIABETIC COUNSELING VACANT SPACE	0	0 41, 546	-	0 41, 546		193. 03 194. 00
194. 01	07951	BOARD OF HEALTH	0	22, 478		22, 478	4, 373	194. 01
194. 02	07952	PUTNAM/HENRY PRENATAL	11, 144	0	2, 917	14, 061	2, 735	194. 02

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B		
				From 01/01/2015 To 12/31/2015		nared·	
				12, 01, 2010	3/30/2016 4:3		
		CAPITAL					
		RELATED COSTS					
Cost Center Description	Net Expenses	NEW BLDG &	EMPLOYEE	Subtotal	ADMI NI STRATI VE		
	for Cost	FLXT	BENEFITS		& GENERAL		
	Allocation		DEPARTMENT				
	(from Wkst A						
	col. 7)						
	0	1. 00	4.00	4A	5. 00		
200.00 Cross Foot Adjustments				0		200. 00	
201.00 Negative Cost Centers		0		0	0	201. 00	
202.00 TOTAL (sum lines 118-201)	31, 420, 572	2, 717, 781	3, 957, 15	31, 420, 572	5, 117, 041	202. 00	

Provi der CCN: 151333

			10	12/31/2015	3/30/2016 4:3	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	0.00	10.00	11 00	
GENERAL SERVICE COST CENTERS	7. 00	8. 00	9. 00	10. 00	11. 00	
1. 00 O0100 NEW CAP REL COSTS-BLDG & FLXT						1. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL					l	5. 00
7.00 00700 OPERATION OF PLANT	1, 837, 616				ļ	7. 00
8.00   00800 LAUNDRY & LINEN SERVICE	15, 686	184, 340				8. 00
9. 00   00900   HOUSEKEEPI NG	13, 041	1, 030				9. 00
10. 00   01000   DI ETARY	67, 640	762		426, 496	/10 707	10.00
11. 00   01100   CAFETERI A	37, 219	0	13, 084	0	618, 707	11.00
13. 00   01300   NURSI NG   ADMINISTRATION 16. 00   01600   MEDI CAL   RECORDS & LI BRARY	12, 832 96, 993	0	4, 511	0	6, 440	13. 00 16. 00
17. 00 01700 SOCIAL SERVICE	96, 993	0	34, 098 0	0	38, 422 0	17. 00
17. 00   01700  3001AE   3ERVICE 17. 01   01701  UTILI ZATI ON REVIEW	3, 133	0	· -	0	0	17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	0,100		1, 101	<u> </u>	0	17.01
30. 00 03000 ADULTS & PEDIATRICS	202, 548	40, 102	71, 206	360, 842	64, 444	30. 00
31.00 03100 INTENSIVE CARE UNIT	65, 923	30, 963		65, 654	42, 324	31. 00
41. 00   04100   SUBPROVI DER -   RF	0	0	0	0	0	41. 00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00   04300   NURSERY	0	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS	21/ 50/	14 400	7/ 1/1	ما	27 017	FO 00
50.00   05000   0PERATING ROOM 51.00   05100   RECOVERY ROOM	216, 586 53, 253	14, 499 14, 499		0	27, 817 9, 384	50. 00 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	03, 233	14, 477 1	10, 721	0	9, 304	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	6, 416	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	72, 837	13, 820	25, 606	o o	51, 182	54. 00
54. 01   05401 NUCLEAR MEDICINE-DIAGNOSTIC	3, 249	0	1, 142	0	0	54. 01
57.00 05700 CT SCAN	30, 629	0	10, 768	0	11, 275	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0	0	0	0	59. 00
60. 00   06000   LABORATORY	57, 360	0	20, 165	0	67, 413	60. 00
60. 01   06001   BLOOD LABORATORY	0	0	0	0	0	60. 01
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	15 040	0	U F F72	0	0	64.00
65. 00   06500   RESPI RATORY   THERAPY   66. 00   06600   PHYSI CAL   THERAPY	15, 848 74, 601	5, 090	5, 572 26, 226	0	22, 000 0	65. 00 66. 00
67. 00   06700   OCCUPATI ONAL THERAPY	74,001	5, 0 <del>9</del> 0	20, 220	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	Ö	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	2, 320	0	816	o	5, 171	69. 00
69. 01   06901   CARDI AC   REHAB	16, 776	0	5, 898	0	12, 568	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	0	0	0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	18, 006	0	6, 330	0	9, 719	73. 00
73. 01 07301 0NCOLOGY	113, 119	5, 923	39, 767	0	24, 657	73. 01
0UTPATIENT SERVICE COST CENTERS 88.00 08800 PPIM	20 (11	2 424	10.050	ol	42.712	00 00
88. 00   08800   PPI M 88. 01   08801   FMC	28, 611 48, 241	3, 434	10, 058 0	0	43, 713 0	88. 00 88. 01
88. 02   08802   NPFH	23, 250	0	8, 174	0	0	88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	0, , ,	o	0	89. 00
90. 00   09000   CLI NI C	3, 759	0	1, 321	0	0	90.00
91. 00 09100 EMERGENCY	139, 317	44, 884	48, 977	0	86, 181	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	т				_	
99. 10   09910   CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS  109. 00 10900 PANCREAS ACQUISITION	0	0	0	ol	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
111. 00 11100   SLET ACQUISITION	0	0	0	0		111. 00
113. 00 11300   NTEREST EXPENSE				Ĭ	١	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 432, 777	175, 006	476, 636	426, 496	529, 126	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 068		3, 891	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	374, 349	9, 334	128, 211	0	89, 581	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19301 DME 193. 02 19302 LACTATION CONSULTING		0	0	0		193. 01 193. 02
193. 02 19302 LACTATION CONSULTING 193. 03 19303 DI ABETI C COUNSELING		0		0		193. 02 193. 03
194. 00 07950  VACANT SPACE	0	) n		0		193. 03
194. 01 07951 BOARD OF HEALTH	19, 422	0	6, 828	ő		194. 01
194. 02 07952 PUTNAM/HENRY PRENATAL	0	Ö	0	ol		194. 02
200.00 Cross Foot Adjustments					- 1	200. 00
201.00 Negative Cost Centers	0	0	0	O		201. 00
202.00 TOTAL (sum lines 118-201)	1, 837, 616	184, 340	615, 566	426, 496	618, 707	202. 00

Provider CCN: 151333 | Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared:

Company   Comp					o 12/31/2015		
SEMBLY   13.00   16.00   17.00   17.00   24.00   17.00   17.01   24.00   17.00   17.01   24.00   17.00   17.01   24.00   17.00   17.01   24.00   17.00   17.01   24.00   17.00   17.00   17.01   24.00   17.	Cost Center Description			SOCIAL SERVICE			o piii
DEPERMINE SERVICE COST CENTERS   1,00			LI BRARY	47.00			
1.00   00000   DURING CAP HEL COSTS-SHEDGE A FIN	GENERAL SERVICE COST CENTERS	13.00	16.00	17.00	17.01	24.00	
10.00   10.000   DETARY	1.00						4. 00 5. 00 7. 00
17.00   1700   SCOLAL SERVICE   0   0   0   16.9.218   17.00   1701	10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	1	1 040 045	7			10. 00 11. 00 13. 00
30.00   3000   ABULTS & PEDIATRICS   87, 790   562, 367   0   143, 169   3, 264, 004   30.00	17. 00   01700   SOCIAL SERVICE 17. 01   01701   UTILIZATION REVIEW	0	_	0			17. 00
31.00   03100   INTERIS VE CARE UNIT   57,749   0   0   26,040   1,608,607   31.00   42.00   4		87 930	562 367	7 0	143 169	3 264 004	30 00
42.00   04200   MURSERY   0   0   0   0   0   0   42.00		1 1		1			1
43. 00   04300   NURSERY   0   0   0   0   0   0   43. 00		-	C	1 °	0		ı
ANCILLARY SERVICE COST CENTERS 50.00   SOSIO OPERATINES ROOM   37,955   217,550   0   0   2,203,361   50.00   51.00   05100   DECOUNDERY ROOM   12,804   0   0   0   0   229,479   51.00   52.00   05200   DELIVERY ROOM   6,000   0   0   0   0   52.00   53.00   05200   DELIVERY ROOM   6,000   0   0   0   0   0   52.00   53.00   05200   RESPIRATION   0   0   0   0   412,574   53.00   54.01   05400   ROULDIGY - DIAGNOSTIC   0   0   0   0   179,771   54.00   54.01   05401   NUCLEAR MEDICINE-DIAGNOSTIC   0   0   0   0   179,771   54.00   54.01   05401   NUCLEAR MEDICINE-DIAGNOSTIC   0   0   0   0   179,771   54.00   55.00   05700   OF SCAM   0   0   0   0   0   0   0   0   55.00   05700   OF SCAM   0   0   0   0   0   0   0   0   0   55.00   05700   OF SCAM   0   0   0   0   0   0   0   0   0   55.00   05700   OF SCAM   0   0   0   0   0   0   0   0   0		-	(	1	0		1
50.00		l ol		<u> </u>	l ol	0	43.00
0   0   0   0   0   0   0   0   0   0	50. 00 05000 OPERATING ROOM	1	217, 560	•			1
19.0   0.5300   AMESTRES OLDGY		1	C	1			
54.00   05-400   RADIOLOGY-DI AGNOSTI C		1	(	1	0		
54.01		1 I	(		o		
S8.00   OSBOD   MAGNETIC RESONANCE   MAGN NG (MRI )		O	C	0	0		•
59.00   05900   CARDIAC CATHETERIZATION   0   0   0   0   59.00		1	C	0	0	•	•
0.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.00000000		0	(	1	-		•
0.00   0.0001   0.000   0.00			1 255	1	_		ł
44-0.0   0.0400   INTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0			1, 255		o o		1
66.00   06600   PHYSI CAL THERAPY   0   0   0   780,338   66. 00   67.		0	C	0	0	0	64. 00
67: 00   05/7000   05/7000   05/7000   05/7000   05/7000   05/7000   05/7000   05/7000   05/7000   05/		0	C	0	0		•
68.0 0   66800   SPECH PATHOLOGY   0 0 0 0 0 29, 641   68.0 0 0   69.0 0   6900   LECTROCARDIOLOGY   0 0 0 0 0 0 195, 448   89.00   69.0 1   6900   LECTROCARDIOLOGY   0 0 0 0 0 0 254, 599   69.01   71.0 0   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   0 0 0 0 0 0 19, 733   72.00   72.00   IMPL. DEV. CHARGED TO PATIENTS   0 0 0 0 0 0 19, 733   72.00   73.0 0   07300   IMPL. DEV. CHARGED TO PATIENTS   0 0 0 0 0 0 0 4, 015, 803   73.00   73.01   07300   IMPL. DEV. CHARGED TO PATIENTS   0 0 0 0 0 0 4, 015, 803   73.00   07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 0 0 4, 015, 803   73.00   07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 0 1, 545, 603   73.00   07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 0 1, 545, 603   73.00   07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 0 1, 545, 603   73.00   07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 0 0 1, 545, 603   73.00   07300   DRUGS CHARGED TO PATIENTS   0 0 0 0 0 0 0 1, 545, 603   88.00   B80.00   PIDE TO PATIENTS   0 0 0 0 0 0 0 0 0 0 0 0 0   1, 545, 603   88.00   B80.00   PIDE TO PATIENTS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	(		0		•
69.00   06900   CARDIA CAREJALOLOCY   0   0   0   195, 448   69, 00			(		0		•
71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   19,733   72.00		0	C		o		•
72. 00 07200   IMPL DEV. CHARGED TO PATIENT 0 0 0 0 0 0 0 0 19, 733   72. 00 073.00   073.00   DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 4, 015, 803   73. 00 73. 01 073.01   ONCOLOGY 0UTPATIENT SERVICE COST CENTERS  88. 00   OSBOO   PPI M		17, 148	C	0	0	254, 599	69. 01
73. 01 07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   4, 015, 803   73. 00   73. 01 07301   ONCOLOGY   33, 643   29, 132   0   0   0   859, 182   73. 01 00001   ONCOLOGY   0   0   0   0   859, 182   73. 01 00001   ONCOLOGY   0   0   0   0   0   88. 01 08800   PPI M   0   0   0   0   0   1, 545, 093   88. 01 08801   FMC   0   0   0   0   0   0   0   88. 02 08801   FMC   0   0   0   0   0   0   662, 999   88. 03 08802   NPFH   0   0   0   0   0   0   662, 999   88. 00 08802   NPFH   0   0   0   0   0   0   0   89. 00 08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   0   0   0   99. 00 09000   CLI NI C   0   229, 733   0   0   241, 769   91. 00 09100   EMERGENCY   0   0   0   0   0   0   0   92. 00 09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   0   0   99. 10 09910   CORF   0   0   0   0   0   0   0    100. 01 1000   INTESTI NAL ACQUISITION   0   0   0   0   0   0   0   111. 00   11100   INTESTI NAL ACQUISITION   0   0   0   0   0   0   0   113. 00   11300   INTERSTE EXPENSE   113. 00   114. 00   11400   UTILIZATION REVIEW-SNF   113. 00   115. 00   1900   OFF, CORF   0   0   0   0   0   0   0   0   116. 00   1900   OFF, CORF   0   0   0   0   0   0   0   117. 00   1900   OFF, CORF   0   0   0   0   0   0   0   118. 00   SUBTOTALS (SUM OF LINES 1-117)   423, 547   1, 040, 047   0   169, 218   26, 634, 823   118. 00   190. 00   1900   PHYSI CLANS* PRIVATE OFFICES   0   0   0   0   0   0   0   0   193. 00   193.00   19300   NONPAID WORKERS   0   0   0   0   0   0   0   0   193. 00   193.00   19300   NONPAID WORKERS   0   0   0   0   0   0   0   194. 00   07950   VACANT SPACE   0   0   0   0   0   0   0   194. 00   07950   VACANT SPACE   0   0   0   0   0   0   0   194. 00   07950   PUTIMANH/ENRY PRENATAL   0   0   0   0   0   0   0   194. 00   07950   PUTIMANH/ENRY PRENATAL   0   0   0   0   0   0   0   0   194. 00   07950   PUTIMANH/ENRY PRENATAL   0   0   0   0   0   0   0   0   201. 00   Negative cost centers   0   0   0   0   0   0   0   0   0   201. 00   Negative cost centers   0		0	C	0	0		1
73.01   07301   07301   07301   00XCOLOCY   0   859, 182   73.01		0	(		0		1
Name   Content		33.643	29, 132				1
88. 01   08801   MC		00/010	277102	-1	<u> </u>	0077102	, , , , , ,
88. 02		1		1			1
89. 00 08900   FEDERALLY QUALIFIED HEALTH CENTER   0 0 229,733   0 0 241,769   90. 00 90. 00 90.00   0.00		-	-				1
90. 00   09000   CLINIC   0   229, 733   0   0   241, 769   90. 00   91. 00   09100   EMERGENCY   100, 441   0   0   0   3, 005, 551   91. 00   92. 00   09200   09SERVATI ON BEDS (NON-DISTINCT PART)   0   0   0   0   0   92. 00   99. 10   00   00   0   0   0   0   0   0		1	(		_	•	1
91. 00   09100   EMERGENCY   100, 441   0   0   0   3, 005, 551   91. 00   92.00   09200   09SERVATION BEDS (NON-DISTINCT PART)   92. 00   00   00   00   00   00   00   00		1	229, 733				
OTHER REIMBURSABLE COST CENTERS   O	91. 00   09100   EMERGENCY	100, 441	. (		0		91.00
99. 10   09910   CORF   0							92.00
SPECIAL PURPOSE COST CENTERS   109.00   10900   PANCREAS ACQUISITION   0 0 0 0 0 0 0 0 109.00   110.00   1NTESTI NAL ACQUISITION   0 0 0 0 0 0 0 0 110.00   111.00						0	99 10
110.00   11000   INTESTI NAL ACQUI SITI ON   0   0   0   0   0   110.00     111.00   11100   ISLET ACQUI SITI ON   0   0   0   0   0     113.00   11300   INTEREST EXPENSE   113.00     114.00   11400   UTI LI ZATI ON REVI EW-SNF   113.00     118.00   SUBTOTALS (SUM OF LINES 1-117)   423,547   1,040,047   0   169,218   26,634,823     118.00   NONREI MBURSABLE COST CENTERS   190.00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   30,261     192.00   19200   PHYSI CI ANS' PRI VATE OFFI CES   0   0   0   0   0     193.00   19300   NONPAI D WORKERS   0   0   0   0   0     193.01   19301   DME   0   0   0   0   0     193.02   19302   LACTATI ON CONSULTI NG   0   0   0   0     193.03   19303   10 ABETI C COUNSELI NG   0   0   0   0     194.00   07950   VACANT SPACE   0   0   0   0   0     194.01   07951   BOARD OF HEALTH   0   0   0   0     194.02   07952   PUTNAM/HENRY PRENATAL   0   0   0   0     201.00   Negati ve Cost Centers   0   0   0   0     100.00   100.00   100.00		<u> </u>		21	<u> </u>		77. 10
111. 00   11100   1SLET ACQUI SI TI ON   0   0   0   0   0   111. 00   113. 00   113.00   1NTEREST EXPENSE   113. 00   114.		0	С	0	0		
113. 00   11300   11300   11300   11300   11300   11300   11400   11		0	C		_		
114. 00 118. 00 119. 0		0	C		0	0	
118. 00   SUBTOTALS (SUM OF LINES 1-117)   423, 547   1, 040, 047   0   169, 218   26, 634, 823   118. 00   NONREI MBURSABLE COST CENTERS   190. 00   19200   19200   19200   19200   19200   19300							
190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   0   0   0   30, 261   190. 00   192. 00   19200   19200   19200   19300		423, 547	1, 040, 047	7 0	169, 218	26, 634, 823	
192. 00   19200   19200   19200   19200   193000   193000   193000   193000   19300   19300   19300   19300   19300   19300   19300   19300							
193. 00       19300       NONPAI D WORKERS       0       0       0       0       193. 00         193. 01       19301       DME       0       0       0       0       0       193. 01         193. 02       19302       LACTATI ON CONSULTI NG       0       0       0       0       0       193. 02         193. 03       19303       DI ABETI C COUNSELI NG       0       0       0       0       0       193. 03         194. 00       07950       VACANT SPACE       0       0       0       49, 628       194. 00         194. 01       07951       BOARD OF HEALTH       0       0       0       53, 101       194. 01         194. 02       07952       PUTNAM/HENRY PRENATAL       0       0       0       0       16, 796       194. 02         200. 00       Cross Foot Adj ustments       0       0       0       0       0       00       0       0       201. 00		-		1			
193. 01   19301   DME		1	(				
193. 03 19303 DI ABETI C COUNSELI NG 194. 00 07950 VACANT SPACE 194. 01 07951 BOARD OF HEALTH 194. 02 07952 PUTNAM/HENRY PRENATAL 200. 00 Cross Foot Adj ustments 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 193. 03 0 49, 628 194. 00 0 0 0 0 53, 101 194. 01 0 0 0 0 16, 796 194. 02 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		o	Č	1	-		
194. 00   07950   VACANT SPACE	193.02 19302 LACTATION CONSULTING	0	C	0	o	0	193. 02
194. 01 07951 BOARD OF HEALTH 0 0 0 0 53, 101 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 0 16, 796 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 0 0 201. 00		0	(	0	0		
194. 02 07952 PUTNAM/HENRY PRENATAL 0 0 0 16, 796 194. 02 200. 00 Cross Foot Adjustments 0 0 0 0 0 0 0 200. 00 201. 00 0 0 0 0 0 0 0 0 0 0 201. 00		0	(	م ال	0		
200.00   Cross Foot Adjustments   0   200.00   201.00   Negative Cost Centers   0   0   0   0   0   201.00			(		0		
201.00   Negative Cost Centers   0 0 0 0 0 201.00 202.00   TOTAL (sum lines 118-201)   423,547   1,040,047   0 169,218   31,420,572 202.00	200.00 Cross Foot Adjustments					0	200. 00
202.00		0	4 2			0	201. 00
	ZUZ.UU    IUIAL (SUM IINES II8-201)	423, 547	1, 040, 047	′I 0	169, 218	31, 420, 5/2	J202. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151333 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 3/30/2016 4:36 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01701 UTILIZATION REVIEW 17.01 17.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 3, 264, 004 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 1,608,607 31.00 04100 SUBPROVI DER - I RF 41 00 41 00 04200 SUBPROVI DER 42.00 0 42.00 04300 NURSERY 0 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0 50 00 2, 203, 361 05100 RECOVERY ROOM 0 51.00 289, 479 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 000000000000000000 412.574 53.00 05400 RADI OLOGY-DI AGNOSTI C 54 00 1, 655, 639 54 00 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 179, 771 54.01 05700 CT SCAN 503, 938 57.00 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 59.00 2, 774, 263 60.00 06000 LABORATORY 60.00 06001 BLOOD LABORATORY 60.01 60.01 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 64.00 64.00 703, 200 65.00 65 00 06600 PHYSI CAL THERAPY 780, 338 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 138, 580 67.00 06800 SPEECH PATHOLOGY 68.00 29, 641 68.00 06900 ELECTROCARDI OLOGY 69.00 195, 448 69.00 69.01 06901 CARDI AC REHAB 254, 599 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 19, 733 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 4, 015, 803 73.00 07301 ONCOLOGY 859, 182 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 PPI M 1, 545, 093 88.00 88.01 08801 FMC 0 0 0 1, 291, 251 88.01 662, 999 88. 02 08802 NPFH 88.02 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 90.00 09000 CLI NI C 241, 769 90.00 09100 EMERGENCY 0 91.00 3,005,551 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 99. 10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111. 00 0 113.00 11300 INTEREST EXPENSE 113.00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114 00 SUBTOTALS (SUM OF LINES 1-117) 26, 634, 823 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 30, 261 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 4, 635, 963 193. 00 19300 NONPALD WORKERS 0000000 193.00 C 193. 01 19301 DME 193. 01 0 193. 02 19302 LACTATION CONSULTING 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG 0 193. 03 194.00 07950 VACANT SPACE 49, 628 194.00 194. 01 07951 BOARD OF HEALTH 53, 101 194. 01

16, 796

194. 02

200.00

201.00

200.00

201.00

194. 02 07952 PUTNAM/HENRY PRENATAL

Cross Foot Adjustments

Negative Cost Centers

Health Financial Systems	PUTNAM COUNT	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151333	Peri od:	Worksheet B			
				From 01/01/2015				
				To 12/31/2015	Date/Time Pre			
				L .	3/30/2016 4:3	6 pm		
Cost Center Description	Intern &	Total						
	Residents Cost							
	& Post							
	Stepdown							
	Adjustments							
	25. 00	26.00						
202.00 TOTAL (sum lines 118-201)	0	31, 420, 572	2			202.00		

