Heal th Financia	I Systems	GREENE COUNTY GENER	RAL HOSPI TAL	In Lieu	u of Form CMS-2552-10
	required by law (42 USC 1395g;				FORM APPROVED
payments made s	since the beginning of the cost	reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 09-30-2025
	OSPITAL HEALTH CARE COMPLEX COST	F REPORT CERTIFICATION	Provider CCN: 15-131		Worksheet S
AND SETTLEMENT	SUMMARY			From 01/01/2022 To 12/31/2022	Parts I-III Date/Time Prepared:
				10 12/01/2022	5/30/2023 1:05 pm
PART I - COST F	REPORT STATUS				
	1. [ X ] Electronically prepared			Date:	Ti me:
2	2. [ ] Manually prepared cost i				
	3. [0] If this is an amended re				ost report
	4. [ F ] Medicare Utilization. En				
		Date Received: Contractor No.		0. NPR Date: 1. Contractor's Vendo	n Codo: 1
use only	(1) As submitted 7. (2) Settled without Audit 8.	[ N ] Initial Report fo	or this Provider CCN 1	2. [0] If line 5. co	olumn 1 is 4: Enter
	(3) Settled with Audit 9.	[ N ] Final Report for	this Provider CCN		tes reopened = $0-9$ .
	(4) Reopened				
	(5) Amended				
	IFICATION BY A CHIEF FINANCIAL (				
	ON OR FALSIFICATION OF ANY INFO ACTION, FINE AND/OR IMPRISONMEN				
	OCURED THROUGH THE PAYMENT DIREC				
	ACTION, FINES AND/OR IMPRISONME		RICKBACK OK WERE OT		TINAE, OT TE AND
CERTIFI	ICATION BY CHIEF FINANCIAL OFFIC	CER OR ADMINISTRATOR OF	PROVIDER(S)		
	BY CERTIFY that I have read the				
	onically filed or manually submi				
	ent of Revenue and Expenses prep				
	beginning 01/01/2022 and ending				
	ent are true, correct, complete				
	able instructions, except as not ing the provision of health care				
				a in this cost report	L WEIE
provi de	ed in compliance with such laws	and regulations.			

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRA	TOR CHECKBOX	ELECTRONI C	
	1		SI GNATURE STATEMENT	
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

			Title	XVIII			
		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	746, 530	-281, 917	0	0	1.00
2.00	SUBPROVIDER - IPF	0	0	0		0	2.00
3.00	SUBPROVIDER - IRF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	217, 925	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		52, 765		0	10.00
10.01	RURAL HEALTH CLINIC II	0		79, 116		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-33, 727		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		40, 279		0	10.03
200.00	TOTAL	0	964, 455	-143, 484	0	0	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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

Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

	L HEALIH CARE COMPLEX	I DENTIFICATION DATA	Provio	ler CCN: 1		Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/30/20	me Pre	epare
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	lospital Health Care Co		-		-					
0 Street: R.R 1 0 City: LINTON		PO Box: 1000 State: IN	Zin Cod	e· 47441_	9457 Count	ty: GREENE				1
		Component Name	CCN	CBSA	Provi der	1	Payme	nt Syst	em (P,	
			Number	Number	Туре	Certified		, 0, or		
		1.00	2.00	2.00	4.00	F 00	V	XVIII	XIX	-
Hospital and H	lospital-Based Component	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
) Hospital		GREENE COUNTY GENERAL	151317	99915	1	02/01/2003	N	0	0	3
		HOSPI TAL								
Subprovider -										4
<ul><li>Subprovi der -</li><li>Subprovi der -</li></ul>										5
) Swing Beds - S		GREENE COUNTY GENERAL	15Z317	99915		02/01/2003	Ν	0	N	7
5		HOSPI TAL								
) Swing Beds - N										8
<ul> <li>Hospital - Based</li> <li>Hospital - Based</li> </ul>										9
00 Hospi tal -Based										111
00 Hospital-Based										12
00 Separately Cer										13
00 Hospital -Based	•		150505	00015		10/10/2010	N		N	14
	d Health Clinic - RHC d Health Clinic - RHC	MY LINTON CLINIC MY BLOOMFIELD CLINIC	158535 158533	99915 99915		12/18/2018	N N	N N	N N	15
	or mic - Mic		100000			2, 10, 2010	14	1.4		'
02 Hospital-Based	d Health Clinic – RHC	MY WESTGATE CLINIC	158534	99915		12/18/2018	Ν	N	N	15
 03  Hospital-Based	d Health Clinic - RHC	MY WORTHINGTON CLINIC	158538	99915		12/12/2018	Ν	N	N	15
			130330	77713		12/12/2010	IN	IN		
	d Health Clinic - FQHC									16
00 Hospital-Based										17
00 Renal Dialysis 00 Other	5									18
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	g Period (mm/dd/yyyy)					01/01/20	022	12/31/	/2022	
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<ul> <li>Inpati ent PPS</li> <li>Does this facidi sproportiona §412.106? In facility subjection to the second state of the sec</li></ul>	Information Iity qualify and is i ate share hospital adju- column 1, enter "Y" for column 2, enter "Y" for tal receive interim Uu- orting period? Enter in on of the cost reporting of umn 2, "Y" for yes or g period occurring on or y merged hospital than- cost report settlements s or "N" for no, for the co October 1. Enter in or on of the cost reporting tal receive a geographe sult of the OMB standards in FY2015? Enter in or of the cost reporting sult of the OMB standards in FY2015? Enter in or of the cost reporting tal contain at least cordance with 42 CFR 4 no. tal receive a geographe sult of the revised OMB in FY 2021? Enter in on of the cost reporting sult of the revised OMB in FY 2021? Enter in on of the cost reporting sult of the revised OMB in FY 2021? Enter in on of the cost reporting sult of the revised OMB in FY 2021? Enter in or of the cost reporting sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2021? Enter in or of the cost reporting Sult of the revised OMB in FY 2005 or "N" for of the cost reporting Sult of the revised OMB in FY 2005 or "N" for of the cost reporting Sult of the revised OMB in FY 2005 or "N" fo	ustment, in accordance w or yes or "N" for no. Is §412.106(c)(2)(Pickle am or yes or "N" for no. CPs, including supplement n column 1, "Y" for yes ng period occurring priot r "N" for no for the port or after October 1. (see t requires a final UCP t t? (see instructions) En ne portion of the cost r column 2, "Y" for yes of nic reclassification fro rds for delineating stat column 1, "Y" for yes or ng period prior to Octob no for the portion of t ter October 1. (see inst 100 but not more than 4 12.105)? Enter in column column 1, "Y" for yes of a delineations for stati column 1, "Y" for yes of the portion of the cost for the october 1. (see inst 100 but not more than 4 12.105)? Enter in column column 1, "Y" for yes of the october 1, "Y" for yes of the october 1, "Y" for yes of the october 1, "Y" for yes of the october 1, "Y" for yes of th	ith 42 CFF this endment tal UCPs, or "N" for r to Octof tion of th o be ter in col eporting r "N" for tober 1. m urban to istical ar ructions) 99 beds (i 3, "Y" for m urban to stical aro r "N" for er 1. Ento he cost r "N" for er 1. Ento he cost r uctions) 99 beds (i stical aro	for no per ne umn no, preas no er eas no er	N	9 2.00 N N		3. (	00	21 22 22 22 22 22 22

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CO	CN: 15-1317	Period: From 01/0		Workshe Part I		
					To 12/3	31/2022	Date/Ti 5/30/20		
				1.00	2.	00	3.	00	-
3. 00	Which method is used to determine Medicaid days on li below? In column 1, enter 1 if date of admission, 2 i if date of discharge. Is the method of identifying th reporting period different from the method used in th reporting period? In column 2, enter "Y" for yes or	f census c ne days in ne prior co	lays, or 3 this cost ost		0				23.0
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Med	ither di cai d days	
4 00	Le this speciales is as LDDC bestited, astes the	1.00	2.00	3.00	4.00	5.00	0	6.00	
	If this provider is an IPPS hospital, enter the 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. If this provider is an IRF, enter the in-state						0	(	0 24. C
	Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
					Urban/F	Rural S	Date of 2.0		-
5.00	Enter your standard geographic classification (not wa		at the beg	ginning of t		2			26.0
7.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status - "2" for r	rural. If ap		st	2			27. (
5. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status ir	n Begin	0 ni ng:	Endi	ng:	35.
5.00	Enter applicable beginning and ending dates of SCH st	tatus Subs	crint line	36 for numb	1. )er	00	2.	00	36.0
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	es.				0			37. (
7. 01	Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37. (
8. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. (
					Y/ 1.		Y/ 2.0		-
9.00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	), (ii), or the mileage	(iii)? En requiremen	ter in colum nts in	ท	J	Ν	J	39. (
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	per 1. Ente	er "Y" for y			J	N		40.0
						V 1.00	XVIII 2.00	-	-
5. 00	Prospective Payment System (PPS)–Capital Does this facility qualify and receive Capital paymer	nt for disr	roporti opat	te share in	accordanco	N	N	N	45. (
	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	eption for	extraordi na	ary circumst	ances	N	N	N	46. (
7.00 3.00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment Teaching Hospitals					N N	N	N N	47.0
6.00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter " cost reporting periods beginning on or after December the instructions. For column 2, if the response to co involved in training residents in approved GME progra and are you are impacted by CR 11642 (or applicable C "Y" for yes; otherwise, enter "N" for no in column 2.	'Y" for yes 27, 2020, blumn 1 is ams in the CRs) MA dir	or "N" for under 42 ( "Y", or if prior year	r no in colu CFR 413.78(b this hospit or penultin	umn 1. For b)(2), see cal was nate year,	N			56. (

OSPI T	Financial Systems GREENE COU TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT		Provider CC	CN: 15-1317	Period: From 01/01, To 12/31,	/2022	u of For Workshe Part I Date/Ti	et S-2	)
					10 12, 01,		5/30/20	23 1:0	
						V	XVIII ) 2.00	XI X 3.00	-
	For cost reporting periods beginning prior to Decembe is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this co "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFR which month(s) of the cost report the residents were for yes, enter "Y" for yes in column 1, do not comple If line 56 is yes, did this facility elect cost reimb	resider columr ost rep Worksh applica 413.77 on duty te colu	nts in approved n 1. If column porting period neet E-4. If co able. For cost 7(e)(1)(iv) an 7, if the respo umn 2, and comp	d GME program 1 is "Y", di 2 Enter "Y" olumn 2 is "N reporting pe nd (v), regar onse to line olete Workshe	ns trained d for yes or N", eriods rdless of 56 is "Y" eet E-4.	N			57. C
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complet	te Wkst. D-5.						
7.00	Are costs claimed on line 100 of Worksheet A? If yes	, compl	ete Wkst. D-2,	Pt. I. NAHE 413.8	5 Workshe		Pass-Th	rough	59.0
				Y/N	Line	#	Qualifi Criteric	cation	1
		(1) 1 - 2		1.00	2.00	)	3. 0	00	1
0. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col- is "Y", are you impacted by CR 11642 (or subsequent C adjustment? Enter "Y" for yes or "N" for no in colum	85? (s umn 1. R) NAHE	see If column 1	N					60.0
		Y/N	IME	Direct GME			Di rect		
00	Did your hospital receive FTE slots under ACA	1.00 N	2.00	3.00	4.00	) 0. 00	5.0		0 61.0
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see					0.00		0.00	61. 0
. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								61. (
. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)								61. (
. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).								61. (
. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)								61. (
. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)								61. (
		Pro	ogram Name	Program Coc	le Unweighte FTE Cou		Unweig Direct ( Cou	ĞМЕ FTE	
			1.00	2.00	3.00		4.0	00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4,					0.00			) 61. <sup>-</sup>

IOSPITAL AND HOSPI	TAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider	CCN: 15-1317	Period: From 01/01/2022	Worksheet S-2 Part I	
					To 12/31/2022	Date/Time Pre 5/30/2023 1:0	pared: 5 pm
						1.00	-
		Ith Resources and Ser				0.00	
		s that your hospital funding (see instruc		t reporting pe	riod for which	0.00	62.00
2.01 Enter the nu during in the nu	umber of FTE resident nis cost reporting pe	s that rotated from a <u>riod of HRSA THC prog</u> sidents in Nonprovide	Teaching Health Ce ram. (see instructi		o your hospital	0.00	62.01
3.00 Has your fac	cility trained reside	nts in nonprovider se	ttings during this			N	63.00
"Y" for yes	or "N" for no in col	umn 1. If yes, comple	te lines 64 through	67. (see inst Unweighted		Ratio (col. 1/	,
				FTEs Nonprovi der Si te	FTEs in	(col. 1 + col. 2))	
				1.00	2.00	3.00	1
		r FTE Residents in No		-This base yea	r is your cost r	reporting	
		uly 1, 2009 and befor yes, or your facilit		0.	0.00	0. 000000	64.00
resi dent FTI	Es attributable to ro	ber of unweighted non tations occurring in number of unweighted	all nonprovider				
		ur hospital. Enter in					
		1 + column 2)). (see Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
		-		FTEs	FTEs in	$(col \cdot 3 + col \cdot$	
				Nonprovi der Si te	Hospi tal	4))	
		1.00	2.00	3.00	4.00	5.00	
trained resi year period, associated of FTEs for ead program in or residents. I the program column 3, th unweighted p residents ai rotations or non-provide column 4, th unweighted p resident FTT your hospita 5, the ratio divided by	your facility dents in the base the program name with primary care ch primary care which you trained Enter in column 2, code. Enter in the number of orimary care FTE ttributable to occurring in all r settings. Enter in the number of orimary care Es that trained in al. Enter in column of (column 3 + column hstructions)			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der Si te	Hospi tal	2))	-
Section 550	4 of the ACA Current	Year FTE Residents ir	Nonprovider Settin	1.00 gsEffective	2.00 for cost reporti	3.00 ng periods	
begi nni ng oi	n or after July 1, 20	10	•		· · · · · · · · · · · · · · · · · · ·		
FTEs attribu Enter in col FTEs that th	utable to rotations o umn 2 the number of rained in your hospit	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	ovider settings. y care resident the ratio of	0. (	00 0.00	0. 000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
				0.10			

Heal th	Financial Systems	GREENE CO	UNTY GENERAL HOSP	I TAL	In Li	eu of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provi de		Period: From 01/01/2022	Worksheet S-2 Part I	
					To 12/31/2022	Date/Time Pre	pared:
		Program Name	Program Code	Unweighted	Unweighted	5/30/2023 1:0 Ratio (col. 3/	
				FTEs	FTEsin	(col. 3 + col.	
				Nonprovider Site	Hospi tal	4))	
		1.00	2.00	3.00	4.00	5.00	-
67.00	Enter in column 1, the program			0.0	0 0.0	0 0. 000000	67.00
	name associated with each of your primary care programs in						
	which you trained residents.						
	Enter in column 2, the program code. Enter in column 3, the						
	number of unweighted primary						
	care FTE residents attributable to rotations occurring in all						
	non-provider settings. Enter in						
	column 4, the number of unweighted primary care						
	resident FTEs that trained in						
	your hospital. Enter in column 5, the ratio of (column 3						
	divided by (column 3 + column						
	4)). (see instructions)						
						1.00	-
(0.00	Direct GME in Accordance with th						(0.00
68.00	For a cost reporting period begi MAC to apply the new DGME formul					N	68.00
	(August 10, 2022)?			, .			
					1.0	0 2.00 3.00	-
	Inpatient Psychiatric Facility P						
70.00	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no		PF), or does it o	contain an IPF sub	provider? N		70.00
71.00	If line 70 is yes: Column 1: Did	l the facility have ar				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 (see instructions)	cate which program ye	ear began during t	this cost reportin	g period.		
	Inpatient Rehabilitation Facilit						
75.00	ls this facility an Inpatient Re subprovider? Enter "Y" for yes		/(IRF), or does i	t contain an IRF	N		75.00
76.00	If line 75 is yes: Column 1: Did		n approved GME tea	aching program in	the most	0	76.00
	recent cost reporting period end	5		2			
	no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente						
	indicate which program year bega						
						1.00	
	Long Term Care Hospital PPS		C L UNUL O	6			
	Is this a long term care hospita Is this a LTCH co-located within				period? Enter	N N	80.00
	"Y" for yes and "N" for no.	•	•	1 3			
85.00	TEFRA Providers Is this a new hospital under 42	CFR Section §413.40(1	<sup>c</sup> )(1)(i) TEFRA? F		or "N" for no.	N	85.00
	Did this facility establish a ne	w Other subprovider (	(excluded unit) ur				86.00
87 00	§413.40(f)(1)(ii)? Enter "Y" fo Is this hospital an extended neo	or yes and "N" for no. Inclastic disease care	hosnital classifi	ed under section		N	87.00
	1886(d)(1)(B)(vi)? Enter "Y" for				- 1		07.00
					Approved for Permanent	Number of Approved	
					Adj ustment	Permanent	
					(Y/N)	Adjustments	-
88.00	Column 1: Is this hospital appro	ved for a permanent a	adjustment to the	TEFRA target	1.00	2.00	88.00
	amount per discharge? Enter "Y"						
	89. (see instructions) Column 2: Enter the number of ap	proved permanent adju	ustments.				
							-

PITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	F		Worksheet S-2 Part I Date/Time Pre 5/30/2023 1:0	epared
		Wkst. A Line No.	Effecti ve Date	Approved Permanent Adjustment Amount Per Discharge	
		1.00	2.00	3.00	
00 Column 1: If line 88, column 1 is Y, enter the Worksheet A li on which the per discharge permanent adjustment approval was Column 2: Enter the effective date (i.e., the cost reporting beginning date) for the permanent adjustment to the TEFRA tar per discharge. Column 3: Enter the amount of the approved permanent adjustme TEFRA target amount per discharge.	based. period rget amount	0. 00			0 89.0
			V	XI X 2.00	4
Title V and XIX Services			1.00	2.00	-
00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Er	iter "Y" for	N	Y	90. (
00 Is this hospital reimbursed for title V and/or XIX through th full or in part? Enter "Y" for yes or "N" for no in the appli	cable column.		Ν	Y	91.0
00 Are title XIX NF patients occupying title XVIII SNF beds (dua instructions) Enter "Y" for yes or "N" for no in the applicab	ole column.	, .		N	92.0
00 Does this facility operate an ICF/IID facility for purposes of "Y" for yes or "N" for no in the applicable column.			N	N	93.0
00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a applicable column.			N	N	94.
00 If line 94 is "Y", enter the reduction percentage in the appl 00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			0. 00 N	0. 00 N	95. 96.
<ul> <li>O IF line 96 is "Y", enter the reduction percentage in the appl</li> <li>Does title V or XIX follow Medicare (title XVIII) for the int</li> <li>stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for</li> <li>column 1 for title V, and in column 2 for title XIX.</li> </ul>	terns and resi	dents post	0. 00 N	0. 00 Y	97. 98.
01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit			N	Y	98.
<ul> <li>title XIX.</li> <li>Does title V or XIX follow Medicare (title XVIII) for the cal bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.</li> </ul>			Ν	Y	98.
101 title V, and in column 2 for title XIX. O3 Does title V or XIX follow Medicare (title XVIII) for a criti reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.			Ν	Ν	98.
04 Does title V or XIX follow Medicare (title XVIII) for a CAH r outpatient services cost? Enter "Y" for yes or "N" for no in			N	Ν	98.
<ul> <li>in column 2 for title XIX.</li> <li>05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co</li> </ul>			N	Y	98.
<pre>column 2 for title XIX. 06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column column 2 for title XIX.</pre>			Ν	Υ	98.
Rural Providers					4.0-
<ul> <li>00Does this hospital qualify as a CAH?</li> <li>00 If this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)</li> </ul>	nclusive meth	nod of payment	Y N		105. 106.
7.00 Column 1: If line 105 is Y, is this facility eligible for costraining programs? Enter "Y" for yes or "N" for no in column Column 2: If column 1 is Y and line 70 or line 75 is Y, do y approved medical education program in the CAH's excluded IPF	1. (see ins ou train I&Rs and/or IRF נ	ructions) s in an	Ν		107.
Enter "Y" for yes or "N" for no in column 2. (see instruction 8.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee schee		Y		108.
	Physi cal	Occupational	Speech	Respi ratory	-
	1.00 N	2.00 N	3.00 N	4.00 N	109.
0.00 If this hospital qualifies as a CAH or a cost provider, are					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC	N: 15-1317	Period: From 01/01/2022	Worksheet S- Part I	
			To 12/31/2022	Date/Time Pr 5/30/2023 1:	repared: 05 pm
				1.00	_
10.00 Did this hospital participate in the Rural Community Hospital Demonstration)for the current cost reporting period? Enter "Y complete Worksheet E, Part A, lines 200 through 218, and Work applicable.	" for yes or	"N" for no.	lf yes,	N	110. 0
			1.00	2.00	-
11.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	t reporting p umn 1 is Y, e icipating in	eriod? Enter nter the column 2.	N		111.0
	-	1.00	2.00	3.00	-
<ul> <li>12.00 Did this hospital participate in the Pennsylvania Rural Healt (PARHM) demonstration for any portion of the current cost rep period? Enter "Y" for yes or "N" for no in column 1. If col "Y", enter in column 2, the date the hospital began participa demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable.</li> <li>13.00 Did this hospital participate in the Community Health Access Transformation (CHART) model for any portion of the current content.</li> </ul>	oorting umn 1 is ating in the sed and Rural	Ν			112. C
reporting period? Enter "Y" for yes or "N" for no. Miscellaneous Cost Reporting Information					-
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub.15-1, chapter 22, §2208.1.	or E only) 3" percent ncludes	N			0115.0
16.00 Is this facility classified as a referral center? Enter "Y" f	or yes or	Ν			116. 0
"N" for no. 17.00 s this facility legally-required to carry malpractice insura	nce? Enter	Y			117. (
"Y" for yes or "N" for no. 18.00 Is the malpractice insurance a claims-made or occurrence poli	cy? Enter 1		1		118. (
if the policy is claim-made. Enter 2 if the policy is occurre	ence.	Premiums	Losses	Insurance	
18.01 List amounts of malpractice premiums and paid losses:		1.00 369,5	2.00	3.00	0 118. 0
18.02 Are malpractice premiums and paid losses reported in a cost c			1.00 N	2.00	118. (
Administrative and General? If yes, submit supporting schedu and amounts contained therein.	le listing co	st centers			
19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" difies for th	for yes or e Outpatient		Ν	119. ( 120. (
21.00 Did this facility incur and report costs for high cost implar	ntable devices	charged to	Y		121. (
patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. (
23.00 Did the facility and/or its subproviders (if applicable) purces services, e.g., legal, accounting, tax preparation, bookkeepi management/consulting services, from an unrelated organizatic for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e.,	ng, payroll, m?In column	and/or 1, enter "Y"			123.
professional services expenses, for services purchased from u located in a CBSA outside of the main hospital CBSA? In colum "N" for no.	inrelated orga	ni zati ons			
Certified Transplant Center Information 25.00 Does this facility operate a Medicare-certified transplant ce		Y" for yes	N		125.
and "N" for no. If yes, enter certification date(s) (mm/dd/yy 26.00 If this is a Medicare-certified kidney transplant program, er	iter the certi	fication dat	e		126.
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare-certified heart transplant program, ent		ication date			127. (
in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare-certified liver transplant program, ent		ication date	•		128. (
in column 1 and termination date, if applicable, in column 2. 29.00 f this is a Medicare-certified lung transplant program, ente		cation date			129.

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLE	GREENE COUNT EX IDENTIFICATION DATA	Provider CCN	N: 15-1317	From O	: 1/01/2022 2/31/2022		epared:
					1.00	2.00	1
0.00 If this is a Medicare-certified p			ti fi cati o	n			130. 0
date in column 1 and termination 1.00 If this is a Medicare-certified i			erti fi cati	ion			131.0
date in column 1 and termination							101.0
2.00 If this is a Medicare-certified i			cation d	ate			132. 0
in column 1 and termination date, 3.00 Removed and reserved	ir applicable, in col	umn 2.					133.0
4.00 If this is a hospital-based organ in column 1 and termination date, All Providers			e OPO numl	ber			134. 0
0.00 Are there any related organizatio	n or home office costs	s as defined in CMS F	Pub. 15-1	,	N		140. 0
chapter 10? Enter "Y" for yes or	"N" for no in column 1	. If yes, and home of	office co				
are claimed, enter in column 2 th 1.00	e home office chain nu	umber. (see instructi 2.00	ons)		3.00		
If this facility is part of a cha	in organization, enter		gh 143 th	e name and		of the	
home office and enter the home of	<u>fice contractor name a</u>	and contractor numbe	r.				
1.00 Name: 2.00 Street:	Contractor's Nam PO Box:	ne:	Contra	actor's Nu	imber:		141.0
3. 00 Ci ty:	State:		Zip Co	ode:			142.0
4.00 Are provider based physicians' co	sts included in Worksh	peet 12				1.00 Y	144. C
4. OUNTE provider based physicialis co	sts merdded mi worksi					1	144.0
5.00  f costs for renal services are c					1.00	2.00	145. 0
inpatient services only? Enter "Y no, does the dialysis facility in	clude Medicare utiliza						
period? Enter "Y" for yes or "N" 6.00Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	gy changed from the pr n column 1. (See CMS P			lf	N		146. 0
6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i	gy changed from the pr n column 1. (See CMS P			lf	N	1.00	146. C
6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2.	Pub. 15-2, chapter 4(	D, §4020)	lf	N	1.00 N	146. C
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist</li> <li>8.00 Was there a change in the order o</li> </ul>	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y	Pub. 15-2, chapter 40 for yes or "N" for n " for yes or "N" for n	D, §4020)		N	N N	147. 0 148. 0
6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y	Pub. 15-2, chapter 40 for yes or "N" for r /" for yes or "N" for pd? Enter "Y" for yes	D, §4020)	for no.		N N N	147. 0
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/</li> <li>7.00 Was there a change in the statist</li> <li>8.00 Was there a change in the order o</li> <li>9.00 Was there a change to the simplif</li> </ul>	gy changed from the pr n column 1. (See CMS P <u>dd/yyyy) in column 2.</u> ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho	Pub. 15-2, chapter 4 for yes or "N" for r " for yes or "N" for d? Enter "Y" for yes Part A 1.00	0, §4020) no. r no. s or "N" Part 1 2.00	for no. B T	itle V 3.00	N N Title XIX 4.00	147. ( 148. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov</li> </ul>	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter 4 for yes or "N" for in y" for yes or "N" for yd? Enter "Y" for yes Part A 1.00 pr an exemption from	0, §4020) no. r no. s or "N" Part 1 2.00 the appl	for no. B T ication of	itle V 3.00 f the lowe	N N Title XIX 4.00 er of costs	147. ( 148. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm// 7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> </ul>	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter 4 for yes or "N" for in y" for yes or "N" for yd? Enter "Y" for yes Part A 1.00 pr an exemption from	0, §4020) no. r no. s or "N" Part 1 2.00 the appl	for no. B T ication of	itle V 3.00 f the lowe	N N Title XIX 4.00 er of costs	147. ( 148. ( 149. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> </ul>	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	for yes or "N" for ye	D, §4020) no. r no. s or "N" Part I 2.00 the appl and Part N N	for no. B T ication of	itle V 3.00 f the lowe 2 CFR §413 N N	N N Title XIX 4.00 er of costs 3.13) N N	147. ( 148. ( 149. ( 149. ( 155. ( 156. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> </ul>	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	for yes or "N" for yes or an exemption for part A N	0, §4020) no. no. s or "N" <u>Part I</u> <u>2.00</u> the appl and Part N	for no. B T ication of	itle V 3.00 f the lowe 2 CFR §413 N	N N Title XIX 4.00 er of costs 3.13) N	147. ( 148. ( 149. ( 149. ( 155. ( 156. ( 157. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> <li>8.00 SUBPROVIDER</li> </ul>	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter 40 for yes or "N" for r "for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption from omponent for Part A N N N	D, §4020)	for no. B T ication of	itle V 3.00 f the lowe <u>2 CFR §413</u> N N N	N N Title XIX 4.00 er of costs 3.13) N N N	147. ( 148. ( 149. ( 149. ( 155. ( 156. ( 157. ( 158. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist 8.00 Was there a change in the order o 9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> </ul>	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	for yes or "N" for ye	D, §4020) no. r no. s or "N" Part I 2.00 the appl and Part N N	for no. B T ication of	itle V 3.00 f the lowe 2 CFR §413 N N	N N Title XIX 4.00 er of costs 3.13) N N	147. ( 148. ( 149. ( 149. ( 155. ( 156. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist</li> <li>8.00 Was there a change in the order o</li> <li>9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> </ul>	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter 40 for yes or "N" for r "for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption from poponent for Part A N N N N	D, §4020)	for no. B T ication of	itle V 3.00 f the Iowe 2 CFR §413 N N N N	N N Title XIX 4.00 er of costs 3.13) N N N	147. ( 148. ( 149. ( 155. ( 156. ( 157. ( 158. ( 159. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm// </li></ul>	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo	Pub. 15-2, chapter 40 for yes or "N" for r "for yes or "N" for d? Enter "Y" for yes Part A 1.00 or an exemption from poponent for Part A N N N N	D, §4020) no. no. no. no. Part 1 2.00 the appl and Part N N N N N	for no. B T ication of	itle V 3.00 f the lowe <u>2 CFR §413</u> N N N N	N N Title XIX 4.00 Fr of costs 3.13) N N N N N N N	147. ( 148. ( 149. ( 155. ( 156. ( 157. ( 158. ( 159. ( 160. (
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<ul> <li>6. 00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/</li> <li>7. 00 Was there a change in the statist</li> <li>8. 00 Was there a change in the order o</li> <li>9. 00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5. 00 Hospital</li> <li>6. 00 Subprovider - IPF</li> <li>7. 00 Subprovider - IRF</li> <li>8. 00 SUBPROVIDER</li> <li>9. 00 SNF</li> <li>0. 00 HOME HEALTH AGENCY</li> <li>1. 00 CMHC</li> </ul> Multicampus 5. 00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no.	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co	for yes or "N" for r for yes or "N" for r for yes or "N" for r Part A 1.00 or an exemption from poponent for Part A N N N N N N N	no. no. no. s or "N" Part 1 2.00 the appl and Part N N N N N N Sees in di	for no. B T i cati on of B. (See 42 fferent CB	itle V 3.00 f the lowe 2 CFR §413 N N N N N N N SSAS?	N N N Title XIX 4.00 Pr of costs 3.13) N N N N N N N N N N N N N FTE/Campus 5.00	147. 148. 149. 149. 155. 156. 157. 158. 157. 160. 161. 161.
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<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist 8.00 Was there a change in the order o</li> <li>9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - 1PF</li> <li>7.00 Subprovider - 1RF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> <li>0.00 HOME HEALTH AGENCY</li> <li>1.00 CMHC</li> </ul> Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 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	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y" ied cost finding metho ider that qualifies for "N" for no for each co "N" for no for each co ampus hospital that ha Name	Pub. 15-2, chapter 40 for yes or "N" for r (" for yes or "N" for r od? Enter "Y" for yes Part A 1.00 or an exemption from ponent for Part A N N N N N N N N N N N N N N N N N N N	D, \$4020) no. r no. s or "N" Part 1 2.00 the appl and Part N N N N N N Sees in di <sup>-</sup>	for no. B T i cation of B. (See 42 fferent CB Zip Code	itle V 3.00 f the lowe 2 CFR §413 N N N N N N SAs? CBSA	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. ( 148. ( 149. ( 155. ( 156. ( 157. ( 158. ( 159. ( 160. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist 8.00 Was there a change in the order o</li> <li>9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - 1PF</li> <li>7.00 Subprovider - 1RF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> <li>0.00 HOME HEALTH AGENCY</li> <li>1.00 CMHC</li> </ul> Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 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	gy changed from the pr n column 1. (See CMS P dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y ied cost finding metho ider that qualifies fo "N" for no for each co "N" for no for each co ampus hospital that ha Name 0	for yes or "N" for r for yes or "N" for r for yes or "N" for r Part A 1.00 pr an exemption from poponent for Part A N N N N N N N N N N N N N	D, \$4020)	for no. B T i cati on of B. (See 42 See 42 Fferent CB Zi p Code 3. 00	itle V 3.00 f the lowe 2 CFR §413 N N N N N N SAs? CBSA	N N N Title XIX 4.00 Pr of costs 3.13) N N N N N N N N N N N N N FTE/Campus 5.00	147. ( 148. ( 149. ( 149. ( 155. ( 156. ( 157. ( 158. ( 157. ( 158. ( 160. ( 161. ( 165. ( 165. (
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist</li> <li>8.00 Was there a change in the order o</li> <li>9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - 1PF</li> <li>7.00 Subprovider - 1RF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> <li>0.00 HOME HEALTH AGENCY</li> <li>1.00 CMHC</li> </ul> Multicampus 5.00 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) Heal th Information Technology (HI 7.00 Is this provider a meaningful use	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each co "N" for no for each co ampus hospital that ha Name 0 1 1 incentive in the Am r under §1886(n)? Ent	Pub. 15-2, chapter 40         for yes or "N" for in         (" for yes or "N" for yes or "N" for yes or "N" for yes         Part A         1.00         or an exemption from part A         N <td>D, \$4020)</td> <td>for no. B T i cation of B. (See 42 fferent CB Zip Code 3.00 ment Act</td> <td>i tl e V         3.00         f the lowe         2 CFR §413         N         N         N         N         N         N         N         SSAs?         CBSA         4.00</td> <td>N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N</td> <td>147.0 148.0 149.0 155.0 155.0 157.0 157.0 157.0 157.0 157.0 165.0 165.0 165.0 165.0 165.0</td>	D, \$4020)	for no. B T i cation of B. (See 42 fferent CB Zip Code 3.00 ment Act	i tl e V         3.00         f the lowe         2 CFR §413         N         N         N         N         N         N         N         SSAs?         CBSA         4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147.0 148.0 149.0 155.0 155.0 157.0 157.0 157.0 157.0 157.0 165.0 165.0 165.0 165.0 165.0
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist</li> <li>8.00 Was there a change in the order o</li> <li>9.00 Was there a change in the order o</li> <li>9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - 1PF</li> <li>7.00 Subprovider - 1RF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> <li>0.00 HOME HEALTH AGENCY</li> <li>1.00 CMHC</li> </ul> Multicampus 5.00 Is this hospital part of a Multic Enter "Y" for yes or "N" for no. 6.00 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) Heal th Information Technology (HI 7.00 Is this provider a meaningful use 8.00 If this provider is a CAH (line 1)	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each co "N" for no for each co	Pub. 15-2, chapter 40 for yes or "N" for r /" for yes or "N" for r /" for yes or "N" for r /" for yes or "N" for r Part A 1.00 or an exemption from pomponent for Part A N N N N N N N N N N N N N	D, \$4020)	for no. B T i cation of B. (See 42 fferent CB Zip Code 3.00 ment Act	i tl e V         3.00         f the lowe         2 CFR §413         N         N         N         N         N         N         N         SSAs?         CBSA         4.00	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. ( 148. ( 149. ( 155. ( 157. ( 157. ( 157. ( 157. ( 157. ( 157. ( 157. ( 160. ( 161. ( 161. ( 161. ( 165. ( 165. ( 165. ( 166. ( 16
<ul> <li>6.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no i yes, enter the approval date (mm//</li> <li>7.00 Was there a change in the statist</li> <li>8.00 Was there a change in the order o</li> <li>9.00 Was there a change to the simplif</li> <li>Does this facility contain a prov or charges? Enter "Y" for yes or</li> <li>5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> <li>0.00 HOME HEALTH AGENCY</li> <li>1.00 CMHC</li> <li>Multicampus</li> <li>5.00 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)</li> <li>Heal th Information Technology (HI</li> <li>7.00 Is this provider a meaningful use</li> </ul>	gy changed from the pr n column 1. (See CMS F dd/yyyy) in column 2. ical basis? Enter "Y" f allocation? Enter "Y" ied cost finding method ider that qualifies for "N" for no for each co "N" for no for each co ampus hospital that ha Name 0 T) incentive in the Am r under §1886(n)? Ent 05 is "Y") and is a me HIT assets (see instru	Pub. 15-2, chapter 40 for yes or "N" for r /" for yes or "N" for r /" for yes or "N" for part A 1.00 or an exemption from mponent for Part A N N N N N N N N N N N N N	D, \$4020)	for no. B T ication of B. (See 42 Fferent CE Zip Code 3.00 ment Act	itle V 3.00 f the lowe 2 CFR §413 N N N N N N N N N N N N N	N N N Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N N N N N N N	147. ( 148. ( 149. ( 155. ( 157. ( 157. ( 158. ( 157. ( 158. ( 167. ( 160. ( 160. ( 160. ( 160. ( 160. ( 160. ( 160. ( 167. ( 167. ( 167. ( 167. (

Health Financial Systems	GREENE COUNTY GENE	RAL HOSPITAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA		Period:	Worksheet S-2	2
			From 01/01/2022		
			To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
			Beai nni na	Endi na	
					-
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	ginning date and ending da	te for the reporting			170.00
			1.00	2.00	-
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	Ν		0171.00
section 1876 Medicare cost plans re	ported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in colum	n 1. lfcolumn 1 is yes, e	nter the number of section	1		
1876 Medicare days in column 2. (se	e instructions)				

OSPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Date/Time Pr	epared:
				Y/N	5/30/2023 1: Date	
				1.00	2.00	+
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	_
. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.0
	reporting period: in yes, enter the date of the change in t	Jor unit 2. (366	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for	N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members or of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug ler or its of the board	Y			3.0
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, Nilable in	Y	A		4.0
. 00	Are the cost report total expenses and total revenues different those on the filed financial statements? If yes, submit reconcisional statements of the statement of the stateme		N			5.0
			1	Y/N	Legal Oper.	
				1.00	2.00	
00	Approved Educational Activities	0 16		- N	1	
. 00 . 00	Column 1: Are costs claimed for a nursing program? Column the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	r N N		6.0		
. 00 . 00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved		8. C			
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated c	IS.		N		10.0
1. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	Ν		11. (
					Y/N	
					1.00	
	Bad Debts Is the provider seeking reimbursement for bad debts? If yes		tions		Y	1 12 0
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	12. (
4. 00	If line 12 is yes, were patient deductibles and/or coinsura instructions. Bed Complement	ince amounts wa	aived? If yes,	, see	N	14. (
5.00	Did total beds available change from the prior cost reporti	ng period? If	yes, see ins	tructions.	N	15. (
			rt A		rt B	
		Y/N	Date	Y/N	Date	_
	PS&R Data	1.00	2.00	3.00	4.00	
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 instructions)	Y	03/31/2023	Y	03/31/2023	16. (
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Ν		Ν		17. (
3. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Ν		Ν		18. (
9. 00	If line 16 or 17 is yes, see instructions. Report data for corrections of other PS&R Report information? If yes, see instructions.	Ν		Ν		19. (

Health Financial System

GREENE COUNTY GENERAL HOSPITA	۹L
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In Lieu of Form CMS-2552-10

Heal th	FINANCIAI Systems GREENE COUNTY G	ENERAL HUSPITAL		In Lie	U OT FORM CMS	5-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet S Part II Date/Time Pi 5/30/2023 1	repared:
		Descr	iption	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS H	HOSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			Ν	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	sals made duri	ng the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	porting period?	Ν	24.00		
25.00	Have there been new capitalized leases entered into during instructions.	lfyes, see	Ν	25.00		
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t instructions.	f yes, see	Ν	26.00		
27.00	Has the provider's capitalization policy changed during th copy.	yes, submit	Ν	27.00		
	Interest Expense					
28.00	Were new Loans, mortgage agreements or letters of credit e period? If yes, see instructions.	Ν	28.00			
29.00	Did the provider have a funded depreciation account and/or	eserve Fund)	Y	29.00		
30. 00	treated as a funded depreciation account? If yes, see inst Has existing debt been replaced prior to its scheduled mat	see	Ν	30.00		
31.00	instructions. Has debt been recalled before scheduled maturity without i	see	Ν	31.00		
	instructions. Purchased Services					
	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr	ructions.	0		Ν	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	plied pertainin	ng to competit	tive bidding? If	Ν	33.00
	Provi der-Based Physi ci ans			•		
34.00	Were services furnished at the provider facility under an If yes, see instructions.	arrangement wi	th provider-ba	ased physicians?	Y	34.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see i		nts with the p	provi der-based	Ν	35.00
	priver and during the cost reporting periodi in yes, cost			Y/N	Date	
				1.00	2.00	
	Home Office Costs					
	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 p	prepared by the	home office?	Ν		37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of			N		38.00
39. 00	the provider? If yes, enter in column 2 the fiscal year en If line 36 is yes, did the provider render services to oth			N		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	lfyes, see	N		40.00
	instructions.					_
		1.	. 00	2.	00	_
	Cost Report Preparer Contact Information			- I		
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ERI C	CARMACK		41.00	
42.00	Enter the employer/company name of the cost report	FORVIS, LLP				42.00
43.00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-4000		ERIC. CARMACK@F(	DRVIS.COM	43.00

Heal th	Financial Systems GREENE COUNT	Y GE	ENERAL HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1317		eri od:	Worksheet S-2		
				T	rom 01/01/2022 b 12/31/2022		pared: 5 pm	
			3.00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position		MANAGING DI RECTOR				41.00	
	held by the cost report preparer in columns 1, 2, and 3	,						
	respectively.							
42.00	Enter the employer/company name of the cost report						42.00	
	preparer.							
43.00	Enter the telephone number and email address of the cos	t					43.00	
	report preparer in columns 1 and 2, respectively.							

	<u>Financial Systems</u> GR TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	EENE COUNTY GEN AL DATA	Provi der CC	N: 15-1317	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 01/01/2022 To 12/31/2022	Part I Date/Time Prep	
				I		5/30/2023 1:05	
						<u>Visits / Trips</u>	
	Component	Worksheet A Line No.	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
	PART I – STATISTICAL DATA						
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	20	7,30	34, 752. 00	0	1.
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)						2.
. 00	HMO IPF Subprovider						3.
. 00	HMO IRF Subprovider						4.
. 00	Hospital Adults & Peds. Swing Bed SNF					0	5.
. 00	Hospital Adults & Peds. Swing Bed NF					0	6.
. 00	Total Adults and Peds. (exclude observation		20	7,30	00 34, 752. 00	0	7.
. 00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	5	1, 82	4, 992. 00	0	8.
. 00	CORONARY CARE UNI T	51.00	5	1, 02	4, 992.00	0	9.
0.00	BURN INTENSIVE CARE UNIT						10
1.00	SURGI CAL INTENSI VE CARE UNI T						11
2.00	OTHER SPECIAL CARE (SPECIFY)						12
3.00	NURSERY	43.00				0	13
4.00	Total (see instructions)		25	9, 12	39, 744. 00	0	14
5.00	CAH visits					0	15
5.00 7.00	SUBPROVI DER – I PF SUBPROVI DER – I RF						16   17
3. 00	SUBPROVI DER						18
7.00	SKILLED NURSING FACILITY						19
0. 00	NURSING FACILITY						20
1.00	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY						22
3.00	AMBULATORY SURGICAL CENTER (D. P. )						23
4.00	HOSPICE	20.00					24
4. 10 5. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24 25
5.00	RURAL HEALTH CLINIC	88.00				0	26
5. 01	RURAL HEALTH CLINIC II	88.01				Ő	26
b. 02	RURAL HEALTH CLINIC III	88. 02				0	26
5. 03	RURAL HEALTH CLINIC IV	88. 03				0	26
5. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26
7.00	Total (sum of lines 14-26)		25				27
8.00	Observation Bed Days					0	28
). 00 ). 00	Ambulance Trips Employee discount days (see instruction)						29 30
. 00	Employee discount days (see first detroit)						31
2.00	Labor & delivery days (see instructions)		о		0		32
2.01	Total ancillary labor & delivery room		Ŭ				32
	outpatient days (see instructions)						
3.00	LTCH non-covered days						33
3.01	LTCH site neutral days and discharges		_			_	33
t. 00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0		0	0	34

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	CN: 15-1317	Period: From 01/01/2022 To 12/31/2022		epared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
	PART I – STATISTICAL DATA					1	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	833	46	1, 44	18		1.00
. 00	HMO and other (see instructions)	149	0				2.00
. 00	HMO I PF Subprovider	0	0				3.00
. 00	HMO IRF Subprovider	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	243	0	27	73		5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 076	46	1, 72	21		7.00
. 00	INTENSIVE CARE UNIT	72	10	20	08		8.00
. 00	CORONARY CARE UNIT						9.0
0. 00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGI CAL INTENSI VE CARE UNI T						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)						12.0
3.00	NURSERY		78	11			13.0
4.00	Total (see instructions)	1, 148	134	2, 04	12 0.00	295.61	
5.00	CAH visits	0	0		0		15.0
6.00 7.00	SUBPROVI DER – I PF SUBPROVI DER – I RF						16.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
4.00	HOSPI CE						24.0
4. 10	HOSPICE (non-distinct part)				0		24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC	3, 672	593				
6.01	RURAL HEALTH CLINIC II	1, 685	136	9, 01			
6.02	RURAL HEALTH CLINIC III	971	37	4, 53			
6.03	RURAL HEALTH CLINIC IV	539	68	2, 57			
6.25 7.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
8.00	Total (sum of lines 14-26) Observation Bed Days		128	1, 20		337.67	27.0
8.00 9.00	Ambul ance Trips	0	120	1, 20	71		20.0
9.00 0.00	Employee discount days (see instruction)	0			0		30.0
1.00	Employee discount days (see first detroit)				0		31.0
2.00	Labor & delivery days (see instructions)	0	30	4	17		32.0
2.00	Total ancillary labor & delivery room	Ĭ	50		0		32.0
	outpatient days (see instructions)				-		
3.00	LTCH non-covered days	О					33.0
3. 01	LTCH site neutral days and discharges	0					33. C
1 00	Temporary Expansion COVID-19 PHE Acute Care	0	0		0		34.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	AL DATA	Provider CO	CN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet S-3 Part I Date/Time Pre 5/30/2023 1:0	pared:
		Full Time		Di s	charges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
	PART I – STATISTICAL DATA	11100	12100	10100	11100	10100	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2!	57 60	761	1.00
2.00 3.00 4.00 5.00 6.00 7.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation				33 0 0 0		2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00 14.00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	0. 00	0	25	57 60	761	8.00 9.00 10.00 11.00 12.00 13.00 14.00
$\begin{array}{c} 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 10\\ \end{array}$	CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P. ) HOSPICE HOSPICE (non-distinct part)	0.00	U	2:	,, 60	/01	$\begin{array}{c} 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 24.\ 10\\ \end{array}$
25. 00 26. 00 26. 01 26. 02 26. 03 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	CMHC - CMHC RURAL HEALTH CLINIC RURAL HEALTH CLINIC II RURAL HEALTH CLINIC III RURAL HEALTH CLINIC IV FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary Labor & delivery room submaticat days (see instructions)	0.00 0.00 0.00 0.00 0.00 0.00					$\begin{array}{c} 25.\ 00\\ 26.\ 00\\ 26.\ 01\\ 26.\ 02\\ 26.\ 03\\ 26.\ 25\\ 27.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 32.\ 01\\ \end{array}$
33. 00 33. 01 34. 00	outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care				0		33. 00 33. 01 34. 00

Heal th	Financial Systems GF	REENE COUNTY GE	ENERAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Peri od:	Worksheet S-8	
			Component		From 01/01/2022 To 12/31/2022		
					RHC I		
					1.	00	
1 00	Clinic Address and Identification				1010 1 1000 1		1 00
1.00	Street		Ci	ty	1210 N. 1000 W State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		LI NTON	00		47441	2.00
					-		
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u			0	3.00
					t Award 1.00	Date 2.00	
	Source of Federal Funds				1.00	2.00	
4.00	Community Health Center (Section 330(d), PHS	Act)					4.00
5.00	Migrant Health Center (Section 329(d), PHS Ad						5.00
6.00	Health Services for the Homeless (Section 340	O(d), PHS Act)					6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECI FY)		-				9.00
					1.00	2.00	
10.00	Does this facility operate as other than a ho	ospital-based f	RHC or FQHC? En	iter "Y" for	N		10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)						
	1001 S. )	Sur	nday	Mc	onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
	Facility hours of operations (1)	I	T	1		1	
11.00	CLINIC						11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the produ	uctivity standa	urd?	Y	2.00	12.00
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report.	d in CMS Pub. ′ umn 1. If yes,	100-04, chapter enter in colum	9, section n 2 the	Ň	0	
	numbers below.			Drout	dor namo	CCN	
					der name 1.00	2.00	
14.00	RHC/FQHC name, CCN					2.00	14.00
		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 GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by Intern & Residents for titles V, XVIII, and						
	XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)						
				inty			
2.00				00			2.00
2.00	City, State, ZIP Code, County	Tuesday	GREENE	esday	Thur	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

					u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1317	Period: From 01/01/2022	Worksheet S-8	8
		Component (	CCN: 15-8535	To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
			_	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 CLINIC						11.00

Heal th	Financial Systems GF	REENE COUNTY GE	ENERAL HOSPITAL	-	In Lie	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-8	3
			Component		From 01/01/2022 To 12/31/2022		epared: D5 pm
					RHC II		
					1.	. 00	
1.00	Clinic Address and Identification Street				55 N. JUDGE ST	r	1.00
1.00			Ci	ty	State	ZIP Code	1.00
				00	2.00	3.00	
2.00	City, State, ZIP Code, County		BLOOMFIELD		IN	47424	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	or "P" for rur	al or "II" for i	irban		1.00	3.00
3.00	THOSE TRE-DASED TURCS UNET. DESIGNATION - Ente				t Award	Date	3.00
				-	. 00	2.00	
	Source of Federal Funds						
4.00 5.00 6.00 7.00 8.00 9.00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340 Appalachian Regional Commission Look-Alikes OTHER (SPECIFY)	ct)					4.00 5.00 6.00 7.00 8.00 9.00
10.00	Deer this facility operate as other than a he	conital bacad [	DUC or EOUC2 Er	tor "V" for	1.00 N	2.00	0 10.00
10.00	Does this facility operate as other than a horyes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of d	other operatior	ns in column	N		10.00
		Sur	nday	Мо	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC		1	L		1	11.00
11.00					1.00	2.00	11.00
	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 colu number of providers included in this report. numbers below.	d in CMS Pub. ′ umn 1. If yes,	100-04, chapter enter in colum	9, section n 2 the	Y N		12.00 13.00
				Provia	der name	CCN	
	1			1	. 00	2.00	
14.00	RHC/FQHC name, CCN	V /NI		VV/111	VIV	Total Minist	14.00
		Y/N 1.00	V 2.00	XVIII 3.00	4.00	Total Visits 5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)				4.00	5.00	15.00
		County					
2 00	City State 7LB Code County			00			2.00
2.00	City, State, ZIP Code, County	Tuesday	GREENE	esday	Thu	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)		1			1	
11.00	CLINIC		1			1	11.00

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1317	Period: From 01/01/2022	Worksheet S-8	3
		Component	CCN: 15-8533	To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
				RHC II		
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11.00 CLINIC						11.00

Heal th	Financial Systems GR	REENE COUNTY GE	ENERAL HOSPITAL		In Li	eu of Form CMS-	2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1317	Peri od:	Worksheet S-8	
			Component	CCN: 15-8534	From 01/01/2022 To 12/31/2022		
					RHC III		
					1	. 00	-
	Clinic Address and Identification						_
1.00	Street		C:	+	1985 E. FREEDO		1.00
				ty 00		ZIP Code 3.00	
2.00	City, State, ZIP Code, County		NEWBERRY	00		N 47449	2.00
3.00	HOSPITAL-BASED FOHCs ONLY: Designation - Ente	pr "P" for rur	al or "II" for u	Irban		1.00	3.00
3.00	THOSPITAL-BASED FUNCS UNLT. DESIGNATION - ENTE				t Award	Date	3.00
					1. 00	2.00	
	Source of Federal Funds			1			
4.00	Community Health Center (Section 330(d), PHS						4.00
5.00 6.00	Migrant Health Center (Section 329(d), PHS Ac Health Services for the Homeless (Section 340						5.00 6.00
7.00	Appal achi an Regi onal Commi ssi on	J(u), THS ACT)					7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a ho	spital-based F	RHC or FQHC? En	ter "Y" for	N	2.00	10.00
	yes or "N" for no in column 1. If yes, indica 2.(Enter in subscripts of line 11 the type of hours.)	ate number of a	other operation	ns in column			
	10013.)	Sur	nday	Mc	onday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1) CLINIC						11.00
11.00							11.00
					1.00	2.00	
	Have you received an approval for an exceptic Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report. numbers below.	d in CMS Pub. ´ umn 1. If yes,	100-04, chapter enter in colum	9, section n 2 the	Y N	0	12.00 13.00
					der name	CCN	
14.00				1	1.00	2.00	14.00
14.00	RHC/FQHC name, CCN	Y/N	V	XVIII	XIX	Total Visits	14.00
		1.00	2.00	3.00	4.00	5.00	
15.00	Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)						15.00
				inty	_		
2.00	City, State, ZIP Code, County		4. GREENE	00			2.00
2.00	orty, state, zir code, county	Tuesday	-	esday	Thu	rsday	2.00
		to	from	to	from	to	
		6.00	7.00	8.00	9.00	10.00	
11 00	Facility hours of operations (1)		1	1			111 00
11.00	CLINIC	l	1	I		1	11.00

Health Financial Systems G		In Lieu of Form C				
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1317	Period: From 01/01/2022	Worksheet S-8	3
		Component	CCN: 15-8534	To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
				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 CLINIC						11.00