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151333

				To	12/31/2015	Date/Time Pre 3/30/2016 4:3	
Cost Center Desc	ription	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS NEW BLDG & FIXT	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMINISTRATIVE & GENERAL	
		0	1.00	2A	4. 00	5. 00	
GENERAL SERVICE COST C						I	1 00
1. 00 00100 NEW CAP REL COST 4. 00 00400 EMPLOYEE BENEFI T 5. 00 00500 ADMI NI STRATI VE & 7. 00 00700 OPERATI ON OF PLA 8. 00 00800 LAUNDRY & LI NEN 9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI ST 16. 00 01600 MEDI CAL RECORDS 17. 00 01701 UTI LI ZATI ON REVI 10. NDAT ENT POLITINE SERVI	S DEPARTMENT GENERAL NT SERVICE  RATION & LI BRARY	0 0 0 0 0 0 0 0	0 369, 022 180, 416 18, 154 15, 093 78, 284 43, 076 14, 851 112, 256 0 3, 625	180, 416 18, 154 15, 093 78, 284 43, 076 14, 851 112, 256		369, 022 21, 581 1, 981 7, 064 3, 926 6, 676 4, 695 10, 224 0 1, 938	1. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 16. 00 17. 00
30.00 O3000 ADULTS & PEDIATR		0	234, 422	234, 422	C	20, 334	30.00
31. 00	NIT F	0 0 0	76, 297 0 0	1	C C C	15, 230 0 0	31. 00 41. 00 42. 00 43. 00
50. 00 05000 OPERATI NG ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNO 54. 01 05401 NUCLEAR MEDI CI NE 57. 00 05700 CT SCAN	STI C -DI AGNOSTI C	0 0 0 0 0		61, 633 0 0 84, 300 3, 760 35, 449	0 0 0 0 0	2, 124 0 4, 667 16, 805 2, 060 5, 231	50. 00 51. 00 52. 00 53. 00 54. 00 54. 01 57. 00
58. 00   05800   MAGNETI C RESONAN 59. 00   05900   CARDI AC CATHETER 60. 00   06000   LABORATORY 60. 01   06001   BLOOD   LABORATORY 64. 00   06400   I NTRAVENOUS   THER	I ZATI ON	0 0 0	0 0 66, 387 0		0 0 0 0	0 0 30, 865 0	58. 00 59. 00 60. 00 60. 01 64. 00
65. 00 06500 RESPI RATORY THER 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THE 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOG	RAPY	0 0 0	18, 342 86, 341 0	86, 341 0 0	0 0 0	7, 749 7, 921 1, 628 348 2, 198	65. 00 66. 00 67. 00 68. 00
69. 00   06900  ELECTROCARDI OLOG 69. 01   06901  CARDI AC REHAB 71. 00   07100  MEDI CAL SUPPLI ES 72. 00   07200  IMPL DEV. CHARG 73. 00   07300  DRUGS CHARGED TO	CHARGED TO PATIENTS ED TO PATIENT	0 0 0	2, 686 19, 417 0 0 20, 840	19, 417 0 0	000000000000000000000000000000000000000	2, 196 2, 375 0 232 46, 763	69. 00 69. 01 71. 00 72. 00 73. 00
73. 01 07301 ONCOLOGY OUTPATIENT SERVICE COS	T CENTEDO	0	130, 921	130, 921	C	7, 199	73. 01
88. 00 08800 PPI M 88. 01 08801 FMC 88. 02 08802 NPFH 89. 00 08900 FEDERALLY QUALI F 90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	LED HEALTH CENTER	0 0 0 0 0	55, 833 26, 909 0 4, 351	55, 833 26, 909 0 4, 351	C C C C	17, 130	88. 01 88. 02 89. 00 90. 00
92. 00 09200 OBSERVATION BEDS OTHER REIMBURSABLE COS				0			92. 00
99. 10   09910   CORF SPECIAL PURPOSE COST C	FNTERS	0	0	0	C	0	99. 10
109. 00 10900 PANCREAS ACQUISI 110. 00 11000 INTESTINAL ACQUI 111. 00 11100 ISLET ACQUISITIO 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVI 118. 00 SUBTOTALS (SUM 0	TION SITION N EW-SNF F LINES 1-117)	0 0 0	0	2, 207, 689	C C C	0 0	109. 00 110. 00 111. 00 113. 00 114. 00 118. 00
NONREI MBURSABLE COST C 190. 00 19000 GI FT, FLOWER, CO 192. 00 19200 PHYSI CI ANS' PRI V 193. 00 19300 NONPAI D WORKERS 193. 01 19301 DME 193. 02 19302 LACTATI ON CONSUL 193. 03 19303 DI ABETI C COUNSEL 194. 00 07950 VACANT SPACE 194. 01 07951 BOARD OF HEALTH	FFEE SHOP & CANTEEN ATE OFFICES TING	0 0 0 0 0 0	12, 810 433, 258 0 0 0 41, 546 22, 478	433, 258 0 0 0 0 0 41, 546	C C C C C	47, 389 0 0 0 0 0 583	190. 00 192. 00 193. 00 193. 01 193. 02 193. 03 194. 00 194. 01
194. 02 07952 PUTNAM/HENRY PRE 200. 00 Cross Foot Adjus		0	0	0 0	C	197	194. 02 200. 00

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B		
				From 01/01/2015			
				To 12/31/2015	Date/Time Pre	pared:	
					3/30/2016 4:3	6 pm	
		CAPI TAL					
		RELATED COSTS					
Cost Center Description	Di rectly	NEW BLDG &	Subtotal	EMPLOYEE	ADMI NI STRATI VE		
·	Assigned New	FLXT		BENEFI TS	& GENERAL		
	Capi tal			DEPARTMENT			
	Related Costs						
	0	1. 00	2A	4. 00	5. 00		
201.00 Negative Cost Centers		0		0 0	0	201. 00	
202.00 TOTAL (sum lines 118-201)	0	2, 717, 781	2, 717, 78	1 C	369, 022	202. 00	

Provi der CCN: 151333

				12/31/2015	3/30/2016 4:3	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	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 O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMINISTRATIVE & GENERAL						5. 00
7. 00   00700   OPERATION OF PLANT	201, 997	21 050				7. 00
8.00   00800   LAUNDRY & LINEN SERVICE 9.00   00900   HOUSEKEEPING	1, 724 1, 433					8. 00 9. 00
10. 00   01000 DI ETARY	7, 435			90, 651		10.00
11. 00 01100 CAFETERI A	4, 091	0	504	0	54, 347	
13.00 01300 NURSING ADMINISTRATION	1, 411	0	174	О	566	13. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	10, 662	0	1, 313	0	3, 375	16. 00
17. 00   01700   SOCIAL SERVICE	0	•	0	0	0	17. 00
17. 01 01701 UTI LI ZATI ON REVI EW	344	0	42	0	0	17. 01
30. 00 03000 ADULTS & PEDIATRICS	22, 265	4, 755	2, 743	76, 696	5, 661	30.00
31. 00   03100   NTENSI VE CARE UNI T	7, 246			13, 955	3, 718	
41. 00   04100   SUBPROVI DER -   I RF	0	0,072	0	0	0	41. 00
42. 00   04200   SUBPROVI DER	0	0	0	o	0	42. 00
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS				ما	0.440	
50.00   05000   0PERATI NG ROOM 51.00   05100   RECOVERY ROOM	23, 808 5, 854	1		0	2, 443	1
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0, 654	1, 719	721 0	0	824 0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	Ö	o	564	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	8, 007	1, 639	986	Ō	4, 496	1
54. 01   05401 NUCLEAR MEDICINE-DIAGNOSTIC	357	0	44	o	0	54. 01
57. 00   05700   CT   SCAN	3, 367	0	415	0	990	57. 00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	1	0	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON 60. 00   06000   LABORATORY	0	1	0 777	0	0 5, 921	59. 00 60. 00
60. 00   06000   LABORATORY	6, 305 0		///	0	5, 921	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0		Ö	Ö	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 742	Ö	215	Ō	1, 932	1
66. 00 06600 PHYSI CAL THERAPY	8, 200	604	1, 010	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0	0	0	67. 00
68. 00   06800   SPEECH PATHOLOGY	0	1	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	255		31	0	454	69.00
69. 01   06901   CARDI AC REHAB 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1, 844	0	227 0	0	1, 104 0	69. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT			0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 979	Ö	244	o	854	73. 00
73. 01 07301 ONCOLOGY	12, 434	702	1, 532	0	2, 166	73. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00   08800   PPI M	3, 145		387	0	3, 840	
88. 01   08801   FMC 88. 02   08802   NPFH	5, 303 2, 556		0 315	0	0	88. 01 88. 02
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	2, 550		0	0	0	89.00
90. 00   09000   CLINIC	413		51	o	0	
91. 00 09100 EMERGENCY	15, 314			o	7, 570	
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	1	ı .	I al	ما		
99. 10   09910  CORF   SPECI AL PURPOSE COST CENTERS	0	0	0	0	0	99. 10
109. 00 10900 PANCREAS ACQUISITION	0	0	0	ol	0	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	Ö	l e		Ö		110. 00
111. 00 11100   SLET ACQUI SI TI ON	0		0	Ō		111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	157, 494	20, 752	18, 360	90, 651	46, 478	118. 00
NONREI MBURSABLE COST CENTERS	1 217		150	ol	0	100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	1, 217 41, 151		150 4, 939	0		190. 00 192. 00
193. 00 19300 NONPALD WORKERS	41, 131		4, 737	0		193. 00
193. 01 19301 DME	0	Ö	Ö	o		193. 01
193. 02 19302 LACTATION CONSULTING	0	0	0	o		193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	0	0	o		193. 03
194. 00 07950 VACANT SPACE	0 405	0	0	0		194. 00
194. 01 07951 BOARD OF HEALTH	2, 135	0	263	0		194. 01
194. 02 07952 PUTNAM/HENRY PRENATAL	0	0		O	0	194. 02 200. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	_		0	0	0	200.00
202.00 TOTAL (sum lines 118-201)	201, 997	21, 859	23, 712	90, 651		202.00
		, , , , , , , , , , , , , , , , , , , ,	,		, -, -, -,	

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151333

			Ţ	0 12/31/2015	Date/Time Pre 3/30/2016 4:3	
Cost Center Description	NURSI NG	MEDI CAL	SOCIAL SERVICE	UTI LI ZATI ON	Subtotal	o piii
	ADMI NI STRATI ON	RECORDS & LI BRARY		REVI EW		
	13.00	16. 00	17. 00	17. 01	24. 00	
GENERAL SERVICE COST CENTERS						
1. 00   00100   NEW CAP REL COSTS-BLDG & FLXT						1.00
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT 5.00   00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00   00700   OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10.00
11. 00   01100   CAFETERI A	21 (07					11.00
13. 00   01300   NURSI NG ADMINI STRATI ON 16. 00   01600   MEDI CAL RECORDS & LI BRARY	21, 697	137, 830				13. 00 16. 00
17. 00 01700 SOCI AL SERVI CE		137, 030	1			17. 00
17. 01 01701 UTI LI ZATI ON REVI EW	0	C	0	5, 949		17. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	T					
30. 00   03000   ADULTS & PEDI ATRI CS	4, 504 2, 958	74, 526	1		450, 939	
31. 00   03100   INTENSIVE CARE UNIT 41. 00   04100   SUBPROVIDER - IRF	2, 958	C			124, 885 0	1
42. 00   04200   SUBPROVI DER	o	C			0	42. 00
43. 00 04300 NURSERY	0	C	0	0	0	ı
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATI NG ROOM	1, 944	28, 832	1		331, 290	1
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELIVERY ROOM & LABOR ROOM	656	C			73, 531 0	1
53. 00   05300   ANESTHESI OLOGY	448	C	1		5, 679	1
54. 00   05400   RADI OLOGY-DI AGNOSTI C	3, 137	C	0	0	119, 370	1
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	C	0	0	6, 221	1
57. 00 05700 CT SCAN	301	C	0	0	45, 753	
58.00   O5800   MAGNETIC RESONANCE I MAGING (MRI) 59.00   O5900   CARDIAC CATHETERIZATION	0	C	1	0	0	58. 00 59. 00
60. 00   06000 LABORATORY		166	1	0	110, 421	ı
60. 01   06001   BLOOD   LABORATORY	o	C	1	0	0	1
64.00 06400 INTRAVENOUS THERAPY	0	C	0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	C	0	0	29, 980	1
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	0	C		0	104, 076	1
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY				0	1, 628 348	1
69. 00   06900   ELECTROCARDI OLOGY		C	ol o	0	5, 624	1
69. 01   06901   CARDI AC REHAB	878	C	0	0	25, 845	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C	1	0	232	ı
73. 00   07300   DRUGS CHARGED TO PATIENTS 73. 01   07301   ONCOLOGY	1, 723	3, 861	1		70, 680 160, 538	1
OUTPATIENT SERVICE COST CENTERS	1, 725	3,001		<u> </u>	100, 550	73.01
88. 00 08800 PPI M	0	C	0	0	58, 030	88. 00
88. 01   08801   FMC	0	C	1		75, 734	1
88. 02   08802   NPFH	0	C	0	0	37, 197	1
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC		30, 445	5 0	0	0 35, 342	
91. 00   09100   EMERGENCY	5, 148	30, 443			226, 851	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					-,	92.00
OTHER REIMBURSABLE COST CENTERS						
99. 10   09910   CORF	0	C	) 0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS  109.00 10900 PANCREAS ACQUISITION	O	C	) 0	l ol	0	109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON		C				110.00
111. 00 11100   SLET ACQUI SI TI ON	Ö	C				111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	04 (07	407.000			0 400 404	114.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	21, 697	137, 830	)  0	5, 949	2, 100, 194	]118.00 ]
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	C	) 0	0	14 357	190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	o	C			535, 713	1
193.00 19300 NONPALD WORKERS	o	C	0	0		193. 00
193. 01 19301 DME	0	C	0	0		193. 01
193. 02 19302 LACTATION CONSULTING 193. 03 19303 DIABETIC COUNSELING	0	C	1	0		193. 02 193. 03
194. 00 07950 VACANT SPACE		C	1			194. 00
194. 01 07951 BOARD OF HEALTH		C	) 0			194. 01
194.02 07952 PUTNAM/HENRY PRENATAL	0	C	0	0		194. 02
200.00 Cross Foot Adjustments		_	,			200.00
201.00   Negative Cost Centers 202.00   TOTAL (sum lines 118-201)	21, 697	137, 830	0		0 2, 717, 781	201.00
	21,077	137, 330	.1	0, 747	2,717,701	1-02.00

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151333 Period: Worksheet B

From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 3/30/2016 4:36 pm Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01701 UTILIZATION REVIEW 17.01 17.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 450, 939 30.00 03100 INTENSIVE CARE UNIT 31.00 0 0 124, 885 31.00 04100 SUBPROVIDER - IRF 41 00 41 00 Ω 04200 SUBPROVI DER 42.00 0 42.00 43.00 04300 NURSERY 0 43.00 0 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 50 00 0 331 290 05100 RECOVERY ROOM 51.00 73, 531 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 000000000000000000 5, 679 53.00 05400 RADI OLOGY-DI AGNOSTI C 119, 370 54 00 54 00 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 6, 221 54.01 05700 CT SCAN 57.00 57.00 45, 753 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 60.00 06000 LABORATORY 110, 421 60.00 06001 BLOOD LABORATORY 60.01 60.01 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 64.00 64.00 29, 980 65.00 65 00 06600 PHYSI CAL THERAPY 104,076 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 1, 628 67.00 06800 SPEECH PATHOLOGY 68.00 348 68.00 06900 ELECTROCARDI OLOGY 5, 624 69.00 69.00 69.01 06901 CARDI AC REHAB 25, 845 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 232 73.00 07300 DRUGS CHARGED TO PATIENTS 0 70, 680 73.00 07301 ONCOLOGY 160, 538 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 0 88.00 08800 PPI M 58,030 88.00 88.01 08801 FMC 0 0 0 75, 734 88.01 37, 197 88. 02 08802 NPFH 88.02 08900 FEDERALLY QUALIFIED HEALTH CENTER 89 00 89 00 90.00 09000 CLI NI C 35, 342 90.00 09100 EMERGENCY 0 91.00 226, 851 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 99. 10 09910 CORF 0 99.10 SPECIAL PURPOSE COST CENTERS 109. 00 10900 PANCREAS ACQUISITION 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111. 00 0 113.00 11300 INTEREST EXPENSE 113.00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114 00 SUBTOTALS (SUM OF LINES 1-117) 0 2, 100, 194 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 14, 357 190.00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 192. 00 535, 713 193. 00 19300 NONPALD WORKERS 0000000 193.00 C 193. 01 19301 DME 193. 01 0 193. 02 19302 LACTATION CONSULTING 0 193. 02 193. 03 19303 DI ABETI C COUNSELI NG C 193. 03 194.00 07950 VACANT SPACE 194.00 42, 129 194. 01 07951 BOARD OF HEALTH 25, 191 194. 01 194. 02 07952 PUTNAM/HENRY PRENATAL 194. 02 197 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Health Financial Systems	PUTNAM COUNTY	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 151333	Peri od: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Pre 3/30/2016 4:3			
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26.00						
202.00 TOTAL (sum lines 118-201)	0	2, 717, 781				202. 00		

	Financial Systems	PUTNAM COUNTY				u of form CMS-	
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2015 To 12/31/2015	Worksheet B-1 Date/Time Pre 3/30/2016 4:3	pared:
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG & FIXT (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)		ADMI NI STRATI VE & GENERAL (ACCUM. COST)	PLANT (SQUARE FEET)	
	TOTAL OFFICE OFF	1.00	4. 00	5A	5. 00	7. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT	101, 200		1			1.00
4. 00 5. 00 7. 00 8. 00 9. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0 13, 741 6, 718 676 562	14, 334, 651 2, 368, 647 246, 823 28, 499 307, 907	-5, 117, 04° (	26, 303, 531 1, 538, 349 141, 188 503, 538		4. 00 5. 00 7. 00
10. 00	01000 DI ETARY	2, 915	85, 244	•	279, 870		•
11. 00	01100 CAFETERI A	1, 604	207, 214	1	475, 836	1, 604	1
13.00	01300 NURSI NG ADMI NI STRATI ON	553	66, 002	1	334, 660		1
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 180	366, 818	3	728, 762	4, 180	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	) (	0	0	17. 00
17. 01	01701 UTILIZATION REVIEW	135	101, 903		138, 115	135	17. 01
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.700	040 470	.1	4 440 407	0.700	00.00
30.00	03000 ADULTS & PEDIATRICS	8, 729	918, 473	1	1, 449, 427	8, 729	1
31. 00 41. 00	03100   INTENSI VE CARE UNI T   04100   SUBPROVI DER -   I RF	2, 841	753, 974	1	1, 085, 583 0	2, 841 0	ı
42.00	04200 SUBPROVI DER	0	0	1		0	42.00
43. 00	04300 NURSERY	O	0	1			ı
	ANCILLARY SERVICE COST CENTERS		-		-		
50.00	05000 OPERATI NG ROOM	9, 334	449, 517	' (	1, 350, 148	9, 334	50.00
51.00	05100 RECOVERY ROOM	2, 295	65, 063		151, 371	2, 295	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	563, 640		332, 684	0	53.00
54. 00 54. 01	05400   RADI OLOGY-DI AGNOSTI C   05401   NUCLEAR MEDI CI NE-DI AGNOSTI C	3, 139 140	682, 241		1, 197, 911	3, 139 140	
57. 00	05700 CT SCAN	1, 320	155, 507		146, 818 372, 853	1, 320	ı
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0,2,000	0	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59.00
60.00	06000 LABORATORY	2, 472	644, 116	o  (	2, 200, 072	2, 472	60.00
60. 01	06001 BLOOD LABORATORY	0	0	) (	0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	224 742		0	0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	683 3, 215	334, 743	1	552, 331 564, 587	683 3, 215	•
67. 00	06700 OCCUPATI ONAL THERAPY	3, 213	0	1	116, 011	3, 213	1
68. 00	06800 SPEECH PATHOLOGY	o	0		24, 814	0	1
69. 00	06900 ELECTROCARDI OLOGY	100	65, 060	) (	156, 664	100	69. 00
69. 01	06901 CARDI AC REHAB	723	111, 259		169, 278	723	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	0	107 215	1	16, 519		
	07300   DRUGS CHARGED TO PATIENTS   07301   ONCOLOGY	776 4, 875	107, 315 283, 515		3, 333, 295 513, 120		73. 00 73. 01
70.01	OUTPATIENT SERVICE COST CENTERS	1,070	200, 010		5 010, 120	1,070	70.01
88. 00	08800 PPI M	1, 233	792, 454	. (	1, 221, 625	1, 233	88. 00
88. 01	08801 FMC	2, 079	624, 369		1, 040, 578		88. 01
88. 02	08802 NPFH 08900 FEDERALLY QUALIFIED HEALTH CENTER	1, 002	313, 538		528, 719		
90.00	09000 CLINIC	0 162	0		5, 823	0 162	
	09100 EMERGENCY	6, 004	1, 636, 775		2, 164, 645		ı
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		.,,		_,,	-,	92.00
	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0	) (	0 0	0	99. 10
100.00	SPECIAL PURPOSE COST CENTERS 10900 PANCREAS ACQUISITION					0	100.00
	11000   NTESTINAL ACQUISITION	0	0		0 0		109. 00 110. 00
	11100 I SLET ACQUI SI TI ON	0	0				111.00
	11300   NTEREST EXPENSE		_				113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
118.00		82, 206	12, 280, 616	-5, 117, 04	1 22, 835, 194	61, 747	118. 00
100.00	NONREI MBURSABLE COST CENTERS	477			12.010	477	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	477 16, 133	0 2, 043, 469	1	12, 810 3, 377, 442		190. 00 192. 00
	19300 NONPALD WORKERS	10, 133	2, 043, 407	1	0 3,377,442		193. 00
193. 01	19301 DME		Ö		o o		193. 01
	19302 LACTATION CONSULTING		0		0		193. 02
193. 03	19303 DIABETIC COUNSELING	0	0	) (	0		193. 03
194.00	07950 VACANT SPACE	1, 547	0		41, 546		194. 00
194.01	07951 BOARD OF HEALTH 07952 PUTNAM/HENRY PRENATAL	837	0 10, 566		22, 478 14, 061		194. 01 194. 02
194.02	O 7 7 0 2 FO FINAIN/ HEINKT PRENATAL	1 0	10, 566	η	14,061	<u> </u>	1174. UZ

Health Fina	ncial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCA	ATION - STATISTICAL BASIS		Provi der	CCN: 151333	Peri od:	Worksheet B-1	
					From 01/01/2015 To 12/31/2015		
	Cost Center Description	CAPITAL RELATED COSTS NEW BLDG &		Reconciliati	on ADMI NI STRATI VE		
		FIXT	BENEFITS		& GENERAL	PLANT	
		(SQUARE FEET)	DEPARTMENT (GROSS		(ACCUM. COST)	(SQUARE FEET)	
		1 221)	SALARI ES)		6031)		
		1.00	4. 00	5A	5. 00	7. 00	
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	2, 717, 781	3, 957, 150		5, 117, 041	1, 837, 616	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	26. 855543	0. 276055		0. 194538	23. 203980	203. 00
204.00	Cost to be allocated (per Wkst. B, Part II)		0		369, 022	201, 997	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 000000		0. 014029	2. 550660	205. 00

PRITAL In Lieu of Form CMS-2552-10

Provider CCN: 151333 | Period: | Worksheet B-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

				To	12/31/2015		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	3/30/2016 4: 30 NURSI NG	o piii
		LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(PATIENT DAYS)	(MANHOURS)	ADMI NI STRATI ON	
		LAUNDRY)				(DI RECT	
		8.00	9.00	10.00	11.00	NRSING HRS) 13.00	
	GENERAL SERVICE COST CENTERS	8.00	7.00	10.00	11.00	13.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	173, 671					8.00
9.00	00900 HOUSEKEEPI NG	970		2 501			9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	718	2, 915 1, 604		25, 845		10. 00 11. 00
13. 00		0	553	1	269	12, 967	13. 00
16. 00		0	4, 180	0	1, 605	0	16. 00
17. 00		0	0		0	0	17.00
17. 01	01701 UTILIZATION REVIEW INPATIENT ROUTINE SERVICE COST CENTERS	0	135	ı U	0	U	17. 01
30.00		37, 781	8, 729	2, 116	2, 692	2, 692	30.00
31. 00		29, 171	2, 841	385	1, 768		31. 00
41. 00 42. 00		0	0	0	0	0	41. 00 42. 00
43. 00		0		0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS				_		
50.00		13, 660	1	1	1, 162	1, 162	50.00
51. 00 52. 00		13, 660	2, 295		392	392	51. 00 52. 00
53. 00	1	0		Ö	268	268	53. 00
54. 00		13, 020	3, 139	0	2, 138	1, 875	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0		1	0	0	54. 01
57. 00 58. 00		0	1, 320	0	471 0	180 0	57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		Ö	0	0	59. 00
60.00	06000 LABORATORY	0	2, 472	0	2, 816	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
64. 00 65. 00		0	683	0	919	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 795		1	0	Ö	66. 00
67. 00		0	0	0	0	0	67. 00
68. 00		0	0	0	0	0	68. 00
69. 00 69. 01	06900 ELECTROCARDI OLOGY 06901 CARDI AC REHAB	0	100 723	1	216 525	0 525	69. 00 69. 01
71. 00		0	0	Ö	0	0	71. 00
72. 00		0	0	0	0	0	72. 00
73. 00 73. 01		0 5, 580	776 4, 875		406 1, 030	0 1, 030	73.00
73.01	OUTPATIENT SERVICE COST CENTERS	5, 560	4, 6/3	ıj U	1,030	1, 030	73. 01
88. 00	08800 PPI M	3, 235	1, 233	0	1, 826	0	88. 00
88. 01		0	0	0	0	0	88. 01
88. 02 89. 00		0	1, 002	0	0	0	88. 02 89. 00
90. 00		0	162	1 4	0	0	90.00
91. 00		42, 287			3, 600	3, 075	91. 00
92. 00	,						92. 00
99 10	OTHER REIMBURSABLE COST CENTERS 09910 CORF	0	0	0	0	0	99. 10
	SPECIAL PURPOSE COST CENTERS			<u> </u>			77. 10
	0 10900 PANCREAS ACQUISITION	0	•	0	0		109. 00
	O 11000 INTESTINAL ACQUISITION O 11100 ISLET ACQUISITION	0	0	0	0		110. 00 111. 00
	0 11100 13LE1 ACQUISTITON 0 11300 INTEREST EXPENSE		0		U	Ü	111.00
	0 11400 UTILIZATION REVIEW-SNF						114. 00
118. 0	,	164, 877	58, 430	2, 501	22, 103	12, 967	118. 00
100 0	NONREIMBURSABLE COST CENTERS   19000  GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	477	0	0	0	190. 00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	8, 794			3, 742		190.00
	19300 NONPALD WORKERS	0	0	Ō	0		193. 00
	1 19301 DME	0	0	0	0		193. 01
	2 19302 LACTATION CONSULTING 3 19303 DIABETIC COUNSELING	0	0	0	0		193. 02 193. 03
	0 07950 VACANT SPACE		0	0	0		193. 03
	1 07951 BOARD OF HEALTH	0	837	Ö	0	0	194. 01
	2 07952 PUTNAM/HENRY PRENATAL	0	0	0	0		194. 02
200. 0 201. 0							200. 00 201. 00
201.0	ol lineAari ve cost centers	1	I	I I			ZU 1. UU