Heal th	Financial Systems GR	REENE COUNTY GE	ENERAL HOSPITAL		In Li	eu of Form CMS-	-2552-10
	AL-BASED RHC/FQHC STATISTICAL DATA		Provider C		Period:	Worksheet S-	8
			Component		From 01/01/2022 To 12/31/2022		epared: 05 pm
					RHC IV		
					1	. 00	-
	Clinic Address and Identification					. 00	
1.00	Street				102 E. MAIN ST	TREET	1.00
				ty	State	ZIP Code	
0.00				00	2.00	3.00	0.00
2.00	City, State, ZIP Code, County		WORTHI NGTON		11	47471	2.00
						1.00	
3.00	HOSPITAL-BASED FQHCs ONLY: Designation - Ente	er "R" for rura	al or "U" for u	ırban			3.00
					Award	Date	
				1	. 00	2.00	
4.00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)					4.00
4.00 5.00	Migrant Health Center (Section 329(d), PHS Ac						5.00
6.00	Health Services for the Homeless (Section 340						6.00
7.00	Appalachian Regional Commission						7.00
8.00	Look-Alikes						8.00
9.00	OTHER (SPECIFY)						9.00
					1.00	2.00	
10.00	Does this facility operate as other than a ho	ospital-based f	RHC or FQHC? Er	ter "Y" for	N 1.00		0 10.00
	yes or "N" for no in column 1. If yes, indica 2. (Enter in subscripts of line 11 the type of hours.)	ate number of a	other operatior	ns in column			
		Sur	nday	Мо	nday	Tuesday	
		from	to	from	to	from	
		1.00	2.00	3.00	4.00	5.00	
11 00	Facility hours of operations (1)					1	111 00
11.00	CLINIC						11.00
					1.00	2.00	
12.00	Have you received an approval for an exception	on to the produ	uctivity standa	ird?	Y		12.00
13.00	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu number of providers included in this report. numbers below.	umn 1. If yes,	enter in colum	n 2 the	N	(	0 13.00
	Indiliber 3 ber ow.			Provid	ler name	CCN	
					. 00	2.00	
14.00	RHC/FQHC name, CCN						14.00
		Y/N	V	XVIII	XIX	Total Visits	
15 00	Have you provided all or substantially all	1.00	2.00	3.00	4.00	5.00	15.00
15.00	GME cost? Enter "Y" for yes or "N" for no in						15.00
	column 1. If yes, enter in columns 2, 3 and						
	4 the number of program visits performed by						
	Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the						
	number of total visits for this provider.						
	(see instructions)						
				inty			
				00			
2.00	City, State, ZIP Code, County	Tuocday	GREENE	ocday	Thu	reday	2.00
		Tuesday to	from Wedn	esday to	from	rsday to	
		6.00	7.00	8.00	9.00	10.00	
	Facility hours of operations (1)						
11.00	CLINIC						11.00

Health Financial Systems G	In Lieu of Form CM			2552-10		
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provider C	CN: 15-1317	Period: From 01/01/2022	Worksheet S-8	8
		Component (	CCN: 15-8538	To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
				RHC IV		
	Fri	day	Sa	turday		
	from	to	from	to		
	11.00	12.00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC						11.00

Heal th	Financial Systems GREENE COUNTY GENER	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10			
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1317	Period:	Worksheet S-1				
				From 01/01/2022 To 12/31/2022					
					1.00				
	Uncompensated and indigent care cost computation				1.00				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by lir	ne 202 column	8)	0. 336233	1.00			
0.00	Medicaid (see instructions for each line)				0.004.405				
2.00 3.00	Net revenue from Medicaid Did you receive DSH or supplemental payments from Medicaid?				3, 021, 105 Y	2.00 3.00			
3.00 4.00	If line 3 is yes, does line 2 include all DSH and/or supplement	tal navments	s from Medica	i d2	N N	4.00			
5.00	If line 4 is no, then enter DSH and/or supplemental payments f			ru:	1, 198, 096				
6.00	Medi cai d charges				35, 866, 470				
7.00	Medicaid cost (line 1 times line 6)				12, 059, 491	7.00			
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	•		es 2 and 5; if	7, 840, 290	8.00			
	Children's Health Insurance Program (CHIP) (see instructions f	or each line	e)						
9.00	Net revenue from stand-al one CHIP				0				
10. 00 11. 00					0				
12.00		(line 11 mir	nus line 9 <sup>,</sup> i	f < zero then	0				
12.00	enter zero)								
12 00	Other state or local government indigent care program (see ins			<u>`````````````````````````````````````</u>	0	13.00			
13.00 14.00		Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)       0       13.         Charges for patients covered under state or local indigent care program (Not included in lines 6 or       0       14.							
14.00	(10)								
15.00	State or local indigent care program cost (line 1 times line 14) 0 15								
16.00		digent care	program (lir	e 15 minus line	0	16.00			
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see								
	instructions for each line)	ir and state		ent care progra	115 (566				
17.00	Private grants, donations, or endowment income restricted to f				0				
18.00				· • • • •	0				
19.00	Total unreimbursed cost for Medicaid, CHIP and state and loca 8, 12 and 16)	I indigent of	care programs	(sum of lines	7, 840, 290	19.00			
			Uni nsured	Insured	Total (col. 1				
		-	patients 1.00	patients 2.00	+ col. 2) 3.00				
	Uncompensated Care (see instructions for each line)	I	1.00	2.00	0.00				
20.00	Charity care charges and uninsured discounts for the entire fa (see instructions)	cility	360, 24	7 C	360, 247	20.00			
21.00	Cost of patients approved for charity care and uninsured disco instructions)	unts (see	121, 12	.7 C	121, 127	21.00			
22.00	Payments received from patients for amounts previously written	off as		o c	0	22.00			
23.00	charity care Cost of charity care (line 21 minus line 22)		121, 12	.7 C	121, 127	23.00			
					1.00				
24.00	Does the amount on line 20 column 2, include charges for patie	nt days beyo	ond a length	of stay limit	N 1.00	24.00			
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond t		care program	's length of	0	25.00			
	stay limit								
26.00 27.00			ructions)		1, 507, 106	•			
27.00	· · ·				347, 206 534, 162				
28.00					972, 944				
29.00		pense (see i	instructions)		514, 092				
30.00			,		635, 219	•			
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			8, 475, 509	31.00			

ANCI LLARY         SERVI CE         COST         CENTERS           50.00         05000         OPERATI NG         ROOM         581, 626         519, 229         1, 100, 855         0         1, 100,           52.00         05200         DELI VERY         ROOM         177, 082         828         177, 910         -175, 678         2,           53.00         05300         ANESTHESI OLOGY         0         864, 506         864, 506         -763, 727         100,           54.00         05400         RADI OLOGY-DI AGNOSTI C         1, 051, 567         799, 138         1, 850, 705         0         1, 850,           60.00         06000         LABORATORY         907, 183         2, 627, 421         3, 534, 604         0         3, 534,	Prepared: 1: 05 pm ed dice - - - - - - - - - - - - -
Cost Center Description         Salaries         Other         Total (col. 1 + col. 2)         Reclassificati nons (See A-6)         Trial Bala (col. 3 + col. 4)           1.00         2.00         3.00         4.00         5.00           00100 CAP REL COSTS-BLDG & FIXT 2.00         00200 (CAP REL COSTS-BLDG & FIXT 2.00         1, 661, 417         1, 661, 417         69, 224         1, 730, 535, 715           3.00         04.00         5.00           00200 CAP REL COSTS-BLDG & FIXT 2.00         00200 (CAP REL COSTS-BLDG & FIXT 535, 715         0         535, 54, 00         5284, 228         5, 254, 228         99, 163         5, 553, 536, 346           3.00         00000 PERATION OF PLANT         760, 759         1, 129, 644         1, 890, 403         0         1, 890, 1, 890, 403         1, 890, 1, 890, 403         0         1, 890, 1, 890, 403         1, 890, 1, 890, 403         1, 890, 1, 890, 403         1, 890, 1, 890, 403         0         1, 890, 1, 890, 403         0         1, 890, 1, 890, 403         1, 890, 1, 890, 403         0         1, 890, 1, 890, 1, 90, 1, 90, 1, 90, 1, 90, 1, 90, 1, 90, 90, 90, 90, 90, 90, 90, 90, 90, 90	1: 05 pm         ed         icce         -         641         1. 00         715         2. 00         391         4. 00         760         5. 00         403         7. 00         944         8. 00         165         9. 00         656         10. 00         848         813. 00         810         14. 00         150         15. 00         669         17. 00         727         19. 00         079         30. 00         325
Cost Center Description         Salaries         Other         Total (col. + col. 2)         Reclassificati ons (See A-6)         Reclassificati Tral Bala (col. 3)           6         0         00100         CAP REL COSTS ENDG & FIXT         1.00         2.00         3.00         4.00         5.00           1.00         00200 CAP REL COSTS-BLDG & FIXT         1.661.417         1.661.417         69.224         1.730, 0535, 715         0         535, 0535, 715         0         535, 0535, 715         0         535, 01         535, 050         535, 715         0         1.661, 0         417         1.661, 417         69, 224         1, 730, 0         535, 053, 715         0         535, 0         555, 961         8.204, 414         356, 346         8, 650, 0         8, 650, 0         0         0         0         279, 944         279, 0         279, 944         279, 0         0         0         0         0         279, 944         390, 0         1, 800, 0         0         0         0         0         0         8, 646, 648         846, 13, 00         1000 DI ETARY         640, 559         382, 945         1, 023, 504         -846, 848         846, 13, 00         1100 OIOD OFETERIA         0         0         0         0         846, 648         846, 13, 00         1000 OIOD DI	ed icce - - - - - - - - - - - - -
GENERAL SERVICE COST CENTERS         (col. 4)           1.00         2.00         3.00         4.00         5.00           1.00         00100         CAP REL COSTS-BLDG & FIXT         1.661,417         1.661,417         69,224         1,730,           2.00         00200         CAP REL COSTS-MUBLE EQUIP         535,715         535,715         0         535,715           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT         0         5.254,228         5,254,228         99,163         5,353,35           5.00         00700         OPERATI ON OF PLANT         760,759         1,129,644         1,890,403         0         1,890,           8.00         00800         LAUNDRY & LINEN SERVICE         0         0         0         279,944         279,           9.00         00900         HOUSEKEPING         315,813         354,296         670,109         -219,944         390,           10.00         01000         DI ETARY         640,559         382,945         1,023,504         =46,848         176,           11.00         01100         CAFETERIA         0         0         0         846,848         846,           12.00         01400         CENTRAL SERVICES & SUPPLY         0	-         -           641         1.00           715         2.00           391         4.00           760         5.00           403         7.00           944         8.00           165         9.00           656         10.00           848         11.00           848         11.00           870         15.00           699         16.00           665         17.00           727         19.00           079         30.00           325         31.00
CENTRAL SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           1.00         00100         CAP REL COSTS-ENDG & FIXT         1.661.417         1.661.417         69.224         1.730.           2.00         00200         CAP REL COSTS-MUBLE COULP         535,715         535,715         0         535.           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT         0         5.254,228         5.254,228         99,163         5.353.           5.00         00500         ADMI NI STRATI VE & GENERAL         2.638,453         5.565,961         8.204,414         356,346         8.560.           7.00         00700         PERATION OF FUANT         760,759         1,129,644         1,890,403         0         1.890.           8.00         00300         LAUNDRY & LINEN SERVICE         0         0         0         279,944         279.           9.00         00900         HOUSEKEEPI NG         315,813         354.296         670,109         -279.944         390.           10.00         OLTRAY         640.559         382.945         1,023,504         684.84         76.           14.00         OLNG ADMINI STRATI ON         572.778         185.001         779         -2	641         1.00           715         2.00           391         4.00           760         5.00           403         7.00           944         8.00           165         9.00           656         10.00           848         11.00           848         13.00           810         14.00           150         15.00           6695         17.00           727         19.00           079         30.00           325         31.00
I.00         2.00         3.00         4.00         5.00           GENERAL SERVI CE COST CENTERS	715       2.00         391       4.00         760       5.00         403       7.00         944       8.00         165       9.00         656       10.00         848       11.00         898       13.00         810       14.00         150       15.00         665       17.00         727       19.00         079       30.00         325       31.00
GENERAL SERVICE COST CENTERS           1.00         00100 CAP REL COSTS-BLDG & FIXT         1, 661, 417         1, 661, 417         69, 224         1, 730,           2.00         00200 CAP REL COSTS-BUDG & FIXT         0         535, 715         535, 715         0         535,           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT         0         5, 254, 228         5, 254, 228         99, 163         5, 353,           5.00         00500 ADMI NI STRATI VE & GENERAL         2, 638, 453         5, 565, 961         8, 204, 414         356, 346         8, 660,           7.00         00700 OPERATI ON OF PLANT         760, 759         1, 129, 644         1, 890, 403         0         1, 890,           9.00         00900 HOUSEKEEPI NG         315, 813         354, 296         670, 109         -279, 944         390,           10.00         DI ETARY         640, 559         382, 945         1, 023, 504         -846, 848         176,           11.00         CHAFTERI A         0         0         0         846, 848         176,           12.00         01300 NURSI NG ADMI NI STRATI ON         572, 778         185, 001         757, 779         -214, 881         542,           14.00         01400         CENTRAL SERVI CE         0<	715       2.00         391       4.00         760       5.00         403       7.00         944       8.00         165       9.00         656       10.00         848       11.00         898       13.00         810       14.00         150       15.00         665       17.00         727       19.00         079       30.00         325       31.00
1.00       00100       CAP       REL       COSTS-BLDG & FIXT       1, 661, 417       1, 661, 417       69, 224       1, 730, 535, 715         2.00       00200       CAP       REL       COSTS-MVBLE       EQUIP       535, 715       535, 715       0       535, 715         4.00       00400       EMPLOYEE       BENETITS       DEPARTMENT       0       5, 254, 228       99, 163       5, 355, 356         5.00       00500       ADMINISTRATIVE       & GENERAL       2, 638, 453       5, 565, 961       8, 204, 414       356, 346       8, 560, 0         7.00       00700       OPERATION OF PLANT       760, 759       1, 129, 644       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       0       0       0       0       0       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 890, 403       0       1, 800, 403       0       1, 800, 403       0       1, 800, 404       1, 500, 444       16, 504       1, 500, 500 <td>715       2.00         391       4.00         760       5.00         403       7.00         944       8.00         165       9.00         656       10.00         848       11.00         898       13.00         810       14.00         150       15.00         665       17.00         727       19.00         079       30.00         325       31.00</td>	715       2.00         391       4.00         760       5.00         403       7.00         944       8.00         165       9.00         656       10.00         848       11.00         898       13.00         810       14.00         150       15.00         665       17.00         727       19.00         079       30.00         325       31.00
2.00         00200         CAP         REL         COST-MVBLE         EQUIP         535, 715	715       2.00         391       4.00         760       5.00         403       7.00         944       8.00         165       9.00         656       10.00         848       11.00         898       13.00         810       14.00         150       15.00         665       17.00         727       19.00         079       30.00         325       31.00
4.00       00400       EMPLOYEE BENEFITS DEPARTMENT       0       5, 254, 228       5, 254, 228       99, 163       5, 353,         5.00       00500       ADMI NI STRATI VE & GENERAL       2, 638, 453       5, 565, 961       8, 204, 414       356, 346       8, 560,         7.00       00700       OPERATI ON OF PLANT       760, 759       1, 129, 644       1, 890, 403       0       1, 890,         8.00       00800       LAUNDRY & LINEN SERVICE       0       0       0       279, 944       279,         9.00       00900       HOUSEKEEPI NG       315, 813       354, 296       670, 109       -279, 944       390,         10.00       01000       DETARY       640, 559       382, 945       1, 023, 504       -846, 848       176,         11.00       01300       NURSI NG ADMI NI STRATI ON       572, 778       185, 001       757, 779       -214, 881       542,         14.00       01400       CENTRAL SERVI CES & SUPPLY       0       -90, 810       -90, 810       0       -90,         15.00       01500       PHARMACY       285, 693       31, 006       316, 699       0       316,         17.00       01700       SOCI AL SERVI CE       200, NOPHAYSI CI AN ANESTHETI STS       0	391       4.00         760       5.00         403       7.00         944       8.00         165       9.00         656       10.00         848       11.00         849       13.00         810       14.00         150       15.00         665       17.00         727       19.00         079       30.00         325       31.00
5.00         00500         ADMI NI STRATI VE & GENERAL         2, 638, 453         5, 565, 961         8, 204, 414         356, 346         8, 560,           7.00         00700         OPERATI ON OF PLANT         760, 759         1, 129, 644         1, 890, 403         0         1, 890,           8.00         00800         LAUNDRY & LI NEN SERVI CE         0         0         0         279, 944         279,           9.00         00900         HOUSEKEEPI NG         315, 813         354, 296         670, 109         -279, 944         390,           10.00         D1000         CAFETERI A         0         0         846, 848         846,           11.00         O1300         NURSI NG ADMI NI STRATI ON         572, 778         185, 001         757, 779         -214, 881         542,           14.00         01400         CENTRAL SERVI CES & SUPPLY         0         -90, 810         -90, 810         0         90           15.00         01500         PHARMACY         285, 693         31, 006         316, 699         0         316,           17.00         O1700         SOCI AL SERVI CE         250, 866         21, 799         272, 665         0         272,           19.00         NONPHYSI CI AN ANESTHETI STS </td <td>760         5.00           403         7.00           944         8.00           165         9.00           656         10.00           848         11.00           878         13.00           810         14.00           150         15.00           669         16.00           665         17.00           727         19.00           079         30.00           325         31.00</td>	760         5.00           403         7.00           944         8.00           165         9.00           656         10.00           848         11.00           878         13.00           810         14.00           150         15.00           669         16.00           665         17.00           727         19.00           079         30.00           325         31.00
7.00       00700       OPERATI ON OF PLANT       760, 759       1, 129, 644       1, 890, 403       0       1, 890,         8.00       00800       LAUNDRY & LI NEN SERVI CE       0       0       0       279, 944       279,         9.00       00900       HOUSEKEEPI NG       315, 813       354, 296       670, 109       -279, 944       390,         10.00       01000       DI ETARY       640, 559       382, 945       1, 023, 504       -846, 848       846,         11.00       01100       CAFETERI A       0       0       0       846, 848       846,         13.00       01300       NURSI NG ADMI NI STRATI ON       572, 778       185, 001       757, 779       -214, 881       542,         14.00       O1400       CENTRAL SERVI CES & SUPPLY       0       -90, 810       0       90,         15.00       01500       PHARMACY       736, 961       1177, 189       854, 150       0       854,         16.00       01600       MEDI CAL RECORDS & LI BRARY       285, 693       31, 006       316, 699       0       316,         17.00       01700       SOCI AL SERVI CE       0       0       0       0       763, 727       763,         1	403         7.00           944         8.00           165         9.00           656         10.00           848         11.00           898         13.00           810         14.00           150         15.00           669         16.00           665         17.00           727         19.00           079         30.00           325         31.00
8.00         00800         LAUNDRY & LINEN SERVICE         0         0         0         0         279, 944         279, 944         390, 315, 813         354, 296         670, 109         -279, 944         390, 390, 1000         DI SEREPING         315, 813         354, 296         670, 109         -279, 944         390, 390, 1000         DI SEREPING         310, 0100         DI STARY         640, 559         382, 945         1, 023, 504         -846, 848         176, 1100           11.00         01100         CAFETERIA         0         0         0         846, 848         846, 348           13.00         01300         NURSI NG ADMI NI STRATI ON         572, 778         185, 001         757, 779         -214, 881         542, 542, 543           14.00         01400         CENTRAL SERVI CES & SUPPLY         0         -90, 810         -90, 810         0         90, 316, 790, 316, 790, 316, 790, 316, 790, 316, 799         272, 665         0         272, 72, 72, 72, 72, 72, 72, 72, 72, 72,	944         8.00           165         9.00           656         10.00           848         11.00           898         13.00           810         14.00           150         15.00           665         17.00           727         19.00           079         30.00           325         31.00
10.00         01000         DI ETARY         640, 559         382, 945         1, 023, 504        846, 848         176,           11.00         01100         CAFETERIA         0         0         0         846, 848         846,           13.00         01300         NURSI NG ADMI NI STRATI ON         572, 778         185, 001         757, 779        214, 881         542,           14.00         01400         CENTRAL SERVI CES & SUPPLY         0         -90, 810         -90, 810         0         901           15.00         01500         PHARMACY         736, 961         117, 189         854, 150         0         854,           16.00         01600         MEDI CAL RECORDS & LI BRARY         285, 693         31, 006         316, 699         0         316,           17.00         01700         SOCI AL SERVI CE         250, 866         21, 799         272, 665         0         272,           19.00         03000         ADULTS & PEDI ATRI CS         2, 599, 721         1, 333, 664         3, 933, 385         607, 694         4, 541,           31.00         03100         INTENSI VE CARE UNI T         449, 007         287, 318         736, 325         0         736,           43.00         0430	6556         10.00           848         11.00           898         13.00           810         14.00           150         15.00           699         16.00           665         17.00           727         19.00           0779         30.00           325         31.00
10.00         DI ETARY         640, 559         382, 945         1, 023, 504        846, 848         176,           11.00         01100         CAFETERIA         0         0         0         846, 848         846,           13.00         01300         NURSI NG ADMI NI STRATI ON         572, 778         185, 001         757, 779        214, 881         542,           14.00         01400         CENTRAL SERVI CES & SUPPLY         0         -90, 810         -90, 810         0         970,           15.00         01500         PHARMACY         736, 961         117, 189         854, 150         0         854,           16.00         01600         MEDI CAL RECORDS & LI BRARY         285, 693         31, 006         316, 699         0         316,           17.00         01700         SOCI AL SERVI CE         250, 866         21, 799         272, 665         0         272,           19.00         NONPHYSI CI AN ANESTHETI STS         0         0         0         763, 727         763,           117.189         8540         INTRI ENT ROUTI NE SERVI CE COST CENTERS         736, 313, 3064         3, 933, 385         607, 694         4, 541,           13.00         03100         INTENSI VE CARE UNI T	6556         10.00           848         11.00           898         13.00           810         14.00           150         15.00           699         16.00           665         17.00           727         19.00           0779         30.00           325         31.00
13.00       01300       NURSI NG ADMI NI STRATI ON       572, 778       185, 001       757, 779       -214, 881       542,         14.00       01400       CENTRAL SERVI CES & SUPPLY       0       -90, 810       -90, 810       0       -90,         15.00       01500       PHARMACY       736, 961       117, 189       854, 150       0       854,         16.00       01600       MEDI CAL       RECORDS & LI BRARY       225, 693       31, 006       316, 699       0       316,         17.00       01700       SOCI AL       SERVI CE       250, 866       21, 799       272, 665       0       272,         19.00       00       NONPHYSI CI AN ANESTHETI STS       0       0       0       763, 727       776,         10.00       ADULTS & PEDI ATRI CS       2, 599, 721       1, 333, 664       3, 933, 385       607, 694       4, 541,         31.00       03000       ADULTS & PEDI ATRI CS       2, 599, 721       1, 333, 664       3, 933, 385       607, 694       4, 541,         31.00       03100       INTENSI VE CARE UNI T       449, 007       287, 318       736, 325       0       736,         43.00       04300       NURSERY       0       969       969 <t< td=""><td>898       13.00         810       14.00         150       15.00         699       16.00         665       17.00         727       19.00         079       30.00         325       31.00</td></t<>	898       13.00         810       14.00         150       15.00         699       16.00         665       17.00         727       19.00         079       30.00         325       31.00
14.00         01400         CENTRAL SERVICES & SUPPLY         0         -90, 810         -90, 810         0         -90,           15.00         01500         PHARMACY         736, 961         117, 189         854, 150         0         854,           16.00         01600         MEDICAL RECORDS & LIBRARY         225, 693         31, 006         316, 699         0         316,           17.00         01700         SOCIAL SERVICE         250, 866         21, 799         272, 665         0         272,           19.00         01900         NONPHYSICIAN ANESTHETISTS         0         0         0         763, 727         763,           10.00         ADULTS & PEDIATRICS         2, 599, 721         1, 333, 664         3, 933, 385         607, 694         4, 541,           31.00         03100         INTENSI VE CARE UNIT         449, 007         287, 318         736, 325         0         736,           43.00         04300         NURSERY         0         969         969         93, 584         94,           ANCI LLARY SERVICE COST CENTERS         0         969         969         93, 584         94,           50.00         05200         DELI VERY ROOM & LABOR ROOM         177, 082         828	810         14.00           150         15.00           699         16.00           665         17.00           727         19.00           079         30.00           325         31.00
15.00       01500       PHARMACY       736, 961       117, 189       854, 150       0       854,         16.00       01600       MEDI CAL_RECORDS & LI BRARY       285, 693       31, 006       316, 699       0       316,         17.00       01700       SOCI AL_SERVI CE       250, 866       21, 799       272, 665       0       272,         19.00       NONPHYSI CI AN ANESTHETI STS       0       0       0       763, 727       763,         INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00       03100       INTENSI VE CARE UNI T       449, 007       287, 318       736, 325       0       736,         31.00       04300       NURSERY       0       969       969       93, 584       94,         ANCI LLARY SERVI CE COST CENTERS       0       969       969       93, 584       94,         50.00       05000       OPERATI NG ROOM       581, 626       519, 229       1, 100, 855       0       1, 100,         52.00       05200       DELI VERY ROOM & LABOR ROOM       177, 082       828       177, 910       -175, 678       2,         53.00       05300       ANESTHESI OLOGY       0       864, 506       864, 506       -763, 727	15.0         15.00           699         16.00           665         17.00           727         19.00           079         30.00           325         31.00
16.00         01600         MEDI CAL         RECORDS & LI BRARY         285,693         31,006         316,699         0         316,           17.00         01700         SOCI AL         SERVI CE         250,866         21,799         272,665         0         272,           19.00         O1900         NONPHYSI CI AN ANESTHETI STS         0         0         0         763,727         763,           1NPATI ENT ROUTI NE SERVI CE COST CENTERS          0         0         0         736,325         0         736,           30.00         03000         ADULTS & PEDI ATRI CS         2,599,721         1,333,664         3,933,385         607,694         4,541,           31.00         03100         INTENSI VE CARE UNI T         449,007         287,318         736,325         0         736,           43.00         04300         NURSERY         0         969         969         93,584         94,           ANCI LLARY SERVI CE COST CENTERS          0         969         969         93,584         94,           50.00         05000         OPERATI NG ROOM         581,626         519,229         1,100,855         0         1,100,           52.00         05200         DELI VERY	699       16.00         665       17.00         727       19.00         000       30.00         325       31.00
17.00       01700       SOCI AL SERVICE       250,866       21,799       272,665       0       272,         19.00       01900       NONPHYSI CI AN ANESTHETI STS       0       0       0       763,727       763,         INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00       03000       ADULTS & PEDI ATRI CS       2,599,721       1,333,664       3,933,385       607,694       4,541,         31.00       03100       INTENSI VE CARE UNI T       449,007       287,318       736,325       0       736,         43.00       04300       NURSERY       0       969       969       93,584       94,         ANCI LLARY SERVI CE COST CENTERS       50.00       052000       DELI VERY ROOM       581,626       519,229       1,100,855       0       1,100,         52.00       05200       DELI VERY ROOM & LABOR ROOM       177,082       828       177,910       -175,678       2,         53.00       05300       ANESTHESI OLOGY       0       864,506       864,506       -763,727       100,         54.00       05400       RADI OLOGY-DI AGNOSTI C       1,051,567       799,138       1,850,705       0       1,850,         60.00       06000       LABORATORY	665       17.00         727       19.00         079       30.00         325       31.00
19.00         01900         NONPHYSICIAN ANESTHETISTS         0         0         763, 727         763, 727           30.00         03000         ADULTS & PEDIATRICS         2, 599, 721         1, 333, 664         3, 933, 385         607, 694         4, 541, 31.00           30.00         03000         ADULTS & PEDIATRICS         2, 599, 721         1, 333, 664         3, 933, 385         607, 694         4, 541, 31.00           31.00         03100         INTENSI VE CARE UNIT         449, 007         287, 318         736, 325         0         736, 43.00           0         04300         NURSERY         0         969         969         93, 584         94, 49, 907           ANCI LLARY SERVICE COST CENTERS         50.00         05000         OPERATING ROOM         581, 626         519, 229         1, 100, 855         0         1, 100, 52.00           52.00         05200         DELI VERY ROOM & LABOR ROOM         177, 082         828         177, 910         -175, 678         2, 53.00         2, 53.00         05300         ANESTHESI OLOGY         0         864, 506         864, 506         -763, 727         100, 54.00         05400         RADI OLOGY-DI AGNOSTI C         1, 051, 567         799, 138         1, 850, 705         0         1, 850, 60.00         3, 5	727       19.00         079       30.00         325       31.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS         2, 599, 721         1, 333, 664         3, 933, 385         607, 694         4, 541,           31. 00         03100   NTENSI VE CARE UNI T         449, 007         287, 318         736, 325         0         736,           43. 00         04300   NURSERY         0         969         969         93, 584         94,           ANCI LLARY SERVI CE COST CENTERS         0         581, 626         519, 229         1, 100, 855         0         1, 100,           52. 00         05200 DELI VERY ROOM & LABOR ROOM         177, 082         828         177, 910         -175, 678         2,           53. 00         05300 ANESTHESI OLOGY         0         864, 506         864, 506         -763, 727         100,           54. 00         05400 RADI OLOGY-DI AGNOSTI C         1, 051, 567         799, 138         1, 850, 705         0         1, 850,           60. 00         06000 LABORATORY         907, 183         2, 627, 421         3, 534, 604         0         3, 534,	079 30.00 325 31.00
30. 00       03000       ADULTS & PEDIATRICS       2, 599, 721       1, 333, 664       3, 933, 385       607, 694       4, 541,         31. 00       03100       INTENSIVE CARE UNIT       449, 007       287, 318       736, 325       0       736,         43. 00       04300       NURSERY       0       969       969       969       93, 584       94,         ANCILLARY SERVICE COST CENTERS       0       581, 626       519, 229       1, 100, 855       0       1, 100,         50. 00       05200       DELIVERY ROOM & LABOR ROOM       177, 082       828       177, 910       -175, 678       2,         53. 00       05300       ANESTHESI OLOGY       0       864, 506       864, 506       -763, 727       100,         54. 00       05400       RADI OLOGY-DI AGNOSTI C       1, 051, 567       799, 138       1, 850, 705       0       1, 850,         60. 00       06000       LABORATORY       907, 183       2, 627, 421       3, 534, 604       0       3, 534,	325 31.00
31.00         03100         INTENSIVE CARE UNIT         449,007         287,318         736,325         0         736,           43.00         04300         NURSERY         0         969         969         93,584         94,           ANCI LLARY SERVICE COST CENTERS         0         969         969         93,584         94,           50.00         05000         OPERATING ROOM         581,626         519,229         1,100,855         0         1,100,           52.00         05200         DELI VERY ROOM & LABOR ROOM         177,082         828         177,910         -175,678         2,           53.00         05300         ANESTHESI OLOGY         0         864,506         864,506         -763,727         100,           54.00         05400         RADI OLOGY-DI AGNOSTI C         1,051,567         799,138         1,850,705         0         1,850,           60.00         06000         LABORATORY         907,183         2,627,421         3,534,604         0         3,534,	325 31.00
43.00         04300         NURSERY         0         969         969         93,584         94, ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM         581,626         519,229         1,100,855         0         1,100, 1,100,855         0         1,100, 22,00         05200         DELI VERY ROOM & LABOR ROOM         177,082         828         177,910         -175,678         2, 1,00,855         0         1,100, 2,53.00         05300         ANESTHESI OLOGY         0         864,506         864,506         -763,727         100, 1,850, 60.00         05400         RADI OLOGY-DI AGNOSTI C         1,051,567         799,138         1,850,705         0         1,850, 3,534,604         0         3,534,	
ANCI LLARY         SERVI CE         COST         CENTERS           50.00         05000         OPERATI NG         ROOM         581, 626         519, 229         1, 100, 855         0         1, 100,           52.00         05200         DELI VERY         ROOM         177, 082         828         177, 910         -175, 678         2,           53.00         05300         ANESTHESI OLOGY         0         864, 506         864, 506         -763, 727         100,           54.00         05400         RADI OLOGY-DI AGNOSTI C         1, 051, 567         799, 138         1, 850, 705         0         1, 850,           60.00         06000         LABORATORY         907, 183         2, 627, 421         3, 534, 604         0         3, 534,	553 43.00
50. 00         05000         OPERATI NG_ROOM         581, 626         519, 229         1, 100, 855         0         1, 100,           52. 00         05200         DELI VERY_ROOM & LABOR_ROOM         177, 082         828         177, 910         -175, 678         2,           53. 00         05300         ANESTHESI OLOGY         0         864, 506         864, 506         -763, 727         100,           54. 00         05400         RADI OLOGY-DI AGNOSTI C         1, 051, 567         799, 138         1, 850, 705         0         1, 850,           60. 00         06000         LABORATORY         907, 183         2, 627, 421         3, 534, 604         0         3, 534,	
52.00         05200         DELI VERY         ROOM & LABOR         177,082         828         177,910         -175,678         2,           53.00         05300         ANESTHESI OLOGY         0         864,506         864,506         -763,727         100,           54.00         05400         RADI OLOGY-DI AGNOSTI C         1,051,567         799,138         1,850,705         0         1,850,           60.00         06000         LABORATORY         907,183         2,627,421         3,534,604         0         3,534,	
53.00         05300         ANESTHESI OLOGY         0         864, 506         864, 506         -763, 727         100,           54.00         05400         RADI OLOGY-DI AGNOSTI C         1, 051, 567         799, 138         1, 850, 705         0         1, 850,           60.00         06000         LABORATORY         907, 183         2, 627, 421         3, 534, 604         0         3, 534,	
54. 00         05400         RADI OLOGY-DI AGNOSTI C         1, 051, 567         799, 138         1, 850, 705         0         1, 850, 60. 00           60. 00         06000         LABORATORY         907, 183         2, 627, 421         3, 534, 604         0         3, 534,	232 52.00
60. 00 06000 LABORATORY 907, 183 2, 627, 421 3, 534, 604 0 3, 534,	
65. 00 06500 RESPI RATORY THERAPY 785, 354 97, 588 882, 942 -4, 423 878,	
66. 00         06600         PHYSI CAL         THERAPY         552, 537         59, 405         611, 942         0         611,           67. 00         06700         0CCUPATI ONAL         THERAPY         201, 801         0         201, 801         0         201,	
	960 68.00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0	0 69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 2, 034, 410 2, 034, 410 -1, 095, 371 939,	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 1,095,371 1,095,	
73. 00 07300 DRUGS CHARGED TO PATIENTS 254, 902 2, 049, 047 2, 303, 949 0 2, 303,	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0	0 77.00
OUTPATIENT SERVICE COST CENTERS	
88.00 [08800 RURAL HEALTH CLINIC 3, 053, 231] 1, 250, 381] 4, 303, 612] -454, 429] 3, 849,	183 88.00
88. 01 08801 RURAL HEALTH CLINIC II 782, 555 334, 130 1, 116, 685 136, 466 1, 253,	
88. 02 08802 RURAL HEALTH CLINIC III 490, 874 239, 449 730, 323 -13, 450 716,	
88. 03 08803 RURAL HEALTH CLINIC IV 342, 271 157, 985 500, 256 1, 117 501,	
91. 00 09100 EMERGENCY 2, 453, 919 1, 480, 567 3, 934, 486 4, 423 3, 938,	909 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS	
102.00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0	0 102.00
SPECIAL PURPOSE COST CENTERS	
	054 118.00
NONREI MBURSABLE COST CENTERS	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0	
	0 190. 00
	623 192.00
194. 00         07950         FOUNDATION / MOBS         0         52, 989, 677         0         52, 989, 677         0         52, 989, 52         989, 677         0         52, 989, 57         0         52, 989,	