Heal th Fina	ncial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der	F	Period: From 01/01/2015	Worksheet B-1	
					Го 12/31/2015	Date/Time Pre 3/30/2016 4:3	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
			(SQUARE FEET)	(PATIENT DAYS)	(MANHOURS)	ADMI NI STRATI ON	
		(POUNDS OF					
		LAUNDRY)				(DI RECT	
						NRSING HRS)	
		8. 00	9. 00	10.00	11.00	13. 00	
202. 00	Cost to be allocated (per Wkst. B, Part I)	184, 340	615, 566	426, 496	618, 707	423, 547	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 061432	8. 157406	170. 530188	23. 939137	32. 663453	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	21, 859	23, 712	90, 651	54, 347	21, 697	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 125864	0. 314229	36. 245902	2. 102805	1. 673247	205. 00

Provider CCN: 151333

				3/30/2016 4:	
Cost Center Description	MEDI CAL	SOCIAL SERVICE	UTI LI ZATI ON		
	RECORDS &		REVI EW		
	LI BRARY	(PATI ENT	(PATIENT DAYS)		
	(TIME SPENT)	DAYS)			
	16. 00	17. 00	17. 01		
GENERAL SERVICE COST CENTERS	1		1		
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					5. 00
7. 00   00700   OPERATION OF PLANT					7. 00
8. 00   00800   LAUNDRY & LINEN SERVICE					8. 00
9. 00   00900   HOUSEKEEPI NG			•		9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A					10.00
· · · · · · · · · · · · · · · · · · ·					11.00
13. 00   01300   NURSI NG ADMI NI STRATI ON 16. 00   01600   MEDI CAL RECORDS & LI BRARY	140 707				13. 00 16. 00
17. 00 01700 SOCIAL SERVICE	160, 797 0	2, 501			17. 00
17. 00   01700   300TAL   3ERVICE 17. 01   01701   UTI LI ZATI ON REVIEW	0	2, 301	i I		17. 00
INPATIENT ROUTINE SERVICE COST CENTERS	ı o	0	2, 301		- 17.01
30. 00 03000 ADULTS & PEDIATRICS	86, 945	2, 116	2, 116		30.00
31. 00   03100   NTENSI VE CARE UNI T	00, 743	385			31.00
41. 00   04100   SUBPROVI DER -   RF		0	I		41. 00
42. 00   04200   SUBPROVI DER		0			42. 00
43. 00 04300 NURSERY	0	0			43. 00
ANCI LLARY SERVI CE COST CENTERS	١		<u> </u>		10.00
50. 00   05000   OPERATING ROOM	33, 636	0	O		50.00
51. 00   05100   RECOVERY   ROOM	0	0			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	o	0	0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0		53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0	0	0		54. 00
54. 01   05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0			54. 01
57. 00   05700   CT   SCAN	o	0	o o		57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0	Ö		58. 00
59. 00   05900 CARDI AC CATHETERI ZATI ON	o	0	Ö		59.00
60. 00   06000   LABORATORY	194	0	Ö		60.00
60. 01   06001   BLOOD   LABORATORY	0	0	Ö		60. 01
64. 00 06400 I NTRAVENOUS THERAPY	ol	0	Ö		64. 00
65. 00 06500 RESPIRATORY THERAPY	ol	0	Ö		65. 00
66. 00 06600 PHYSI CAL THERAPY	ol	0	Ö		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0	Ö		67. 00
68.00 06800 SPEECH PATHOLOGY	o	0	o		68. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0	o		69. 00
69. 01 06901 CARDI AC REHAB	o	0	o		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	0		73. 00
73. 01   07301   0NCOLOGY	4, 504	0	0		73. 01
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 PPI M	0	0	0		88. 00
88. 01   08801   FMC	0	0	0		88. 01
88. 02   08802   NPFH	0	0	0		88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89. 00
90. 00  09000   CLI NI C	35, 518	0	0		90. 00
91. 00   09100   EMERGENCY	0	0	0		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
OTHER REIMBURSABLE COST CENTERS					
99. 10   09910   CORF	0	0	0		99. 10
SPECIAL PURPOSE COST CENTERS					4.5.5
109. 00 10900 PANCREAS ACQUISITION	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE					113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	160, 797	2, 501	2, 501		118. 00
NONREI MBURSABLE COST CENTERS					100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	<u> </u>		193. 00
193. 01 19301 DME	0	0	0		193. 01
193. 02 19302 LACTATION CONSULTING	0	0	0		193. 02
193. 03 19303 DI ABETI C COUNSELI NG	0	0	0		193. 03
194. 00 07950 VACANT SPACE	0	0			194. 00
194. 01 07951 BOARD OF HEALTH	0	0			194. 01
194. 02 07952 PUTNAM/HENRY PRENATAL	0	0	1 0		194. 02
200.00   Cross Foot Adjustments 201.00   Negative Cost Centers					200. 00 201. 00
201.00   Negative Cost Centers	ı l		I I		J201.00

Heal th Fi	nancial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der		Peri od: From 01/01/2015	Worksheet B-1	
			_		To 12/31/2015	Date/Time Pre 3/30/2016 4:3	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE	UTI LI ZATI ON			
		RECORDS &		REVI EW			
		LI BRARY	(PATI ENT	(PATIENT DAYS	5)		
		(TIME SPENT)	DAYS)				
		16. 00	17. 00	17. 01			
202.00	Cost to be allocated (per Wkst. B, Part I)	1, 040, 047	0	169, 21	8		202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	6. 468075	0. 000000	67. 66013	36		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	137, 830	0	5, 94	.9		204. 00
005 00	11 . 1 . 1 . 1	0 0574/0	0 000000	0 070/4			000

0. 857168

0.000000

2. 378649

205. 00

Unit cost multiplier (Wkst. B, Part

205.00

			1	o 12/31/2015	Date/lime Pre   3/30/2016 4:3	
		Ti t	le XVIII	Hospi tal	Cost	о рііі
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		ı	1 00// 00/	1		
30. 00   03000   ADULTS & PEDI ATRI CS	3, 264, 004		3, 264, 004		0	
31. 00   03100   INTENSIVE CARE UNIT	1, 608, 607		1, 608, 607		0	31.00
41. 00   04100   SUBPROVI DER -   I RF	0		C	_	0	41.00
42. 00   04200   SUBPROVI DER	0		C		0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0			) 0	0	43. 00
50. 00   05000   OPERATING ROOM	2, 203, 361	I	2, 203, 361	0	0	50. 00
51. 00   05100   RECOVERY   ROOM	289, 479		289, 479		0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	207, 477		207, 477	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	412, 574		412, 574		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 655, 639		1, 655, 639		0	54.00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	179, 771		179, 771	0	0	54. 01
57. 00   05700 CT SCAN	503, 938		503, 938	_	0	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	000,700		000, 700		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		i o	Ö	0	59. 00
60. 00   06000   LABORATORY	2, 774, 263		2, 774, 263	_	0	60.00
60. 01   06001   BLOOD   LABORATORY	2,771,200		2, , , , , 200		0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0			_	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	703, 200		0 703, 200	0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	780, 338		0 780, 338		0	66, 00
67. 00 06700 OCCUPATI ONAL THERAPY	138, 580		0 138, 580		0	67. 00
68.00 06800 SPEECH PATHOLOGY	29, 641		0 29, 641	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	195, 448		195, 448	0	0	69. 00
69. 01   06901   CARDI AC   REHAB	254, 599		254, 599	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		C	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	19, 733		19, 733	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 015, 803		4, 015, 803	0	0	73. 00
73. 01 07301 ONCOLOGY	859, 182		859, 182	0	0	73. 01
OUTPAȚI ENT SERVI CE COST CENTERS						
88. 00   08800   PPI M	1, 545, 093		1, 545, 093	0	0	
88. 01   08801   FMC	1, 291, 251		1, 291, 251	0	0	88. 01
88. 02   08802   NPFH	662, 999		662, 999		0	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	_	0	89. 00
90. 00   09000   CLI NI C	241, 769		241, 769	0	0	90.00
91. 00   09100   EMERGENCY	3, 005, 551		3, 005, 551	0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 139, 766		1, 139, 766	)	0	92.00
OTHER REIMBURSABLE COST CENTERS		I				00 10
99. 10 O9910 CORF  SPECI AL PURPOSE COST CENTERS	0		C	1	0	99. 10
109. 00 10900 PANCREAS ACQUISITION	T 0			(		109. 00
110. 00 11000   NTESTI NAL ACQUI SI TI ON						110.00
111. 00 11100   SLET ACQUISITION	0					111.00
113. 00 11300   NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
200.00 Subtotal (see instructions)	27, 774, 589		0 27, 774, 589	n	n	200.00
201.00 Less Observation Beds	1, 139, 766		1, 139, 766			201.00
202.00 Total (see instructions)	26, 634, 823		0 26, 634, 823			202. 00
		1		-1	•	

					.0 12,01,2010	3/30/2016 4: 3	6 pm
			Ti tl	e XVIII	Hospi tal	Cost	<u> </u>
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	The state of the s			+ col. 7)	Rati o	Inpati ent	
				,		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
1	NPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 ADULTS & PEDI ATRI CS	1, 594, 622		1, 594, 62	2		30.00
	03100 INTENSIVE CARE UNIT	636, 435		636, 43			31.00
	04100 SUBPROVI DER – I RF	030, 433					41.00
	04200 SUBPROVI DER						42.00
	04300 NURSERY	0					
		l U			<u> </u>		43. 00
	ANCI LLARY SERVI CE COST CENTERS	504 450	0.050.004	0.047.70	0 570700	0.000000	F0 00
	D5000 OPERATING ROOM	594, 452	3, 252, 281				50.00
	D5100 RECOVERY ROOM	48, 578	402, 908			0. 000000	51.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	
	D5300 ANESTHESI OLOGY	20, 764	296, 623			0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	467, 221	5, 558, 455			0. 000000	
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	33, 894	754, 706			0. 000000	
	05700 CT SCAN	521, 164	14, 694, 756	15, 215, 920	0. 033119	0. 000000	57. 00
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0. 000000	0. 000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0.000000	59. 00
60.00	06000 LABORATORY	1, 250, 797	14, 037, 375	15, 288, 17:	0. 181465	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0.000000	0.000000	60. 01
64.00	06400 INTRAVENOUS THERAPY	o	0		0. 000000	0. 000000	64. 00
65.00	06500 RESPIRATORY THERAPY	825, 006	661, 049	1, 486, 05	0. 473199	0. 000000	65. 00
	06600 PHYSI CAL THERAPY	396, 554	1, 648, 051			0. 000000	
	06700 OCCUPATI ONAL THERAPY	200, 542	323, 243			0. 000000	67. 00
	06800 SPEECH PATHOLOGY	32, 345	81, 598			0. 000000	
	06900 ELECTROCARDI OLOGY	34, 487	966, 814			0. 000000	
	06901 CARDI AC REHAB	01, 107	358, 821	358, 82		0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		030, 021		0. 000000	0. 000000	
	07200 IMPL. DEV. CHARGED TO PATIENT		333, 910			0. 000000	1
	07300 DRUGS CHARGED TO PATIENTS	1, 235, 911	6, 193, 801			0.00000	
	1	1					
	07301  ONCOLOGY	1, 488	675, 199	676, 68	1. 269689	0.000000	73. 01
	OUTPATIENT SERVICE COST CENTERS		4 5/5 554	4 5/5 55			00.00
	08800 PPI M	0	1, 565, 551				88. 00
	08801 FMC	0	1, 430, 197				88. 01
	08802 NPFH	0	423, 487				88. 02
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		O		89. 00
	09000 CLI NI C	0	4, 820				
	09100 EMERGENCY	112, 097	7, 784, 369		0. 380620		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 003, 644	2, 003, 64	0. 568847	0.000000	92.00
C	OTHER REIMBURSABLE COST CENTERS						
99. 10	09910 CORF	0	0		)		99. 10
S	SPECIAL PURPOSE COST CENTERS						1
109.001	10900 PANCREAS ACQUISITION	0	0		)		109. 00
110.001	11000 INTESTINAL ACQUISITION	o	0		)		110. 00
	11100   SLET ACQUISITION	0	0		)		111. 00
	11300 I NTEREST EXPENSE		· ·				113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
200.00	Subtotal (see instructions)	8, 006, 357	63, 451, 658	71, 458, 01	_		200.00
201.00	Less Observation Beds	0,000,007	05, 451, 050	71, 430, 01.	1		201.00
202.00	Total (see instructions)	8, 006, 357	63, 451, 658	71, 458, 01	5		202.00
202.00	Total (See Histructions)	0,000,337	03, 431, 030	1 11, 450, 01	ا ا	l	1202.00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333
Period:
From 01/01/2015
To 12/31/2015
Part I
Date/Time Prepared:

3/30/2016 4:36 pm Title XVIII Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 42.00 04200 SUBPROVI DER 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 53 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54. 01 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.000000 57. 00 05700 CT SCAN 0.000000 57.00 58.00 |05800 | MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 06000 LABORATORY 0.000000 60.00 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64 00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 06901 CARDI AC REHAB 69. 01 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 73. 01 07301 ONCOLOGY 0.000000 73.01 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 PPI M 88.00 08801 FMC 88. 01 88. 01 88 02 08802 NPFH 88 02 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 90.00 09000 CLI NI C 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.000000 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 99.10 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 | SLET ACQUISITION 111.00 113.00 11300 I NTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 200.00 Subtotal (see instructions) 200. 00 201.00 Less Observation Beds 201. 00

202.00

202.00

Total (see instructions)

			T	o 12/31/2015	Date/Time Pre 3/30/2016 4:3	
		Ti t	le XIX	Hospi tal	Cost	Орш
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1				
30. 00 03000 ADULTS & PEDI ATRI CS	3, 264, 004		3, 264, 004	0	3, 264, 004	30.00
31. 00 03100 INTENSIVE CARE UNIT	1, 608, 607		1, 608, 607	0	1, 608, 607	31.00
41. 00   04100   SUBPROVI DER -   I RF 42. 00   04200   SUBPROVI DER	0		0	0	0	41. 00 42. 00
42. 00   04200  SUBPROVI DER 43. 00   04300  NURSERY	0		0	0	0	42.00
ANCI LLARY SERVI CE COST CENTERS				U U	0	43.00
50. 00 05000 OPERATING ROOM	2, 203, 361		2, 203, 361	0	2, 203, 361	50.00
51. 00   05100   RECOVERY   ROOM	289, 479		289, 479	o	289, 479	
52.00 05200 DELIVERY ROOM & LABOR ROOM	207, 477		207, 477	0	207, 477	52.00
53. 00   05300   ANESTHESI OLOGY	412, 574		412, 574	0	412, 574	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 655, 639		1, 655, 639	Ö	1, 655, 639	54. 00
54. 01   05401 NUCLEAR MEDICINE-DI AGNOSTI C	179, 771		179, 771	0	179, 771	54. 01
57. 00   05700   CT   SCAN	503, 938		503, 938	o	503, 938	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0	0	59. 00
60. 00 06000 LABORATORY	2, 774, 263		2, 774, 263	0	2, 774, 263	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	703, 200	0	703, 200	0	703, 200	65. 00
66. 00 06600 PHYSI CAL THERAPY	780, 338	0	780, 338	0	780, 338	
67. 00 06700 OCCUPATI ONAL THERAPY	138, 580	0	138, 580	0	138, 580	
68.00 06800 SPEECH PATHOLOGY	29, 641	0	29, 641	0	29, 641	68. 00
69. 00 06900 ELECTROCARDI OLOGY	195, 448		195, 448	0	195, 448	
69. 01   06901   CARDI AC   REHAB	254, 599		254, 599	0	254, 599	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	19, 733		19, 733	0	19, 733	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 015, 803		4, 015, 803	0	4, 015, 803	
73. 01 07301 ONCOLOGY OUTPATIENT SERVICE COST CENTERS	859, 182		859, 182	0	859, 182	73. 01
88. 00 08800 PPIM	1, 545, 093		1, 545, 093	0	1, 545, 093	88. 00
88. 01   08801 FMC	1, 291, 251		1, 291, 251	0	1, 291, 251	88. 01
88. 02   08802   NPFH	662, 999		662, 999	0	662, 999	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	002,777		002, 777	Ö	002, 777	89. 00
90. 00   09000   CLINI C	241, 769		241, 769	0	241, 769	
91. 00 09100 EMERGENCY	3, 005, 551		3, 005, 551	o	3, 005, 551	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 139, 766		1, 139, 766		1, 139, 766	92. 00
OTHER REIMBURSABLE COST CENTERS		ļ.	, , , , , , , , , , , , , , , , , , , ,		, , , , , ,	
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 INTESTINAL ACQUISITION	0		0			110. 00
111. 00 11100 I SLET ACQUI SI TI ON	0		0		0	111. 00
113. 00 11300   INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
200.00 Subtotal (see instructions)	27, 774, 589	l			27, 774, 589	
201.00 Less Observation Beds	1, 139, 766	l e	1, 139, 766		1, 139, 766	
202.00   Total (see instructions)	26, 634, 823	0	26, 634, 823	0	26, 634, 823	J2U2. UU

					.0 12,01,2010	3/30/2016 4: 3	6 pm
			Ti t	le XIX	Hospi tal	Cost	•
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
				,		Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
li li	NPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 ADULTS & PEDIATRICS	1, 594, 622		1, 594, 62	)		30.00
4	03100 INTENSIVE CARE UNIT	636, 435		636, 43			31. 00
	04100 SUBPROVI DER – I RF	0					41. 00
	04200 SUBPROVI DER						42. 00
	04300 NURSERY	0					43. 00
	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u> </u>	J		45.00
	D5000 OPERATING ROOM	594, 452	3, 252, 281	3, 846, 73	0. 572788	0. 000000	50.00
	D5100 RECOVERY ROOM	48, 578	3, 232, 261 402, 908			0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	40, 370	402, 900				1
	05300 ANESTHESI OLOGY	١	ŭ		0.00000	0.000000	
	D5300  ANESTHESTOLOGY D5400  RADI OLOGY-DI AGNOSTI C	20, 764	296, 623			0.000000	
4		467, 221	5, 558, 455			0.000000	1
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	33, 894	754, 706			0.000000	
	05700 CT SCAN	521, 164	14, 694, 756			0.000000	1
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0.000000	0.000000	
	05900 CARDI AC CATHETERI ZATI ON	0	0		0. 000000	0. 000000	
	06000 LABORATORY	1, 250, 797	14, 037, 375			0. 000000	1
	06001 BLOOD LABORATORY	0	0		0. 000000	0. 000000	
4	06400 INTRAVENOUS THERAPY	0	0		0. 000000	0. 000000	1
	06500 RESPI RATORY THERAPY	825, 006	661, 049			0. 000000	
1	06600 PHYSI CAL THERAPY	396, 554	1, 648, 051			0. 000000	1
	06700 OCCUPATI ONAL THERAPY	200, 542	323, 243			0. 000000	
	06800 SPEECH PATHOLOGY	32, 345	81, 598			0. 000000	1
	06900 ELECTROCARDI OLOGY	34, 487	966, 814			0. 000000	1
	06901 CARDI AC REHAB	0	358, 821	358, 82°		0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0. 000000	0. 000000	1
	07200 IMPL. DEV. CHARGED TO PATIENT	0	333, 910	333, 910	0. 059097	0. 000000	72. 00
73.00	D7300 DRUGS CHARGED TO PATIENTS	1, 235, 911	6, 193, 801	7, 429, 71	0. 540506	0.000000	73. 00
73. 01	D7301 ONCOLOGY	1, 488	675, 199	676, 68	1. 269689	0.000000	73. 01
C	DUTPATIENT SERVICE COST CENTERS						
88. 00	08800 PPI M	0	1, 565, 551	1, 565, 55	0. 986932	0. 000000	88. 00
88. 01	08801 FMC	0	1, 430, 197	1, 430, 19	0. 902848	0. 000000	88. 01
88. 02	08802 NPFH	0	423, 487	423, 48	7 1. 565571	0. 000000	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.000000	0.000000	89. 00
90.00	09000 CLI NI C	0	4, 820	4, 820	50. 159544	0.000000	90.00
91.00	09100 EMERGENCY	112, 097	7, 784, 369	7, 896, 46	0. 380620	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	2, 003, 644	2, 003, 64	0. 568847	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
99. 10	09910 CORF	0	0		)		99. 10
	SPECIAL PURPOSE COST CENTERS				-		
	10900 PANCREAS ACQUISITION	0	0		)		109. 00
110.00	11000 INTESTINAL ACQUISITION	o	0		)		110.00
	11100   SLET ACQUISITION	1 0	0				111. 00
	11300 INTEREST EXPENSE		· ·				113. 00
4	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
200.00	Subtotal (see instructions)	8, 006, 357	63, 451, 658	71, 458, 01	5		200.00
201.00	Less Observation Beds	2,000,007	22, 101, 300				201. 00
202.00	Total (see instructions)	8, 006, 357	63, 451, 658	71, 458, 01	5		202. 00
_52.50	1.2.2. (666 1.161 461 616)	0,000,007	55, 15., 666	, , , , , , , , , , , , , , , , , , , ,	=1 !	1	1-32. 00

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

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151333
Period: From 01/01/2015 Form 01/01/2015 To 12/31/2015 Date/Time Prepared:

3/30/2016 4:36 pm Title XIX Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 42.00 04200 SUBPROVI DER 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM 0.000000 50.00 51.00 05100 RECOVERY ROOM 0.000000 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0.000000 53 00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54. 01 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0.000000 57. 00 05700 CT SCAN 0.000000 57.00 58.00 |05800 | MAGNETIC RESONANCE I MAGING (MRI) 0.000000 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.000000 59.00 06000 LABORATORY 0.000000 60.00 60.00 06001 BLOOD LABORATORY 0.000000 60.01 60.01 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64 00 65.00 06500 RESPIRATORY THERAPY 0.000000 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 06901 CARDI AC REHAB 69. 01 0.000000 69.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 73. 01 07301 ONCOLOGY 0.000000 73.01 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 PPI M 0.000000 88.00 08801 FMC 0.000000 88. 01 88. 01 88 02 08802 NPFH 0.000000 88 02 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 89.00 90.00 09000 CLI NI C 0.000000 90.00 91.00 09100 EMERGENCY 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 09910 CORF 99.10 SPECIAL PURPOSE COST CENTERS 109.00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 | SLET ACQUISITION 111.00 113.00 11300 I NTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 200.00 Subtotal (see instructions) 200. 00

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	PUTNAM COUN	TY HOSPI TAL		In Lie	u of Form CMS-2	552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi de	r CCN: 151333	From 01/01/2015	Worksheet D Part II Date/Time Prep 3/30/2016 4:36	
		Ti 1	le XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charge	s Ratio of Cos	t Inpatient	Capital Costs	