Heal th	Financial Systems GF	REENE COUNTY GE	ENERAL HOSPITAL	In Lieu	of Form CMS-2552-
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15-1	1317 Period:	Worksheet A
				From 01/01/2022 To 12/31/2022	Date/Time Prepared
					5/30/2023 1:05 pm
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6.00	7.00		
1 00	GENERAL SERVICE COST CENTERS	(0.4/0	1 ((0, 170)		
1.00	00100 CAP REL COSTS-BLDG & FIXT	-62, 168			1.0
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0			2.0
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0,000,071		4. (
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-2, 363, 843			
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	-3, 897			7.
9.00	00900 HOUSEKEEPING	0			9.
10.00	01000 DI ETARY	-31, 535			10.
11.00	01100 CAFETERI A	-134, 874			10.
13.00	01300 NURSI NG ADMI NI STRATI ON	-134, 074			13.
14.00	01400 CENTRAL SERVICES & SUPPLY	0			14.
15.00	01500 PHARMACY	0			14.
16.00	01600 MEDICAL RECORDS & LIBRARY	-7, 152			16.
17.00	01700 SOCIAL SERVICE	-7, 132	272, 665		10.
19.00	01900 NONPHYSI CI AN ANESTHETI STS	-519, 293			19.
17.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	517,275	277, 707		17.1
30. 00	03000 ADULTS & PEDIATRICS	-566, 709	3, 974, 370		30.
31.00	03100 I NTENSI VE CARE UNI T	0			31.
43.00	04300 NURSERY	0			43.
.0.00	ANCI LLARY SERVICE COST CENTERS		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
50.00	05000 OPERATING ROOM	0	1, 100, 855		50.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			52.
53.00	05300 ANESTHESI OLOGY	0			53.
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1,850,705		54.
60.00	06000 LABORATORY	0			60.
65.00	06500 RESPI RATORY THERAPY	-3, 280	875, 239		65.
66.00	06600 PHYSI CAL THERAPY	0	611, 942		66.
67.00	06700 OCCUPATI ONAL THERAPY	0	201, 801		67.
58.00	06800 SPEECH PATHOLOGY	0	45, 960		68.
69.00	06900 ELECTROCARDI OLOGY	0	0		69.
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-79, 512	859, 527		71.
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 095, 371		72.
73.00	07300 DRUGS CHARGED TO PATIENTS	-274, 385	2, 029, 564		73.
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77.
	OUTPATIENT SERVICE COST CENTERS	1	· · · · · ·		
88. 00	08800 RURAL HEALTH CLINIC	0			88.
38. 01	08801 RURAL HEALTH CLINIC II	0	.,====,.=.		88.
88. 02	08802 RURAL HEALTH CLINIC III	0			88.
88. 03	08803 RURAL HEALTH CLINIC IV	0	501, 373		88.
91.00	09100 EMERGENCY	-944, 214	2, 994, 695		91.
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.
	OTHER REIMBURSABLE COST CENTERS	1	1		
102.00	0 10200 OPI OI D TREATMENT PROGRAM	0	0		102.
	SPECIAL PURPOSE COST CENTERS		1		
118.00		-4, 990, 862	45, 730, 192		118.
	NONREI MBURSABLE COST CENTERS		-		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.
	19200 PHYSI CI ANS' PRI VATE OFFI CES	-40, 214	2, 228, 409		192.
	07950 FOUNDATION / MOBS	0	0		194. (
200.00	) TOTAL (SUM OF LINES 118 through 199)	-5, 031, 076	47, 958, 601		200. (

		OUNTY GENERAL HOSPITAL	E 4047	Period:	eu of Form CMS-2552-	
COST C	ENTERS USED IN COST REPORT	Provider CCN: 1	Provider CCN: 15-1317		Worksheet Non-CMS	
					Date/Time Prepared	
					5/30/2023 1	1:05 pm
	Cost Center Description		CMS Code	Standard I		
				Non-Standa	ard Lodes	
			1.00	2.0	00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT		00100			1.00
2.00	CAP REL COSTS-MVBLE EQUIP		00200			2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT		00400			4.00
5.00 7.00	ADMINISTRATIVE & GENERAL		00500 00700			5.00
8.00	OPERATION OF PLANT LAUNDRY & LINEN SERVICE		00800			8.00
9.00	HOUSEKEEPING		00900			9.00
10.00	DI ETARY		01000			10.00
11.00	CAFETERIA		01100			11.00
13.00	NURSING ADMINISTRATION		01300			13.00
14.00	CENTRAL SERVICES & SUPPLY		01400			14.00
15.00	PHARMACY		01500			15.00
	MEDICAL RECORDS & LIBRARY		01600			16.00
17.00	SOCIAL SERVICE		01700			17.00
19.00	NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS		01900			19.00
30.00	ADULTS & PEDIATRICS		03000			30.00
31.00	INTENSIVE CARE UNIT		03100			31.00
43.00	NURSERY		04300			43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	OPERATING ROOM		05000			50.00
52.00	DELIVERY ROOM & LABOR ROOM		05200			52.00
53.00	ANESTHESI OLOGY		05300			53.00
54.00	RADI OLOGY - DI AGNOSTI C		05400			54.00
60.00 65.00	LABORATORY RESPI RATORY THERAPY		06000 06500			60.00
66.00	PHYSI CAL THERAPY		06600			66.00
67.00	OCCUPATI ONAL THERAPY		06700			67.00
68.00	SPEECH PATHOLOGY		06800			68.00
69.00	ELECTROCARDI OLOGY		06900			69.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		07100			71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS		07200			72.00
73.00	DRUGS CHARGED TO PATIENTS		07300			73.00
77.00	ALLOGENEI CHSCT ACQUI SI TI ON		07700			77.00
88.00	OUTPATIENT SERVICE COST CENTERS RURAL HEALTH CLINIC		08800			88.00
88.00	RURAL HEALTH CLINIC II		08800			88.0
88. 02	RURAL HEALTH CLINIC III		08802			88. 02
88.03	RURAL HEALTH CLINIC IV		08803			88. 0
91.00	EMERGENCY		09100			91.00
92.00	OBSERVATION BEDS (NON-DISTINCT PART)		09200			92.00
	OTHER REIMBURSABLE COST CENTERS		10055			-
102.00	OPIOID TREATMENT PROGRAM		10200			102.00
110 00	SPECIAL PURPOSE COST CENTERS	1				110 0
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS					118.00
190 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	19000			190. 00
	PHYSICIANS' PRIVATE OFFICES		19000			192.00
	FOUNDATION / MOBS		07950			194.00
	TOTAL (SUM OF LINES 118 through 199)					200. 00

Heal th	Financial Systems	GR	REENE COUNTY GEN	ERAL HOSPITAL	_	In Lie	u of Form CMS-	2552-10
	SIFICATIONS			Provider C	CN: 15-1317	Peri od:	Worksheet A-6	5
						From 01/01/2022		
						To 12/31/2022	Date/Time Pre 5/30/2023 1:0	epared: )5 nm
		Increases					0,00,2020 110	
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A – CRNA RECLASS							
1.00	NONPHYSI CLAN ANESTHETI STS		0	76 <u>3, 7</u> 27				1.00
	0		0	763, 727				
	B - LABOR & DELIVERY							
1.00	ADULTS & PEDIATRICS		175, 678	0 0				1.00
	0		175, 678	0				-
	C - DIETARY RECLASS							
1.00		<u>11.00</u>	<u>529, 999</u>	<u>316, 8</u> 49				1.00
	0		529, 999	316, 849				-
	D - RHC ALLOCATION							
1.00	RURAL HEALTH CLINIC	88.00	118, 062	0				1.00
2.00	RURAL HEALTH CLINIC II	88.01	144, 952	0				2.00
3.00	RURAL HEALTH CLINIC III	88.02	7, 739	0				3.00
4.00	RURAL HEALTH CLINIC III	88.02	778	0				4.00
5.00	RURAL HEALTH CLINIC	88.00	27, 356	0				5.00
6.00	RURAL HEALTH CLINIC III	88.02	5, 870	0 0				6.00
7.00 8.00	RURAL HEALTH CLINIC II RURAL HEALTH CLINIC IV	88. 01 88. 03	35, 390 36, 138	0				7.00 8.00
8.00 9.00	RURAL HEALTH CLINIC IV	88. 03 88. 01	36, 138 46, 563	0				9.00
9.00 10.00	RURAL HEALTH CLINIC III	88.02	24, 059	0				10.00
11.00	RURAL HEALTH CLINIC	88.02	14, 301	0				11.00
12.00	PHYSICIANS' PRIVATE OFFICES	192.00	20, 444	0				12.00
13.00	ADMI NI STRATI VE & GENERAL	5.00	524, 733	0				13.00
14.00	ADMINI STRATI VE & GENERAE	0.00	524, 755	0				14.00
14.00			1,006,385	<u> </u>				14.00
	E - INSURANCE RECLASS		1,000,000	0				-
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	69, 224				1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	99, 163				2.00
	0			168, 387				
	F - LAUNDRY AND HOUSEKEEPING	RECLASS						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	279, 944				1.00
	0		0	279, 944				1
	G - IMPLANTABLE DEVICES RECLA	SS						1
1.00	IMPL. DEV. CHARGED TO	72.00	0	1, 095, 371				1.00
	PATI ENTS							
	0		0	1, 095, 371				
	I - HOSPITALIST RECLASS							
1.00	ADULTS & PEDIATRICS		<u>525, 6</u> 00	<u>0</u>				1.00
	0		525, 600	0				_
	J - NURSERY RECLASS			-				
1.00	NURSERY	43.00	93, 584	00				1.00
			93, 584	0				
1 00	K - EKG RECLASSI FI CATI ON	01 00		4 400				1 00
1.00	EMERGENCY	<u>91.00</u>	— — — ¥	<u>4, 423</u> <u>4, 423</u>				1.00
500 00	Grand Total: Increases		2, 331, 246	2, 628, 701				500.00
500.00		I	2, 331, 240	2,020,701				000.00

TASS	SEFECATIONS			Provider (	CCN: 15-1317	Peri od:	Worksheet A-6
,ENDE					50N. 10 1017	From 01/01/2022 To 12/31/2022	Date/Time Prepar 5/30/2023 1:05 p
		Decreases		- 1			
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	·	
	6.00	7.00	8.00	9.00	10.00		
	A – CRNA RECLASS				1		
00	ANESTHESIOLOGY	53.00	0	76 <u>3, 7</u> 27		Q	1
	0		0	763, 727			
	B - LABOR & DELIVERY				1		
00	DELIVERY ROOM & LABOR ROOM	52.00	17 <u>5, 6</u> 78	C		Q	1
	0		175, 678	C			
	C – DIETARY RECLASS						
00	DI ETARY	10.00	529, 999	316, 849		0	1
	0		529, 999	316, 849			
	D - RHC ALLOCATION						
00	NURSING ADMINISTRATION	13.00	214, 881	C		0	1
00	RURAL HEALTH CLINIC	88.00	48, 133	C		0	2
00	RURAL HEALTH CLINIC	88.00	7, 739	C	)	0	3
00	RURAL HEALTH CLINIC	88.00	778	C	)	0	4
00	RURAL HEALTH CLINIC III	88.02	27, 356	C		0	5
	RURAL HEALTH CLINIC	88.00	5, 870	C		0	e
	RURAL HEALTH CLINIC	88.00	71, 528	C		0	
	RURAL HEALTH CLINIC	88.00	70, 622	C	)	0	8
	RURAL HEALTH CLINIC III	88.02	14, 301	Ċ		0	ç
	RURAL HEALTH CLINIC	88.00	20, 444	C	)	0	10
	RURAL HEALTH CLINIC	88.00	389, 034	C		0	11
	RURAL HEALTH CLINIC II	88.01	90, 439	C		0	12
	RURAL HEALTH CLINIC III	88. 02	10, 239	C		0	13
	RURAL HEALTH CLINIC IV	88.03	35, 021	0		0	14
00			1,006,385	0		<u>u</u>	14
	E - INSURANCE RECLASS		1,000,303		1		
	ADMI NI STRATI VE & GENERAL	5.00	0	168, 387	-	2	1
0	ADMINISTRATIVE & GENERAL	0,00	0	100, 307		2	2
0			0	168, 387		2	2
	F - LAUNDRY AND HOUSEKEEPING		U	100, 307			
	HOUSEKEEPING	9.00	0	279, 944	1	0	1
0			0	<u>279,944</u> 279,944		<u>u</u>	
	G - IMPLANTABLE DEVICES RECLA	°C	U	279,944	·		
	MEDICAL SUPPLIES CHARGED TO	71.00	0	1, 095, 371	1	0	1
		71.00	0	1,095,371		0	
	PATI ENTS	+		1,095,371	<u> </u>	-	
	I – HOSPITALIST RECLASS		U	1,095,371			
0		102.00	E2E 400			0	
00	PHYSICIANS'_PRIVATE_OFFICES_	1 <u>92.</u> 00	<u>525, 600</u> 525, 600	0		Ō	1
			5∠5, 600	L L	1		
0	J - NURSERY RECLASS	20.00	02 504		d	0	
00	ADULTS & PEDIATRICS		9 <u>3, 5</u> 84	c	<u>                                     </u>	Ō	1
			93, 584	C			
	K - EKG RECLASSI FI CATI ON	(5.00		4 100	1		
00	RESPIRATORY_THERAPY		0	<u>4, 423</u> 4, 423		0	1

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

## GREENE COUNTY GENERAL HOSPITAL

In Lieu of Form CMS-2552-10 Period: Worksheet A-6 From 01/01/2022 Non-CMS Worksheet To 12/31/2022 Date/Time Prepared: Provider CCN: 15-1317

						To	0 12/31/2022	Date/Time Pre 5/30/2023 1:0	
		Incre	ases		Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Sal ary	Other	
	2.00 A - CRNA RECLASS	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
1.00	NONPHYSI CI AN	19.00	0	763, 727 A	ANESTHESI OLOGY	53.00	0	763, 727	1.00
	ANESTHETISTS		— — <sub>0</sub>	763, 7270	)		— — — o	763, 727	
1.00	B - LABOR & DELIVERY ADULTS & PEDIATRICS	30.00	175, 678	0	DELIVERY ROOM & LABOR	52.00	175, 678	0	1.00
	0		175, 678	F	<u>ROO</u> M	$\vdash$ $\downarrow$	175, 678	— — <u> </u>	
	C - DIETARY RECLASS	· ·							
1.00	CAFETERI A	<u>11</u> . <u>00</u>	<u> </u>	<u>316, 8</u> 49 [ 316, 849 [		<u>10</u> . <u>00</u>	<u> </u>	<u>316, 8</u> 49 316, 849	1.00
	D - RHC ALLOCATION								
1.00	RURAL HEALTH CLINIC	88.00	118, 062		NURSI NG ADMI NI STRATI ON	13.00	214, 881	0	1.00
2.00	RURAL HEALTH CLINIC	88. 01	144, 952		RURAL HEALTH CLINIC	88.00	48, 133	0	2.00
3.00	RURAL HEALTH CLINIC	88. 02	7, 739	OF	RURAL HEALTH CLINIC	88.00	7, 739	0	3.00
4.00	RURAL HEALTH CLINIC	88. 02	778	OF	RURAL HEALTH CLINIC	88.00	778	0	4.00
5.00	RURAL HEALTH CLINIC	88.00	27, 356		RURAL HEALTH CLINIC	88.02	27, 356	0	5.00
6.00	RURAL HEALTH CLINIC	88. 02	5, 870		II RURAL HEALTH CLINIC	88.00	5, 870	0	6.00
7.00	III RURAL HEALTH CLINIC	88. 01	35, 390	OF	RURAL HEALTH CLINIC	88.00	71, 528	0	7.00
8.00	II RURAL HEALTH CLINIC	88. 03	36, 138	OF	RURAL HEALTH CLINIC	88.00	70, 622	0	8.00
9.00	IV RURAL HEALTH CLINIC	88. 01	46, 563		RURAL HEALTH CLINIC	88.02	14, 301	0	9.00
10.00	II RURAL HEALTH CLINIC	88. 02	24, 059		II RURAL HEALTH CLINIC	88.00	20, 444	0	10.00
11.00	III RURAL HEALTH CLINIC	88.00	14, 301		RURAL HEALTH CLINIC	88.00	389, 034	0	11.00
12.00	PHYSI CI ANS' PRI VATE OFFI CES	192.00	20, 444		RURAL HEALTH CLINIC I	88.01	90, 439	0	12.00
13.00	ADMI NI STRATI VE & GENERAL	5.00	524, 733		RURAL HEALTH CLINIC	88.02	10, 239	0	13.00
14.00		0.00	0		RURAL HEALTH CLINIC V	88.03	35, 021	0	14.00
	0		1,006,385		)		1,006,385	0	
1.00	E - I NSURANCE RECLASS CAP REL COSTS-BLDG &	1.00	0	69, 224 A	ADMINISTRATIVE &	5.00	0	168, 387	1.00
2.00	FIXT EMPLOYEE BENEFITS	4.00	0	99, 163	GENERAL	0.00	0	0	2.00
	DEPARTMENT			168, 3870	<u> </u>			168, 387	
	F - LAUNDRY AND HOUSEK	EEPI NG		100,007	,			100,007	
1.00	LAUNDRY & LI NEN SERVICE	8.00	0	279, 944 H	IOUSEKEEPI NG	9.00	0	279, 944	1.00
	0		0	279, 9440	)			279, 944	
1.00	G - IMPLANTABLE DEVICE		SSO	1 005 271	MEDICAL SUPPLIES	71.00	0	1, 095, 371	1.00
1.00	PATI ENTS	/2.00			CHARGED TO PATIENTS	/1.00			1.00
	I - HOSPITALIST RECLAS	is I	0	1, 095, 3710	)		0	1, 095, 371	
1.00	ADULTS & PEDIATRICS	30.00	525, 600		PHYSI CI ANS' PRI VATE	192.00	525, 600	0	1.00
			525, 600		DFFICES		525, 600	0	
1.00	J - NURSERY RECLASS	43.00	93, 584		ADULTS & PEDIATRICS	30.00	93, 584	0	1.00
	0 K – EKG RECLASSIFICATI	ON	93, 584	0 0	)		93, 584	0	
1.00	EMERGENCY	91.00	0	4, 423 F	RESPI RATORY THERAPY	65.00	0	4, 423	1.00
	0		0	4, 4230	)			4, 423	
500.00	Grand Total: Increases		2, 331, 246		Grand Total: Decreases		2, 331, 246	2, 628, 701	500. 00