				From 01/01/2015	Part II	
				Γο 12/31/2015	Date/Time Pre 3/30/2016 4:3	
		Ti +I	e XVIII	Hospi tal	Cost	о рііі
Cost Center Description	Capi tal	Total Charges			Capital Costs	
cost center beserver on		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col.		column 4)	
	Part II, col.	8)	2)	onal goo	001 0	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	•			*		
50. 00 05000 OPERATING ROOM	331, 290	3, 846, 733	0. 086122	2 377, 808	32, 538	50. 00
51.00   05100   RECOVERY ROOM	73, 531	451, 486	0. 162864	25, 597	4, 169	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	5, 679	317, 387	0. 017893	10, 770	193	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	119, 370	6, 025, 676	0. 019810	252, 764	5, 007	54.00
54. 01   05401 NUCLEAR MEDICINE-DIAGNOSTIC	6, 221	788, 600	0. 007889	22, 435	177	54. 01
57.00   05700   CT SCAN	45, 753	15, 215, 920	0.00300	7 263, 766	793	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0. 000000	0	0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	0	0. 000000	0	0	59. 00
60. 00   06000   LABORATORY	110, 421	15, 288, 172	0.007223	671, 250	4, 848	60.00
60. 01   06001   BLOOD LABORATORY	0	0	0. 000000	0	0	60. 01
64.00 06400 INTRAVENOUS THERAPY	0	0	0. 000000	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	29, 980	1, 486, 055	0. 020174	414, 053	8, 353	65. 00
66. 00 06600 PHYSI CAL THERAPY	104, 076	2, 044, 605	0.050903	135, 542	6, 899	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 628			56, 376	175	67. 00
68. 00 06800 SPEECH PATHOLOGY	348	113, 943	0. 003054	12, 102	37	68. 00
69. 00 06900 ELECTROCARDI OLOGY	5, 624	1, 001, 301	0. 00561	19, 374	109	69. 00
69. 01   06901   CARDI AC   REHAB	25, 845	358, 821	0. 072028	3 0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0. 000000	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	232	333, 910	0. 00069!	5 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	70, 680	7, 429, 712	0. 009513	581, 362	5, 530	73. 00
73. 01 07301 ONCOLOGY	160, 538	676, 687	0. 23724	789	187	73. 01
OUTPAȚI ENT SERVI CE COST CENTERS						
88. 00 08800 PPI M	58, 030	1, 565, 551			0	88. 00
88. 01  08801 FMC	75, 734	1, 430, 197			0	88. 01
88. 02   08802   NPFH	37, 197	423, 487			0	88. 02
89.00  08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	1 0.00000		0	89. 00
90. 00  09000   CLI NI C	35, 342				0	90. 00
91. 00   09100   EMERGENCY	226, 851	7, 896, 466			256	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	190, 665				0	92.00
200.00   Total (lines 50-199)	1, 715, 035	69, 226, 958		2, 852, 900	69, 271	200. 00

Health Financial Systems	PUTNAM COUNTY HOS	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 151333	From 01/01/2015	Worksheet D Part IV Date/Time Prepared:

				Т	o 12/31/2015	Date/Time Prep 3/30/2016 4:30	
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		1	1			
	05000 OPERATING ROOM	0	0	C	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	0	C	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	C	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54.00
	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	0	C	0	0	54. 01
	05700 CT SCAN	0	0	C	0	0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	C	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	0	59. 00
60.00	06000 LABORATORY	0	0	C	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0	0	C	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0	C	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	C	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	C	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	69. 00
69. 01	06901 CARDI AC REHAB	0	0	C	0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0	l c	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	l c	0	0	73. 00
73. 01	07301 ONCOLOGY	0	0	l c	0	0	73. 01
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 PPI M	0	0	C	0	0	88. 00
88. 01	08801 FMC	0	0	C	0	0	88. 01
88. 02	08802 NPFH	0	0	C	0	0	88. 02
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	l c	0	0	89. 00
90.00	09000 CLI NI C	0	0	C	0	0	90.00
91.00	09100 EMERGENCY	0	0	l c	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	l c	0	0	92.00
200.00		0	0	C	0	0	200. 00
		•	•	•		'	•

leal th Financial	Systems		PUTNAM COUNT	ΓΥ HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF THROUGH COSTS	I NPATI ENT/OUTPATI ENT	ANCILLARY S	SERVICE OTHER PAS	S	Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
					Ti tl	e XVIII	Hospi tal	Cost	
Cost	: Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4) 6.00	(from Part	Wkst. C,	Ratio of Cos to Charges (col. 5 ÷ col 7)	Ratio of Cost	Inpatient Program Charges	
	SERVICE COST CENTERS			J	3. 846. 733	0, 00000	0. 000000	377, 808	50. 0
50. 00  05000 0PEF	KATING ROOM			ή	3, 040, 733	0.00000	0.000000	377, 606	50.

	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 + col.	to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6.00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	3, 846, 733			377, 808	
	05100 RECOVERY ROOM	0	451, 486			25, 597	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000		0	
53. 00	05300 ANESTHESI OLOGY	0	317, 387	0.000000	0.000000	10, 770	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 025, 676	0.000000	0.000000	252, 764	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0	788, 600	0.000000	0.000000	22, 435	54. 01
57. 00	05700 CT SCAN	0	15, 215, 920	0.000000	0.000000	263, 766	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58. 00
59. 00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0. 000000	0	59. 00
60.00	06000 LABORATORY	0	15, 288, 172	0.000000	0. 000000	671, 250	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60. 01
64. 00	06400 INTRAVENOUS THERAPY	0	0	0. 000000	0.000000	0	64.00
65. 00	06500 RESPIRATORY THERAPY	0	1, 486, 055	0.000000	0.000000	414, 053	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 044, 605	0.000000	0.000000	135, 542	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	523, 785	0.000000	0.000000	56, 376	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	113, 943	0.000000	0.000000	12, 102	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	1, 001, 301	0.000000	0.000000	19, 374	69. 00
69. 01	06901 CARDI AC REHAB	0	358, 821	0.000000	0.000000	0	69. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0	333, 910	0.000000	0.000000	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	7, 429, 712	0.000000	0.000000	581, 362	73. 00
73. 01	07301 ONCOLOGY	0	676, 687	0.000000	0.000000	789	73. 01
Ī	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 PPI M	0	1, 565, 551	0.000000	0.000000	0	88. 00
88. 01	08801 FMC	0	1, 430, 197	0.000000	0.000000	0	88. 01
88. 02	08802 NPFH	0	423, 487		0. 000000	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000	0. 000000	0	89. 00
	09000 CLI NI C	0	4, 820	0. 000000	0. 000000	0	90.00
91. 00	09100 EMERGENCY	0	7, 896, 466	0. 000000	0. 000000	8, 912	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
200.00	Total (lines 50-199)	0				2, 852, 900	
		1	,	'	1	, ,	

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151333 Period: Worksheet D Part IV To 12/31/2015 Date/Time Prepared:

				10 12/31/2015	3/30/2016 4:3	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. '	)		
	x col. 10)		x col. 12)			
	11.00	12. 00	13. 00			
ANCI LLARY SERVI CE COST CENTERS			. [			
50.00   05000   OPERATING ROOM	0	0	)	0		50. 00
51.00   05100   RECOVERY ROOM	0	0		0		51. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	)	0		53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0	)	0		54. 00
54. 01   05401   NUCLEAR MEDICINE-DIAGNOSTIC	0	0	)	0		54. 01
57. 00  05700   CT   SCAN	0	0	)	0		57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0	0		0		58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0	0		0		59. 00
60. 00   06000   LABORATORY	0	0		O		60.00
60. 01   06001   BLOOD   LABORATORY	0	0		o		60. 01
64.00 06400 INTRAVENOUS THERAPY	0	0		o		64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0		o		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	O		o		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		o		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	O		o		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		o		69. 00
69. 01   06901   CARDI AC   REHAB	0	0		o		69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		ol		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	o	0		ol		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0		o		73. 00
73. 01 07301 ONCOLOGY	o	0		o		73. 01
OUTPATIENT SERVICE COST CENTERS	-1		1	- 1		
88. 00 08800 PPI M	0	0		0		88. 00
88. 01   08801   FMC	0	O		o		88. 01
88. 02   08802   NPFH	0	0		o		88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		o		89. 00
90. 00  09000 CLI NI C	0	0		o		90.00
91. 00 09100 EMERGENCY	0	0		o		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		o		92. 00
200.00 Total (lines 50-199)	O	O		O		200.00
	1		1	1		•

| Peri od: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared:

					0 12/31/2015	3/30/2016 4:3	pared: 6 pm
			Ti tl	e XVIII	Hospi tal	Cost	<u> </u>
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	'	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9	,	Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 572788		1, 208, 131	0	0	50. 00
	05100 RECOVERY ROOM	0. 641169		110, 286	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000		(	-	0	52. 00
	05300 ANESTHESI OLOGY	1. 299908	0	84, 312	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 274764	0	1, 553, 518	0	0	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 227962	0	267, 387	0	0	54. 01
57.00	05700 CT SCAN	0. 033119	0	4, 298, 964	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	(	0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	(	0	0	59. 00
60.00	06000 LABORATORY	0. 181465	0	5, 281, 168	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	(	0	0	60. 01
	06400 INTRAVENOUS THERAPY	0. 000000	0	(	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 473199	0	255, 843	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 381657	0	633, 766	0	0	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0. 264574	0	91, 073	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 260139	0	32, 878	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 195194	0	303, 117	0	0	69. 00
69. 01	06901 CARDI AC REHAB	0. 709543	0	132, 688	0	0	69. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	(	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 059097	0	(	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 540506	0	2, 936, 718	0	0	73. 00
73. 01	07301 ONCOLOGY	1. 269689	0	332, 045	0	0	73. 01
	OUTPATIENT SERVICE COST CENTERS						
	08800 PPI M	0. 000000				0	88. 00
88. 01	08801 FMC	0. 000000				0	88. 01
88. 02	08802 NPFH	0. 000000				0	88. 02
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00	09000 CLI NI C	50. 159544	0	(	0	0	90. 00
	09100 EMERGENCY	0. 380620	0	1, 660, 930	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 568847	0	971, 348	0	0	92.00
200.00	Subtotal (see instructions)		0	20, 154, 172	0	0	200. 00
201.00				(	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	20, 154, 172	2 0	0	202. 00

Health Financial Systems	PUTNAM COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151333	Peri od:	Worksheet D

From 01/01/2015 | Part V To 12/31/2015 | Date/Time Prepared: 3/30/2016 4:36 pm Titl<u>e XVIII</u> Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 692, 003 50.00 51.00 05100 RECOVERY ROOM 70, 712 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 53.00 05300 ANESTHESI OLOGY 109, 598 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 426, 851 54.00 54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 60.954 0 54.01 05700 CT SCAN 0 57.00 142, 377 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 06000 LABORATORY 958, 347 60 00 60 00 60.01 06001 BLOOD LABORATORY 0 60.01 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 06500 RESPIRATORY THERAPY 65.00 121,065 65.00 0 66.00 06600 PHYSI CAL THERAPY 241, 881 66.00 67.00 06700 OCCUPATIONAL THERAPY 24,096 0 67.00 68.00 06800 SPEECH PATHOLOGY 8,553 68.00 69.00 06900 ELECTROCARDI OLOGY 59, 167 0 69.00 06901 CARDI AC REHAB 69.01 0 69.01 94, 148 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 587, 314 0 73.00 73.00 07301 ONCOLOGY 421, 594 0 73.01 73.01 OUTPATIENT SERVICE COST CENTERS 88. 00 08800 PPI M 88.00 88.01 08801 FMC 0 0 88.01 0 0 88.02 08802 NPFH 88.02 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 90.00 09000 CLI NI C 90.00 91 00 09100 EMERGENCY 632, 183 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 552, 548 0 92.00 200.00 Subtotal (see instructions) 6, 203, 391 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

6, 203, 391

0

202.00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	PUTNAM COUNTY HOS	SPI TAL	In Lieu	u of Form CMS-2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 151333	Peri od: From 01/01/2015	Worksheet D Part V

Component CCN: 15Z333 From 01/01/2015 Part V To 12/31/2015 Date/Time Prepared: 3/30/2016 4:36 pm

		Component	. CCN. 132333 1	0 12/31/2013	3/30/2016 4:3	
		Ti tl	e XVIII Si	wing Beds - SNF		
		<u>'</u>	Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	,	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0. 572788	0	0	0	0	
51.00   05100   RECOVERY ROOM	0. 641169	0	0	0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	1. 299908	0	0	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 274764	0	0	0	0	54. 00
54. 01   05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 227962	0	0	0	0	54. 01
57. 00  05700 CT SCAN	0. 033119	0	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. 181465	0	0	0	0	60.00
60. 01   06001   BLOOD   LABORATORY	0. 000000	0	0	0	0	60. 01
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 473199	0	0	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 381657	0	0	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 264574	0	0	0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 260139	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 195194	0	0	0	0	69. 00
69. 01   06901   CARDI AC REHAB	0. 709543	0	0	0	0	69. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN	TS 0. 000000	0	0	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 059097	0	0	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 540506	0	0	0	0	73. 00
73. 01 07301 ONCOLOGY	1. 269689	0	0	0	0	73. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 PPI M	0. 000000				0	88. 00
88. 01 08801 FMC	0. 000000				0	88. 01
88. 02 08802 NPFH	0. 000000				0	88. 02
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00   09000   CLI NI C	50. 159544	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0. 380620	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	T) 0. 568847	0	0	0	0	92. 00
200.00 Subtotal (see instructions)	•	0	0	o	0	200. 00
201.00 Less PBP Clinic Lab. Services-Prog	ram		0	o	1	201. 00
Only Charges					I	
202.00   Net Charges (line 200 +/- line 201	)	0	0	0	0	202. 00

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151333 Period: From 01/01/2015 Part V

Component CCN: 15Z333 To 12/31/2015 Date/Time Prepared:

		Compone	ent CCN: 15Z333	То	12/31/	/2015	Date/Time Pr 3/30/2016 4:	
		Ti	tle XVIII	Swi no	Beds	- SNF		
	Cos	sts						
Cost Center Description	Cost	Cost						
· ·	Rei mbursed	Reimbursed						
	Servi ces	Services No	t					
	Subject To	Subject To						
	Ded. & Coins.	Ded. & Coins	s.					
	(see inst.)	(see inst.)	)					
	6.00	7. 00						
ANCILLARY SERVICE COST CENTERS								
50.00   05000   OPERATING ROOM	0		0					50. 00
51.00   05100   RECOVERY ROOM	0		0					51. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0		0					52. 00
53. 00   05300   ANESTHESI OLOGY	0		o					53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		o					54. 00
54. 01 05401 NUCLEAR MEDICINE-DIAGNOSTIC	0		o					54. 01
57. 00 05700 CT SCAN	0		ol					57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0					58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		o					59. 00
60. 00   06000   LABORATORY	0		o					60.00
60. 01   06001   BLOOD LABORATORY	0		o					60. 01
64. 00   06400   NTRAVENOUS THERAPY	0		o					64. 00
65. 00 06500 RESPIRATORY THERAPY	0		o					65. 00
66. 00   06600   PHYSI CAL THERAPY	0		0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0		o					67. 00
68. 00   06800   SPEECH PATHOLOGY	0		o					68.00
69. 00 06900 ELECTROCARDI OLOGY	0		0					69. 00
69. 01   06901   CARDI AC REHAB	0		o					69. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0					71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0		o					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0					73. 00
73. 01   07301   0NCOLOGY	0	ŀ	0					73. 01
OUTPATIENT SERVICE COST CENTERS			- 01					70.0.
88. 00 08800 PPI M	0		0					88. 00
88. 01   08801   FMC	0	l	0					88. 01
88. 02   08802   NPFH	0	l .	0					88. 02
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0					89. 00
90. 00   09000   CLINI C	0		0					90.00
91. 00   09100   EMERGENCY	0		0					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0					92. 00
200.00 Subtotal (see instructions)			0					200. 00
201.00 Less PBP Clinic Lab. Services-Program			٦					200.00
Only Charges								201.00
202.00 Net Charges (line 200 +/- line 201)	0		0					202. 00
1 1 2 2 3 2 3 2 2 3 2 3 3 3 3 3 3 3 3 3	1	1	1					1

Health Financial Systems	PUTNAM COUNTY HOSPITAL	TNAM COUNTY HOSPITAL In Lieu			
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151333	From 01/01/2015	Worksheet D-1 Date/Time Pre 3/30/2016 4:3		
	Title XVIII	Hospi tal	Cost		
Coot Contan Docorintian					

Description  PART I All FROM/PRIES COMPONENTS    POWER TO All FROM/PRIES COMPONENTS   1.00	-		Title XVIII	Hospi tal	3/30/2016 4: 3 Cost	6 pm
NACT 1 - ALL PROVIDER COMPONENTS		Cost Center Description	i tie xviii	HOSPI tai	COST	
IMPATE INT DAYS		<u> </u>			1. 00	
Impatient days (including private room days and saling-bed days, excluding newborn)						
2.00   Inipatient days (including private room days)	1 00		excluding newborn)		3 237	1 00
do not complete this line. 4. OS Sell-private room days (sectualing swing-bed and observation bed days) 5.00 Total swing-bed SW type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period in the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total Inpatient days (including private room days) after December 31 of the cost reporting period in the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total Inpatient days including private room days applicable to the Program (excluding swing-bed and next reporting period (if calendar year, enter 0 on this line) 8.00 Total Inpatient days including private room days applicable to the Program (excluding private room days) 8.01 Total Inpatient days applicable to it tile XVIII only (including private room days) 8.02 Swing-bed SWF type inpatient days applicable to it tile XVIII only (including private room days) 8.03 Independent and of the cost reporting period (see instruction this line) 9.04 Total swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 9.05 Total swing-bed NF type inpatient days applicable to title SVIII only (including private room days) 9.06 Total swing-bed NF type inpatient days applicable to title SVIII only (including private room days) 9.07 Total swing-bed NF type inpatient days applicable to title SVIII only (including private room days) 9.08 Total swing-bed NF type inpatient days applicable to swing-bed SWF type inpatient days applicable to swing-bed SWF type swing-bed SWF type inpatient days applicable to swing-bed SWF type inpatient days applicable to swing-bed SWF type inpatient days applicable to swing-bed SW						
3.60   Semi-private room days (excluding swing-bed And observation bed days)   1.533   4.00	3.00	Private room days (excluding swing-bed and observation bed days		vate room days,	0	3. 00
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Total swing-bed NF type inpatient days (including private room days) affer December 31 of the cost	6.00	Total swing-bed SNF type inpatient days (including private room	days) after December :	31 of the cost	0	6. 00
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Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   10.00	7.00		days) through December	31 or the cost	21	7.00
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December 31 of the cost reporting period (if cal endar year, enter 0 on this line)   12.00   12.00   12.00   13.00	10.00			Join days)	407	10.00
12. 00 Swing-bed NF type inpatient days applicable to titles \( \text{V or XIX only \( \text{ (including private room days )} \)  13. 00 Swing-bed NF type inpatient days applicable to titles \( \text{V or XIX only \( \text{ (including private room days )} \)  14. 00 Medically necessary private room days applicable to the Program \( \text{ (excluding swing-bed days )} \)  16. 00 Medicall pnecessary private room days applicable to the Program \( \text{ (excluding swing-bed days )} \)  16. 00 Medically necessary private room days applicable to the Program \( \text{ (excluding swing-bed days )} \)  17. 00 Mursery days \( \text{ (title V or XIX only )} \)  18. 00 Mursery days \( \text{ (title V or XIX only )} \)  18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period \( \text{ (reporting period )} \)  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period \( \text{ (Porting Period )} \)  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost \( \text{ (Porting Period )} \)  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost \( \text{ (Porting Period )} \)  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost \( \text{ (Porting Period )} \)  19. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost \( \text{ (Porting Period )} \)  19. 00 Total general inpatient routine service cost (see instructions)  20. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 \( \text{ (Porting Period )} \)  21. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 \( \text{ (Porting Period )} \)  22. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 \(  (Porting Period	11. 00			oom days) after	0	11. 00
through December 31 of the cost reporting period  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  16.00 Novery days (title V or XIX only)  17.00 Total nursery days (title V or XIX only)  18.00 Swing BED ADJUSTMENT  18.00 Mich care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (line day reporting day reporting period (line day reporting reporting day reporting day reporti	10.00			d)		10.00
3. 00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   14. 00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14. 00   0. 15. 00	12.00	through December 31 of the cost reporting period	only (including private	e room days)	0	12.00
14.00   Modically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   15.00	13.00		only (including private	e room days)	0	13. 00
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SWING BED ADJUSTNENT  17.00  18.00  1						
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reporting period  20.00   Redicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00   20.00	10.00		arter becomber or or	the cost		10.00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 7 total general inpatient routine service cost (see instructions) 3, 264,004 21.00 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 24.00 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 568, 361 26.00 Total swing-bed cost (see instructions) 568, 361 26.00 Total swing-bed cost (see instructions) 568, 361 26.00 Total swing-bed cost (see instructions) 568, 361 26.00 PRI VATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 29.00 Pri vate room charges (excluding swing-bed charges) 0 29.00 31.00 Semi-pri vate room charges (excluding swing-bed charges) 0 29.00 31.00 Semi-pri vate room per diem charge (line 29 + line 3) 0.00 32.00 Average per diem private room charge differential (line 27 + line 28) 0.000 32.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 0.00 32.00 33.00 Average per diem private room charge differential (line 34 x line 31) 0.00 35.00 Average per diem private room charge differential (line 34 x line 31) 0.00 35.00 Average per diem private room charge differential (line 34 x line 31) 0.00 35.00 Average per diem private room charge differential (line 37 x line 31) 0.00 35.00 Average per diem private room charge differential (line 37 x line 31) 0.00 35.00 Average per diem private room charge differential (line 37 x line 31) 0.00 35.00 Average per diem private room charg	19. 00		through December 31 of	the cost	0.00	19. 00
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5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 vine 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 25.00 x line 20)  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERNTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  33.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  Private room cost differential adjustment (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			04 6 11			
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ± line 28)  32.00 Average periode private room per diem charge (line 29 ± line 3)  33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 35)  36.00 Private room cost differential dijustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,695,643)  37.00 Average per diem private room cost differential (line 37 x line 35)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22.00		31 or the cost report	ing period (iine	0	22.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 ÷ line 3)  31.00 Average per diem private room per diem charge (line 30 ÷ line 4)  32.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 Private room cost differential adjustment (line 3 x line 35)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23. 00	1	1 of the cost reporting	g period (line 6	0	23. 00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  27.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)					_	
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) 37.00 General inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 910, 39.00 Program general inpatient routine service cost (line 9 x line 38) 910, 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	24.00		31 of the cost reportion	ng period (line	0	24.00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRI VATE ROOM DIFFERNTI AL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 31.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) 32.00 Average per diem private room cost differential (line 3 x line 35) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Average per diem private room cost differential (line 3 x line 35) 35.00 Average per diem private room cost differential (line 3 x line 35) 36.00 Average per diem private room cost differential (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 38.00 Ajusted general inpatient routine service cost per diem (see instructions) 38.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	25. 00		of the cost reporting	period (line 8	0	25. 00
27. 00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   2, 695, 643   27. 00     PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   29. 00     Pri vate room charges (excluding swing-bed charges)   0   29. 00     30. 00   Semi-pri vate room charges (excluding swing-bed charges)   0   30. 00     General inpatient routine service cost/charge ratio (line 27 + line 28)   0. 0000000     31. 00   General inpatient routine service cost/charge ratio (line 27 + line 28)   0. 0000000     32. 00   Average pri vate room per diem charge (line 29 + line 3)   0. 00     33. 00   Average semi-private room per diem charge (line 30 + line 4)   0. 00     33. 00   Average per diem private room charge differential (line 32 minus line 33) (see instructions)   0. 00   34. 00     34. 00   Average per diem private room cost differential (line 34 x line 31)   0. 00   35. 00     35. 00   Average per diem private room cost differential (line 3 x line 35)   0. 36. 00     37. 00   General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643     27 minus line 36)   PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   1,014.93   38. 00     39. 00   Program general inpatient routine service cost (line 9 x line 38)   910, 392   39. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0   40. 00						
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average pri vate room per diem charge (line 29 + line 3)  33. 00 Average semi-pri vate room per diem charge (line 30 + line 4)  34. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem pri vate room cost differential (line 34 x line 31)  36. 00 Pri vate room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 2, 695, 643)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  910, 392 39. 00  40. 00 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35)  0 28. 00  28. 00  29.			ing 21 minus ling 26)			
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.01 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  30.00 Average per diem private room cost applicable to the Program (line 14 x line 35)  30.00 Average per diem private room cost applicable to the Program (line 14 x line 35)	27.00		The 21 millius Title 20)		2, 073, 043	27.00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.0	28. 00		and observation bed ch	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  910, 392  910, 392  910, 392  940.00						
32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 910, 392 900 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,	lino 20)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  37.00 36.00  37.00 27.00  38.00 37.00  39.00 Adjusted general inpatient routine service cost (line 9 x line 38)  910,392 39.00		,	TITIE 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 34.00  36.00 2, 695, 643  37.00  1, 014.93  38.00  910, 392  940.00						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,695,643 37.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 2,695,643 37.00			s line 33)(see instruc	tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 2,695,643 37.00 2,695,643 37.00 2,695,643 37.00 2,695,643 37.00 2,695,643 37.00 2,695,643 37.00 2,695,643 37.00 2,695,643 37.00 2,695,643				,		
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,014.93 38.00 Program general inpatient routine service cost (line 9 x line 38)  910,392 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	36.00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,014.93 38.00  Program general inpatient routine service cost (line 9 x line 38)  910,392 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	37. 00		d private room cost di	fferential (line	2, 695, 643	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,014.93 38.00  Program general inpatient routine service cost (line 9 x line 38)  910,392 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00						
38.00Adjusted general inpatient routine service cost per diem (see instructions)1,014.9338.0039.00Program general inpatient routine service cost (line 9 x line 38)910,39239.0040.00Medically necessary private room cost applicable to the Program (line 14 x line 35)0 40.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 910, 392 39.00 40.00	38. 00				1. 014. 93	38, 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00  Total Program general inpatient routine service cost (line 39 + line 40)   910,392   41.00	40.00				0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		910, 392	41. 00

	Financial Systems	PUTNAM COUNT			In Lie	eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi de	er CCN: 151333	Peri od: From 01/01/2015	Worksheet D-1	
					To 12/31/2015		
			Ti	tle XVIII	Hospi tal	Cost	o piii
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost	Inpatient Day	ysDrem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0		0 0.	00 0	0	42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	1, 608, 607	31	85 4, 178.	20 176	735, 363	43.00
44. 00	CORONARY CARE UNIT	1, 222, 221		.,			44. 00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description			_			
48. 00	Program inpatient ancillary service cost (Wk	s+ D 2 col 2	Line 200)			1. 00 1, 040, 054	48. 00
	Total Program inpatient costs (sum of lines			i ons)		2, 685, 809	1
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,			
50. 00	Pass through costs applicable to Program inp.	atient routine	services (fr	om Wkst. D, su	m of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (	from Wkst. D,	sum of Parts II	0	51.00
	and IV)						
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu-		lated non-n	hvsician anest	hetist and	0 0	
33. 00	medical education costs (line 49 minus line		ratea, non p	nysi er arr ariest	netrat, and		33.00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0	56. 00
57. 00	1	ing cost and ta	rget amount	(line 56 minus	line 53)	0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996.	updated and c	ompounded by the	0.00	
	market basket		-				
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line					0.00	ı
01.00	which operating costs (line 53) are less than						01.00
(2.00	amount (line 56), otherwise enter zero (see	instructions)					(2.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	62. 00 63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST		,				
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of t	he cost report	ing period (See	494, 271	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65. 00
	instructions)(title XVIII only)					404.074	,, ,,
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(TITIE XVI	II only). For	494, 271	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eporting period	0	67. 00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 o	f the cost ren	orting period	0	68. 00
00.00	(line 13 x line 20)	e costs after b	ecember 31 0	Title cost rep	or tring perrou		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil		•		)		70. 00
71. 00	Adjusted general inpatient routine service c	ost per diem (I		•	,		71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 v	lino 2E)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75. 00
76. 00	26, line 45)   Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line	. *					77. 00
	Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp.				nus line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on			,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I		•				82.00
83.00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in		3)				83. 00 84. 00
85.00	Utilization review - physician compensation	(see instructio					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions					1, 123	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			1, 014. 93	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 139, 766	89. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015 Date/Time Pr 3/30/2016 4:		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital -related cost	450, 939	2, 695, 643	0. 16728	1, 139, 766	190, 665	90.00
91.00 Nursing School cost	0	2, 695, 643	0.00000	1, 139, 766	0	91.00
92.00 Allied health cost	0	2, 695, 643	0.00000	1, 139, 766	0	92.00
93.00 All other Medical Education	0	2, 695, 643	0.00000	1, 139, 766	0	93.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 151333	Peri od: From 01/01/2015	Worksheet D-1	
			Date/Time Prep 3/30/2016 4:30	
	Title XIX	Hospi tal	Cost	
Cost Center Description				

Cast Center Description    1,00			Title XIX	Hospi tal	3/30/2016 4: 3	o piii
IRBATILE NAMS   IRBATILE NAME   IRBATILE NAM		Cost Center Description				
IMPATIENT DAYS		DADT I ALL DOOM DED COMPONENTO			1. 00	
Inpatient days (including private room days and swing-bed days, excluding newborn)   3,237   1,00						
2.06 (Inpatient days (Including private room days, excluding swing-bad and neisborn days) 2.666 2.00 2.00 Private room days (excluding swing-bad and observation bed days) 3.00 Private room days (excluding swing-bad and observation bed days) 3.01 Private room days (excluding swing-bad and observation bed days) 3.02 Private room days (excluding swing-bad and observation bed days) 3.03 Private room days (excluding swing-bad and observation bed days) 3.04 Private room days (excluding swing-bad s	1.00		excluding newborn)		3, 237	1. 00
do not complete this line.  4. OS Semi-provider room days (secluding swing-bed and observation bed days)  1. Total swing-bed Wif type inpatient days (including private room days) through December 31 of the cost  7. OD Total swing-bed Wif type inpatient days (including private room days) after December 31 of the cost  7. OD Total swing-bed Wife type inpatient days (including private room days) after December 31 of the cost  7. OD Total swing-bed Wife type inpatient days (including private room days) after December 31 of the cost  8. OD Total swing-bed Wife type inpatient days (including private room days) after December 31 of the cost  8. OD Total swing-bed Wife (including private room days) after December 31 of the cost  7. OD Swing-bed SWI type inpatient days (including private room days) after December 31 of the cost  8. OD Total inputient days including private room days applicable to the Program (excluding swing-bed and inputient days applicable to the Program (excluding private room days)  8. OD Total inputient days applicable to the SWI to observe the Cost Inpution of the Cost Inputient days applicable to the Program (excluding private room days)  9. OD Wife SWING December 31 of the cost reporting period (see instruction)  10. OS Swing-bed Wife type inputient days applicable to thitle Word North (including private room days)  11. OD Swing-bed Wife type inputient days applicable to thitle Word North (including private room days)  12. OD Wife Swing-bed Wife Swing-bed SWI see inputient days applicable to thitle Word North (including private room days)  13. OD Wife Swing-bed Wife Swing-bed SWI see inputient days applicable to the Program (oxcluding swing-bed days)  14. OD Wife Swing-bed Wife Swing-bed SWI services applicable to services through December 31 of the cost reporting period with the Word Wife Swing-bed SWI services applicable to services through December 31 of the cost reporting period with the Word Wife Swing-bed SWI services applicable to services through December 31 of the cost reporting period	2.00	Inpatient days (including private room days, excluding swing-be	d and newborn days)		2, 656	2. 00
5.00   Total swing-hed SRF type inpartient days (including private room days) after December 31 of the cost reporting period regarding perio	3.00		). If you have only pri	vate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7.00 reporting period (if calendar year, enter 0 on this line)  8.01 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.02 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.01 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.02 SNF year inpatient days (and under sapplicable to the Program (excluding swing-bed and nazara days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  11.00 SNF year inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  12.00 SNF year inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 SNF year inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  14.00 Total nursery days (title V or XIX only)  15.00 New Year years (title V or XIX only)  16.00 New Year years (title V or XIX only)  17.00 Total nursery days (title V or XIX only)  18.00 New Year years (title V or XIX only)  18.00 New Year years (title V or XIX only)  18.00 New Year years (title V or XIX only)  18.00 New Year years (title V or XIX only)  18.00 New Year years (title V or XIX only)  18.00 New Year years (title V or XIX only)  18.00 New Year years (title Y or XIX only)  18.00 New Year years (title Y or XIX only)  18.00 New Year years (title Y or XIX only)  18.00 New Year years (title Y or	4 00		daya)		1 522	4 00
reporting period (if calendar year, enter 0 on this line)  7.00 Total swing-hed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  8.00 Total swing-hed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  10.00 Swing-hed SNF type inpatient days applicable to title (if calendar year) and introduced the cost reporting period (if calendar year, enter 0 on this line)  11.00 Swing-hed SNF type inpatient days applicable to title (if calendar year) and introduced the cost reporting period (see instructions)  11.00 Swing-hed SNF type inpatient days applicable to title (if calendar year) and introduced the cost reporting period (see instructions)  12.00 Swing-hed SNF type inpatient days applicable to title (if calendar year) and introduced the cost reporting period (see instructions)  13.00 Swing-hed SNF type inpatient days applicable to title (if calendar year) and introduced the cost reporting period (see instructions)  13.00 Swing-hed SNF type inpatient days applicable to title (if calendar year, enter 0 on this line)  14.00 Medically in occessory private room days applicable to title (if calendar year, enter 0 on this line)  15.00 Instruction of the cost reporting period (if calendar year, enter 0 on this line)  16.00 Norting year (if the cost reporting period (if calendar year, enter 0 on this line)  17.00 Total nursery days (title V or XIX only)  18.00 Norting year (if the cost reporting year)  18.00 Norting year (if year)  18.00 N				31 of the cost		
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reporting period  8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)  10. 00 Suing-bed SMF type Inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SMF type Inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  12. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after 0 becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  13. 00 Swing-bed SMF type inpatient days applicable to titles V or XIX only (including private room days) 1 12. 00 through Becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 1 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 1 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 1 15. 00 10 10 10 nursery days (title V or XIX only) 1 15. 00 10 10 10 nursery days (title V or XIX only) 1 15. 00 10 10 10 nursery days (title V or XIX only) 1 15. 00 10 10 10 nursery days (with year becamber 31 of the cost reporting period 1 10 10 10 10 10 10 10 10 10 10 10 10 1	7.00		da	21 -6 +1+	24	7.00
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newborn days    10.00   50   10.00		reporting period (if calendar year, enter 0 on this line)	3 ,			
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after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14,00   15.00   15	13. 00		only (including private	room days)	0	13. 00
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SWING BED ADJUSTMENT  17.00  18.00  1						
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reporting period  20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 Private room charges (excluding swing-bed charges)  29.00 Private room charges (excluding swing-bed charges)  29.00 Average private room per diem charge (line 29 + line 3)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 32 minus line 35)  30.00 Average per diem private room cost differential (line 32 minus line 33)  30.00 Average per diem private room cost differential (line 32 minus line 35)  30.00 Average per diem private room cost differential (line 32 minus line 35)  30.00 Average p	19. 00		through December 31 of	the cost	0.00	19. 00
reporting period Total general inpatient routine service cost (see instructions) 3, 264, 004 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 3, 264, 004 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions)  Semi-private room charges (excluding swing-bed cost (line 21 minus line 26) Total swing-bed cost (see instructions) Total swing-bed cost (see instruct		reporting period				
21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room period (line 27 + line 28)  30.00 Average semi-private room per diem charge (line 29 + line 3)  30.00 Average per diem private room per diem charge (line 30 + line 4)  34.00 Average per diem private room charge differential (line 3 x line 31)  35.00 Average per diem private room charge differential (line 3 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  37.00 Forgram general inpatient routine service cost per diem (see instructions)  38.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Average per diem private room cost differential (line 3 x line 35)  39.00 Average per diem private room cost differential (line 3 x line 35)  39.00 Average peral inpatient routine service cost per diem (see instructions)  39.00 Average peral inpatient routine service cost per diem (see instructions)  30.00 Senderal inpatient routine service cost per diem (see instructions)  30.00 Average peral inpatient routine service cost per diem (see instructions)  30.00 Average peral inpatient routine service cost per diem (se	20. 00		after December 31 of th	e cost	0.00	20. 00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 Part of the cost reporting period (line 8 cost see instructions)  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32.00 Average private room per diem charge (line 29 + line 3)  32.00 Average semi-private room per diem charge (line 30 + line 4)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 Program general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost to the Program (line 14 x line 35)  39.00 Program general inpatient routine service cost to the Program (line 14 x line 35)  40.00 On 40.00 dedically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 On 40.00	21. 00	1			3, 264, 004	21. 00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charges (line 29 ± line 3)  30.00 Average per vate room per diem charge (line 29 ± line 3)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Private room cost differential djustment (line 3 x line 35)  30.00 Average per diem private room cost differential (line 34 x line 35)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 37 x line 38)  30.00 Average per diem private room cost differential (line 38			31 of the cost reporti	ng period (line		
x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24.00 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 0 25.00 x line 20)  26.00 Total swing-bed cost (see instructions) 568, 361 26.00  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2, 695, 643 27.00  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  29.00 Private room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00  31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 0.000031.00  32.00 Average private room per diem charge (line 29 * line 3) 0.00  33.00 Average semi-private room per diem charge (line 30 * line 4) 0.00  34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 0.00  35.00 Average per diem private room cost differential (line 34 x line 31) 0.00  36.00 Average per diem private room cost differential (line 34 x line 31) 0.00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) 0.00  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) 0.00  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 1014, 93  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 1014, 93  39.00 Program general inpatient routine service cost per diem (see instructions) 1, 1014, 93  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00	00.00	1				00.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  25.00 X line 20)  26.00 Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) O Private room charges (excluding swing-bed charges) O Semi-private room charges (excluding swing-bed charges) O Semi-private room charges (excluding swing-bed charges) O Average perivate room per diem charge (line 29 + line 3) O Average semi-private room per diem charge (line 30 + line 4) O Average per diem private room charge differential (line 32 minus line 33) (see instructions) O Average per diem private room cost differential (line 3 x line 31) O Average per diem private room cost differential (line 3 x line 35) O Average per diem private room cost differential (line 3 x line 35) O Average neral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) O Program general inpatient routine service cost per diem (see instructions) O Program general inpatient routine service cost per diem (see instructions) O Medically necessary private room cost applicable to the Program (line 14 x line 35) O 40.00 O Medically necessary private room cost applicable to the Program (line 14 x line 35) O 40.00	23.00		of the cost reporting	period (iine 6	0	23.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30.00 Average per vate room per diem charge (line 29 ÷ line 3)  30.00 Average per diem private room per diem charge (line 30 ÷ line 4)  30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  30.00 Private room cost differential adjustment (line 3 x line 31)  30.00 Private room cost differential adjustment (line 3 x line 35)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adjusted general inpatient routine service cost per diem (see instructions)  30.00 Adj	24. 00		31 of the cost reportin	g period (line	0	24. 00
x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  37. 00 General inpatient routine service cost per diem (see instructions)  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  568, 361  26. 00  27. 00  28. 00  28. 00  29. 00  29. 00  20. 00  20. 00  20. 00  21. 00  20. 00						
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 31.00 Average semi-private room per diem charge (line 30 + line 4) 32.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 36.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PRART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	25. 00		of the cost reporting	period (line 8	0	25. 00
27. 00   Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   2, 695, 643   27. 00     PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00     General inpatient routine service charges (excluding swing-bed and observation bed charges)   0   28. 00     Private room charges (excluding swing-bed charges)   0   29. 00     30. 00   Semi-private room charges (excluding swing-bed charges)   0   30. 00     31. 00   General inpatient routine service cost/charge ratio (line 27 ± line 28)   0   0.000000   31. 00     32. 00   Average private room per diem charge (line 29 ± line 3)   0   0.00   32. 00     33. 00   Average semi-private room per diem charge (line 30 ± line 4)   0. 00   33. 00     34. 00   Average per diem private room charge differential (line 32 minus line 33) (see instructions)   0. 00   34. 00     35. 00   Average per diem private room cost differential (line 34 x line 31)   0. 00   35. 00     36. 00   Private room cost differential adjustment (line 3 x line 35)   0   36. 00     37. 00   General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643     27 minus line 36)   PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   1,014. 93   38. 00     39. 00   Program general inpatient routine service cost (line 9 x line 38)   32,478   39. 00     40. 00   Medically necessary private room cost applicable to the Program (line 14 x line 35)   0   40. 00	26. 00	1			568. 361	26. 00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 27 + line 28)  30.00 Average private room per diem charge (line 29 + line 3)  30.00 Average semi-private room per diem charge (line 30 + line 4)  30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  38.00 Adj usted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  30.00 Augusted general inpatient routine service cost (line 9 x line 38)  30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)			ne 21 minus line 26)			
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 30.00 30.00 30.00 30.00 31.00 0.00 32.00 0.00 32		PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		`		
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.000000000000000000000000000000000			and observation bed cha	rges)		
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi -private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  37.00 PART II - HOSPI TAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 00000000000000000000000000000000						
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  79.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			ine 28)			
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 34.00  37.00 35.00  37.00 36.00  37.00 37.00  38.00 37.00						
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 .00 35.00 26.00 37.00			1: 00) (			
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,695,643 and 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  79.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  36.00 2,695,643 37.00 37.0				ions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 695, 643 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  79.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37.00 2, 695, 643 37.00 37.00 37.00 37.00			31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		,	d private room cost dif	ferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,014.93 38.00  Program general inpatient routine service cost (line 9 x line 38)  22,478 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00		27 minus line 36)		•		
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,014.93 38.00  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  1,014.93 38.00  32,478 39.00  40.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 32,478 39.00 40.00	38 00				1 014 03	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		, , , , , , , , , , , , , , , , , , , ,	•			
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   32,478   41.00		, ,	•		0	40.00
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		32, 478	41. 00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi de	er CCN: 151333	Peri od: From 01/01/2015	Worksheet D-1	
					To 12/31/2015		
				itle XIX	Hospi tal	Cost	<u> </u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Da	Average Per ysDiem (col. 1	Program Days	Program Cost	
		•		col . 2)		4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	0 0.0	4.00	5. 00	42. 00
40.00	Intensive Care Type Inpatient Hospital Units	4 (00 (07	0	05 4 470 6			40.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 608, 607	3	85 4, 178. 2	0	0	43. 00 44. 00
	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					34, 173	48. 00
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	1 through 48)(	see instruct	i ons)		66, 651	49. 00
50.00	Pass through costs applicable to Program inpa	ntient routine	servi ces (fr	om Wkst. D, sum	of Parts I and	0	50. 00
51. 00	III) Pass through costs applicable to Program inpa	ntient ancillar	v services (	from Wkst D s	um of Parts II	0	51.00
	and IV)		) 55. 1. 555 (		a 01 . a. to		
52. 00 53. 00	Total Program excludable cost (sum of lines 5 Total Program inpatient operating cost exclud		lated, non-p	hvsician anesth	etist, and	0	52. 00 53. 00
	medical education costs (line 49 minus line 5						
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55.00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and ta	rget amount	(line 56 minus	line 53)	0	
58.00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	porting period	ending 1996,	updated and co	impounded by the	0.00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than	expected cost					01.00
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of t	he cost reporti	ng period (See	0	64. 00
4E 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	· ·		•		0	65. 00
65. 00	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	costs through	December 31	of the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19)  Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 o	of the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20)  Total title V or XIX swing-bed NF inpatient r	outine costs (	line 67 + li	ne 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY	, AND ICF/II	D ONLY			70.00
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	,		, ,			70. 00 71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applications)		(line 14 v	lino 2E)			72. 00 73. 00
74.00	Total Program general inpatient routine servi						74.00
75. 00	Capital-related cost allocated to inpatient r 26, line 45)	routine service	costs (from	Worksheet B, P	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lir	,					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	costs (from p					79. 00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		ost limitati	on (line 78 min	us line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (li	ne 9 x line 81	•				82. 00
83. 00 84. 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		s)				83. 00 84. 00
85.00	Utilization review - physician compensation (	see instructio					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				86. 00
87. 00	Total observation bed days (see instructions)		line 2)			1, 123	1
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•	iine 2)			1, 014. 93 1, 139, 766	1
		-,					•

Health Financial Systems	PUTNAM COUNT	Y HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 3/30/2016 4:30	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	450, 939	2, 695, 643	0. 16728	4 1, 139, 766	190, 665	90.00
91.00 Nursing School cost	0	2, 695, 643	0.00000	0 1, 139, 766	0	91.00
92.00 Allied health cost	0	2, 695, 643	0.00000	0 1, 139, 766	0	92.00
93.00 All other Medical Education	0	2, 695, 643	0. 00000	1, 139, 766	0	93. 00

Health Financial Systems	PUTNAM COUNTY HOSI	PI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der	CCN: 151333	Peri od: From 01/01/2015	Worksheet D-3	
					Date/Time Pre 3/30/2016 4:3	
		Title	e XVIII	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	The state of the s	Inpatient	

				Γο 12/31/2015	Date/Time Pre 3/30/2016 4:3	
		Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS			705, 333		30. 00
31. 00	03100 I NTENSI VE CARE UNI T			280, 735		31.00
41. 00	04100 SUBPROVI DER - I RF			0		41.00
42.00	04200 SUBPROVI DER			0		42.00
43. 00	04300 NURSERY					43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS  05000 OPERATI NG ROOM		0. 57278	377, 808	216, 404	50.00
51. 00	05100 RECOVERY ROOM		0. 64116			1
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0.00000			1
53. 00	05300 ANESTHESI OLOGY		1. 29990			1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 27476			1
54. 01	05401 NUCLEAR MEDICINE-DI AGNOSTI C		0. 22796			1
57. 00	05700 CT SCAN		0. 03311			
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000			1
59.00	05900 CARDI AC CATHETERI ZATI ON		0. 000000	0	0	59. 00
60.00	06000 LABORATORY		0. 18146		121, 808	60.00
60. 01	06001 BLOOD LABORATORY		0.00000	0	0	60. 01
64. 00	06400 I NTRAVENOUS THERAPY		0. 000000	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY		0. 47319			1
66. 00	06600 PHYSI CAL THERAPY		0. 38165			1
67. 00	06700 OCCUPATI ONAL THERAPY		0. 26457	·		
68. 00	06800 SPEECH PATHOLOGY		0. 26013			
69. 00	06900 ELECTROCARDI OLOGY		0. 19519			1
69. 01	06901 CARDI AC REHAB		0. 70954			
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.000000		1	
72. 00 73. 00	07200   IMPL. DEV. CHARGED TO PATIENT   07300   DRUGS CHARGED TO PATIENTS		0. 05909		1	
	07301 ONCOLOGY		0. 54050 1. 26968			1
73.01	OUTPATIENT SERVICE COST CENTERS		1.20900	7 707	1,002	73.01
88. 00	08800 PPI M		0.00000	)	0	88. 00
88. 01	08801 FMC		0. 000000		0	
88. 02	08802 NPFH		0. 000000		0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 000000		l o	89. 00
90.00	09000 CLINIC		50. 15954		1	1
91.00	09100 EMERGENCY		0. 380620		3, 392	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 56884		0	1
200.00	Total (sum of lines 50-94 and 96-98)			2, 852, 900	1, 040, 054	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)			2, 852, 900		202. 00

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 151333 F	Period: Worksheet D-3

From 01/01/2015 To 12/31/2015 Component CCN: 15Z333 Date/Time Prepared: 3/30/2016 4:36 pm Title XVIII Swing Beds - SNF Cost Inpatient Inpati ent Cost Center Description Ratio of Cost To Charges Program Costs Program (col. 1 x col Charges 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 0 30.00 30.00 03100 INTENSIVE CARE UNIT 31.00 31 00 41.00 04100 SUBPROVI DER - I RF 0 41.00 04200 SUBPROVI DER o 42.00 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.572788 50.00 51.00 05100 RECOVERY ROOM 0.641169 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 0 52.00 Λ 53.00 05300 ANESTHESI OLOGY 1. 299908 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 274764 19, 828 5, 448 54.00 54.01 05401 NUCLEAR MEDICINE-DIAGNOSTIC 0. 227962 54.01 0 05700 CT SCAN 57.00 57.00 0.033119 14, 198 470 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0.000000 0 58.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 0 59.00 06000 LABORATORY 60 00 0 181465 109, 675 19 902 60 00 60.01 06001 BLOOD LABORATORY 0.000000 Λ 60.01 64.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 0 06500 RESPIRATORY THERAPY 65.00 0.473199 161, 030 76, 199 65.00 06600 PHYSI CAL THERAPY 64, 655 66.00 0.381657 169, 406 66 00 67.00 06700 OCCUPATIONAL THERAPY 0.264574 101, 319 26,806 67.00 06800 SPEECH PATHOLOGY 68.00 0.260139 11, 583 3, 013 68.00 1, 647 69 00 06900 ELECTROCARDI OLOGY 0.195194 321 69 00 69.01 06901 CARDI AC REHAB 0.709543 0 0 69.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENT 72.00 0.059097 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0.540506 228, 589 123, 554 73 00 73.01 07301 ONCOLOGY 1.269689 888 73.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 PPI M 0.000000 0 88.00 08801 FMC 88.01 0.000000 88.01 0 88.02 08802 NPFH 0.000000 0 88.02 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 89.00 90.00 09000 CLI NI C 50. 159544 90.00 0 09100 EMERGENCY 0.380620 91.00 91.00 583 222 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.568847 0 92.00