		CENE COUNTY GE	NERAL HOSPITAL				u of Form CMS-2	
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	N: 15-1317		riod: om 01/01/2022	Worksheet A-7 Part I	
					To	12/31/2022		pared <sup>.</sup>
						12/01/2022	5/30/2023 1:0	5 pm
				Acqui si ti on	s			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	1, 598, 975	0		0	0	974, 377	1.00
2.00	Land Improvements	213, 562	3, 272, 199		0	3, 272, 199	0	2.00
3.00	Buildings and Fixtures	9, 090, 776	1, 969, 874		0	1, 969, 874	0	3.00
4.00	Building Improvements	0	0		0	0	0	4.00
5.00	Fixed Equipment	4, 445, 520	673, 991		0	673, 991	0	5.00
6.00	Movable Equipment	4, 887, 770	0		0	0	326, 850	6.00
7.00	HIT designated Assets	145, 036	0		0	0	145, 036	7.00
8.00	Subtotal (sum of lines 1-7)	20, 381, 639	5, 916, 064		0	5, 916, 064	1, 446, 263	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	20, 381, 639	5, 916, 064		0	5, 916, 064	1, 446, 263	10.00
		Ending Balance	Fully					
		J	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	624, 598	0					1.00
2.00	Land Improvements	3, 485, 761	0					2.00
3.00	Buildings and Fixtures	11, 060, 650	0					3.00
4.00	Building Improvements	0	0					4.00
5.00	Fixed Equipment	5, 119, 511	0					5.00
6.00	Movable Equipment	4, 560, 920	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	24, 851, 440	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	24, 851, 440	0					10.00

Heal th	Financial Systems GF	REENE COUNTY GENERAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS			Provider CO		Period:	Worksheet A-7	
					From 01/01/2022 To 12/31/2022		narod
					10 12/31/2022	5/30/2023 1:0	5 pm
			SL	JMMARY OF CAPI	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	· ·	
			10.00	44.00		instructions)	
	DADT IL DEGONOLI LATION OF ANOUNTO FROM WOR	9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK						
1.00	CAP REL COSTS-BLDG & FIXT	776, 301		397, 80	0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	535, 715			0 0	0	2.00
3.00	Total (sum of lines 1-2)	1, 312, 016	487, 316	397, 80	0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description		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	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 661, 417				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	535, 715				2.00
3.00	Total (sum of lines 1-2)	0	2, 197, 132				3.00

Heal th	n Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 1:05	bared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				0.01(170		
1.00	CAP REL COSTS-BLDG & FIXT	20, 290, 520		20, 290, 520			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 560, 920		4, 560, 920		0	2.00
3.00	Total (sum of lines 1-2)	24, 851, 440		24, 851, 440			3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					F CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate	cols. 5			
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	C	) (	714, 133	487, 316	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	C	) (	535, 715	0	2.00
3.00	Total (sum of lines 1-2)	0	C	) (	1, 249, 848	487, 316	3.00
			SI	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capital - Relate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	397, 800	69, 224	. (	0 0	1, 668, 473	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	C	) (	0 0	535, 715	2.00
3.00	Total (sum of lines 1-2)	397, 800	69, 224	(	0 0	2, 204, 188	3.00

Heal th Financial	Sustems
near th i maneral	Systems
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## GREENE COUNTY GENERAL HOSPITAL

	Financial Systems	GRE	ENE COUNTY GEI	NERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMENTS TO EXPENSES		Provi der CCN: 15-1317		Period: From 01/01/2022 To 12/31/2022			
				Expense Classification on To/From Which the Amount is	n Worksheet A	5/30/2023 1:0	
	Cost Center Description	Basi s/Code (2)	Amount 2.00	Cost Center 3.00	Li ne #	Wkst. A-7 Ref. 5.00	
1.00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
0.00	COSTS-BLDG & FIXT (chapter 2)			AR REL COSTO MURIE FOULR			
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) Trade, quantity, and time		о		0.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)		J.				
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	А	-3, 897	OPERATION OF PLANT	7.00	0	7.00
3.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		о		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-1, 514, 203			0	10.00
11.00	Sale of scrap, waste, etc.		О		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	0			0	12.00
3.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.00
	Cafeteria-employees and guests	В	-139, 293	CAFETERI A	11.00		
5.00	Rental of quarters to employee and others		0		0.00	0	15.00
6. 00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
7.00	Sale of drugs to other than		0		0.00	0	17.00
8.00	patients Sale of medical records and	В	-7, 152	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
	abstracts Nursing and allied health		0		0.00	0	19.00
	education (tuition, fees, books, etc.)		-				
20.00 21.00	Vending machines Income from imposition of	В	4, 419	CAFETERI A	11.00 0.00	0	
. 1. 00	interest, finance or penalty		0		0.00	0	21.00
22.00	charges (chapter 21) Interest expense on Medicare		o		0.00	0	22.00
	overpayments and borrowings to		-				
23.00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
	therapy costs in excess of limitation (chapter 14)						
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	NONPHYSI CI AN ANESTHETI STS	19.00		28.00
	Physicians' assistant		0	NONFITSICIAN ANESTIETISIS	0.00		•
	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.00
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for	A		CAP REL COSTS-MVBLE EQUIP	2.00	9	
	Depreciation and Interest						
33.00	CPR TRAINING	В	365	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Heal th	Financial Systems	GREENE COUNTY GENERAL HOSPI TAL			In Lieu of Form CMS-2552-10		
ADJUSTMENTS TO EXPENSES					Period:	Worksheet A-8	
					rom 01/01/2022 o 12/31/2022	Date/Time Pre	narod
					0 12/31/2022	5/30/2023 1:0	
	·			Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4,00	5.00	
33.01	MISC REVENUE - ADMIN	В	-19, 396	ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33.02	AHA DUES	A	-2, 797	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
33.03	I HA DUES	A	-1, 288	ADMI NI STRATI VE & GENERAL	5.00	0	33.03
33.04	MARKETING & ADVERTISING	A	-230, 422	ADMI NI STRATI VE & GENERAL	5.00	0	33.04
33.05	RENTAL OF PROVIDER SPACE -	В	-41, 182	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
	BENEFI TS						
33.07	340B EXPENSE	A		DRUGS CHARGED TO PATIENTS	73.00		00107
33.08	CRNA TO MARKET ADJUSTMENT	A		NONPHYSICIAN ANESTHETISTS	19.00		33.08
33.10	ORTHO CLINIC - START-UP COSTS	A		PHYSICIANS' PRIVATE OFFICES	192.00		33.10
33. 11	HOSPITAL ASSESSMENT FEE	A		ADMI NI STRATI VE & GENERAL	5.00		
33. 12	BOND AMORTIZATION EXPENSE	A	10, 195	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 12
	ADJUSTMENT					_	
33.13	MISC EXPENSE - ADMIN	A		ADMI NI STRATI VE & GENERAL	5.00		001.10
33.16	INUSRANCE PROCEEDS - CAPITAL	В		CAP REL COSTS-BLDG & FIXT	1.00		33.16
33. 17	REBATES	В		MEDICAL SUPPLIES CHARGED TO	71.00	0	33. 17
22 10	CATERING REVENUE	В		PATI ENTS	10.00	0	22 10
33. 18 50. 00		В		DI ETARY	10.00	0	33.18 50.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A,		-5, 031, 076				30.00
	column 6, line 200.)						
					1	l	

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Syste	ems	GREENE COUNTY G	ENERAL HOSPITA	L	In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC				CCN: 15-1317	Period: From 01/01/2022	Worksheet A-8	3-2
						To 12/31/2022	Date/Time Pre 5/30/2023 1:0	epared: )5 nm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remunerati on	Component	Component		ider Component	
					•		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ADULTS & PEDIATRICS	584, 236				0	
2.00		RESPI RATORY THERAPY	3, 280				0	
3.00		EMERGENCY	1, 311, 408				0	
4.00	0.00		0	-			0	
5.00	0.00		0	-			0	
6.00	0.00		0	-		-	0	
7.00	0.00		0	0	(	° °	0	
8.00	0.00		0	0	(	° °	0	
9.00	0.00		0	0	(	0 0	0	
10.00	0.00		0	0	(	0 0	0	
200.00			1, 898, 924	1, 514, 203			0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE			of Malpractice	
				Limit	Continuing	Share of col. 12	Insurance	
	1.00	2.00	8.00	9.00	Education 12.00	13.00	14.00	
1.00		ADULTS & PEDIATRICS	0.00				14.00	1.00
2.00		RESPI RATORY THERAPY	0				0	
3.00		EMERGENCY	0				0	
4.00	0.00	Emeridenci	0	-			0	
5.00	0.00		0	0	(	-	0	
6.00	0.00		0	0		-	0	
7.00	0.00		0	0			0	
8.00	0.00		0	0	(		0	
9.00	0.00		0	-	(		0	
10.00	0.00		0	0	(	0	0	
200.00			0	0	(	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	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		ADULTS & PEDIATRICS	0	-				1.00
2.00		RESPI RATORY THERAPY	0					2.00
3.00		EMERGENCY	0					3.00
4.00	0.00		0	-		-		4.00
5.00	0.00		0	-		-		5.00
6.00	0.00		0	0		° °		6.00
7.00	0.00		0			-		7.00
8.00	0.00		0					8.00
9.00	0.00		0			-		9.00
10.00	0.00		0					10.00
200.00			0	0	(	1, 514, 203		200. 00

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	LLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1317	Period:	Worksheet B	
					From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	nared
						5/30/2023 1:0	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		Cubtotol	
	cost center bescription	for Cost	BLDG & FIXI	MVBLE EQUIP	EMPLOYEE BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
		0	1.00	2.00	4.00	4A	
1 00	GENERAL SERVICE COST CENTERS	1 ( ( 0 472	1 ( ( 0 47)				1 1 00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	1, 668, 473	1, 668, 473		-		1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	535, 715 5, 353, 391	0	535, 71			4.00
4.00 5.00	00500 ADMINISTRATIVE & GENERAL	6, 196, 917	144, 971	37, 87		7, 105, 657	5.00
7.00	00700 OPERATION OF PLANT	1, 886, 506	217, 801	56, 902		2, 335, 789	
8.00	00800 LAUNDRY & LINEN SERVICE	279, 944	11, 595			294, 568	
9.00	00900 HOUSEKEEPING	390, 165	11, 572			477, 233	
10.00	01000 DI ETARY	145, 121	62, 658			249, 521	10.00
11.00	01100 CAFETERI A	711, 974	62, 658	16, 370	121, 625	912, 627	11.00
13.00	01300 NURSING ADMINISTRATION	542, 898	11, 388	2, 97	5 82, 131	639, 392	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	-90, 810	78, 524	20, 51	5 0	8, 229	14.00
	01500 PHARMACY	854, 150	29, 481	7, 702	2 169, 119	1, 060, 452	
	01600 MEDICAL RECORDS & LIBRARY	309, 547	24, 476			405, 978	
	01700 SOCI AL SERVI CE	272, 665				338, 488	
19.00	01900 NONPHYSI CLAN ANESTHETI STS	244, 434	0	(	0 0	244, 434	19.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2 074 270	200, 200	101 70	1 70/ 00/	F 201 400	20.00
	03000 ADULTS & PEDIATRICS	3, 974, 370				5, 201, 400	
	03100 I NTENSI VE CARE UNI T 04300 NURSERY	736, 325 94, 553	61, 533 8, 702			916, 973 127, 004	
43.00	ANCI LLARY SERVI CE COST CENTERS	94, 555	0, 702	2,21	21,470	127,004	43.00
50.00	05000 OPERATI NG ROOM	1, 100, 855	112, 597	29, 41	7 133, 473	1, 376, 342	50.00
	05200 DELIVERY ROOM & LABOR ROOM	2, 232	4, 730			8, 520	
	05300 ANESTHESI OLOGY	100, 779	0	(		100, 779	
	05400 RADI OLOGY-DI AGNOSTI C	1, 850, 705	104, 561	27, 31	7 241, 316	2, 223, 899	
60.00	06000 LABORATORY	3, 534, 604	59, 949	15, 662	2 208, 182	3, 818, 397	60.00
65.00	06500 RESPI RATORY THERAPY	875, 239	2, 686	702	2 180, 225	1, 058, 852	65.00
66.00	06600 PHYSI CAL THERAPY	611, 942	20, 733	5, 41	7 126, 797	764, 889	
	06700 OCCUPATI ONAL THERAPY	201, 801	20, 733			274, 261	
	06800 SPEECH PATHOLOGY	45, 960	11, 113			70, 216	
	06900 ELECTROCARDI OLOGY	0	0			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	859, 527	0		-	859, 527	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	1,095,371	10 241	( E 02	-	1, 095, 371	
	07700 ALLOGENEIC HSCT ACQUISITION	2, 029, 564 0	19, 241 0	5, 02		2, 112, 327 0	
77.00	OUTPATIENT SERVICE COST CENTERS	0	0	1 (	<u> </u>	0	//.00
88.00	08800 RURAL HEALTH CLINIC	3, 849, 183	0	37,01	7 596, 378	4, 482, 578	88.00
	08801 RURAL HEALTH CLINIC II	1, 253, 151	0			1, 485, 609	
	08802 RURAL HEALTH CLINIC III	716, 873	0				
	08803 RURAL HEALTH CLINIC IV	501, 373	0			603, 226	
	09100 EMERGENCY	2, 994, 695	130, 368			3, 722, 253	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	(	0 0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118.00		45, 730, 192	1, 607, 904	519, 89	1 4, 919, 003	45, 219, 411	118.00
100.00	NONREI MBURSABLE COST CENTERS		4 699			0.051	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2 2 2 2 4 2 2	6, 383 E4, 194				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 228, 409	54, 186	14, 150	6 434, 388	2, 731, 139	192.00
194.00 200.00	07950 FOUNDATION / MOBS Cross Foot Adjustments	0	0		ן וי		200.00
200.00			0				200.00
201.00		47, 958, 601	1, 668, 473			47, 958, 601	
202.00		, ,,,	., 666, 775	1 000,710		, ,00,001	

	Financial Systems G ALLOCATION - GENERAL SERVICE COSTS	REENE COUNTY GE	Provi der C		Peri od:	u of Form CMS- Worksheet B	2002 10
0001 /					From 01/01/2022	Part I	
					To 12/31/2022	Date/Time Pre 5/30/2023 1:0	epared: )5 nm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVIC			
		5.00	7.00	8.00	9.00	10.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	7 405 457					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	7, 105, 657					5.00
7.00	00700 OPERATION OF PLANT	406, 271	2, 742, 060				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	51, 235	18, 838	364, 64			8.00
9.00	00900 HOUSEKEEPI NG	83,007	18, 801		0 579, 041		9.00
10.00	01000 DI ETARY	43, 400	101, 800		0 0	394, 721	
11.00	01100 CAFETERI A	158, 736	101, 800		0 0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	111, 211	18, 502		0 0	0	
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 431	127, 576		0 0	0	14.00
15.00	01500 PHARMACY	184, 448	47, 897		0 12, 524	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	70, 613	39, 765		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	58, 874	10, 631		0 0	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	42, 515	0		0 0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	904, 680	632, 470	80, 79	94 160, 745	276, 289	30.00
31.00	03100 INTENSIVE CARE UNIT	159, 492	99, 972	18, 64	45 63, 940	118, 432	31.00
43.00	04300 NURSERY	22,090	14, 138	1	0 5,085	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	239, 391	182, 933	28, 98	82, 774	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 482	7, 684		0 6,027	0	52.00
53.00	05300 ANESTHESI OLOGY	17, 529	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	386, 809	169, 877	56, 10	16, 291	0	54.00
60.00	06000 LABORATORY	664, 145	97, 398		0 33, 618	0	60.00
65.00	06500 RESPI RATORY THERAPY	184, 169	4, 364			0	65.00
66.00	06600 PHYSI CAL THERAPY	133, 039				0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	47, 703			0 1,507	0	
68.00	06800 SPEECH PATHOLOGY	12, 213			0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	149, 500	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	190, 521	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	367, 403	31, 260		0 0	0	1
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	
//.00	OUTPATIENT SERVICE COST CENTERS	0	0		<u> </u>	0	11.00
88.00	08800 RURAL HEALTH CLINIC	779, 668	230, 196		0 0	0	88.00
88.01	08801 RURAL HEALTH CLINIC II	258, 396	134, 067		0 0	0	
88. 02	08802 RURAL HEALTH CLINIC III	146, 907	113, 102		0 0	0	1
	08803 RURAL HEALTH CLINIC IV				0 0	0	
88.03	09100 EMERGENCY	104, 921	143, 355		с - С		
91.00		647, 423	211, 806	93, 92	144, 078	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
102.00	OTHER REIMBURSABLE COST CENTERS		0			0	100.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
440.00	SPECIAL PURPOSE COST CENTERS	( ( 00 000	0 ( 40 , (55	0(4.4	14 E ( 7 4 E 0	004 704	1110 00
118.00		6, 629, 222	2, 643, 655	364, 64	41 567, 458	394, 721	1118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,400			0 377		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	475, 035	88, 035		0 11, 206		192.00
	07950 FOUNDATION / MOBS	0	0		0 0	0	194.00
	Cross Foot Adjustments						200.00
200.00							
200.00 201.00 202.00	Negative Cost Centers	0 7, 105, 657	0 2, 742, 060	364, 64	0 0 11 579, 041	0 394, 721	201.00

COST ALLO	CATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1317	Period: From 01/01/2022 To 12/31/2022	u of Form CMS-: Worksheet B Part I Date/Time Pre 5/30/2023 1:0	pared:
	Cost Center Description		NURSI NG DMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	NERAL SERVICE COST CENTERS				1		1 1 00
	100 CAP REL COSTS-BLDG & FIXT 200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00 004	400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	500 ADMINISTRATIVE & GENERAL						5.00
7.00 007	700 OPERATION OF PLANT						7.00
	300 LAUNDRY & LINEN SERVICE						8.00
9.00 009	POO HOUSEKEEPI NG						9.00
10.00 010	DOO DI ETARY						10.00
	IOO CAFETERI A	1, 173, 163					11.00
13.00 013	300 NURSI NG ADMI NI STRATI ON	91, 630	860, 735				13.00
14.00 014	400 CENTRAL SERVICES & SUPPLY	0	0	137, 23	36		14.00
	500 PHARMACY	61, 411	0	38	35 1, 367, 117		15.00
16.00 016	500 MEDICAL RECORDS & LIBRARY	44, 421	0	6	68 0	560, 845	16.00
	700 SOCIAL SERVICE	19, 454	0	Ę	51 0	6, 445	17.00
19.00 019	200 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	19.00
	PATIENT ROUTINE SERVICE COST CENTERS						
30.00 030	DOO ADULTS & PEDIATRICS	253, 880	442, 590	3, 75	53 0	62, 730	30.00
31.00 031	100 INTENSIVE CARE UNIT	37, 028	64, 612	52	20 0	6, 158	31.00
43.00 043	300 NURSERY	7, 328	0		4 0	1, 862	43.00
ANC	CILLARY SERVICE COST CENTERS						
50.00 050	DOO OPERATING ROOM	50, 646	88, 246	92	29 0	67, 886	50.00
52.00 052	200 DELIVERY ROOM & LABOR ROOM	130	0		0 0	6, 158	52.00
53.00 053	300 ANESTHESI OLOGY	0	0	17	72 0	0	53.00
54.00 054	100 RADI OLOGY-DI AGNOSTI C	112, 057	0		68 0	28, 930	54.00
60.00 060	DOO LABORATORY	118, 736	0	53, 16	60 0	75, 763	60.00
65.00 065	500 RESPI RATORY THERAPY	75, 807	0	2, 20	0 00	15, 468	65.00
66.00 066	500 PHYSI CAL THERAPY	60, 503	0	29	91 0	19, 621	66.00
67.00 067	700 OCCUPATI ONAL THERAPY	14,007	0		0 0	5, 156	67.00
68.00 068	BOO SPEECH PATHOLOGY	5, 058	0		0 0	2, 435	68.00
69.00 069	200 ELECTROCARDI OLOGY	0	0		0 0	286	69.00
71.00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	32, 39	97 0	0	71.00
72.00 072	200 IMPL. DEV. CHARGED TO PATIENTS	0	0	37, 79	90 0	0	72.00
73.00 073	BOO DRUGS CHARGED TO PATIENTS	18, 028	0	-	78 1, 367, 117	0	73.00
77.00 077	700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
	PATIENT SERVICE COST CENTERS						
	BOO RURAL HEALTH CLINIC	0	0		0 0	6, 015	88.00
	301 RURAL HEALTH CLINIC II	0	0		0 0	6, 015	
	302 RURAL HEALTH CLINIC III	0	0		0 0	6, 015	88. 02
	BO3 RURAL HEALTH CLINIC IV	0	0		0 0	6, 015	88.03
	IOO EMERGENCY	152, 133	265, 287	1, 36	61 0	237, 887	91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTH	IER REIMBURSABLE COST CENTERS						
	200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
SPE	CLAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 122, 257	860, 735	134, 12	27 1, 367, 117	560, 845	118.00
	IREI MBURSABLE COST CENTERS	-1	-1				100 0-
	DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	200 PHYSI CLANS' PRI VATE OFFI CES	50, 906	0	3, 10	0 0		192.00
	P50 FOUNDATION / MOBS	0	0		0 0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00 202.00	Negative Cost Centers	0	0		0 0		201.00
	TOTAL (sum lines 118 through 201)	1, 173, 163	860, 735	137, 23	36 1, 367, 117		202.00

		REENE COUNTY GE				u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part I Date/Time Pre	
	Cost Center Description	SOCI AL SERVI CE	ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	5/30/2023 1:0 Total	<u>15 pm</u>
		17.00	19.00	24.00	25.00	26.00	-
	GENERAL SERVICE COST CENTERS	1			1		1 4 65
	00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY						16.00
17.00	01700 SOCIAL SERVICE	433, 943					17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	286, 949				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	313, 331	0	8, 332, 6	62 0	8, 332, 662	30.00
31.00	03100 INTENSIVE CARE UNIT	20, 976	0	1, 506, 7	48 0	1, 506, 748	31.00
43.00	04300 NURSERY	0	0	177, 5	11 0	177, 511	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 311	0	2, 119, 4	45 0	2, 119, 445	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	22, 287	0	52, 2	88 0	52, 288	52.00
	05300 ANESTHESI OLOGY	0	286, 949	405, 4	29 0	405, 429	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	2, 994, 9	39 0	2, 994, 939	54.00
60.00	06000 LABORATORY	0	0	4, 861, 2	17 0	4, 861, 217	60.00
65.00	06500 RESPI RATORY THERAPY	0	0	1, 363, 4	67 0	1, 363, 467	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	1, 116, 4	75 0	1, 116, 475	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	376, 3	18 0	376, 318	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	107, 9	77 0	107, 977	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	2	86 0	286	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,041,4	24 0	1, 041, 424	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1, 323, 6	82 0	1, 323, 682	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	3, 896, 2	13 0	3, 896, 213	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	5, 498, 4	57 0	5, 498, 457	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	1, 884, 0	87 0	1, 884, 087	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	1, 110, 6	44 0	1, 110, 644	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	857, 5	17 0	857, 517	88. 03
91.00	09100 EMERGENCY	76, 038	0	5, 552, 1	87 0		
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS						1
	10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118.00		433, 943	286, 949	44, 578, 9	73 0	44, 578, 973	118.00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	20, 1	98 0	20, 198	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	3, 359, 4		3, 359, 430	
192.00							
	07950 FOUNDATION / MOBS	0	OI		0 0	0	194.00
		0	0		0 0		
194.00	Cross Foot Adjustments	0	0 0 0			0	200. 00 201. 00

Heal th	Fi nanci al	Systems
A T200		2017217472

15.00 PHARMACY

 16. 00
 MEDI CAL
 RECORDS
 & LI BRARY

 17. 00
 SOCI AL
 SERVI CE
 19. 00
 NONPHYSI CI AN
 ANESTHETI STS

						6 F 949	
	Financial Systems	GREENE COUNTY GENER				u of Form CMS-	
COST A	ALLOCATION STATISTICS		Provider CC		Period:	Worksheet Non	-CMS W
					From 01/01/2022		
					To 12/31/2022	Date/Time Pre	
						5/30/2023 1:0	5 pm
	Cost Center Description			Statistics	Stati sti cs I	Description	
				Code			
				1.00	2.0	00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT			50	SQUARE FEET		1.00
2.00	CAP REL COSTS-MVBLE EQUIP			1	SQUARE FEET		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT			S	GROSS SALARIES		4.00
5.00	ADMINISTRATIVE & GENERAL			-5	ACCUM. COST		5.00
7.00	OPERATION OF PLANT			1	SQUARE FEET		7.00
8.00	LAUNDRY & LINEN SERVICE			30	POUNDS OF LAUNE	DRY	8.00
9.00	HOUSEKEEPI NG			9	HOURS OF SERVIC	Έ	9.00
10.00	DI ETARY			10	MEALS SERVED		10.00
11.00	CAFETERI A			25	HOURS		11.00
13.00	NURSI NG ADMI NI STRATI ON			13	DIRECT NURS. HF	RS.	13.00
14.00	CENTRAL SERVICES & SUPPLY			14	COSTED REQUIS.		14.00
15 00	DUADMACY			15	COSTED DEOULS		1 - 00

COSTED REQUIS. TIME SPENT TIME SPENT ASSIGNED TIME

15

16

17 19

15.00

16.00 17.00 19.00

Heal th	Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1317	Peri od:	Worksheet B	
					From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/30/2023 1:0	5 pm
			CAPITAL REL	LATED CUSTS			
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFITS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0	0 144, 971	37.87		0	
5.00 7.00	00700 OPERATION OF PLANT	0	217, 801	56, 90		0	
8.00	00800 LAUNDRY & LINEN SERVICE	0	11, 595			0	8.00
9.00	00900 HOUSEKEEPING	0	11, 572	3, 02		0	9.00
10.00	01000 DI ETARY	0	62, 658			0	10.00
11.00	01100 CAFETERI A	0	62, 658			0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	11, 388	2, 97	5 14, 363	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	78, 524	20, 51	5 99, 039	0	14.00
15.00	01500 PHARMACY	0	29, 481	7,70	2 37, 183	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	24, 476			0	
17.00	01700 SOCIAL SERVICE	0	6, 544	1, 71		0	17.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	19.00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		200, 200	101 70	400.004	0	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	389, 290 61, 533			0	
43.00	04300 NURSERY	0	8, 702	2, 27		0	
43.00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0,702	2,21	5 10, 775	0	43.00
50.00	05000 OPERATING ROOM	0	112, 597	29, 41	7 142,014	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	4, 730	1, 23		0	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	104, 561	27, 31	7 131, 878	0	54.00
60.00	06000 LABORATORY	0	59, 949	15, 66		0	60.00
65.00	06500 RESPI RATORY THERAPY	0	2, 686			0	65.00
66.00	06600 PHYSI CAL THERAPY	0	20, 733			0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	20, 733			0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	11, 113 0	2,90	14, 016	0	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	19, 241	5, 02	24, 268	0	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0,02	0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	37, 01		0	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0	0			0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0			0	
	08803 RURAL HEALTH CLINIC IV	0	0	/		0	
	09100 EMERGENCY	0	130, 368	34, 06	0 164, 428	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
102 00	OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS	V	0	I	0	0	102.00
118.00		0	1, 607, 904	519, 89	2, 127, 795	0	118.00
	NONREI MBURSABLE COST CENTERS			1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 383				190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	54, 186	14, 15	6 68, 342		192.00
	07950 FOUNDATION / MOBS	0	0		0 0	0	194.00
200.00	5		~		0	_	200.00
201.00 202.00		0	0 1, 668, 473	535, 71	0 0 5 2, 204, 188		201. 00 202. 00
202.00	THE (Sum THES THE UNDURING 201)	I U	1,000,473	555,71	2, 204, 100	0	202.00