818, 557

818, 557

321, 478 200. 00

201. 00

202. 00

200.00

201.00

202.00

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

Net Charges (line 200 minus line 201)

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

Health Financial Systems	PUTNAM COUNTY HOS	SPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der		Period: From 01/01/2015	Worksheet D-3	
					Date/Time Pre 3/30/2016 4:3	pared: 6 pm
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description			Ratio of Cos	t Inpatient	Inpati ent	
·			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				ŭ	2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS				23, 688		30.00
31 OO O3100 INTENSIVE CAPE UNIT				21 640		21 00

	Cost Center Description	Ratio of Cost	Inpati ent	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1		1	
30. 00	03000 ADULTS & PEDI ATRI CS		23, 688		30. 00
31. 00	03100 INTENSIVE CARE UNIT		21, 640		31. 00
41. 00	04100 SUBPROVI DER - I RF		0		41. 00
42.00	04200 SUBPROVI DER		0		42. 00
43.00	04300 NURSERY		0		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	O5000  OPERATI NG ROOM	0. 572788	7, 563	4, 332	50.00
51.00	05100  RECOVERY ROOM	0. 641169	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESI OLOGY	1. 299908	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 274764	5, 906	1, 623	54.00
54. 01	05401 NUCLEAR MEDICINE-DIAGNOSTIC	0. 227962	. 0	0	54. 01
57. 00	05700 CT SCAN	0. 033119	36, 343	1, 204	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0	1	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	Ö	59. 00
60.00	06000 LABORATORY	0. 181465	32, 312	5, 863	
60. 01	06001 BLOOD LABORATORY	0. 000000	02, 012	0,000	60. 01
64. 00	06400 I NTRAVENOUS THERAPY	0.000000	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 473199	3, 043	_	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 473144	1, 170		66. 00
			•		
67. 00	06700 OCCUPATI ONAL THERAPY	0. 264574	994		67. 00
68.00	06800 SPEECH PATHOLOGY	0. 260139	0.045	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 195194	8, 345		69. 00
69. 01	06901 CARDI AC REHAB	0. 709543	0	0	69. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	0. 059097	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 540506	22, 644	l	73. 00
73. 01	07301 ONCOLOGY	1. 269689	0	0	73. 01
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 PPI M	0. 986932	0	0	88. 00
88. 01	08801 FMC	0. 902848	0	0	88. 01
88. 02	08802  NPFH	1. 565571	0	0	88. 02
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89. 00
90.00	09000 CLI NI C	50. 159544	0	0	90.00
91.00	09100 EMERGENCY	0. 380620	13, 485	5, 133	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 568847	0	0	92.00
200.00			131, 805	34, 173	
201.00			0		201. 00
202.00			131, 805		202. 00
	1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	, 000	1	

Health Financial Systems	PUTNAM COUNTY HOSPITAL	AL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Prov		From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 3/30/2016 4:36 pm
-		T' 11 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		

			10 12/31/2015	3/30/2016 4:3	pared: 6 nm
		Title XVIII	Hospi tal	Cost	о ріп
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			6, 203, 391	
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	
3.00	PPS payments		0		
4.00	Outlier payment (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	1
6.00	Line 2 times line 5			0	
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	1
8.00	Transitional corridor payment (see instructions)	/! 12 !: 200		0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	7, COL. 13, TINE 200		0	
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			_	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			6, 203, 391	111.00
	Reasonable charges				1
12. 00	Ancillary service charges			0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ne 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	ic 07)		0	
14.00	Customary charges				14.00
15. 00	Aggregate amount actually collected from patients liable for pa	nyment for services on	a charge basis	0	15.00
16. 00	Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)		ir a chargebasis		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.00
18. 00	Total customary charges (see instructions)			0	1
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	
	instructions)		, ,		
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		6, 265, 425	21.00
22. 00	Interns and residents (see instructions)			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			41, 867	1
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			3, 020, 184	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23] (see	3, 203, 374	27. 00
00.00	instructions)	50)			00.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ie 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			3, 203, 374	1
31.00	Primary payer payments			584	1
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	·c)		3, 202, 790	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	.3)		0	33. 00
34. 00	Allowable bad debts (see instructions)			468, 406	1
35. 00	Adjusted reimbursable bad debts (see instructions)			304, 464	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		418, 938	1
37. 00		ictions)		3, 507, 254	
	MSP-LCC reconciliation amount from PS&R			3, 507, 254	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 00 39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 30	Partial or full credits received from manufacturers for replace		tions)	0	
	·	ed devices (see institut	tions)		
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00	Subtotal (see instructions)			3, 507, 254 70, 145	1
40. 01					
41.00					41.00
42.00	,			140.970	•
43.00	Balance due provider/program (see instructions)	on with CMS Dub 15 2	chantar 1	-160, 870	1
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	cnapter I,	0	44.00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				1
90. 00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.00
74. UU	Tiotal (Sail Of Titles 71 and 73)			1	74.00

Health Financial Systems PUTANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 151333

					3/30/2016 4: 36	5 pm
			e XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		2, 437, 080		3, 597, 979	1. 00
2.00	Interim payments payable on individual bills, either		(	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(		0	3. 01
3. 02			Ċ		0	3. 02
3. 03				)	l ol	3. 03
3.04			Ċ		0	3. 04
3.05					0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(	)	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		(	)	0	3. 99
4 00	3. 50-3. 98)		2 427 000		2 507 070	4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		2, 437, 080	,	3, 597, 979	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
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5. 02			(		0	5. 02
5. 03			(	)	0	5. 03
F F0	Provi der to Program					F F0
5. 50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51 5. 52					0	5. 51 5. 52
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 52 5. 99
3. 77	5. 50-5. 98)			,	ا	5. 77
6.00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		(		o	6. 01
6. 02	SETTLEMENT TO PROGRAM		34, 179	p	160, 870	6. 02
7.00	Total Medicare program liability (see instructions)		2, 402, 901		3, 437, 109	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00		(	)	1. 00	2. 00	0.00
8.00	Name of Contractor					8. 00

		'			3/30/2016 4: 3	6 pm
				Swing Beds - SNF		
		Inpatier	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		812, 54	1	0	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,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)		<u> </u>			
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER		1	0		3. 01
3. 02			1	0		3. 02
3. 03			1	0		3. 03
3. 05			l	o		3. 05
5.05	Provider to Program			<u> </u>		3.03
3.50	ADJUSTMENTS TO PROGRAM			o	0	3. 50
3. 51			1	o	Ö	3. 51
3. 52				O	0	3. 52
3.53				O	0	3. 53
3.54				О	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)		812, 54	1	0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		I			5. 00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		1			
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02			1	Ö	Ö	5. 02
5.03				O	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51			l .	0	0	5. 51
5.52			1	0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					, 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER			0	0	6. 01
6. 01	SETTLEMENT TO PROVIDER		13, 75	~	0	6. 02
7. 00	Total Medicare program liability (see instructions)		798, 78			
7.00	Total medicale program frability (see Histructions)		170,70	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	· '			•		

Health Financial Systems PUTNAM COUNTY HOSPITAL In Lieu of Fo				u of Form CMS-2	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 151333   Period:   Worksheet   From 01/01/2015   Part II				
			To 12/31/2015	Date/Time Prep	
				3/30/2016 4:36	5 pm
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST RI				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CA				
1. 00	Total hospital discharges as defined in AARA §4102 f		14	673	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of I			1, 073 13	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 I			1, 918	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 li	ne 200		71, 458, 015	5. 00
6.00	Total hospital charity care charges from Wkst. S-10,	col. 3 line 20		1, 217, 798	6.00
7.00	CAH only - The reasonable cost incurred for the purc	hase of certified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instru	ctions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10.00	Calculation of the HIT incentive payment after seque	stration (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instruct	i ons)		0	30.00
31.00	Other Adjustment (specify)			0	31.00
	Balance due provider (line 8 (or line 10) minus line	30 and line 31) (see instruction	s)	0	32.00

Health Financial Systems	PUTNAM COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 151333		Worksheet E-2
			From 01/01/2015	
		Component CCN: 15Z333	To 12/31/2015	Date/Time Prepared:
		•		3/30/2016 4:36 pm
				_

		·		3/30/2016 4:3	6 pm
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		499, 214	0	
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A		324, 693	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see insti				
4.00	Per diem cost for interns and residents not in approved teaching	g program (see		0.00	4.00
	instructions)				
5.00	Program days		487	0	5.00
6.00	Interns and residents not in approved teaching program (see ins			0	6.00
7.00	Utilization review - physician compensation - SNF optional metho	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		823, 907	0	8.00
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		823, 907	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applical	ole to physician	0	0	11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		823, 907	0	12. 00
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	8, 820	0	13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	)	815, 087	0	15. 00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	1
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)	0	0	18. 00
19.00	Total (see instructions)		815, 087	0	19. 00
19. 01	Sequestration adjustment (see instructions)		16, 302	0	19. 01
	Interim payments		812, 541	0	20.00
	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, and	d 21)	-13, 756	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance chapter 1, §115.2	e with CMS Pub. 15-2,	0	0	23. 00

Health Financial Systems	nancial Systems PUTNAM COUNTY HOSPITAL In Lieu		u of Form CMS-2	2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151333	From 01/01/2015	Worksheet E-3 Part V Date/Time Prep 3/30/2016 4:30	pared:
		Title XVIII	Hospi tal	Cost	
				1 00	

				3/30/2016 4:30	6 pm
		Title XVIII	Hospi tal	Cost	
	<u> </u>				
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR V - CALCULA	ADT A SERVICES - COST	DELMBLIDSEMENT	1.00	
1.00	Inpatient services	ANT A SERVICES - COST	KLIWDONSLWLNI	2, 685, 809	1. 00
		-)			
2.00	Nursing and Allied Health Managed Care payment (see instruction	5)		0	2.00
3.00	Organ acqui si ti on			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			2, 685, 809	
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 712, 667	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7.00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	
9. 00	Organ acquisition charges, net of revenue			0	
10. 00	Total reasonable charges			0	
10.00	Customary charges			U	10.00
11 00			b	0	11 00
11. 00	Aggregate amount actually collected from patients liable for pa				11.00
12. 00	Amounts that would have been realized from patients liable for	payment for services o	n 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	13. 00
14.00	Total customary charges (see instructions)			0	14.00
15.00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)				
16.00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
	instructions)		, ,		
17. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	,		-	
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	11110 47)		2, 712, 667	
20. 00	Deductibles (exclude professional component)				
				317, 260	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			2, 395, 407	
23. 00	Coinsurance			0	
24. 00	Subtotal (line 22 minus line 23)			2, 395, 407	
25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		86, 974	25. 00
26.00	Adjusted reimbursable bad debts (see instructions)			56, 533	26. 00
27.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		22, 932	27. 00
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	ŕ		2, 451, 940	28. 00
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Recovery of Accelerated Depreciation			0	
				-	
30.00	Subtotal (see instructions)			2, 451, 940	
30. 01	Sequestration adjustment (see instructions)			49, 039	
31. 00	Interim payments			2, 437, 080	
32. 00	Tentative settlement (for contractor use only)			0	32. 00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, an			-34, 179	
34.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	34. 00
	§115. 2				

Health Financial Systems	PUTNAM COUNTY HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151333	From 01/01/2015	Worksheet E-3 Part VII Date/Time Prepared: 3/30/2016 4:36 pm

			10 12/31/2015	3/30/2016 4:3	
		Title XIX	Hospi tal	Cost	
			Inpati ent	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		66, 651		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		66, 651	0	4.00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		66, 651	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		131, 805	0	
10. 00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0	_	11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		131, 805	0	12. 00
40.00	CUSTOMARY CHARGES	<u>.</u>	40.000		40.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	40, 929	0	13. 00
14. 00	basis	normant for compless on	0	0	14. 00
14.00	Amounts that would have been realized from patients liable for a charge basis had such payment been made in accordance with 42		0	Ü	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	CIR 9413. 13(e)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)		131, 805	0.000000	
17. 00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	65, 154	0	
17.00	line 4) (see instructions)	TT TTHE TO EXCEEDED	00, 101	· ·	17.00
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	0	0	18. 00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instru	ctions)	0	0	20. 00
21.00	Cost of covered services (enter the lesser of line 4 or line 16	)	66, 651	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be c	ompleted for PPS provid	ers.		
22. 00	Other than outlier payments		0	0	22. 00
	Outlier payments		0	0	
24. 00	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
	Routine and Ancillary service other pass through costs		0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
29. 00			66, 651	0	29. 00
20.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	20.00
30. 00 31. 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 6) Deductibles		66, 651 0	0	
33. 00			0	0	
	Allowable bad debts (see instructions)		0	0	
35. 00	Utilization review		0	Ü	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	66, 651	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)	00, 031	0	
	Subtotal (line 36 ± line 37)		66, 651	0	
	Direct graduate medical education payments (from Wkst. E-4)		00, 001	O	39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		66, 651	0	
41. 00			68, 453	0	
42. 00	Balance due provider/program (line 40 minus line 41)		-1, 802	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2,	0	0	1
	chapter 1, §115.2	•			
			•		-

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

Provi der CCN: 151333 Peri od: Worksheet G From 01/01/2015 To 12/31/2015 Date/Time Prepared:

			'	0 12/31/2013	3/30/2016 4: 3	
		General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	AUDDENT ASSETS	1.00	2.00	3. 00	4. 00	
1 00	CURRENT ASSETS	7 442 020	ı c	O	0	1 1 00
1. 00 2. 00	Cash on hand in banks Temporary investments	7, 443, 039	1			1. 00 2. 00
3.00	Notes recei vabl e		-		0	ł
4. 00	Accounts receivable	11, 621, 654		0	l o	4. 00
5. 00	Other recei vable	2, 064, 932	l .	0	Ö	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-5, 894, 510	o c	0	0	6. 00
7.00	Inventory	1, 057, 763	C	0	0	7. 00
8.00	Prepai d expenses	239, 740	1	0	0	
9.00	Other current assets	0		0	0	
10.00	Due from other funds	1/ 522 /10	0		0	1
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	16, 532, 618	C	0	0	11. 00
12. 00	Land	457, 767	0	O	0	12. 00
13. 00	Land improvements	437, 707			Ö	13. 00
14. 00	Accumulated depreciation	-242, 304	-		Ö	14. 00
15. 00	Bui I di ngs	29, 389, 370	C	0	0	15. 00
16.00	Accumulated depreciation	-19, 722, 312	c c	0	0	16. 00
17. 00	Leasehold improvements	0	C	0	0	
18. 00	Accumulated depreciation	0	C	-	0	•
19.00	Fixed equipment	0	C	١	0	19. 00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	0		0	0	20. 00 21. 00
21.00	Accumulated depreciation			0		21.00
23. 00	Major movable equipment	21, 280, 016		0	Ö	23. 00
24. 00	Accumul ated depreciation	-16, 807, 953	l .	O	Ö	24. 00
25.00	Mi nor equi pment depreci abl e	0	o c	0	0	25. 00
26.00	Accumulated depreciation	0	o c	0	0	26. 00
27. 00	HIT designated Assets	0	C	0	0	27. 00
28. 00	Accumulated depreciation	0	C		0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	O C		0	29. 00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	14, 354, 584	<u> </u>	0	0	30. 00
31. 00	Investments	49, 593	C	O	0	31. 00
32. 00	Deposits on Leases	17,070	1		l o	
33. 00	Due from owners/officers	0	d	0	0	•
34.00	Other assets	188, 468	c c	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	238, 061	1		0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	31, 125, 263	C	0	0	36. 00
07.00	CURRENT LI ABI LI TI ES	0.400.000	ı			07.00
37. 00	Accounts payable Salaries, wages, and fees payable	2, 198, 089	1		0	37. 00 38. 00
38. 00 39. 00	Payroll taxes payable	44, 254 118, 965	1	0		•
40. 00	Notes and Loans payable (short term)	2, 976, 538	1	0		
41. 00	Deferred income	0	i c	0	Ö	
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	C		0	
	Other current liabilities	553, 229			-	
45. 00	Total current liabilities (sum of lines 37 thru 44)	5, 891, 075	C	0	0	45. 00
46 00	LONG TERM LIABILITIES	1 0	C	O	0	46. 00
46. 00 47. 00	Mortgage payable Notes payable	10, 522, 558	l .			
48. 00	Unsecured Loans	10, 322, 330	1			ł
49. 00	Other long term liabilities	0	d		Ö	
50.00	Total long term liabilities (sum of lines 46 thru 49	10, 522, 558	C	0	0	50. 00
51.00	Total liabilites (sum of lines 45 and 50)	16, 413, 633	C	0	0	51.00
	CAPITAL ACCOUNTS					
52. 00	General fund balance	14, 711, 630	l .			52. 00
53.00	Specific purpose fund		C	0		53. 00 54. 00
54. 00 55. 00	Donor created - endowment fund balance - restricted  Donor created - endowment fund balance - unrestricted			0		55.00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant				0	•
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	14, 711, 630	l .		0	ł
60. 00	Total liabilities and fund balances (sum of lines 51 and	31, 125, 263	C	0	0	60. 00
	[59]	I	I	1	ı .	I

PUTNAM COUNTY HOSPITAL

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					To 12/31/2015	Date/Time Pre 3/30/2016 4:3	
		Genera	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3. 00	4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	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	11, 273, 337 3, 438, 293 14, 711, 630		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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 14, 711, 630		0 0	0	8. 00 9. 00 10. 00 11. 00
12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Deductions (debit adjustments) (specify)	0 0 0 0 0			0 0 0 0 0	0 0 0 0 0	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 14, 711, 630		0		18. 00 19. 00
		Endowment Fund	PI ant	Fund	_		
		6.00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 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		1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0	0 0 0 0		0 0		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	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		12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

			To 12/31/2015	Date/Time Pre 3/30/2016 4:3	
	Cost Center Description	Inpati ent	Outpati ent	Total	O pili
	0000 00000 00000 00000	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	1, 337, 04	9	1, 337, 049	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF		0	0	3. 00
4.00	SUBPROVI DER	1	0	0	4. 00
5.00	Swing bed - SNF	264, 80	7	264, 807	5. 00
6.00	Swing bed - NF	1	0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8.00
9. 00 10. 00	OTHER LONG TERM CARE Total general inpatient care services (sum of lines 1-9)	1, 601, 85	4	1, 601, 856	9. 00 10. 00
10.00	Intensive Care Type Inpatient Hospital Services	1,001,00	o <sub>l</sub>	1, 001, 630	10.00
11. 00	INTENSIVE CARE UNIT	2, 632, 84	5	2, 632, 845	11. 00
12. 00	CORONARY CARE UNIT	2,002,01		2,002,010	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	2, 632, 84	5	2, 632, 845	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	4, 234, 70		4, 234, 701	
18. 00	Ancillary services	5, 779, 65		56, 688, 367	1
19. 00	Outpati ent servi ces	136, 13		10, 040, 122	19. 00
20. 00	PPIM		0 1, 565, 551	1, 565, 551	1
20. 01	FMC		0 1, 430, 197	1, 430, 197	20. 01
20. 02	NPFH		0 423, 487	423, 487	20. 02
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	'	0 0	0	21.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULANCE SERVICES				22. 00 23. 00
24. 00	CMHC				24. 00
24. 00	CORF		0	0	24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )	1		O	25. 00
26. 00	HOSPI CE				26.00
27. 00	PHYSICIAN PRIVATE OFFICES		0 4, 046, 280	4, 046, 280	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	10, 150, 48		78, 428, 705	•
	G-3, line 1)				
	PART II - OPERATING EXPENSES	_			
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		34, 595, 953		29. 00
30. 00	ADD (SPECIFY)	1	0		30. 00
31.00		1	0		31. 00
32.00		1	0		32. 00
33. 00		1	0		33.00
34. 00		1	0		34.00
35. 00 36. 00	Total additions (sum of Lines 20 25)	'	0		35. 00 36. 00
36.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)				37.00
38. 00	DEDUCT (SPECITI)		0		38.00
39. 00			0		39.00
40. 00		1	0		40. 00
41. 00			o l		41. 00
42. 00	Total deductions (sum of lines 37-41)		0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		34, 595, 953		43. 00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems PUTNAM COUNTY HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provi der CCN: 151333	Peri od:	Worksheet G-3	
			From 01/01/2015 To 12/31/2015	Date/Time Prep 3/30/2016 4:30	
4 00	T	00)		1.00	1 00
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			78, 428, 705	1.00
2.00	Less contractual allowances and discounts on patients' accounts			47, 361, 300	2.00
3.00	Net patient revenues (line 1 minus line 2)	`		31, 067, 405	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	)		34, 595, 953	4. 00
5.00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			-3, 528, 548	5. 00
6. 00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8. 00	Revenues from telephone and other miscellaneous communication s	arvi cas		0	8. 00
9. 00	Revenue from television and radio service	ei vi ces		0	9. 00
10. 00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			ő	11. 00
12. 00	Parking lot receipts			ő	12. 00
13. 00				ő	13. 00
	Revenue from meals sold to employees and guests			ő	14. 00
	Revenue from rental of living quarters			ő	15. 00
	Revenue from sale of medical and surgical supplies to other tha	n patients		ol	16. 00
	Revenue from sale of drugs to other than patients	p=		0	17. 00
	Revenue from sale of medical records and abstracts			0	18. 00
	Tuition (fees, sale of textbooks, uniforms, etc.)			o	19. 00
20. 00				o	20.00
21. 00				0	21. 00
22. 00				0	22.00
23. 00	1			o	23.00
24.00				6, 966, 841	24.00
25. 00				6, 966, 841	25. 00
26. 00	Total (line 5 plus line 25)			3, 438, 293	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			3, 438, 293	29. 00

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE			CCN: 151333	Peri od:	Worksheet M-1	
HEALTH	I CENTER COSTS		Component		From 01/01/2015 To 12/31/2015	Date/Time Pre 3/30/2016 4:3	
					Rural Health Clinic (RHC) I	Cost	
		Compensation	Other Costs	Total (col.	1 Reclassificati	Reclassi fied	
		·		+ col. 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	342, 418	0	342, 41	8 0	342, 418	1.00
2.00	Physician Assistant	0	0		0	0	2.00
3.00	Nurse Practitioner	167, 454	0	167, 45	0	167, 454	3. 00
4.00	Visiting Nurse	0	0		0	0	4. 00
5.00	Other Nurse	146, 661	0	146, 66	0 0	146, 661	5. 00
6.00	Clinical Psychologist	0	0		0 0	0	6. 00
7.00	Clinical Social Worker	0	0		0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	656, 533	0	656, 53	0	656, 533	10.00
11.00	Physician Services Under Agreement	0	0		0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0		0	0	12.00
13.00	Other Costs Under Agreement	0	0		0	0	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	0		0	0	14.00
15.00	Medical Supplies	0	0		0	0	15.00
16.00	Transportation (Health Care Staff)	0	0		0	0	16.00
17.00	Depreciation-Medical Equipment	0	0		0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	19.00
20.00	Allowable GME Costs	0	0		0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	0		0	0	21.00
22. 00	Total Cost of Health Care Services (sum of	656, 533	0	656, 53	0	656, 533	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICS						
23.00	Pharmacy	0	0		0	0	23. 00
24. 00	Dental	0	0		0	0	24.00
25. 00	Optometry	0	0		0	0	25. 00
26. 00	All other nonreimbursable costs	0	0		0	0	26. 00
27. 00	Nonallowable GME costs	0	0		0	0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28. 00
	through 27)						ļ
	FACILITY OVERHEAD						
29. 00	1	0	0		0	0	29. 00
30. 00		135, 526					
21 00	Total Facility Overhead (sum of lines 20 and	135 526	262 /15	207 0/	1 _9/ 723	212 210	1 21 00

135, 526

792, 059

262, 415

262, 415

31.00

32.00

313, 218

969, 751

-84, 723

-84, 723

397, 941

1, 054, 474

31.00 Total Facility Overhead (sum of lines 29 and 30)
32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	PUTNAM COUNTY HOS	SPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL HEALTH CENTER COSTS	ALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 151333	Peri od: From 01/01/2015	Worksheet M-1
HEALTH GENTER COSTS		Component CCN: 158515		
			Rural Health	Cost