ALLOC	ATION OF CAPITAL RELATED COSTS		NERAL HOSPITAL Provider C	CN: 15-1317	Peri od:	u of Form CMS-: Worksheet B	
					From 01/01/2022 To 12/31/2022	Part II Date/Time Pre 5/30/2023 1:0	pared: 5 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICI	HOUSEKEEPI NG	DI ETARY	[
		5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	<b>T</b>					
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	182, 846					5.00
7.00	00700 OPERATION OF PLANT	10, 455	285, 158				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 318			)1		8.00
9.00	00900 HOUSEKEEPI NG	2, 136	1, 955		0 18, 686		9.00
10.00	01000 DI ETARY	1, 117	10, 587		0 0	90, 732	10.00
11.00	01100 CAFETERI A	4, 085	10, 587		0 0	0	11.00
13.00	01300 NURSING ADMINISTRATION	2, 862	1, 924		0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	37	13, 267		0 0	0	14.00
15.00	01500 PHARMACY	4, 747	4, 981		0 404	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 817	4, 135		0 0	0	16.00
17.00	01700 SOCIAL SERVICE	1, 515	1, 106		0 0	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	1,094	0		0 0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	23, 269	65, 773	3, 96	6 5, 189	63, 509	1 30. 00
31.00	03100 I NTENSI VE CARE UNI T	4, 104	10, 396	91	5 2,063	27, 223	31.00
43.00	04300 NURSERY	568	1, 470		0 164	0	
	ANCI LLARY SERVICE COST CENTERS			I	<u> </u>		
50.00	05000 OPERATI NG ROOM	6, 161	19, 024	1, 42	2, 671	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	38	799		0 194	0	
53.00	05300 ANESTHESI OLOGY	451	0		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	9,954	17, 666	2, 75	526	0	54.00
60.00	06000 LABORATORY	17, 091	10, 129		0 1,085	0	60.00
65.00	06500 RESPI RATORY THERAPY	4, 739	454			0	65.00
66.00	06600 PHYSI CAL THERAPY	3, 424	3, 503			0	
67.00	06700 OCCUPATI ONAL THERAPY	1, 228	3, 503		0 49	0	
68.00	06800 SPEECH PATHOLOGY	314	1, 878		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 847	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 903	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	9,455	3, 251		0 0	0	
77.00	07700 ALLOGENEIC HSCT ACQUISITION	9,433	3,231		0 0	0	
//.00	OUTPATIENT SERVICE COST CENTERS	0	0		<u> </u>	0	1 / /. 00
88. 00	08800 RURAL HEALTH CLINIC	20.044	23, 939		0 0	0	00 00
	08800 RURAL HEALTH CLINIC	20, 064	13, 942				
88.01		6, 650				0	
88.02	08802 RURAL HEALTH CLINIC III	3, 781	11, 762		0 0	0	
88.03	08803 RURAL HEALTH CLINIC IV	2,700	14, 908		0 0	0	
91.00	09100 EMERGENCY	16, 661	22, 027	4, 61	2 4, 649	0	
92.00							92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	D 10200 OPI OI D TREATMENT PROGRAM	0	0		0 0	0	102.00
	SPECIAL PURPOSE COST CENTERS	170 505	074.005	17.00	4 40 44	00.700	
118.00		170, 585	274, 925	17, 90	18, 312	90, 732	1118.00
105 ·	NONREI MBURSABLE COST CENTERS	1		1			
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	36			0 12		190.00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	12, 225			0 362		192.00
	07950 FOUNDATION / MOBS	0	0		0 0	0	194.00
200.00							200.00
201.00		0	0		0 0		201.00
202.00		182, 846	285, 158	17, 90	18, 686		

Health Financial Systems	GREENE C	OUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provider CC	CN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II Date/Time Pre 5/30/2023 1:0	epared: )5 pm
Cost Center Description	CAFE	TERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11	. 00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT							1 1 00
2.00         00200         CAP         REL         COSTS-MVBLE         EQUIP           4.00         00400         EMPLOYEE         BENEFITS         DEPARTM           5.00         00500         ADMI NI STRATI VE         & GENERAL           7.00         00700         OPERATI ON OF         PLANT           8.00         00800         LAUNDRY         LI NEN         SERVICE           9.00         00900         HOUSEKEEPI NG         10.00         D1000         DI ETARY           11.00         01100         CAFETERI A         CAFETERI A         CAFETERI A		93, 700 7 210					1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY		7, 318 0		67,60	17		13.00
15. 00 01500 PHARMACY		4,905	-	19			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY		3, 548			4 0	40, 404	1
17.00 01700 SOCIAL SERVICE		1, 554			.5 0	464	17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS		0	0		0 0	C	19.00
I NPATI ENT ROUTI NE SERVI CE COST	CENTERS	00.070	10 (00			4 540	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT		20, 278 2, 957		1, 84 25		4, 519 444	1
43. 00 04300 NURSERY		2, 937			2 0	134	1
ANCI LLARY SERVICE COST CENTERS		505	0		2 0	134	40.00
50. 00 05000 OPERATI NG ROOM		4,045	2, 714	45	0 8	4, 891	50.00
52.00 05200 DELIVERY ROOM & LABOR ROO	M	10			0 0	444	52.00
53.00 05300 ANESTHESI OLOGY		0			0	0	
54. 00 05400 RADI OLOGY - DI AGNOSTI C		8,950		47		2,084	
60. 00 06000 LABORATORY 65. 00 06500 RESPI RATORY THERAPY		9, 483 6, 055		26, 18 1, 08		5, 458 1, 114	1
66. 00 06600 PHYSI CAL THERAPY		4,832		14		1, 114	1
67. 00 06700 OCCUPATI ONAL THERAPY		1, 119			0 0	371	1
68.00 06800 SPEECH PATHOLOGY		404	0		0 0	175	1
69.00 06900 ELECTROCARDI OLOGY		0	0		0 0	21	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED		0	0	15, 96		C	71.00
72.00 07200 I MPL. DEV. CHARGED TO PAT		0	-	18, 61		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	1	1, 440			52, 410	0	1
77.00 07700 ALLOGENEIC HSCT ACQUISITI OUTPATIENT SERVICE COST CENTERS		0	0	<u> </u>	0 0	C	77.00
88.00 08800 RURAL HEALTH CLINIC		0	0		0 0	433	88.00
88.01 08801 RURAL HEALTH CLINIC II		0	-		0 0	433	1
88.02 08802 RURAL HEALTH CLINIC III		0	0		0 0	433	88. 02
88.03 08803 RURAL HEALTH CLINIC IV		0	0		0 0	433	
91.00 09100 EMERGENCY		12, 151	8, 157	67	0 0	17, 139	
92. 00 09200 OBSERVATION BEDS (NON-DIS							92.00
OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM		0	0		0 0	0	102.00
SPECIAL PURPOSE COST CENTERS		0	0		0 0	0	102.00
118.00 SUBTOTALS (SUM OF LINES 1	through 117)	89, 634	26, 467	66, 07	6 52, 410	40, 404	118.00
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP	& CANTEEN	0			0 0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI C	ES	4,066		1, 53			192.00
194.00 07950 FOUNDATION / MOBS		0	0		0 0	C	194.00
200.00Cross Foot Adjustments201.00Negative Cost Centers		0		44, 73		0	200.00
202.00 TOTAL (sum lines 118 thro	uah 201)	93, 700	-				201.00
			20, 107	1 112,07	52, 110	10, 104	1-02.00

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
	TION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet B Part II	pared:
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	1	17.00	19.00	24.00	25.00	26.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
8.00 9.00	00900 HOUSEKEEPING						9.00
9.00 10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY						15.00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17.00	01700 SOCIAL SERVICE	12, 918					17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	1, 094				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	9, 328		702, 28	3 0	702, 283	30.00
31.00	03100 I NTENSI VE CARE UNI T	624		128, 57	8 0	128, 578	31.00
43.00	04300 NURSERY	0		13, 89	8 0	13, 898	43.00
	ANCI LLARY SERVICE COST CENTERS					L	-
50.00	05000 OPERATING ROOM	39		183, 44		183, 440	
52.00	05200 DELIVERY ROOM & LABOR ROOM	663		8, 11		8, 114	•
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0		53 174, 28		536 174, 289	•
60. 00	06000 LABORATORY	0		174, 28		145, 045	•
65.00	06500 RESPIRATORY THERAPY	0		17, 92		17, 928	1
66.00	06600 PHYSI CAL THERAPY	0		43, 92		43, 921	•
67.00	06700 OCCUPATI ONAL THERAPY	0		32, 42		32, 420	
68.00	06800 SPEECH PATHOLOGY	0		16, 78		16, 787	•
69.00	06900 ELECTROCARDI OLOGY	0			1 0	21	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		19, 80	0	19, 807	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		23, 52	0 0	23, 520	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0		90, 86	2 0	90, 862	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
~~ ~~	OUTPATIENT SERVICE COST CENTERS			04.45		04.450	1
88.00	08800 RURAL HEALTH CLINIC	0		81, 45		81, 453	•
88.01	08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	0		42, 58		42, 584	
88. 02 88. 03	08802 RURAL HEALTH CLINIC IV	0		34, 16 41, 09		34, 163 41, 093	
	09100 EMERGENCY	2, 264		252, 75			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,204		202,70	0		91.00
72.00	OTHER REIMBURSABLE COST CENTERS				0		92.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0			0 0	0	102.00
102.00	SPECIAL PURPOSE COST CENTERS			<u> </u>	<u> </u>	0	102.00
118.00		12, 918	0	2, 053, 50	0 0	2, 053, 500	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		9, 17	7 0	9. 177	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0		95, 68			192.00
	07950 FOUNDATION / MOBS	0			0 0		194.00
200.00			1, 094	1, 09	4 0	1, 094	200. 00
201.00		0	0	44, 73			201.00
202.00	TOTAL (sum lines 118 through 201)	12, 918	1, 094	2, 204, 18	8 0	2, 204, 188	202.00

	ial Systems GF ON - STATISTICAL BASIS	REENE COUNTY GE	Provi der CO		Period:	u of Form CMS- Worksheet B-1	
				F	From 01/01/2022 0 12/31/2022	Date/Time Pre 5/30/2023 1:0	pare
		CAPI TAL REL	ATED COSTS				
C	cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4. 00	5A	5.00	-
GENERAL	_ SERVICE COST CENTERS						
00 00100 0	CAP REL COSTS-BLDG & FIXT	72, 668					1 1
00200	CAP REL COSTS-MVBLE EQUIP		89, 308				2
	MPLOYEE BENEFITS DEPARTMENT	0	0	23, 328, 197			4
	ADMINISTRATIVE & GENERAL	6, 314	6, 314	3, 163, 186		40, 852, 944	
	PERATION OF PLANT	9, 486	9, 486	760, 759		2, 335, 789	
	AUNDRY & LINEN SERVICE	505	505	0		294, 568	
	IOUSEKEEPI NG	504	504	315, 813		477, 233	
00 01000 E		2,729		110, 560		249, 521	
		2, 729		529, 999		912, 627	
	IURSI NG ADMI NI STRATI ON ENTRAL SERVI CES & SUPPLY	496	496	357, 897 (		639, 392 8 220	
	PHARMACY	3, 420 1, 284	3, 420 1, 284	736, 961	-	8, 229 1, 060, 452	
	IEDI CAL RECORDS & LI BRARY	1, 284	1, 284	285, 693		405, 978	
	OCIAL SERVICE	285		265, 693		338, 488	
	IONPHYSI CI AN ANESTHETI STS	0	203	230, 000		244, 434	
	ENT ROUTINE SERVICE COST CENTERS	, °			,	211/101	1.7
	DULTS & PEDIATRICS	16, 955	16, 955	3, 207, 415	5 0	5, 201, 400	1 30
	NTENSIVE CARE UNIT	2,680	2, 680	449,007	0	916, 973	
00 04300 N	IURSERY	379	379	93, 584	0	127, 004	43
ANCI LLA	ARY SERVICE COST CENTERS						
	PERATING ROOM	4, 904	4, 904	581, 626		1, 376, 342	50
	DELIVERY ROOM & LABOR ROOM	206	206	1, 404	0	8, 520	
	NESTHESI OLOGY	0	0	C	-	100, 779	
	ADD OLOGY-DI AGNOSTI C	4, 554	4, 554	1, 051, 567		2, 223, 899	
	ABORATORY	2,611	2, 611	907, 183		3, 818, 397	
		117	117	785, 354		1, 058, 852	
	PHYSI CAL THERAPY CCUPATI ONAL THERAPY	903 903	903 903	552, 537 201, 801		764, 889 274, 261	
	SPEECH PATHOLOGY	484	484	44, 622		70, 216	
	LECTROCARDI OLOGY	404	404	44, 022		0,210	
	IEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	C	-	859, 527	
	MPL. DEV. CHARGED TO PATIENTS	0	0	C	o o	1, 095, 371	
	RUGS CHARGED TO PATIENTS	838	838	254, 902	2 0	2, 112, 327	
. 00  07700  <i>A</i>	LLOGENEIC HSCT ACQUISITION	0	0	C	0 0	0	77
OUTPATI	ENT SERVICE COST CENTERS						
	RURAL HEALTH CLINIC	0	6, 171	2, 598, 802	2 0	4, 482, 578	
	RURAL HEALTH CLINIC II	0		919, 021		1, 485, 609	
	RURAL HEALTH CLINIC III	0	3, 032			844, 620	
	RURAL HEALTH CLINIC IV	0	3, 843			603, 226	
	MERGENCY	5, 678	5, 678	2, 453, 919	0	3, 722, 253	
	DESERVATION BEDS (NON-DISTINCT PART)						92
	REIMBURSABLE COST CENTERS			~			1000
	PIOID TREATMENT PROGRAM	0	0	C	0 0	0	102
	SUBTOTALS (SUM OF LINES 1 through 117)	70, 030	86, 670	21, 435, 290	-7, 105, 657	38, 113, 754	1110
	MBURSABLE COST CENTERS	70,030	60, 670	21, 435, 290	-7,105,657	30, 113, 754	1,18
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	278	C	0	8, 051	190
	PHYSICIANS' PRIVATE OFFICES	2,360		1, 892, 907		2, 731, 139	
	OUNDATION / MOBS	0	0	C	0		194
	Cross Foot Adjustments						200
	legative Cost Centers						201
	Cost to be allocated (per Wkst. B,	1, 668, 473	535, 715	5, 353, 391		7, 105, 657	
F	Part I)						
	Init cost multiplier (Wkst. B, Part I)	22. 960216	5. 998511	0. 229482	2	0. 173933	
	cost to be allocated (per Wkst. B,			C		182, 846	204
	Part II)					_	
	Init cost multiplier (Wkst. B, Part			0.00000		0.004476	205
	)						200
	IAHE adjustment amount to be allocated						206
	per Wkst. B-2) IAHE unit cost multiplier (Wkst. D,						207
	INTE UNIT COST MULTIPLIEL (WKSL. D,	1					1201

COST ALL	inancial Systems GF LOCATION - STATISTICAL BASIS	CENE COUNTI OL	Provider C	CN: 15-1317	Period:	u of Form CMS- Worksheet B-1	
					From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	(HOURS)	
		(Sebrice FEET)	LAUNDRY)	SERVICE			
		7.00	8.00	9.00	10.00	11.00	
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT		1				1 1.
	0200 CAP REL COSTS-BEDG & TTXT						2.
	0400 EMPLOYEE BENEFITS DEPARTMENT						4.
	0500 ADMI NI STRATI VE & GENERAL						5.
	0700 OPERATION OF PLANT	73, 508					7.
	0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING	505 504			5		8.
	1000 DI ETARY	2, 729			10, 232		10.
	1100 CAFETERIA	2,729			0 0	18, 091	
3.00 0	1300 NURSING ADMINISTRATION	496			o c	1, 413	13.
	1400 CENTRAL SERVICES & SUPPLY	3, 420			0 C	0	
	1500 PHARMACY	1, 284				947	
	1600 MEDICAL RECORDS & LIBRARY	1,066				685 300	
	1700 SOCIAL SERVICE 1900 NONPHYSICIAN ANESTHETISTS	285				300	
	NPATIENT ROUTINE SERVICE COST CENTERS					0	
	3000 ADULTS & PEDIATRICS	16, 955	5, 109	42, 67	5 7, 162	3, 915	30
	3100 I NTENSI VE CARE UNI T	2,680				571	
	4300 NURSERY	379	0	1, 35	0 0	113	43
	NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM	4, 904	1, 833	21, 97	5 0	781	50
	5200 DELIVERY ROOM & LABOR ROOM	4, 904				2	
	5300 ANESTHESI OLOGY	200			0	0	
	5400 RADI OLOGY-DI AGNOSTI C	4, 554	3, 548			1, 728	
	6000 LABORATORY	2, 611	0	8, 92	5 0	1, 831	60
	6500 RESPI RATORY THERAPY	117				1, 169	
	6600 PHYSI CAL THERAPY	903				933	
	6700 OCCUPATI ONAL THERAPY 6800 SPEECH PATHOLOGY	903 484				216 78	
	6900 ELECTROCARDI OLOGY	484				0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0 0	0	
	7200 I MPL. DEV. CHARGED TO PATIENTS	C	0		0 0	0	
	7300 DRUGS CHARGED TO PATIENTS	838			0 0	278	
	7700 ALLOGENEIC HSCT ACQUISITION	C	0	(	0 0	0	77
	UTPATIENT SERVICE COST CENTERS 8800 RURAL HEALTH CLINIC	4 171	0		0 0	0	88
	8801 RURAL HEALTH CLINIC II	6, 171 3, 594				0	
	8802 RURAL HEALTH CLINIC III	3, 032			0 0	0	
	8803 RURAL HEALTH CLINIC IV	3, 843	0	(	o o	0	88
	9100 EMERGENCY	5, 678	5, 939	38, 25	0 0	2, 346	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	THER REIMBURSABLE COST CENTERS	C	0		0 0	0	102
-	PECIAL PURPOSE COST CENTERS		0	\	<u> </u>	0	102
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	70, 870	23, 058	150, 650	0 10, 232	17, 306	118
	ONREIMBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	278					190
	9200 PHYSI CLANS' PRI VATE OFFI CES	2,360	0	2, 97	5 0		192
4.000 0.00	7950 FOUNDATION / MOBS	C	0		0	0	194 200
0.00	Cross Foot Adjustments Negative Cost Centers						200
2.00	Cost to be allocated (per Wkst. B,	2, 742, 060	364, 641	579, 04	1 394, 721	1, 173, 163	
	Part I)				0, 1, 121	., ., ., .,	
03.00	Unit cost multiplier (Wkst. B, Part I)	37. 302879				64.847880	
04.00	Cost to be allocated (per Wkst. B,	285, 158	17, 901	18, 68	6 90, 732	93, 700	204
	Part II)	2 070070	0 776247	0 10155	0 0/7/7	E 170071	205
05.00	Unit cost multiplier (Wkst. B, Part II)	3. 879278	0. 776347	0. 12155	5 8.867475	5. 179371	205
06.00	NAHE adjustment amount to be allocated						206
	(per Wkst. B-2)						
07.00	NAHE unit cost multiplier (Wkst. D,						207.
	Parts III and IV)	1	1				1

	Financial Systems GI LLOCATION - STATISTICAL BASIS	REENE COUNTY GEI	Provider C	CN: 15-1317	In Lie Period:	u of Form CMS-2 Worksheet B-1	
0001 /				F	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 1:0	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S. )	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS	· · · ·					
13.00 14.00 15.00 16.00 17.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	158, 353 0 0 0 0 0 0 0 0	3, 977, 807 11, 167 1, 973 1, 475 0	100 ( (	97, 900	331 0	
	INPATIENT ROUTINE SERVICE COST CENTERS		100 707				
31.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T 04300 NURSERY	81, 425 11, 887 0	108, 797 15, 075 114	(	1, 075	239 16 0	31.00
50.00	ANCI LLARY SERVICE COST CENTERS	16, 235	26, 938	(	11, 850	1	50.00
53.00 54.00 60.00 65.00 66.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0 4, 991 28, 067 1, 540, 809 63, 756 8, 428	(	0 0 5, 050 0 13, 225 0 2, 700 0 3, 425	17 0 0 0 0 0	53.00 54.00 60.00 65.00 66.00
69.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0 0 0	0 0 0	(	425 0 50	0 0 0	67.00 68.00 69.00
72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0	939, 039 1, 095, 371 2, 256	( ( 100	0	0 0 0	71.00 72.00 73.00
	07700 ALLOGENEIC HSCT ACQUISITION	0	0	(		0	77.00
88. 00 88. 01 88. 02	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III	000	0	(		0	88.00 88.01 88.02
88. 03 91. 00	08803 RURAL HEALTH CLINIC IV 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 48, 806	0 39, 447		1, 030 1, 050 41, 525	0 58	88. 03
	OTHER REIMBURSABLE COST CENTERS 10200] OPI OI D TREATMENT PROGRAM	0	0	(		0	102.00
	SPECIAL PURPOSE COST CENTERS						118.00
118.00	NONREI MBURSABLE COST CENTERS	158, 353	3, 887, 703	100	97,900		
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 FOUNDATION / MOBS	0	0 90, 104 0	(		0	190. 00 192. 00 194. 00
200. 00 201. 00 202. 00	Cross Foot Adjustments Negative Cost Centers	860, 735	137, 236			433, 943	200. 00 201. 00
203.00 204.00	Part I) Unit cost multiplier (Wkst. B, Part I)	5. 435546 26, 467		13, 671. 170000	5. 728754	1, 311. 006042 12, 918	203. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	0. 167139	0. 016996			39. 027190	
206.00	II) NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00							207.00

ST A	LLOCATION - STATISTICAL BASIS		Provider CCN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet B-1 Date/Time Prepare
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME) 19.00		1	5/30/2023 1:05 pr
	GENERAL SERVICE COST CENTERS				
00	00100 CAP REL COSTS-BLDG & FIXT				1
	00200 CAP REL COSTS-MVBLE EQUIP				2
	00400 EMPLOYEE BENEFITS DEPARTMENT				4
00	00500 ADMI NI STRATI VE & GENERAL				5
	00700 OPERATION OF PLANT				7
	00800 LAUNDRY & LINEN SERVICE				8
	00900 HOUSEKEEPING				9
	01000 DI ETARY				10
					11
	01300 NURSI NG ADMI NI STRATI ON				13
	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY				14   15
	01500 PHARMACT 01600 MEDICAL RECORDS & LIBRARY				16
	01700 SOCIAL SERVICE				10
	01900 NONPHYSICIAN ANESTHETISTS	100			19
00	INPATIENT ROUTINE SERVICE COST CENTERS	100			
00	03000 ADULTS & PEDI ATRI CS	0			30
	03100 I NTENSI VE CARE UNI T	0			31
	04300 NURSERY	0			43
	ANCI LLARY SERVI CE COST CENTERS				
	05000 OPERATING ROOM	0			50
00	05200 DELIVERY ROOM & LABOR ROOM	0			52
00	05300 ANESTHESI OLOGY	100			53
00	05400 RADI OLOGY-DI AGNOSTI C	0			54
00	06000 LABORATORY	0			60
00	06500 RESPI RATORY THERAPY	0			65
	06600 PHYSI CAL THERAPY	0			66
	06700 OCCUPATI ONAL THERAPY	0			67
	06800 SPEECH PATHOLOGY	0			68
	06900 ELECTROCARDI OLOGY	0			69
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			71
	07200 I MPL. DEV. CHARGED TO PATIENTS	0			72
	07300 DRUGS CHARGED TO PATIENTS	0			73
	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0			77
	08800 RURAL HEALTH CLINIC	0			88
	08801 RURAL HEALTH CLINIC II	0			88
	08802 RURAL HEALTH CLINIC III	0			88
	08803 RURAL HEALTH CLINIC IV	0			88
	09100 EMERGENCY	0			91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				92
	OTHER REIMBURSABLE COST CENTERS	· · · · · ·			
2. 00	10200 OPI OI D TREATMENT PROGRAM	0			102
	SPECIAL PURPOSE COST CENTERS				
8. 00		100			118
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192
	07950 FOUNDATION / MOBS	0			194
0. 00	5				200
. 00 2. 00	u u u u u u u u u u u u u u u u u u u	204 040			201
00	Cost to be allocated (per Wkst. B, Part I)	286, 949			202
. 00	,	2, 869. 490000			203
. 00 . 00		1, 094			203
. 00	Part II)	1,074			204
6. 00		10. 940000			205
		,10000			
. 00					206
	(per Wkst. B-2)				[

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1317		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/30/2023 1:0	
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	8, 332, 662		8, 332, 66	02 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 506, 748		1, 506, 74	8 0	0	31.00
43. 00 04300 NURSERY	177, 511		177, 51	1 0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	2, 119, 445		2, 119, 44		0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	52, 288		52, 28		0	
53. 00 05300 ANESTHESI OLOGY	405, 429		405, 42		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 994, 939		2, 994, 93		0	54.00
60. 00 06000 LABORATORY	4, 861, 217		4, 861, 21		0	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 363, 467	0	1, 363, 46		0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 116, 475		1, 116, 47		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	376, 318	0	376, 31		0	67.00
68.00 06800 SPEECH PATHOLOGY	107, 977	0	107, 97		0	
69. 00 06900 ELECTROCARDI OLOGY	286		28		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 041, 424		1, 041, 42		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	1, 323, 682		1, 323, 68		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 896, 213		3, 896, 21		0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	5, 498, 457		5, 498, 45		0	
88.01 08801 RURAL HEALTH CLINIC II	1, 884, 087		1, 884, 08		0	
88. 02 08802 RURAL HEALTH CLINIC III	1, 110, 644		1, 110, 64		0	88.02
88. 03 08803 RURAL HEALTH CLINIC IV	857, 517		857, 51		0	88.03
91.00 09100 EMERGENCY	5, 552, 187		5, 552, 18		0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	3, 424, 892		3, 424, 89	2	0	92.00
OTHER REIMBURSABLE COST CENTERS		E Contraction of the second seco	[	0	2	100.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0		40,000,07	0		102.00 200.00
200.00Subtotal (see instructions)201.00Less Observation Beds	48, 003, 865 3, 424, 892					200.00
201.00 Less Observation Beds 202.00 Total (see instructions)	3, 424, 892 44, 578, 973		3, 424, 89			201.00
zuz. uuj jiutai (see instructions)	44, 578, 973	0	44, 578, 97	0	0	202.00