				Clinic (RHC) I	
		Adjustments	Net Expenses	STATE (INTO) I	
			for Allocation		
			(col. 5 + col.		
			6)		
		6. 00	7.00	1	
	FACILITY HEALTH CARE STAFF COSTS				
1.00	Physi ci an	0	342, 418	3	1.00
2.00	Physici an Assistant	0	. 0		2. 00
3.00	Nurse Practitioner	0	167, 454		3. 00
4.00	Visiting Nurse	0	0		4. 00
5.00	Other Nurse	0	146, 661		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	Ö		9. 00
10. 00	Subtotal (sum of lines 1 through 9)	0	656, 533	1	10.00
11. 00	Physician Services Under Agreement	0	030, 333		11.00
12. 00	Physician Supervision Under Agreement	0	Ö	l e e e e e e e e e e e e e e e e e e e	12. 00
13. 00	Other Costs Under Agreement	0	0	l e e e e e e e e e e e e e e e e e e e	13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	0	1	14. 00
15. 00	Medical Supplies	0	0		15. 00
16. 00	Transportation (Health Care Staff)	0	0		16. 00
17. 00	Depreciation-Medical Equipment	0			17. 00
18. 00	Professional Liability Insurance	0			18.00
19. 00	Other Health Care Costs	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	656, 533		22. 00
22.00	lines 10, 14, and 21)	Ü	030, 333		22.00
	COSTS OTHER THAN RHC/FQHC SERVICS				
23. 00	Pharmacy	0	0		23. 00
24. 00	Dental	0	0	i de la companya del companya de la companya de la companya del companya de la co	24. 00
25. 00	Optometry	0	0	1	25. 00
26. 00	All other nonreimbursable costs	0	0		26. 00
27. 00	Nonallowable GME costs	0	0		27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	1	28. 00
	through 27)	_			
	FACILITY OVERHEAD				
29. 00	Facility Costs	0	0		29. 00
30.00	Administrative Costs	0	313, 218	3	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	313, 218	I and the second	31. 00
	30)	_			
32.00	Total facility costs (sum of lines 22, 28	0	969, 751		32. 00
	and 31)				

	Financial Systems IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	PUTNAM COUNT		CON 151222	In Lie	eu of Form CMS-2	2552-10
	IS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE   CENTER COSTS	RALLY QUALIFIEL	Provider	CCN: 151333	Period:   From 01/01/2015	Worksheet M-1	
HEALT	OLIVER GOSTS		Componen	t CCN: 158513		Date/Time Pre 3/30/2016 4:3	
					Rural Health	Cost	<u>о р</u>
					Clinic (RHC) II		
		Compensation	Other Costs		1 Reclassi fi cati		
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	1.00	2.00	3.00	4.00	J. 00	
1. 00	Physi ci an	183, 794	(	183, 7	94 0	183, 794	1.00
2. 00	Physician Assistant	172, 956	<b>l</b>			172, 956	2.00
3.00	Nurse Practitioner	0			0 0	0	3. 00
4.00	Visiting Nurse	0			0 0	0	4. 00
5.00	Other Nurse	127, 847		127, 8	47 0	127, 847	5. 00
6.00	Clinical Psychologist	0			0 0	0	6. 00
7.00	Clinical Social Worker	0	(		0 0	0	7. 00
8.00	Laboratory Techni ci an	0			0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	(		0 0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	484, 597	(	484, 5	97 0	484, 597	10.00
11.00	Physician Services Under Agreement	0	(		0 0	0	11. 00
12.00	Physician Supervision Under Agreement	0	(		0 0	0	12. 00
13.00	Other Costs Under Agreement	0	(		0 0	0	13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	(		0	0	14. 00
15. 00	Medical Supplies	0	(		0	0	15. 00
16. 00		0	(		0	0	16. 00
17. 00		0	(		0	0	17. 00
18. 00	,	0	(		0 0	0	18. 00
19.00		0	(		0 0	0	19. 00
20.00		0	(		0	0	20.00
21. 00	Subtotal (sum of lines 15 through 20)	404 507		404 5	97 0	0	21. 00
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	484, 597	(	484, 5	9/	484, 597	22. 00
	COSTS OTHER THAN RHC/FQHC SERVICS						
23. 00	Pharmacy	0		٦	0 0	0	23. 00
24. 00	Dental	0			0 0	0	24. 00
25. 00	Optometry	0				Ö	25. 00
26. 00	All other nonreimbursable costs	0		ól	0 0	ĺ	26.00
27. 00	Nonal Lowable GME costs	0	l		o o	Ö	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	l o	ĺ		0 0	Ö	28. 00
	through 27)	]	1	1		1	

139, 773

139, 773

624, 370

-60, 393

-60, 393

-60, 393

388, 181

388, 181

872, 778

248, 408

248, 408

248, 408

327, 788

327, 788

812, 385

29. 00

30.00

31.00

32.00

through 27)
FACILITY OVERHEAD

30.00 Administrative Costs

29.00 Facility Costs

and 31)

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

31.00

32.00

Health Financial Systems	PUTNAM COUNTY HO	SPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL	HEALTH CLINIC/FEDERALLY QUALIFIED	Provi der CCN: 151333		Worksheet M-1
HEALTH CENTER COSTS			From 01/01/2015	
		Component CCN: 158513	To 12/31/2015	
				3/30/2016 4:36 pm
			Rural Health	Cost
			CLimin (DUC) LL	

Adjustments					Clinic (RHC) II	
FACILITY HEALTH CARE STAFF COSTS			Adiustmonts	Not Exposess	CITIIC (RNC) II	
Cool			Auj us tillerits			
FACILITY HEALTH CARE STAFF COSTS						
FACILITY HEALTH CARE STAFF COSTS						
FACILITY HEALTH CARE STAFF COSTS			6.00			
1.00		FACILITY HEALTH CARE STAFF COSTS	0.00	7.00		
2.00	1 00		0	183 794		1 00
3.00			0			
4.00			0		1	
5.00		1	0	1	•	1
6.00			0	1	l .	
7.00			0	127,047		1
8.00			0			
9.00   Other Facility Health Care Staff Costs   0   0   0   10.00   Subtotal (sum of lines 1 through 9)   0   484,597   10.00   11.00   Physician Services Under Agreement   0   0   0   11.00   12.00   Physician Supervision Under Agreement   0   0   0   0   12.00   12.00   13.00   14.00   Subtotal (sum of lines 11 through 13)   0   0   0   0   14.00   15.00   Medical Supplies   0   0   0   0   15.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   18.00   19		· ·	0	_	l .	1
10.00   Subtotal (sum of lines 1 through 9)   0   484,597     10.00			0		•	
11.00   Physician Services Under Agreement   0   0   0   12.00   Physician Supervision Under Agreement   0   0   0   0   13.00   14.00   15.00   15.00   16.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.00   16.00   17.			0	_	l .	
12.00   Physician Supervision Under Agreement   0   0   0   0   0   13.00   Other Costs Under Agreement   0   0   0   0   0   0   0   0   0		` ,	0		l .	
13.00   Other Costs Under Agreement   0		3	0			
14. 00     Subtotal (sum of lines 11 through 13)     0     0       15. 00     Medical Supplies     0     0       16. 00     Transportation (Heal th Care Staff)     0     0       17. 00     Depreciation-Medical Equipment     0     0       18. 00     Professional Liability Insurance     0     0       19. 00     Other Heal th Care Costs     0     0       20. 00     Allowable GME Costs     0     0       21. 00     Subtotal (sum of lines 15 through 20)     0     0       22. 00     Total Cost of Heal th Care Services (sum of lines 10, 14, and 21)     0     484,597       23. 00     Pharmacy     0     0       24. 00     Dental     0     0       25. 00     Optometry     0     0       26. 00     All other nonrelimbursable costs     0     0       27. 00     Nonal lowable GME costs     0     0       28. 00     Total Nonrelimbursable Costs (sum of lines 23 through 27)     0     0       29. 00     Facility Overhead (sum of lines 29 and 30)     327,788     30.00       30. 00     Total Facility Overhead (sum of lines 29, 28     0     812,385     32.00			0		•	
15.00   Medical Supplies			U	_	l .	
16.00 Transportation (Health Care Staff) 0 0 0 17.00 Depreciation-Medical Equipment 0 0 0 17.00 Depreciation-Medical Equipment 0 0 0 0 17.00 17.00 18.00 Professional Liability Insurance 0 0 0 0 19.00 Other Health Care Costs 0 0 0 19.00 20.00 Allowable GME Costs 0 0 0 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 0 0 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICS 22.00 Dental 0 0 0 0 24.00 Dental 0 0 0 0 24.00 Dental 0 0 0 0 24.00 Dental 0 0 0 0 25.00 Other ry 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		•	
17. 00   Depreciation-Medical Equipment   0   0   0   18. 00   Professional Liability Insurance   0   0   0   0   18. 00     19. 00   Other Health Care Costs   0   0   0     20. 00   Allowable GME Costs   0   0   0     21. 00   Subtotal (sum of lines 15 through 20)   0   0   0     22. 00   Total Cost of Health Care Services (sum of lines 15 through 20)   22. 00     23. 00   Pharmacy   0   0   0     24. 00   Dental   0   0   0     25. 00   Optometry   0   0   0     26. 00   All other nonreimbursable costs   0   0   0     27. 00   Nonallowable GME costs   0   0   0     28. 00   Total Nonreimbursable Costs (sum of lines 23   0   0     29. 00   Total Nonreimbursable Costs   0   0     29. 00   Total Nonreimbursable Costs   0   0     29. 00   Total Facility Costs   0   0     30. 00   Administrative Costs   0   0     31. 00   Total Facility Overhead (sum of lines 29 and 30)     32. 00   Total facility costs (sum of lines 22, 28   0   812,385   32. 00     31. 00   Total facility costs (sum of lines 22, 28   0   812,385   32. 00			Ü	_	l .	
18.00 Professional Liability Insurance 0 0 0 0 19.00 19.00 Other Heal th Care Costs 0 0 0 19.00 20.00 All owable GME Costs 0 0 0 0 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 0 0 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICS  23.00 Pharmacy 0 0 0 22.00 24.00 25.00 Optometry 0 0 0 25.00 25.00 All other nonreimbursable costs 0 0 0 25.00 26.00 All other nonreimbursable costs 0 0 0 0 27.00 Nonal lowable GME costs 0 0 0 0 28.00 Eacl Ity Costs Optometry 0 0 0 0 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		
19.00 Other Health Care Costs 0 0 0 0 20.00 Allowable GME Costs 0 0 0 0 20.00 21.00 Subtotal (sum of lines 15 through 20) 0 0 0 21.00 22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICS  23.00 Pharmacy 0 0 0 22.00 24.00 Pharmacy 0 0 0 0 24.00 25.00 Optometry 0 0 0 0 25.00 Optometry 0 0 0 0 25.00 All other nonreimbursable costs 0 0 0 0 25.00 26.00 All other nonreimbursable costs 0 0 0 0 27.00 Nonallowable GME costs 0 0 0 0 27.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 28.00 Total Nonreimbursable Costs 0 0 0 0 29.00 30.00 Administrative Costs 0 327,788 30.00 30.00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28 0 812,385 32.00			0	0		
20.00 Allowable GME Costs 0 0 0 0 21.00 21.00 21.00 22.00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICS  23.00 Pharmacy 0 0 0 0 23.00 24.00 Dental 0 0 0 0 0 25.00 25.00 All other nonreimbursable costs 0 0 0 0 25.00 26.00 All other nonreimbursable costs 0 0 0 0 27.00 Nonallowable GME costs 0 0 0 0 27.00 Total Nonreimbursable Costs (sum of lines 23 through 27) FACILITY OVERHEAD  29.00 Facility Costs 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		,	0	1	i e	
21.00   Subtotal (sum of lines 15 through 20)   0   0   0   0   0   0   0   0   0			0	1	l .	
22.00   Total Cost of Health Care Services (sum of lines 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICS     23.00   Pharmacy			0	1	l .	
Lines 10, 14, and 21)   COSTS OTHER THAN RHC/FOHC SERVICS   23.00   Pharmacy			0	1	1	
COSTS OTHER THAN RHC/FQHC SERVICS   23.00   24.00   25.00   26.00	22. 00		0	484, 597		22. 00
23. 00 Pharmacy						
24.00   Dental   0   0   0   0   24.00   25.00   Optometry   0   0   0   0   26.00   All other nonreimbursable costs   0   0   0   27.00   Nonallowable GME costs   0   0   28.00   Total Nonreimbursable Costs (sum of lines 23   0   0   29.00   Facility Overhead   0   0   30.00   Administrative Costs   0   0   31.00   Total Facility Overhead (sum of lines 29 and 30)   32.00   Total facility costs (sum of lines 22, 28   0   812, 385   32.00			_	_		
25. 00 Optometry 0 0 0 0 25. 00 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 Nonallowable GME costs 0 0 0 0 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			
26. 00			0	0		
27. 00   Nonallowable GME costs   0   0   0   27. 00   28. 00   Total Nonreimbursable Costs (sum of lines 23   0   0   0			0	0		
28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0	0		
through 27) FACILITY OVERHEAD  29. 00 Facility Costs 30. 00 Administrative Costs 31. 00 Total Facility Overhead (sum of lines 29 and 30)  32. 00 Total facility costs (sum of lines 22, 28			0	1	l .	
FACILITY OVERHEAD  29. 00 Facility Costs	28. 00		0	0		28. 00
29.00   Facility Costs   0   0   29.00   30.00   Administrative Costs   0   327,788   30.00   31.00   Total Facility Overhead (sum of lines 29 and 30)   32.00   Total facility costs (sum of lines 22, 28   0   812,385   32.00   32.00   32.00   32.00   33.						
30.00 Administrative Costs 0 327,788 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 812,385 32.00	00.00				I	
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 812, 385 31.00			0	1	1	1
30) 32.00 Total facility costs (sum of lines 22, 28 0 812, 385 32.00			0		1	1
32.00 Total facility costs (sum of lines 22, 28 0 812, 385 32.00	31. 00		0	327, 788		31.00
	00.00		_	040 335		00.00
lain 31)	32.00		0	812, 385		32.00
		allu 31)		I		1

Heal th	Financial Systems	PUTNAM COUNT	Y HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RURAL HEALTH CLINIC/FEDE	RALLY QUALIFIED	) Provi der	CCN: 151333	Peri od:	Worksheet M-1	
HEALTH	I CENTER COSTS		Component	CCN: 158514	From 01/01/2015 To 12/31/2015	Date/Time Pre 3/30/2016 4:3	
					Rural Health Clinic (RHC) III	Cost	- F
		Compensation	Other Costs	Total (col.	1 Reclassi fi cati	Reclassi fied	
				+ col . 2)	ons	Trial Balance	
						(col. 3 + col.	
						4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	77.000		I 0	, al		
1.00	Physi ci an	77, 902	0				
2.00	Physician Assistant	0	0		0 0	0	
3.00	Nurse Practitioner	125, 679	0	125, 67	79 0	125, 679	1
4.00	Visiting Nurse	74 055	0	74.00	0	0	
5.00	Other Nurse	71, 355	0	71, 35		71, 355	
6.00	Clinical Psychologist	U	0		0	0	
7.00	Clinical Social Worker	U	0		0	0	
8.00	Laboratory Technician	0	0		0	0	
9.00	Other Facility Health Care Staff Costs	274 024	0	274 0	0 0	0	
10.00	Subtotal (sum of lines 1 through 9)	274, 936	0	274, 93		274, 936	1
11.00	Physician Services Under Agreement Physician Supervision Under Agreement	U	0		0 0	0	
12. 00 13. 00	Other Costs Under Agreement	0	0		0 0	0	
14. 00	Subtotal (sum of lines 11 through 13)	0	0			0	14.00
15. 00	Medical Supplies	0	0				1
16. 00	Transportation (Health Care Staff)	0	0			0	1
17. 00	Depreciation-Medical Equipment	0	0		0 0	0	1
18. 00	Professional Liability Insurance	0	0			0	
19. 00	Other Health Care Costs	0	0		0 0	o o	
20.00	Allowable GME Costs	0	0		0 0	0	
21. 00	Subtotal (sum of lines 15 through 20)	o	0		0 0	0	
22. 00	Total Cost of Health Care Services (sum of	274, 936	0	274, 93	36	274, 936	1
	lines 10, 14, and 21)	,					
	COSTS OTHER THAN RHC/FQHC SERVICS						1
23. 00	Pharmacy	0	0		0 0	0	23. 00
24.00	Dental	0	0		0 0	0	24.00
25. 00	Optometry	0	0		0 0	0	25. 00
26. 00	All other nonreimbursable costs	0	0		0 0	0	26. 00
27. 00	Nonallowable GME costs	0	0		0	0	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
	through 27)						1
	FACILITY OVERHEAD				_		
29. 00	1	0	0		0 0	0	
	Administrative Costs	38, 602					
3.1 UU	Total Facility Overhead (sum of lines 29 and	38 602	124 125	162 73	-22 407	140 320	1 31 00

38, 602

313, 538

124, 125

124, 125

162, 727

437, 663

-22, 407

-22, 407

31.00

32.00

140, 320

415, 256

31.00

32.00

Total Facility Overhead (sum of lines 29 and 30)
Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	PUTNAM COUNTY HO	SPI TAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RURAL	HEALTH CLINIC/FEDERALLY QUALIFIED	Provider CCN: 151333		Worksheet M-1
HEALTH CENTER COSTS			From 01/01/2015	
		Component CCN: 158514	To 12/31/2015	
				3/30/2016 4:36 pm
			Rural Health	Cost
			Climia (DUC) III	

				Rural Health Cost	
				Clinic (RHC) III	
		Adjustments	Net Expenses		
			for Allocation		
			(col. 5 + col.		
			6)		
		6. 00	7. 00		
	FACILITY HEALTH CARE STAFF COSTS				
1. 00	Physi ci an	0	77, 902	2	1. 00
2.00	Physician Assistant	0	0		2. 00
3.00	Nurse Practitioner	0	125, 679		3. 00
4.00	Visiting Nurse	0	0		4. 00
5.00	Other Nurse	0	71, 355	5	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	274, 936		10.00
11. 00	Physician Services Under Agreement	0	0		11. 00
12. 00	Physician Supervision Under Agreement	0		1	12. 00
13. 00	Other Costs Under Agreement				13. 00
14. 00	Subtotal (sum of lines 11 through 13)				14. 00
15. 00	Medical Supplies				15. 00
16. 00	Transportation (Health Care Staff)				16.00
17. 00	Depreciation-Medical Equipment				17. 00
18. 00	· ·	0			18.00
	Professional Liability Insurance Other Health Care Costs				
19.00	1	0			19. 00
20.00	Allowable GME Costs	U		)	20.00
21. 00	Subtotal (sum of lines 15 through 20)	U	0	1	21. 00
22. 00	Total Cost of Health Care Services (sum of	0	274, 936	D	22. 00
	lines 10, 14, and 21)				_
22 00	COSTS OTHER THAN RHC/FQHC SERVICS				
	Pharmacy	0	0	l .	23. 00
24. 00	Dental	U	0	)	24. 00
25. 00	Optometry	0		)	25. 00
26. 00	All other nonreimbursable costs	Ü			26. 00
27. 00	Nonallowable GME costs	0			27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0		)	28. 00
	through 27)				_
00.00	FACILITY OVERHEAD			sl	
	Facility Costs	0	۷	1	29. 00
30. 00	Administrative Costs	0	140, 320	l .	30. 00
31. 00	Total Facility Overhead (sum of lines 29 and	0	140, 320	)	31. 00
	30)	_			
32. 00	Total facility costs (sum of lines 22, 28	0	415, 256		32. 00
	and 31)		I		1

	Financial Systems	PUTNAM COUNT					eu of Form CMS-2	
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES			Provi der	CCN: 151333	Peri od:	Worksheet M-2	
				Component	CCN: 158515	From 01/01/2015 To 12/31/2015		
						Rural Health	Cost	о р
						Clinic (RHC) I		
		Number of FTE	Total	Vi si ts	Producti vi t	y Minimum Visits	Greater of	
		Personnel			Standard (1)	(col. 1 x col. 3)	4	
		1.00	2	2. 00	3.00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY							
	Posi ti ons							
1.00	Physi ci an	1. 57		4, 440				1.00
2.00	Physician Assistant	0.00		0				2. 00
3.00	Nurse Practitioner	1. 54		2, 147				3.00
4.00	Subtotal (sum of lines 1 through 3)	3. 11		6, 587		9, 828	9, 828	
5.00	Visiting Nurse	0.00		0			0	5. 00
6.00	Clinical Psychologist	0.00		0			0	6. 00
7.00	Clinical Social Worker	0.00		0			0	7. 00
7.01	Medical Nutrition Therapist (FQHC only)	0.00		0			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	3. 11		6, 587			9, 828	8. 00
	through 7)							
9. 00	Physician Services Under Agreements			0			0	9. 00
							1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO						1	
10. 00				22)			656, 533	
11. 00	Total nonreimbursable costs (from Wkst. M-1,						0	11. 00
12. 00	Cost of all services (excluding overhead) (si		and 1	1)			656, 533	
13. 00	Ratio of RHC/FQHC services (line 10 divided l						1. 000000	
14. 00	Total facility overhead - (from Wkst. M-1, co						313, 218	
15. 00	Parent provider overhead allocated to facili	ty (see instruc	ctions)	)			575, 342	
16.00	Total overhead (sum of lines 14 and 15)						888, 560	
17. 00	Allowable GME overhead (see instructions)						0	
18.00		40 11 :-	- >				888, 560	
	Overhead applicable to RHC/FQHC services (lii						888, 560	
20.00	Total allowable cost of RHC/FQHC services (si	um of lines 10	and 19	<del>)</del> )			1, 545, 093	J 20. 00

ALLOC/	TION OF OVERHEAD TO RHC/FQHC SERVICES		Provi der		Peri od:	Worksheet M-2			
					From 01/01/2015				
			Componen	t CCN: 158513	To 12/31/2015	Date/Time Prep 3/30/2016 4:30			
					Rural Health	Cost	•		
					Clinic (RHC) II				
		Number of FTE	Total Visits		Minimum Visits				
		Personnel		Standard (1)	(col . 1 x col .				
		1.00	2.00	3.00	3) 4. 00	<u>4</u> 5. 00			
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00			
	Posi ti ons						İ		
1. 00	Physi ci an	0. 82	1, 685	4, 200	3, 444		1.00		
2.00	Physi ci an Assi stant	1. 64	4, 784	2, 10	3, 444		2.00		
3.00	Nurse Practitioner	0.00	(	2, 100	0		3.00		
4.00	Subtotal (sum of lines 1 through 3)	2. 46	6, 469		6, 888	6, 888	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	<b>l</b>			0	7. 00		
7. 01	Medical Nutrition Therapist (FQHC only)	0. 00	<b>l</b>			0	7. 01		
7. 02	Diabetes Self Management Training (FQHC	0. 00	(	)		0	7. 02		
0 00	only)	2.44	, ,,,			4 000	8.00		
8. 00	Total FTEs and Visits (sum of lines 4 through 7)	2. 46	6, 469	1		6, 888	8.00		
9. 00	Physician Services Under Agreements		(			0	9. 00		
7.00	Trijer er am der vrides erhaer ingredmente			1		5	7.00		
						1. 00			
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	O RHC/FQHC SERV	'I CES						
10. 00						484, 597			
11. 00	Total nonreimbursable costs (from Wkst. M-1,					0	11. 00		
12. 00	Cost of all services (excluding overhead) (s		and 11)			484, 597			
13. 00	Ratio of RHC/FQHC services (line 10 divided					1. 000000			
14.00	Total facility overhead - (from Wkst. M-1, c					327, 788 478, 866			
15.00									
16. 00 17. 00	Total overhead (sum of lines 14 and 15) Allowable GME overhead (see instructions)					806, 654 0	16. 00 17. 00		
	Subtotal (see instructions)					806, 654			
	Overhead applicable to RHC/FQHC services (Ii	10   ! 10	))			806, 654			
10 ∩∩									