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2022 To 12/31/2022	5/30/2023 1:0	
			XVIII	Hospi tal	Cost	
		Charges			75504	
Cost Center Description	I npati ent	Outpati ent	lotal (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 750, 411		2, 750, 4	11		30.00
31. 00 03100 I NTENSI VE CARE UNI T	375, 076		375, 0			31.00
43. 00 04300 NURSERY	208, 650		208, 6			43.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	977, 514	5, 182, 198	6, 159, 7	0. 344082	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	143, 128	17, 891	161, 0	0. 324732	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	198,006	660, 976	858, 9	0. 471988	0. 000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	632, 304	27, 937, 767			0. 000000	54.00
60. 00 06000 LABORATORY	1, 111, 939	23, 707, 278	24, 819, 2	0. 195865	0. 000000	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 120, 431	3, 204, 956	4, 325, 3	0. 315224	0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	319, 769	3, 659, 829	3, 979, 5	98 0. 280550	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	118, 768	1, 208, 994	1, 327, 7	0. 283423	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	20, 203	216, 612	236, 8	0. 455955	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 166, 023	2, 805, 754	3, 971, 7		0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	416, 546	792, 959	1, 209, 5	1. 094400	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 253, 044	12, 559, 496	14, 812, 5	40 0. 263035	0. 000000	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0.000000	0. 000000	77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	5, 637, 963	5, 637, 9	53		88.00
88.01 08801 RURAL HEALTH CLINIC II	0	2,092,472	2, 092, 4	72		88.01
88.02 08802 RURAL HEALTH CLINIC III	0	987, 263	987, 2	53		88.02
88.03 08803 RURAL HEALTH CLINIC IV	0	594, 537	594, 5	37		88.03
91.00 09100 EMERGENCY	599, 532	26, 746, 792	27, 346, 3	0. 203032	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	206, 790	1, 951, 613			0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						1
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
200.00 Subtotal (see instructions)	12, 618, 134	119, 965, 350	132, 583, 4	34		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	12, 618, 134	119, 965, 350	132, 583, 4	34		202.00

Health Financial Systems G	REENE COUNTY GENE	RAL HOSPITAL	In Lie	In Lieu of Form CMS-25		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/30/2023 1:0	epared: )5 pm	
		Title XVIII	Hospi tal	Cost		
Cost Center Description	PPS Inpatient					
	Ratio					
	11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS					30.00	
31.00 03100 I NTENSI VE CARE UNI T					31.00	
43. 00 04300 NURSERY					43.00	
ANCILLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
50. 00 05000 OPERATI NG ROOM	0.000000				50.00	
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	
60. 00 06000 LABORATORY	0.000000				60.00	
65. 00 06500 RESPI RATORY THERAPY	0.000000				65.00	
66. 00 06600 PHYSI CAL THERAPY	0.000000				66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00	
68.00 06800 SPEECH PATHOLOGY	0.000000				68.00	
69. 00 06900 ELECTROCARDI OLOGY	0.000000				69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000				77.00	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC					88.00	
88.01 08801 RURAL HEALTH CLINIC II					88.01	
88.02 08802 RURAL HEALTH CLINIC III					88.02	
88.03 08803 RURAL HEALTH CLINIC IV					88.03	
91.00 09100 EMERGENCY	0, 000000				91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00	
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM					102.00	
200.00 Subtotal (see instructions)					200.00	
201.00 Less Observation Beds					201.00	
202.00 Total (see instructions)					202.00	
	1					

Health Financial Systems G	REENE COUNTY GEI	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 15-1317		Worksheet C Part I Date/Time Pre 5/30/2023 1:0	pared: 5 pm
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	(from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	8, 332, 662		8, 332, 66	02 0	8, 332, 662	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 506, 748		1, 506, 74	8 0	1, 506, 748	31.00
43. 00 04300 NURSERY	177, 511		177, 51	1 0	177, 511	43.00
ANCI LLARY SERVICE COST CENTERS	r					
50.00 05000 OPERATI NG ROOM	2, 119, 445		2, 119, 44		2, 119, 445	
52.00 05200 DELIVERY ROOM & LABOR ROOM	52, 288		52, 28		52, 288	
53. 00 05300 ANESTHESI OLOGY	405, 429		405, 42		405, 429	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 994, 939		2, 994, 93		2, 994, 939	•
60. 00 06000 LABORATORY	4, 861, 217		4, 861, 21		4, 861, 217	•
65. 00 06500 RESPI RATORY THERAPY	1, 363, 467	0	1, 363, 46		1, 363, 467	
66. 00 06600 PHYSI CAL THERAPY	1, 116, 475	0	1, 116, 47		1, 116, 475	
67.00 06700 OCCUPATI ONAL THERAPY	376, 318	0	376, 31		376, 318	
68.00 06800 SPEECH PATHOLOGY	107, 977	0	107, 97		107, 977	
69. 00 06900 ELECTROCARDI OLOGY	286		28		286	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 041, 424		1, 041, 42		1, 041, 424	•
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 323, 682		1, 323, 68		1, 323, 682	
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 896, 213		3, 896, 21		3, 896, 213	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	5, 498, 457		5, 498, 45		5, 498, 457	
88.01 08801 RURAL HEALTH CLINIC II	1, 884, 087		1, 884, 08		1, 884, 087	
88.02 08802 RURAL HEALTH CLINIC III	1, 110, 644		1, 110, 64		1, 110, 644	
88.03 08803 RURAL HEALTH CLINIC IV	857, 517		857, 51		857, 517	
91.00 09100 EMERGENCY	5, 552, 187		5, 552, 18		5, 552, 187	
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	3, 424, 892		3, 424, 89	2	3, 424, 892	92.00
OTHER REI MBURSABLE COST CENTERS	-1				-	
102.00 10200 OPI OI D TREATMENT PROGRAM	0	-	10,000,00	0		102.00
200.00 Subtotal (see instructions)	48,003,865	0			48, 003, 865	
201.00 Less Observation Beds	3, 424, 892	~	3, 424, 89		3, 424, 892	
202.00  Total (see instructions)	44, 578, 973	0	44, 578, 97	0	44, 578, 973	202.00

Health Financial Systems G	REENE COUNTY GEN	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/30/2023 1:0	pared: 5 pm
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Inpati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 750, 411		2, 750, 4	1		30.00
31.00 03100 I NTENSI VE CARE UNI T	375, 076		375, 0	76		31.00
43.00 04300 NURSERY	208, 650		208, 6	50		43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	977, 514	5, 182, 198	6, 159, 7	0. 344082	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	143, 128	17, 891	161, 0 <sup>-</sup>	0. 324732	0.00000	52.00
53.00 05300 ANESTHESI OLOGY	198, 006	660, 976	858, 9	0. 471988	0.00000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	632, 304	27, 937, 767	28, 570, 0	0. 104828	0.00000	54.00
60. 00 06000 LABORATORY	1, 111, 939	23, 707, 278	24, 819, 2	0. 195865	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 120, 431	3, 204, 956	4, 325, 3	0. 315224	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	319, 769	3, 659, 829	3, 979, 59	0. 280550	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	118, 768	1, 208, 994	1, 327, 70	0. 283423	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	20, 203	216, 612	236, 8	0. 455955	0.00000	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 166, 023	2, 805, 754	3, 971, 7	0. 262206	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	416, 546	792, 959	1, 209, 50	1. 094400	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 253, 044	12, 559, 496	14, 812, 54	0. 263035	0.00000	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0.000000	0.00000	77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	5, 637, 963	5, 637, 9	0. 975256	0.00000	88.00
88.01 08801 RURAL HEALTH CLINIC II	0	2,092,472	2, 092, 4	0. 900412	0.00000	
88.02 08802 RURAL HEALTH CLINIC III	0	987, 263	987, 20	53 1. 124973	0.00000	88.02
88.03 08803 RURAL HEALTH CLINIC IV	0	594, 537	594, 5	1. 442327	0.00000	88.03
91.00 09100 EMERGENCY	599, 532	26, 746, 792	27, 346, 32	0. 203032	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	206, 790	1, 951, 613	2, 158, 40	1. 586771	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
200.00 Subtotal (see instructions)	12, 618, 134	119, 965, 350	132, 583, 4	34		200. 00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	12, 618, 134	119, 965, 350	132, 583, 4	34		202.00

Health Financial Systems G	REENE COUNTY GENE	ERAL HOSPITAL	In Lie	Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1317	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/30/2023 1:0		
		Title XIX	Hospi tal	Cost		
Cost Center Description	PPS Inpatient Ratio					
	11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS					30.00	
31.00 03100 INTENSIVE CARE UNIT					31.00	
43.00 04300 NURSERY					43.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000				50.00	
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	
60. 00 06000 LABORATORY	0. 000000				60.00	
65. 00 06500 RESPI RATORY THERAPY	0. 000000				65.00	
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00	
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00	
68.00 06800 SPEECH PATHOLOGY	0. 000000				68.00	
69.00 06900 ELECTROCARDI OLOGY	0.000000				69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77.00	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00	
88.01 08801 RURAL HEALTH CLINIC II	0. 000000				88.01	
88.02 08802 RURAL HEALTH CLINIC III	0. 000000				88.02	
88. 03 08803 RURAL HEALTH CLINIC IV	0. 000000				88.03	
91. 00 09100 EMERGENCY	0. 000000				91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00	
OTHER REIMBURSABLE COST CENTERS	0.000000					
102. 00 10200 OPI OLD TREATMENT PROGRAM					102.00	
200.00 Subtotal (see instructions)					200.00	
201.00 Less Observation Beds					201.00	
202.00 Total (see instructions)					202.00	
	1 1				1-02.00	

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part II Date/Time Pre 5/30/2023 1:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	183, 440	6, 159, 712	0. 02978	271, 060	8, 072	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	8, 114	161, 019	0. 05039	02 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	536	858, 982			40	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	174, 289	28, 570, 071	0.00610	0 317, 679	1, 938	54.00
60. 00 06000 LABORATORY	145, 045	24, 819, 217	0. 00584	4 571, 617	3, 341	60.00
65. 00 06500 RESPI RATORY THERAPY	17, 928	4, 325, 387	0. 00414	5 566, 959	2, 350	65.00
66. 00 06600 PHYSI CAL THERAPY	43, 921	3, 979, 598	0. 01103	37 116, 973	1, 291	66.00
67.00 06700 OCCUPATI ONAL THERAPY	32, 420	1, 327, 762	0. 02441	7 18, 452	451	67.00
68.00 06800 SPEECH PATHOLOGY	16, 787	236, 815	0. 07088	37 7, 062	501	68.00
69. 00 06900 ELECTROCARDI OLOGY	21	0	0.00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	19, 807	3, 971, 777	0. 00498	515, 975	2, 573	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	23, 520	1, 209, 505	0. 01944	6 214, 710	4, 175	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	90, 862	14, 812, 540	0. 00613	1, 096, 637	6, 727	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000	0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	81, 453	5, 637, 963	0. 01444	17 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	42, 584	2, 092, 472	0. 02035	51 0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	34, 163	987, 263	0. 03460	04 0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	41,093	594, 537	0. 06911	8 0	0	88. 03
91.00 09100 EMERGENCY	252, 758	27, 346, 324	0.00924	41, 832	387	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	288, 653	2, 158, 403	0. 13373	35 0	0	92.00
200.00   Total (lines 50 through 199)	1, 497, 394	129, 249, 347		3, 803, 587	31, 846	200. 00

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS			Period: From 01/01/2022 To 12/31/2022	5/30/2023 1:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician Anesthetist	Nursing Program	Nursing Program	Allied Health Post-Stepdown	Allied Health	
	Cost	Post-Stepdown Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	20	2.00	54	5.00	
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	286, 949	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS		-			-	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II	0	0		0 0	0	88.01
88. 02 08802 RURAL HEALTH CLINIC III 88. 03 08803 RURAL HEALTH CLINIC IV	0	0		0 0	0	88.02
88. 03 08803 RURAL HEALTH CLINIC IV 91. 00 09100 EMERGENCY	0	0		0 0	0	88.03 91.00
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0	0	91.00
200.00 Total (lines 50 through 199)	286, 949	0			-	200.00
	200, 747	0	I	ч U	0	1200.00

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	S Provider CO		Period: From 01/01/2022 To 12/31/2022		
		Title	XVIII	Hospi tal	Cost	5 piii
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50.00 05000 OPERATI NG ROOM	0	0		0 6, 159, 712		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 161, 019		
53.00 05300 ANESTHESI OLOGY	0	286, 949		0 858, 982		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 28, 570, 071		
60. 00 06000 LABORATORY	0	0		0 24, 819, 217		
65. 00 06500 RESPI RATORY THERAPY	0	0		0 4, 325, 387		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 3, 979, 598		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 1, 327, 762		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 236, 815		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.00000	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 3, 971, 777		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 209, 505		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 14, 812, 540	0.000000	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77.00
OUTPATIENT SERVICE COST CENTERS		0			0.00000	
88.00 08800 RURAL HEALTH CLINIC	0	0		0 5, 637, 963		
88.01 08801 RURAL HEALTH CLINIC II	0	0		0 2, 092, 472		
88. 02 08802 RURAL HEALTH CLINIC III	0	0		0 987, 263		
88.03 08803 RURAL HEALTH CLINIC IV	0	0		0 594, 537		
91.00 09100 EMERGENCY	0	0		0 27, 346, 324		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 2, 158, 403		
200.00   Total (lines 50 through 199)	0	286, 949	I	0 129, 249, 347	I	200. 00

Health Financial Systems G	REENE COUNTY GENE	ERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/30/2023 1:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 000000	271, 060		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 000000	64, 631	21, 59	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	317, 679		0 0	0	54.00
60.00 06000 LABORATORY	0. 000000	571, 617		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	566, 959		0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 000000	116, 973		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	18, 452		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	7,062		0 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	515, 975		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	214, 710		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 096, 637		0 0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS			•			
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88.00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0		0 0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0		0 0	0	88.02
88.03 08803 RURAL HEALTH CLINIC IV	0. 000000	0		0 0	0	88.03
91. 00 09100 EMERGENCY	0. 000000	41, 832		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00   Total (lines 50 through 199)		3, 803, 587	21, 59	0 0	0	200. 00

Health Financial Systems GF	REENE COUNTY GENER	RAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THROUGH COSTS	VICE OTHER PASS	Provider CC		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part IV Date/Time Pre 5/30/2023 1:0	
			XVIII	Hospi tal	Cost	
Cost Center Description	Physician Ot	SA Adj. All her Medical ucation Cost 24.00				
ANCI LLARY SERVI CE COST CENTERS	· · · · · ·			· · · · ·		
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 60.00 06000 LABORATORY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATIONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 77.00 07700 ALLOGENEI C HSCT ACQUISITION 0UTPATIENT SERVICE COST CENTERS	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				$\begin{array}{c} 50. \ 00\\ 52. \ 00\\ 53. \ 00\\ 54. \ 00\\ 65. \ 00\\ 65. \ 00\\ 67. \ 00\\ 68. \ 00\\ 69. \ 00\\ 71. \ 00\\ 72. \ 00\\ 73. \ 00\\ 77. \ 00\\ \end{array}$
		0				00 00
88. 00       08800       RURAL       HEALTH       CLINIC         88. 01       08801       RURAL       HEALTH       CLINIC       II         88. 02       08802       RURAL       HEALTH       CLINIC       II         88. 02       08803       RURAL       HEALTH       CLINIC       II         88. 03       08803       RURAL       HEALTH       CLINIC       IV         91. 00       09100       EMERGENCY       92.00       09200       OBSERVATION       BEDS       (NON-DISTINCT       PART)         200. 00       Total       (Lines 50 through 199)       199)       1000	0 0 0 0 0 0					88.00 88.01 88.02 88.03 91.00 92.00 200.00

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1317	Period: From 01/01/2022	Worksheet D Part V	
				To 12/31/2022		pared:
					5/30/2023 1:0	5 pm
		litle	XVIII	Hospi tal	Cost	
Cost Conton Description	Cost to Charge	DDC Deimburged	Charges Cost	Cost	Costs PPS Services	
Cost Center Description	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Servi ces Not	(see mst.)	
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 344082	0	1, 116, 07	79 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 324732	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 471988	0	149, 68	38 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 104828	0	7, 471, 76	04 0	0	54.00
60. 00 06000 LABORATORY	0. 195865	0	6, 396, 90	07 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 315224	0	824, 02	20 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 280550	0	1, 278, 98	32 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 283423	0	433, 23	34 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 455955	0	24, 14	3 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 262206		701, 37		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1.094400		/		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 263035		6, 129, 86	509	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77.00
OUTPATIENT SERVICE COST CENTERS	1			- 1		
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88. 01
88.02 08802 RURAL HEALTH CLINIC III						88.02
88.03 08803 RURAL HEALTH CLINIC IV		_			-	88.03
91. 00 09100 EMERGENCY	0. 203032	0	-,,		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 586771	0	431, 92		0	12.00
200.00 Subtotal (see instructions)		0	30, 423, 35		0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		0	20 422 20	0 70/	0	202.00
202.00  Net Charges (line 200 - line 201)	1	0	30, 423, 35	58 736	0	202.00

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pr 5/30/2023 1:	epared: 05 pm
			XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	204.022	0	1			
50. 00 05000 OPERATING ROOM	384, 023					50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0				52.00 53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	70, 651	0				53.00
60. 00 06000 LABORATORY	783, 250 1, 252, 930					60.00
65. 00 06500 RESPIRATORY THERAPY	259, 751	0				65.00
66. 00 06600 PHYSI CAL THERAPY	358, 818	0				66.00
67. 00 06700 OCCUPATIONAL THERAPY	122, 788					67.00
68. 00 06800 SPEECH PATHOLOGY	11,008					68.00
69. 00 06900 ELECTROCARDI OLOGY	11,008	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	183, 905	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	298, 120					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 612, 369	134				73.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	1,012,309	0				77.00
OUTPATIENT SERVICE COST CENTERS	0	0	1			//.00
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
88. 02 08802 RURAL HEALTH CLINIC III						88.02
88.03 08803 RURAL HEALTH CLINIC IV						88.03
91. 00 09100 EMERGENCY	1,054,340	46				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	685, 363		1			92.00
200.00 Subtotal (see instructions)	7,077,316	180				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	7,077,316	180				202.00

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1317	Period: From 01/01/2022 To 12/31/2022		pared: 5 pm
		Ti tl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			_			
50.00 05000 OPERATING ROOM	0. 344082	0	765, 4	78 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 324732	0	3, 5	78 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 471988	0	9,0	94 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 104828	0	2, 159, 3	67 0	0	54.00
60. 00 06000 LABORATORY	0. 195865	0	2, 917, 9	31 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 315224	0	299, 0	55 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 280550	0	178, 9	20 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 283423	0	55, 2	04 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 455955	0	118, 8	69 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 262206	0	156, 4	18 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1.094400	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 263035		643, 4	83 0	0	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0.000000			0 0	0	
OUTPATIENT SERVICE COST CENTERS			I			
88.00 08800 RURAL HEALTH CLINIC						88.00
88.01 08801 RURAL HEALTH CLINIC II						88.01
88.02 08802 RURAL HEALTH CLINIC III						88.02
88.03 08803 RURAL HEALTH CLINIC IV						88.03
91. 00 09100 EMERGENCY	0. 203032	0	3, 638, 5	80 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 586771	0	160, 5		0	
200.00 Subtotal (see instructions)		0	11, 106, 5		0	200.00
201.00 Less PBP Clinic Lab. Services-Program		0		0 0	Ű	201.00
Only Charges				-		
202.00 Net Charges (line 200 - line 201)		0	11, 106, 5	59 0	0	202.00

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	-2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pro 5/30/2023 1:0	
		Ti tl	e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATI NG ROOM	2(2, 207	0	1			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	263, 387 1, 162	0				50.00
53. 00  05200 DELI VERY ROOM & LABOR ROOM 53. 00  05300 ANESTHESI OLOGY	4, 292					52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	226, 362					54.00
60. 00 06000 LABORATORY	571, 521	0				60.00
65. 00 06500 RESPI RATORY THERAPY	94, 269	0				65.00
66. 00 06600 PHYSI CAL THERAPY	50, 196					66,00
67. 00 06700 OCCUPATI ONAL THERAPY	15, 646					67.00
68. 00 06800 SPEECH PATHOLOGY	54, 199					68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	41, 014	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	41,014					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	169, 259	0				73.00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77.00
OUTPATIENT SERVICE COST CENTERS						- //.00
88. 00 08800 RURAL HEALTH CLINIC						88.00
88. 01 08801 RURAL HEALTH CLINIC II						88.01
88. 02 08802 RURAL HEALTH CLINIC III						88.02
88.03 08803 RURAL HEALTH CLINIC IV						88.03
91. 00 09100 EMERGENCY	738, 748	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	254,807	0				92.00
200.00 Subtotal (see instructions)	2, 484, 862	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	-					
202.00 Net Charges (line 200 - line 201)	2, 484, 862	0				202.00

Heal th	Fi nanci al	Systems	
COMPUT	ATION OF I	NPATI ENT	OPERATI NG

1.00 2.00 3.00

Financial Systems	u of Form CMS-2	2552-10			
TATION OF INPATIENT OPERATING COST		Provider CCN: 15-1317	Peri od:	Worksheet D-1	
			From 01/01/2022	Data (Tima Duas	I
			To 12/31/2022	Date/Time Prep 5/30/2023 1:0	
		Title XVIII	Hospi tal	Cost	
Cost Center Description					
				1.00	
PART I - ALL PROVIDER COMPONENTS					
INPATIENT DAYS					
Inpatient days (including private room day	is and swing-bed days	s, excluding newborn)		2, 922	1.00
Inpatient days (including private room day	s, excluding swing-	bed and newborn days)		2, 649	2.00
Private room days (excluding swing-bed and	l observation bed day	ys). If you have only pr	ivate room days,	0	3.00
do not complete this line.	-	5 51	3		
Semi-private room days (excluding swing-be	ed and observation be	ed days)		1, 448	4.00
Total swing had SNE type inpatient days (i	ncluding privato ro	am dave) through Docombo	r 21 of the cost	272	F 00

	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1, 448	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	273	5.00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	833	9.00
	newborn days) (see instructions)		
10, 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	243	10.00
	through December 31 of the cost reporting period (see instructions)		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	-	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
12.00	through December 31 of the cost reporting period		12100
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
10.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	10.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	
	Nursery days (title V or XIX only)		16.00
10.00	SWING BED ADJUSTMENT	0	10.00
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
17.00	reporting period		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18.00
18.00	reporting period		18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
19.00	reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
20.00	reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	8, 332, 662	21 00
21.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0, 332, 002	
22.00	5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23.00
23.00	x line 18)	0	23.00
24.00		0	24.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
25 00	7 x line 19) Swigg had part anglischla ta NE turg som issa often Deserben 21 of the cost expecting period (line O	0	25 00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
24 00	x line 20) Total amina had anat (and instructions)	770 514	24 00
26.00	Total swing-bed cost (see instructions)	778, 514	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	7, 554, 148	27.00
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	
29.00	Private room charges (excluding swing-bed charges)	0	27100
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.00000	
32.00	Average private room per diem charge (line 29 ÷ line 3)		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	7, 554, 148	37.00
	27 minus line 36)		

General inpatient routine service cost net of swing-bed cost and private room cost differential (line	7, 554, 148	37.00
27 minus line 36)		
PART II - HOSPITAL AND SUBPROVIDERS ONLY		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
Adjusted general inpatient routine service cost per diem (see instructions)	2, 851. 70	38.00
Program general inpatient routine service cost (line 9 x line 38)	2, 375, 466	39.00
Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
Total Program general inpatient routine service cost (line 39 + line 40)	2, 375, 466	41.00
F	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions) 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)	27 minus line 36)         PART II - HOSPITAL AND SUBPROVIDERS ONLY         PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS         Adjusted general inpatient routine service cost per diem (see instructions)       2,851.70         Program general inpatient routine service cost (line 9 x line 38)       2,375,466         Medically necessary private room cost applicable to the Program (line 14 x line 35)       0

	Financial Systems GREENE GREEN	COUNTY GEI	NERAL HOSPITAL	CN: 15-1317	Period:	eu of Form CMS- Worksheet D-1	
				-	From 01/01/2022 To 12/31/2022		
		otal ent Cost	Title Total Inpatient Days	XVIII Average Per Diem (col. 1 col. 2)	Hospital Program Days	Cost Program Cost (col. 3 x col. 4)	
10.00		. 00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.00
43.00		, 506, 748	208	7, 243. 9	3 72	521, 567	43.00
44.00	CORONARY CARE UNIT						44.00
45.00 46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45.00 46.00
	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3	3, col. 3	, line 200)			1, 156, 238	48.00
48.01	Program inpatient cellular therapy acquisition cos	t (Worksh	eet D-6, Part		column 1)	0	
49.00	Total Program inpatient costs (sum of lines 41 thro PASS THROUGH COST ADJUSTMENTS	ough 48.0	1)(see instruc	tions)		4, 053, 271	49.00
50.00	Pass through costs applicable to Program inpatient	routine	services (from	Wkst. D, sum	of Parts I and	0	50.00
F1 00	III)			William D			F1 00
51.00	Pass through costs applicable to Program inpatient and IV)	ancinar	y services (II	UNI WKSL. D, SU	um of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and	,				0	
53.00	Total Program inpatient operating cost excluding ca medical education costs (line 49 minus line 52)	apital re	lated, non-phy	sician anesthe	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program di scharges					0	
55. 00 55. 01	Target amount per discharge Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor use onl	y)				0.00	
56.00	Target amount (line 54 x sum of lines 55, 55.01, and				. 50)	0	
57.00 58.00	Difference between adjusted inpatient operating cos Bonus payment (see instructions)	st and ta	rget amount (I	ine 56 minus i	ine 53)	0	
59.00	Trended costs (lesser of line 53 ÷ line 54, or line	e 55 from	the cost repo	rting period e	endi ng 1996,	0.00	
60.00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or lin	o 55 fro	m prior voar o	ost roport u	dated by the	0.00	60.00
00.00	market basket)		in prior year c	ost report, u	Juated by the	0.00	00.00
61.00	Continuous improvement bonus payment (if line 53 $\div$ 55.01, or line 59, or line 60, enter the lesser of 53) are less than expected costs (lines 54 x 60), or	50% of t	he amount by w	hich operating	g costs (line	0	61.00
62.00	enter zero. (see instructions) Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (se	e instru	ctions)			0	
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine costs thro	ough Dece	mber 31 of the	cost reporti	na period (See	692, 963	64.00
01.00	instructions) (title XVIII only)	agii beec				0,2,,00	
65.00	Medicare swing-bed SNF inpatient routine costs after instructions) (title XVIII only)	er Decemb	er 31 of the c	ost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine cos	ts (line	64 plus line 6	5)(title XVIII	only); for	692, 963	66.00
(7.00	CAH, see instructions						17.00
67.00	Title V or XIX swing-bed NF inpatient routine costs (line 12 x line 19)	s through	December 31 o	T THE COST FE	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs	s after D	ecember 31 of	the cost repor	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routing			,		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NURSING Skilled nursing facility/other nursing facility/ICI						70.00
71.00	Adjusted general inpatient routine service cost per						71.00
72.00 73.00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to	Program	(line 14 v li	ne 35)			72.00
74.00	Total Program general inpatient routine service cos		•	ne 33)			74.00
75.00	Capital-related cost allocated to inpatient routine	e service	costs (from W	orksheet B, Pa	art II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00 79.00	Inpatient routine service cost (line 74 minus line Aggregate charges to beneficiaries for excess costs		rovi der record	c)			78.00
80.00	Total Program routine service costs for comparison	• •		· .	us line 79)		80.00
81.00	Inpatient routine service cost per diem limitation	( 11 m- 01)	<b>`</b>				81.00
82.00 83.00	Inpatient routine service cost limitation (line 9 x Reasonable inpatient routine service costs (see in						82.00 83.00
84.00	Program inpatient ancillary services (see instruction	ons)					84.00
85.00	Utilization review - physician compensation (see in						85.00
86.00	Total Program inpatient operating costs (sum of lin PART IV - COMPUTATION OF OBSERVATION BED PASS THROU					l	86.00
87.00	Total observation bed days (see instructions)					1, 201	
88.00 89.00	Adjusted general inpatient routine cost per diem (1 Observation bed cost (line 87 x line 88) (see inst		line 2)			2, 851. 70 3, 424, 892	
07.00	10000 Vation Dea cost (The Or A The OO) (See Thisti	acti 0115)				J, 424, 092	07.00