	Financial Systems	PUTNAM COUNT					u of Form CMS-2		
ALLOCA	TION OF OVERHEAD TO RHC/FQHC SERVICES		Pro	ovi der		Peri od:	Worksheet M-2		
			Con	nponent		From 01/01/2015 To 12/31/2015	Date/Time Pre 3/30/2016 4:3		
						Rural Health Clinic (RHC) III	Cost		
		Number of FTE	Total V	i si ts		Minimum Visits	Greater of		
		Personnel				(col. 1 x col.			
						3)	4		
		1.00	2.0	0	3.00	4. 00	5. 00		
	VISITS AND PRODUCTIVITY								
	Posi ti ons								
1.00	Physi ci an	0. 50		691	4, 20			1.00	
2.00	Physician Assistant	0.00	•	0	2, 10			2. 00	
3.00	Nurse Practitioner	1. 08		1, 318				3. 00	
4.00	Subtotal (sum of lines 1 through 3)	1. 58	•	2, 009		4, 368		4. 00	
5.00	Visiting Nurse	0.00		0			0	5. 00	
6.00	Clinical Psychologist	0.00		0			0	6. 00	
7. 00	Clinical Social Worker	0.00	•	0			0	7. 00	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	1	0			0	7. 01	
7. 02	Diabetes Self Management Training (FQHC	0.00		0			0	7. 02	
	onl y)								
8. 00	Total FTEs and Visits (sum of lines 4	1. 58		2, 009			4, 368	8. 00	
0.00	through 7)			0			0	0.00	
9. 00	Physician Services Under Agreements			0			0	9. 00	
							1. 00		
	DETERMINATION OF ALLOWABLE COST APPLICABLE TO	DUC/FOUR CERV	// CEC				1.00		
10. 00				12)			274, 936	10.00	
11. 00	Total nonreimbursable costs (from Wkst. M-1,	·		(2)			274, 930	11.00	
12. 00	Cost of all services (excluding overhead) (si						274, 936		
13. 00	Ratio of RHC/FQHC services (line 10 divided		and ii)				1. 000000		
14. 00	Total facility overhead - (from Wkst. M-1, co						140, 320		
15. 00									
16. 00									
17. 00	· ·								
	Subtotal (see instructions)						0 388, 063		
19. 00	,	ne 13 x line 18	3)				388, 063		
	Total allowable cost of RHC/FQHC services (si						662, 999		
_0.00	1.2.2. 2 2 2 2 2 2 2.						332,777	0.00	

	Financial Systems PUTNAM COUNTY H TION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 151333	Peri od:	u of Form CMS-2 Worksheet M-3	
		Component CCN: 158515	From 01/01/2015 To 12/31/2015	Date/Time Pre 3/30/2016 4:3	pared
		Title XVIII	Rural Health Clinic (RHC) I	Cost	<u>-  </u>
			0111110 (1110) 1		
				1. 00	
	DETERMINATION OF RATE FOR RHC/FOHC SERVICES	20)		1 545 002	1.
	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lir Cost of vaccines and their administration (from Wkst. M-4, lir			1, 545, 093	1
	Total allowable cost excluding vaccine (line 1 minus line 2)	le 15)		87, 126 1, 457, 967	1
	Total Visits (from Wkst. M-2, column 5, line 8)			9, 828	1
	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		7, 020	
	Total adjusted visits (line 4 plus line 5)			9, 828	
	Adjusted cost per visit (line 3 divided by line 6)			148. 35	
			Cal cul ati on	of Limit (1)	
			Prior to	On on After	
			January 1	January 1	
00	0.000		1. 00	2.00	_
	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	80. 44	8
	Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		148. 35	148. 35	9
. 00	Program covered visits excluding mental health services (from	contractor records)	0	475	10
	Program cost excluding costs for mental health services (line		0	70, 466	11
	Program covered visits for mental health services (from contra		0	0	12
	Program covered cost from mental health services (line 9 x lir		0	0	
	Limit adjustment for mental health services (see instructions)		0	0	
	Graduate Medical Education Pass Through Cost (see instructions			0	
	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			70, 466 69, 391	
	Total program preventive charges (see instructions)(from provi Total program preventive costs ((line 16.02/line 16.01) times			16 16	
	Total Program non-preventive costs ((Time 16.02/Time 16.01) times Total Program non-preventive costs ((Line 16 minus lines 16.03			55, 596	
	(Titles V and XIX see instructions.)	and ref trilles . 60)		33, 370	10
	Total program cost (see instructions)			55, 612	16
	Primary payer amounts			0	1
	Less: Beneficiary deductible for RHC only (see instructions) records)	(from contractor		955	18
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		13, 684	19
	records) Net Medicare cost excluding vaccines (see instructions)			55, 612	20
	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		12, 694	
	Total reimbursable Program cost (line 20 plus line 21)	,		68, 306	
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
	Net reimbursable amount (see instructions)			68, 306	
	Sequestration adjustment (see instructions)			1, 366	
	Interim payments			43, 919	
	Tentative settlement (for contractor use only) Balance due component/program (line 26 minus lines 26.01, 27,	and 20)		22 021	28
	barance due component/program (fine 26 minus fines 26.01, 27, Protested amounts (nonallowable cost report items) in accordar			23, 021 0	30
	rotested dimedrits (nondritewable cost report rems) in decordar	ice with ome rub. To fit,		O	1 00

	Financial Systems PUTNAM COUNTY HATION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 151333	Peri od:	u of Form CMS-2 Worksheet M-3	
		Component CCN: 158513	From 01/01/2015 To 12/31/2015	Date/Time Pre 3/30/2016 4:3	pared
		Title XVIII	Rural Health Clinic (RHC) II	Cost	•
			0111110 (11110) 11		
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1. 00	
. 00	Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lin	e 20)		1, 291, 251	1.0
00	Cost of vaccines and their administration (from Wkst. M-4, lin			61, 786	
00	Total allowable cost excluding vaccine (line 1 minus line 2)	,		1, 229, 465	1
00	Total Visits (from Wkst. M-2, column 5, line 8)			6, 888	
. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	
. 00	Total adjusted visits (line 4 plus line 5)			6, 888	
. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal aul ati an	178. 49	7.
			Cal cul ati on	or Limit (1)	
			Prior to	On on After	
			January 1	January 1	
. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	4 or your contractor)	1. 00	2. 00 80. 44	8.
. 00	Rate for Program covered visits (see instructions)	o or your contractor)	178. 49	178. 49	
. 00	CALCULATION OF SETTLEMENT		170. 47	170. 47	′
0. 00	Program covered visits excluding mental health services (from	contractor records)	0	722	10.
1.00	Program cost excluding costs for mental health services (line		0	128, 870	
2. 00	Program covered visits for mental health services (from contra		0	0	12
3. 00	Program covered cost from mental health services (line 9 x lin		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 instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2			0 128, 870	
6. 01	Total program charges (see instructions) (from contractor's rec			94, 867	1
6. 02	Total program preventive charges (see instructions)(from provi			94, 007	ı
6. 03	Total program preventive costs ((line 16.02/line 16.01) times			0	1
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.03			100, 825	
6. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)			100, 825	16.
7. 00	Primary payer amounts			100, 825	17.
3. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		2, 839	
9. 00	records) Beneficiary coinsurance for RHC/FQHC services (see instruction records)	s) (from contractor		18, 406	19.
0. 00	Net Medicare cost excluding vaccines (see instructions)			100, 825	20.
1. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		24, 736	21.
2. 00	Total reimbursable Program cost (line 20 plus line 21)			125, 561	22.
3. 00	Allowable bad debts (see instructions)			0	
3. 01	Adjusted reimbursable bad debts (see instructions)			0	
1. 00	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		0	
5. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  Pi opport ACO demonstration payment adjustment (see instructions	)		0	
5. 50 6. 00	Pioneer ACO demonstration payment adjustment (see instructions Net reimbursable amount (see instructions)	,		125, 561	
6. 01	Sequestration adjustment (see instructions)			2, 511	
7. 00					
8. 00	Tentative settlement (for contractor use only)			65, 597 0	27. 28.
9. 00	Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		57, 453	
0.00	Protested amounts (nonallowable cost report items) in accordan		1	0	

	Financial Systems PUTNAM COUNTY H ITION OF REIMBURSEMENT SETTLEMENT FOR RHC/FQHC SERVICES	Provi der CCN: 151333	Peri od:	u of Form CMS-2 Worksheet M-3	
		Component CCN: 158514	From 01/01/2015 To 12/31/2015	Date/Time Prep 3/30/2016 4:30	
		Title XVIII	Rural Health Clinic (RHC) III	Cost	•
			CITILE (KIIC) III		
	DETERMINATION OF RATE FOR RHC/FQHC SERVICES			1. 00	
. 00	DETERMINATION OF RATE FOR RHC/FUHC SERVICES Total Allowable Cost of RHC/FQHC Services (from Wkst. M-2, lin	ne 20)		662, 999	1. (
. 00	Cost of vaccines and their administration (from Wkst. M-4, lin			16, 162	2.
00	Total allowable cost excluding vaccine (line 1 minus line 2)			646, 837	3.
. 00	Total Visits (from Wkst. M-2, column 5, line 8)			4, 368	4.
. 00	Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		0	5.
. 00	Total adjusted visits (line 4 plus line 5)			4, 368	6.
. 00	Adjusted cost per visit (line 3 divided by line 6)			148. 09	7.
			Cal cul ati on	of Limit (1)	
			Prior to	On on After	
			January 1	January 1	
00	Describit assessed limit (form CNC Date 100 04 shorter 0 C20	(	1. 00	2.00	
00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20. Rate for Program covered visits (see instructions)	6 or your contractor)	0. 00 148. 09	80. 44 148. 09	8. 9.
00	CALCULATION OF SETTLEMENT		140. 09	140. 09	9.
0. 00	Program covered visits excluding mental health services (from	contractor records)	0	180	10.
. 00	Program cost excluding costs for mental health services (line		0	26, 656	11.
	Program covered visits for mental health services (from contra		0	0	12.
3. 00	Program covered cost from mental health services (line 9 x lin	,	0	0	
1. 00	Limit adjustment for mental health services (see instructions)		0	0	14.
5.00	Graduate Medical Education Pass Through Cost (see instructions			0	
6. 00 6. 01	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's rec			26, 656 26, 056	•
6. 02	Total program preventive charges (see instructions)(from provi			20, 030	16.
6. 03	Total program preventive costs ((line 16.02/line 16.01) times			0	16.
6. 04	Total Program non-preventive costs ((line 16 minus lines 16.03			21, 054	16.
, 05	(Titles V and XIX see instructions.)			21 054	1,
5. 05   7. 00	Total program cost (see instructions) Primary payer amounts			21, 054 0	16. 17.
7. 00 B. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		338	
5. 00	records)	(11 om conti de toi		555	10.
9. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction records)	s) (from contractor		5, 144	19.
0. 00	Net Medicare cost excluding vaccines (see instructions)			21, 054	20.
1. 00	Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		2, 899	21.
2. 00	Total reimbursable Program cost (line 20 plus line 21)			23, 953	22.
	Allowable bad debts (see instructions)			0	23.
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24.
5. 00 5. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions	.)		0	25. 25.
	Net reimbursable amount (see instructions)	"		23, 953	
6. 01	Sequestration adjustment (see instructions)			479	•
	Interim payments			16, 658	
8. 00	Tentative settlement (for contractor use only)			0	28.
9. 00	Balance due component/program (line 26 minus lines 26.01, 27,	and 28)		6, 816	29.
	Protested amounts (nonallowable cost report items) in accordan		1	0	30.

	Financial Systems PUTNAM COUNTY H		•	u of Form CMS-2	
COMPUT	TATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST	Provider CCN: 151333	Peri od:	Worksheet M-4	
		Component CCN: 158515	From 01/01/2015 To 12/31/2015	Date/Time Pre	nared:
		Component Con. 130313	10 12/31/2013	3/30/2016 4: 3	
		Rural Health	Cost	-	
			Clinic (RHC) I		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		656, 533	656, 533	1. 00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	al health care staff tim	e 0.000000	0. 035040	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (lir	ne 1 x line 2)	0	23, 005	3. 00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	rom your records)	0	14, 016	4.00
5.00 Direct cost of pneumococcal and influenza vaccine (line 3 plus line 4)				37, 021	5.00
6.00 Total direct cost of the facility (from Wkst. M-1, col. 7, line 22)				656, 533	6. 00
7.00 Total overhead (from Wkst. M-2, line 16)				888, 560	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to tot	0. 000000	0. 056389	8.00	
	divided by line 6)				
9. 00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	0	50, 105	9. 00
10. 00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	0	87, 126	10.00
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	0	006	11.00
	Cost per pneumococcal and influenza vaccine injection (line 10		0.00		12.00
	Number of pneumococcal and influenza vaccine injection (inheric		0.00		13.00
13.00	beneficiaries	Stered to Frogram	J	132	13.00
14.00	Program cost of pneumococcal and influenza vaccine and its (th	neir) administration	0	12, 694	14.00
	(line 12 x line 13)				
15. 00	Total cost of pneumococcal and influenza vaccine and its (thei			87, 126	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,				
16. 00	· · · · · · · · · · · · · · · · · · ·			12, 694	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	PUTNAM COUNTY HO	SPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF PNEUMOCOCCAL AND INFLUENZA	VACCINE COST	Provi der CCN: 151333		Worksheet M-4
			From 01/01/2015	
		Component CCN: 15851	3 To 12/31/2015	Date/Time Prepared:
				3/30/2016 4:36 pm
		Title XVIII	Rural Health	Cost
			Clinic (RHC) II	
				1 (1

			man an moan em	0001	
			Clinic (RHC) II		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		484, 597	484, 597	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to total	health care staff time	0.000000	0. 028951	2. 00
3.00	Pneumococcal and influenza vaccine health care staff cost (line	1 x line 2)	0	14, 030	3. 00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (from	m your records)	0	9, 158	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus I	ine 4)	0	23, 188	5.00
6.00	Total direct cost of the facility (from Wkst. M-1, col. 7, line	22)	484, 597	484, 597	6. 00
7.00	Total overhead (from Wkst. M-2, line 16)		806, 654	806, 654	7. 00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to total	direct cost (line 5	0.000000	0.047850	8. 00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x lin	ne 8)	0	38, 598	9. 00
10.00	Total pneumococcal and influenza vaccine cost and its (their) ad	dministration (sum of	0	61, 786	10.00
	lines 5 and 9)				
11. 00	Total number of pneumococcal and influenza vaccine injections (1	from your records)	0	592	11. 00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10/1	i ne 11)	0.00	104. 37	12.00
13.00	Number of pneumococcal and influenza vaccine injections adminis	tered to Program	0	237	13.00
	benefi ci ari es				
14. 00	Program cost of pneumococcal and influenza vaccine and its (thei	r) administration	0	24, 736	14. 00
	(line 12 x line 13)				
15. 00				61, 786	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, I				
16. 00		, ,		24, 736	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this ar	mount to Wkst. M-3,			
	line 21)				

Heal th F	inancial Systems PUTNAM COUNTY HO	In Lie	eu of Form CMS-2552-10			
COMPUTAT	OMPUTATION OF PNEUMOCOCCAL AND INFLUENZA VACCINE COST Provider CCN: 151333			Worksheet M-4		
			From 01/01/2015			
		Component CCN: 158514	To 12/31/2015			
		Donal Haalah	3/30/2016 4: 30	ь рт		
		Title XVIII	Rural Health	Cost		
			Clinic (RHC) III			
			Pneumococcal	I nfl uenza		
			1. 00	2. 00		
1.00 H	ealth care staff cost (from Wkst. M-1, col. 7, line 10)	274, 936	274, 936	1. 00		
2.00 R	atio of pneumococcal and influenza vaccine staff time to total	e 0.000000	0. 014024	2. 00		
3.00 P	neumococcal and influenza vaccine health care staff cost (line	0	3, 856	3. 00		
4.00 M	edical supplies cost - pneumococcal and influenza vaccine (fro	0	2, 846	4. 00		
5.00 D	irect cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	o	6, 702	5. 00	
6.00 T	otal direct cost of the facility (from Wkst. M-1, col. 7, line	22)	274, 936	274, 936	6. 00	
7. 00 T	otal overhead (from Wkst. M-2, line 16)		388, 063	388, 063	7. 00	
8.00 R	atio of pneumococcal and influenza vaccine direct cost to tota	I direct cost (line 5	0. 000000	0. 024377	8. 00	
d	ivided by line 6)	•				
9.00 0	verhead cost - pneumococcal and influenza vaccine (line 7 x li	ne 8)	0	9, 460	9. 00	
10. 00 T	otal pneumococcal and influenza vaccine cost and its (their) a	o	16, 162	10. 00		
	ines 5 and 9)					
11. 00 T	otal number of pneumococcal and influenza vaccine injections (	0	184	11. 00		
	ost per pneumococcal and influenza vaccine injection (line 10/		0.00	87. 84	12. 00	
		1				

33

2, 899

16, 162

13.00

14. 00

15.00

2, 899 16.00

Number of pneumococcal and influenza vaccine injections administered to Program

16.00 Total Program cost of pneumococcal and influenza vaccine and its (their)

Program cost of pneumococcal and influenza vaccine and its (their) administration

Total cost of pneumococcal and influenza vaccine and its (their) administration (sum of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3, line 2)

administration (sum of cols. 1 and 2, line 14) (transfer this amount to Wkst. M-3,

13.00

14.00

15.00

benefi ci ari es

line 21)

(line 12 x line 13)

Health Financial Systems	lealth Financial Systems PUTNAM COUNTY HOS					In Lieu of Form CMS-2552-10			
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVI DER FOR	SERVI CES	Provi der	CCN:	151333			Worksheet	M-5
RENDERED TO PROGRAM BENEFICIARIES			Component	CCN:	: 158515		01/01/2015 12/31/2015		
							al Health	Co	ost

Part 8				Rural Health	Cost	
Monunt   1.00   Total interim payments paid to provider   1.00   2.00   1.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00   1.00   2.00   1.00				Clinic (RHC) I		
Total interim payments paid to provider						
100 Total interim payments paid to provider 1 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.  101 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  102 0 3. 103 0 3. 104 0 0 3. 105 0 0 3. 106 0 0 0 0 3. 107 0 0 0 3. 108 0 0 0 3. 109 Provider to Program  100 0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
100 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.  List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  Provider to Program  Provider to Program  Provider to Program  O 3.  Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  DI BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  D I BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  D I BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  D I BE COMPLETED BY CONTRACTOR  List separately each tentative settlement amount (balance due) based on the cost report. (1)  SETTILEMENT TO PROGRAM  D I Total Medicare program liability (see instructions)  O 1,00  O 1,00  NPR Date (Mo/Day/Yrr)  O 1,00			1. 00			
the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero  List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider	. 00				43, 919	1.0
Non-Non-Fire or enter a zero	. 00				0	2.0
1.1   1.1   1.1   1.2			period. If none, write			
Program to Provider   1						
Payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	. 00					3.0
Program to Provider			. Also show date of each			
1						
10   10   10   10   10   10   10   10		Program to Provider				
10	. 01					3.0
Add	. 02				1 - 1	3.0
Provider to Program	. 03					
Provider to Program	. 04					3.0
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	. 05				0	3.0
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		Provider to Program				
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	. 50					
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	. 51					
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)  Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  Provider to Program  Provider to Program  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROGRAM  Total Medicare program liability (see instructions)  O 1.00 2.00  Subtotal (sum of lines 5.00-3.49 minus sum of lines 5.50-5.98)  Contractor NPR Date (Mo/Day/Yr)  NPR Date (Mo/Day/Yr)  O 1.00 2.00	. 52					
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	. 53				1	
Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)  TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  100 5.  Provider to Program  101 0 5.  Provider to Program  101 0 5.  Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)  102 0 5.  103 0 5.  104 0 5.  105 0 5.  105 0 5.  106 0 5.  107 0 5.  108 0 7.  109 0 6.  109 0 6.  100 0 7.  100	. 54		00)			
27)   TO BE COMPLETED BY CONTRACTOR	. 99				ı	
TO BE COMPLETED BY CONTRACTOR  List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  10 0 5. 1	. 00		ster to worksheet M-3, line		43, 919	4. 0
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider						
each payment. If none, write "NONE" or enter a zero. (1)	. 00		sk raview. Also show data of	;		5.0
Program to Provider	. 00		sk review. Also show date of			3. 0
Discription   Discription						
Determined net settlement amount (balance due) based on the cost report. (1)   SETTLEMENT TO PROVIDER   SETTLEMENT TO PROVIDER   SETTLEMENT TO PROGRAM   O 6. O 6. O 7. O 7. O 7. O 7. O 7. O 7.	. 01				0	5. (
Provider to Program	. 02					5. (
Provider to Program	. 03				1	5. (
0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   5.   0   0   0   0   0   0   0   0   0		Provider to Program				
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	. 50				0	5. 5
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	. 51				0	5. !
Determined net settlement amount (balance due) based on the cost report. (1)  SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00	. 52				0	5. 5
SETTLEMENT TO PROVIDER   23,021   6.     SETTLEMENT TO PROGRAM   0   6.     Total Medicare program liability (see instructions)   Contractor   NPR Date   (Mo/Day/Yr)     Use the program of the progra	. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	. 98)		0	5. 9
0	. 00	Determined net settlement amount (balance due) based on the	e cost report. (1)			6. (
22   SETTLEMENT TO PROGRAM   0   6.   66, 940   7.	. 01	SETTLEMENT TO PROVIDER			23, 021	6. (
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00	. 02	SETTLEMENT TO PROGRAM				6. (
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00	. 00				66, 940	7. (
0 1.00 2.00				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
00 Name of Contractor 8.			0	1. 00	2. 00	
	. 00	Name of Contractor				8. 0

Health Financial Systems	PUTNAM	COUNTY HOS	SPI TAL		In Lieu of Form CMS-2552-10				
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED	RHC/FQHC PROVIDER FOR	SERVI CES	Provi der (	CCN: 151333		Worksheet M-5			
RENDERED TO PROGRAM BENEFICIARIES			Component	CCN: 158513	From 01/01/2015 To 12/31/2015	Date/Time Prepared: 3/30/2016 4:36 pm			
					Rural Health	Cost			

			Rural Health	Cost	
	<u> </u>		Clinic (RHC) II		
				⁻t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to provider			65, 597	1. 00
2.00	Interim payments payable on individual bills, either submit			0	2. 00
	the contractor for services rendered in the cost reporting p	period. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3. 00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider			_	
3. 01				0	3. 01
3. 02				0	3. 02
3.03				0	3. 03
3.04				0	3. 04
3.05				0	3. 05
	Provi der 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 3.50-3.9			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transf	fer to Worksheet M-3, line		65, 597	4. 00
	27)				
F 00	TO BE COMPLETED BY CONTRACTOR		· 1		F 00
5.00	List separately each tentative settlement payment after desk	k review. Also show date of			5. 00
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider				
5. 01	Frogram to Frovider			0	5. 01
5. 02					5. 01
5. 02				0	5. 02
5.05	Provider to Program			0	5. 05
5. 50	Trovider to frogram			0	5. 50
5. 51				0	5. 51
5. 52				l ől	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.9	987		0	5. 99
6.00	Determined net settlement amount (balance due) based on the				6. 00
6. 01	SETTLEMENT TO PROVIDER	3031 Topol 1. (1)		57, 453	6. 01
6. 02	SETTLEMENT TO PROGRAM			07, 433	6. 02
7. 00	Total Medicare program liability (see instructions)			123, 050	7. 00
,. 00	Total medical e program frability (see firstractions)		Contractor	NPR Date	7.00
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
8.00	Name of Contractor	<u> </u>	1.00	2.00	8. 00
5. 00	name of contractor		I .	1 1	0.00

Health Financial Systems	PUTNAM COUNTY HOSPITAL						In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RENDERED TO PROGRAM BENEFICIARIES	RHC/FQHC PROVI DER FOR	SERVI CES	Provi der	CCN:	151333		d: 01/01/2015	Worksheet M-5
KENDERED TO TROOMAW BENEFICIANTES			Component	CCN:	158514			Date/Time Prepared: 3/30/2016 4:36 pm
						Rura	al Health	Cost

			Rural Health	Cost	
			<u>Clinic (RHC) III</u>		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
. 00	Total interim payments paid to provider			16, 658	1. (
. 00	Interim payments payable on individual bills, either submitted or to be submitted to			0	2. (
	the contractor for services rendered in the cost reporting period. If none, write				
	"NONE" or enter a zero				
. 00	List separately each retroactive lump sum adjustment amount based on subsequent				3.
	revision of the interim rate for the cost reporting period. Also show date of each				
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
01				0	3.
. 02				0	3.
. 03				l ol	3.
. 04				l ol	3.
. 05				o	3.
	Provider to Program		<u>'</u>		
50	<u> </u>			0	3.
51				l ol	3.
52				اه	3.
53				ام	3.
54				l ol	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	98)		ا	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line			16, 658	4.
1. 00	27)			10,030	٦.
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after desk review. Also show date of				5.
0.00	each payment. If none, write "NONE" or enter a zero. (1)				0.
	Program to Provi der				
01	g			0	5.
02				0	5.
03				0	5.
00	Provider to Program				
50	1 TOVI GCT TO TITOGI GIII			0	5.
51					5.
52				0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	5.
99 00	Determined net settlement amount (balance due) based on the cost report. (1)				6.
01	SETTLEMENT TO PROVIDER			6, 816	6.
	SETTLEMENT TO PROVIDER			0,816	
02					6.
00	Total Medicare program liability (see instructions)		Ctt	23, 474	7.
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
. 00	Name of Contractor				8.