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 1:0	pared: 5 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	702, 283	8, 332, 662	0. 08428	1 3, 424, 892	288, 653	90.00
91.00 Nursing Program cost	0	8, 332, 662	0.00000	0 3, 424, 892	0	91.00
92.00 Allied health cost	0	8, 332, 662	0.00000	0 3, 424, 892	0	92.00
93.00 All other Medical Education	0	8, 332, 662				93.00

## GREENE COUNTY GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

Heal th	Financial Systems GREENE COUNTY GENER	RAL HOSPI TAL	In Lie	u of Form CMS-2	2552-10	
	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Peri od:	Worksheet D-1		
		Title XIX	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 1:0		
	Cost					
Cost Center Description						
	PART I - ALL PROVIDER COMPONENTS			1.00		
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			2, 922	1.00	
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day		ivate room dave	2, 649 0		
5.00	do not complete this line.	ys). It you have only pr	rvate room days,	0	3.00	
4.00	Semi-private room days (excluding swing-bed and observation be			1, 448		
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	er 31 of the cost	273	5.00	
5.00	reporting period Total swing-bed SNF type inpatient days (including private roo	am dave) after Decomber	21 of the cost	0	6.00	
5.00	reporting period (if calendar year, enter 0 on this line)	bii days) arter becenber	ST OF THE COST	0	0.00	
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7.00	
	reporting period					
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	31 of the cost	0	8.00	
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing_bed and	46	9.00	
	newborn days) (see instructions)		j sinng bed and	10		
0.00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10.00	
1 00	through December 31 of the cost reporting period (see instruc				11.00	
1.00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		coom days) arter	0	11.00	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00	
	through December 31 of the cost reporting period	<u> </u>	5,			
3.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00	
4.00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra	ear, enter 0 on this lin	ie) dave)	0	14.00	
	Total nursery days (title V or XIX only)	an (excluding swing-bed	uays)	113		
6.00	Nursery days (title V or XIX only)			78		
	SWING BED ADJUSTMENT					
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost		17.00	
18.00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18.00	
10.00	reporting period				10.00	
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19.00	
	reporting period			0.00		
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0.00	20.00	
21.00	Total general inpatient routine service cost (see instructions	5)		8, 332, 662	21.00	
2.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22.00	
	5 x line 17)					
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	ng period (line 6	0	23.00	
24.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	na period (line	0	24.00	
	7 x line 19)			_		
25.00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25.00	
24 00	x line 20) Total swing-bed cost (see instructions)			778, 514	24 00	
26.00 27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		7, 554, 148		
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			.,		
28.00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0		
29.00	Private room charges (excluding swing-bed charges)			0		
30.00 31.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ·	· Lino 29)		0 0. 000000	30.00 31.00	
32.00	Average private room per diem charge (line 29 ÷ line 3)	- 1111e 20)		0.000000		
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00		
34.00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0.00		
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00		
36.00 37.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforential (line	0 7, 554, 148		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 5) 27 minus line 36)						
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1	
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1	
	Adjusted general inpatient routine service cost per diem (see			2,851.70		
9.00	Program general inpatient routine service cost (line 9 x line			131, 178		
	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	, , ,		0 131, 178		
1.00	Total riogram general imparient routine service cost (TINE 34			1 131, 170	1 41.0	

From B1/21/2023         From B1/21		Financial Systems GF ATION OF INPATIENT OPERATING COST	REENE COUNTY GEN	Provider C		Peri od:	worksheet D-1	
Cast Center Description         Intel Input int Doal Dynamic Cost Dynamic Cost 20:00         Program Days 20:00         Prog							Date/Time Pre	
1.00         2.00         3.00         4.00         5.00           100         100         100         100         125,520         125,520           100 <t< th=""><th></th><th>Cost Center Description</th><th></th><th>Total</th><th>Average Per Diem (col. 1</th><th>Program Days</th><th>Program Cost (col. 3 x col.</th><th></th></t<>		Cost Center Description		Total	Average Per Diem (col. 1	Program Days	Program Cost (col. 3 x col.	
Intensive Case Type Inpatient Use 15         Image: Case Use Use Use Use Use Use Use Use Use U				2.00	3.00		5.00	
43.00       INTENSIVE CARE UNIT       1,506,748       208       7,243,98       10       72,240         45.00       INTENSIVE CARE UNIT       1,506,748       208       7,243,98       10       72,240         45.00       INTENSIVE CARE UNIT       1,506,748       208       7,243,98       10       72,243,98       10         45.00       INTENSIVE CARE UNIT       1,506,748       208       7,243,98       10       72,2440         46.00       INTENSIVE CARE UNIT       1,506,748       208       7,243,98       10       72,2440         47.00       OTEXES ENFLIA CARE (CERCENT)       10       1,506,748       1,60       1,60         48.00       Program inpatient call unar therap acculation cost (NerkSheet D-6, Part III, Iine 10, column 1)       1,57,741       1,60         51.00       Pass Enfolde Cost ADUSTNETS       Sum of Flance Cost ADUSTNETS       477,91       0         52.00       Ordel Program inpatient operating cost Adust 10       cost 20       0       0       0         52.00       Ordel Program inpatient call uncervalue acculation cost (line 49 minus line 52)       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0	42.00		177, 511	113	1, 570. 8	39 78	122, 529	42.00
44.00       CoROMARY CARE UNIT       100         45.00       BURN INTENSITY CARE UNIT       100         45.00       Program Inpatient cellulary bervice cost (West. D-3. col. 3, line 200)       101         45.01       Forgam Inpatient cellulary bervice cost (West. D-3. col. 3, line 200)       101         45.00       Forgam Inpatient costs (sum of lines 40 through 40 01/see instructurons)       477, 921         50.00       Forgam Inpatient operating costs and 51)       0       0         51.00       Forgam Inpatient operating costs and 51)       0       0         52.00       Total Program exclusible cost (sum of lines 50 and 51)       0       0         52.00       Total Program exclusible cost (sum of lines 50 and 51)       0       0       0         54.00       Forgam end discharge       0 <td>43 00</td> <td></td> <td>1 506 748</td> <td>208</td> <td>7 243 0</td> <td>28 10</td> <td>72 440</td> <td>43.00</td>	43 00		1 506 748	208	7 243 0	28 10	72 440	43.00
44.00         SURGICAL INTERSIVE CARE UNIT         1.00           Cost Center Description         1.01           Cost Center Description         1.02           Cost Center Description         0           Cost Center Descriptin Destion         0			1, 300, 740	200	7,243.		72, 440	44.00
21.00       DNHR SPECIAL CARF (SPECIFY)         0       Total Program Inpatient and Lilary Service cost (Mext, D.3, col. 3, Line 200)       1b1.70         48.00       Program Inpatient and Lilary Service cost (Mext, D.4, Spart Lil, Line 10, column 1)       17.00         48.00       Program Inpatient costs (Sum of Lines 41 through 48.01) (see instructions)       47.93         47.00       Draw Uncode       Draw Uncode       47.93         48.00       Program sculable cost (sum of Lines 50 and 51)       00       Draw Uncode       00         50.00       Program sculable cost (sum of Lines 50 and 51)       00       Draw Uncode       00         50.00       Program sculable cost (sum of Lines 50 and 51)       00       Draw Uncode       00         50.00       Program sculable cost (sum of Lines 50 and 51)       00       00       00         50.00       Program sculable cost (sum of Lines 50 and Sum 50)       00       00       00         50.01       Graget amount (line 54 sum of Lines 55, St.01, and 55.02)       00       00       00         50.00       Difference between agit used inpatient aperating cost and target amount (line 56 minus line 53)       0       00         50.00       Difference between agit used inpatient aperating cost of target amount (lines 56 rom prior yaar cost reporting period ending 1996.       0       0								45.00
Cost Center Description         1.00           48 00         Program Inpatient caller y service cost (West D-3, col. 3, line 200)         157.74           48 00         Program Inpatient caller are therpy acguisition cost (Werksheet D-6, Part 111, line 10, column 1)         427.951           49 00         Program (cost applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and IV)         0           00         Pass through costs applicable to Program inpatient couling services (from Wkst. D, sum of Parts II         0           10         Pass through costs applicable to program inpatient couling services (from Wkst. D, sum of Parts II         0           10         Pass through costs applicable to program inpatient couling services (from Wkst. D, sum of Parts II         0           11         O         Total Program excludable cost (Gun of Times 50 and 51)         0           10         Total Program discharge         0         0           11         Cost Cost Cost (Gun of Times 50 and 51)         0         0           12         Cost Cost (Cost of Times 31 and Total Cost Total and Total and the discharge (cost cost of S5.02)         0         0           12         Cost Cost of S5.01         0         0         0         0           12         Cost of Ine 53 - 11 and total and target amount (Time 56 minus line 53)         0         0								46.00
1.00         Inc.         1.00           86.00         Program inpatient cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)         1.70, 791           86.01         Program inpatient costs (sum of lines 41 through 48.01) (see instructions)         477, 791           875         THROUGH (OST AQUUSTIENTS)         477, 791           876         Program inpatient costs (sum of lines 41 through 48.01) (see instructions)         477, 791           876         Program inpatient costs (sum of lines 45 through services (from Wkst. D. sum of Parts II and on the operating cost excluding capital related, non-physician anesthetist, and madrical education costs (line 40 minus line 52)         0           87.00         Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and minus line 52)         0           87.00         Target amount per discharge         0         0           87.00         Target amount per discharge (contractor use only)         0.00         0         0           87.00         Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)         0         0         0           87.00         Difference between adjusted inpatient sets beso for lines 55 from the cost reporting period ending 1996, 0         0         0         0           87.00         Difference between adjusted inpatient routine costs through becember 31 of the cost repor	47.00	• •						47.00
48. 01       Program Inpattent cellular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1)       0         47.7,931       Post STRUCCH COST ADUCTNENS       4777,931         4777,931       Post Strucy Cost ADUCTNENS       4777,931         4777,931       Post Strucy Cost ADUCTNENS       0         51.00       Pass through costs applicable to Program inpatient ancillary services (from West, D, sum of Parts I and on the pass through costs applicable to Program inpatient ancillary services (from West, D, sum of Parts II) and IV)       0         52.00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and ned cal education costs (line 40 minus line 52)       0         53.00       Target amount per discharge       0.00         50.01       Perment adjustent amount per discharge (contractor use only)       0.00         50.02       Difference batween adjusted inpatient operating cost and target amount (line 56 at sum of lines 51 + line 55, rine 16, or line 55 from the cost reporting period ending 1996, 0.00       0         50.01       Difference batween adjusted inpatient bas + line 54, or line 55 from prior year cost report, updated by the cost of lines 53 + line 54, or line 55 from prior year cost report, updated by the cost report ing period (cost (lines 54 + A0), or 1 % of the target amount (line 56), otherwise 53, or 1 = 05, otherwise 10, otherwise 54, or 1 = 05, otherwise 10, otherwise 11, otherwise 11, otherwise								
40.00       Total Program inpatient costs (sum of lines 41 through 48.01) (see instructions)       477.931         PASS Through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II on instructions)       0         11.00       Program excludable cost (sum of lines 50 and 51)       0         0.01       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and education costs (line 40 minus line 52)       0         0.02       Program devidable cost (sum of lines 50 and 51)       0         0.03       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and education costs (line 40 minus line 52)       0         0.04       Program discharges       0       0         0.05       Target amount per discharge       0       0         0.05       Torget amount quisted inpatient operating cost and target amount (line 54 minus line 53)       0       0         0.00       Disconce between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0       0         0.01       Expected costs (lises of line 54 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market bask(1)       0       0         0.02       Expected costs (lises of line 54 + line 54, or line 54 is line 54, or line 55, or line 50, or line 55, or line 50, or line 55,								
PASS THROUGH COST ADJUSTMENTS         Image: Control of the services of the service						column I)	-	
III)       The set frough costs applicable to Program Inpatient ancillary services (from Wkst. D, sum of Parts II and IV)         100       Pass frrungsh costs applicable to Program Inpatient ancillary services (from Wkst. D, sum of Parts II and IV)         110       Total Program excludable cost (sum of lines 50 and 51)         111       Cotal Program inpatient operating cost excluding capital related, non-physician anesthetist, and D         111       Cotal Program inpatient operating cost excluding capital related, non-physician anesthetist, and D         111       Cotal Program discharge       0         111       Cotarget amount per discharge (cotractor use only)       0         111       Cotarget amount (line 54 x sum of lines 55, 50, 1, and 55, 02)       0         111       Cotarget amount (line 54 x sum of lines 55, 50, 1, and 55, 02)       0         111       Cotarget amount (line 54 x sum of lines 55, 50, 1, and 55, 02)       0         111       Cotarget amount (line 54 x sum of lines 55, 50, 01, and 55, 02)       0         111       Cotarget amount (line 54 x sum of lines 55, 50, 01, and 55, 02)       0         111       Cotarget amount (line 54 x sum of lines 55, 10)       0	47.00						477, 731	47.00
51:00       Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and IV)       0         52:00       Total Program excludable cost (sum of lines 50 and 51)       0         64:00       Total Program excludable cost (sum of lines 50 and 51)       0         7AGET AUDUMT AND LINE COMPUTATION       0         7AGET AUDUMT AND LINE COMPUTATION       0         7AGET AUDUMT AND LINE COMPUTATION       0         75:00       0       0         75:00       0       0         76:00       7arget and uscharge       0         70:00       0       0         70:00       0       0         70:00       0       0         70:00       0       0         70:00       0       0         70:00       0       0         70:00       0       0         70:00       0       0       0         70:00       0       0       0       0         70:00       0       0       0       0       0         70:00       0       0       0       0       0       0       0         70:00       0       0       0       0	50.00	5 11 5 1	atient routine s	services (from	Wkst. D, sun	n of Parts I and	0	50.00
and iVy and iV	E1 00		tiont ancillar	, convigos (fr	om Wkct D	sum of Dorte II	0	51.00
22 00       Total Program excludable cost (sum of lines 50 and 51)       0         AMBEC Hardorm ADD Line 10 perturbing cost excluding capital related, non-physician anesthetist, and undical education costs (line 49 minus line 52)       0         AMBEC HAROWIN ADD LINIT COMPLIATION       0         54:00       Program discharges       0.00         55:01       Target amount per discharge (contractor use only)       0.00         66:00       Target amount (line 54 x sum of lines 55, 55:0; and 55:02)       0         70:01       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0         80:00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0         80:00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 55)       0.00         80:01       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 55)       0.00         80:02       Difference between adjusted inpatient set ine 55 from prior year cost report, updated by the market basket)       0.00         80:03       Difference tasket)       0.00       0.00         80:04       Difference set instructions)       0       0         80:05       Difference set instructions)       0       0         80:01       Difference set instructi	51.00			Services (II	UIII WKSt. D, S		0	51.00
medical education costs (line 4° minus line 52)         0           TARGET AWONT AND LIMI COMPUTATION         0           54:00 Program discharges         0           55:01 Target amount per discharge (contractor use only)         0.00           56:01 Dirget amount (line 54 x sum of lines 55, 55:01, and 55:02)         0.00           50:01 Dirget amount (see instructions)         0           60:01 Dirget amount (see instructions)         0           60:01 Dirget amount (see instructions)         0           60:02 On Dirget amount (see instructions)         0           60:03 Dirget amount (see instructions)         0           60:04 Dirget amount (see instructions)         0           61:00 Continuous Improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus on the most basket)         0           62:00 Relief payment (see instructions)         0         0           63:00 Allowedb le lopation costs (line s54 x 60), or 1 % of the target amount (line 56), otherwise entrice as ing-bed SH inpatient routine costs through becember 31 of the cost reporting period (See Instructions)         0           64:00 Medicacer sein spbed SH inpatient routine costs through becember 31 of the cost reporting period (See Instructions) (lite XVII only)         0           65:00 Instructions of SH inpatient routine costs through December 31 of the cost reporting period (lite 12 x line 19)         0           66:00 Instructio	52.00	Total Program excludable cost (sum of lines !						52.00
TARGET ANDURT AND LIMIT COMPUTATION         40 OP rogram discharges         55.00 Target amount per discharge (contractor use only)         65.01 Permanent adjustment amount per discharge (contractor use only)         65.02 Adjustment amount per discharge (contractor use only)         65.03 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)         65.04 Target amount (line 54 x sum of lines 55, 55.01, and 55.02)         60.05 OT Target amount (line 54 x sum of lines 55, 55.01, and 55.02)         60.06 Donus payment (see Instructions)         60.06 Donus payment (see Instructions)         60.00 Expected costs (lesser of line 53 + line 54, or line 55 rom prior year cost report, updated by the market basket)         60.00 Expected costs (lesser of line 53 + line 54, or line 53 + line 54 is less than the lowest of lines 55 plus 53 or line 50, or line 60, enter the lesser of 50% of the amount by which operating costs (line 55 plus 53 or line 50, or line 50 plus 150.01, or line 50, or line 50 plus 150.01, or line 50, elinstructions)         61.00 Continuous improvement costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise 62         62.00 Relief payment (see instructions)         63.00 All owable inpatient cost plus incentive payment (see instructions)         64.00 Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions         64.00 Medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)         66.00 Title V	53.00			ated, non-phy	sician anesth	netist, and	0	53.00
64.00       Program discharges       0         65.01       Pregrament adjustment amount per discharge       0.00         65.01       Permanent adjustment amount per discharge       0.00         65.01       Parget amount (line 54 x sum of lines 55, 55.01, and 55.02)       0.00         67.00       Difference between adjusted inpartient operating cost and target amount (line 56 minus line 53)       0         68.00       Bonus payment (see instructions)       0.00         00       Difference between adjusted inpartient operating cost and target amount (line 56 minus line 53)       0         00       Difference between banus payment (if line 53 + line 54 rol line 55 from prior year cost report, updated by the market basket)       0.00         01       Cost prevement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus test that basket)       0         01       Cost prevement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus test that basket)       0         02.00       Relief payment (see instructions)       0       0         03       Relief payment (see instructions)       0       0         04.00       Relief payment (see instructions)       0       0         05.01       Medi care swing-bed SF inpatient routine costs through December 31 of the cost reporting period (See instructions)       0         05.0			)2)					
50 01       Permanent adjustment amount per discharge       0.00         55 02       Adjustment amount per discharge (contractor use only)       0.00         56 00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00         56 00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0         58 00       Bonus payment (see instructions)       0         50 01       Experiment amount by the market basket)       0         50 02       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0         50 01       Difference between the sever of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0         51 00       Difference between the sever of 1000 of the 53 + line 54 is less than the lowest of lines 55 plus 55 01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter 240, otherwise enter 240, (see instructions)       0         62 00       Relief payment (see instructions)       0       0         63 00       Allowable inpatient costs (line see instructions)       0       0         64 00       Medi care swing-bed SWF inpatient routine costs (line 64 plus line 65) (tite XVIII only); for 0       0         64 00	54.00						0	54.00
55.02       Adjustment amount (lne S4 x sum of lines 55, S0.1, and 55.02)       0.00         67.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0         67.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0         67.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0         67.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0         67.00       Difference between adjusted inpatient operating cost (line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0.00         60.00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zor. (see instructions)       0         62.00       Relief payment (see instructions)       0         70.00       Allowable Inpatient cost plus incentive payment (see instructions)       0         70.01       Not Molecare swing-bed SF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       0         70.01       Cottal medicare swing-bed SF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         70.01       Cottal words and adverbe								
6:00       Target amount (line 54 xum of lines 55, 55.01, and 55.02)       0			iso only)					
7:00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0         8:00       Bonus payment (see instructions)       0         9:00       Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)       0         0:00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0         0:00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus signating costs (line 50, or 1 % of the target amount (line 56), otherwise enter zoro. (see instructions)       0         9:00       Relief payment (see instructions)       0         9:00       Allowable inpatient cost plus incentive payment (see instructions)       0         9:00       Medi care swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) intervitions (line 45) inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions       0         9:00       Cat it by VI in anglent routine costs fire December 31 of the cost reporting period (line 13 x line 20)       0         9:00       Tat Medicare swing-bed NF inpatient routine costs (line 67 + line 68)       0         9:00       Tat Wedi care swing-bed WF inpatient routine costs (line 74 + line 68)       0         9:00       Tat Wedi care swing-bed WF inpatient routine								56.0
9:00       Trended costs (lesser of line 53 + line 54, or line 55 from the cost reporting period ending 1996, updated and compounded by the market basket)       0:00         0:00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0:00         0:00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus to s5, 01, or line 59 or line 60 enter the lesser of 50% of the amount by which operating costs (line 56), otherwise enter zero. (see instructions)       0         0:00       Relief payment (see instructions)       0         0:01       All obset of cost plus incentive payment (see instructions)       0         0:02       Relief payment (see instructions)       0         0:03       All obset of cost plus incentive payment (see instructions)       0         0:04       Othedicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tilt eX VIII only)       0         0:05:00       Medicare swing-bed NF inpatient routine costs (line 64 plus line 65) (tile XVIII only); for CAH, see instructions       0         0:06       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         0:07       CAH, see instructions       0         0:08:00       Title V or XIX swing-bed NF inpatient routine costs (line 70 + line 23)       0         0:00       Title V or XIX swing-	57.00			get amount (I	ine 56 minus	line 53)	0	57.0
updated and compounded by the market basket)       updated and compounded by the market basket)         0.00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0.00         51.00       Continuous improvement bonus payment (if lines 53 + line 54 is less than the lowest of lines 55 plus of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)       0         52.00       Relief payment (see instructions)       0         74.00       Medic are swing-bed SNF inpatient routine costs through becember 31 of the cost reporting period (See instructions) (title XVIII only)       0         55.00       Medic are swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions of sing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See CAH indeciare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See CAH indeciare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See CAH inter 12 v inter 19)       0         50.01       Totle V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (See CAH inter 14)       0         70.01       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         70.01       Totle V or XIX swing-bed NF inpatient routine costs (line 7 + line 68)       0         70.01       Stille						1 100/	-	58.0
60.00       Expected costs (lesser of line 53 + line 54, or line 55 from prior year cost report, updated by the market basket)       0.00         61.00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus 55 01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)       0         62.00       Relief payment (see instructions)       0         63.00       Allowable Inpatient cost plus incentive payment (see instructions)       0         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tite XVIII only)       0         65.00       Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (tite XVIII only)       0         66.00       Title V or XIX swing-bed NF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions       0         67.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         68.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         71.00       Agusted general inpatient routine service costs (line 7 + line 73)       0         72.00       Total title V or XIX swing-bed NF inpatient routine service cost (line 7 + line 73)       0	59.00		0.00	59.0				
61.00       Continuous improvement bonus payment (if line 53 + line 54 is less than the lowest of lines 55 plus       0         55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise enter zero. (see instructions)       0         62.00       Relief payment (see instructions)       0         63.00       Allowable inpatient cost plus incentive payment (see instructions)       0         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only)       0         65.00       Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions       0         66.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0         67.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         90       Potal title V VII N KIX swing-bed NF inpatient routine costs (line 70 + line 2)       0         71.00       Skilled nursing facility/Toher nursing facility/TC/TID routine service cost (line 71 + line 73)       0         71.00       Medicare swing-bed NF inpatient routine service costs (line 70 + line 2)       0         71.00       Medicare swing-bed NF inpatient routine costs (line 70 + line 2)       0	60.00		or line 55 from	n prior year c	ost report, ι	updated by the	0.00	60.00
enter zero. (see instructions)       0         200 Relief payment (see instructions)       0         PROGRAW INPATIENT ROUTINE SWING BED COST       0         64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       0         65.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CO Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       0         66.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         67.00 Skilled nursing facility/Other nursing facility/ICF/ID routine service cost (line 37)       0         70.00 Skilled nursing facility/Other nursing facility/ICF/ID routine service cost (line 37)       0         71.00 Adjused general inpatient routine service costs (from Vorksheet B, Part II, column 26, line 45)       0         72.00 Program routine service cost (line 75 + line 72)       0       7         73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)       0       0	61. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less	0	61.00				
62:00       Relief payment (see instructions)       0         63:00       Allowable inpatient cost plus incentive payment (see instructions)       0         PROGRAM INPATIENT ROUTINE SWING BED COST       0         64:00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       0         65:00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       0         66:00       Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (CII te 12 x line 19)       0         66:00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (CII te 12 x line 19)       0         67:00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         70:00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         70:01       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         70:02       Skilled nursing facility/other nursing facility/IGF/ID routine service cost (line 37)       7         70:03       Skilled nursing facility/other nursing facility/IGF/ID routine service cost (line 37)       7         70:04       Adjusted general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)			60), or 1 % of	the target am	ount (line 56	b), otherwise		
63.00       Allowable inpatient cost plus incentive payment (see instructions)       0         PROGRAM INPATIENT ROUTINE SWING BED COST       0         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       0         65.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions) (title XVIII only)       0         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions       0         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0         68.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         70.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         71.00       Adjusted general inpatient routine service cost (line 70 + line 2)       0         71.00       Adjusted general inpatient routine service costs (line 70 + line 2)       0         72.00       Program routine service cost (line 74 hine 2)       0         73.00       Medical related cost all located to inpatient routine service cost (line 70 + line 2)       0         74.00       Forgram routine service cost (line 74 hine 2)       0	62.00						0	62.00
<ul> <li>Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)</li> <li>Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)</li> <li>Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See CAR, see instructions) (title XVIII only)</li> <li>Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAR, see instructions</li> <li>Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)</li> <li>Medicare and the 20 cost of the cost reporting period (line 13 x line 20)</li> <li>Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)</li> <li>Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)</li> <li>Medicare and the service cost (line 74 + line 71)</li> <li>Medical general inpatient routine service costs (line 70 + line 2)</li> <li>Medical y necessary private room cost applicable to Program (line 14 x line 35)</li> <li>Medical -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)</li> <li>Medical -related costs (line 75 + line 2)</li> <li>Program coutine service cost (line 75 + line 2)</li> <li>Program coutine service cost for expansions to the cost limitation (line 78 minus line 79)</li> <li>Magregate charges to beneficiaries for excess costs (from provider records)</li> <li>Total Program routine service costs (see instructions)</li> <li>Reasonable inpatient routine service costs (see instructions)</li> <li>Medical reparation review - physician compensation (see instructions)</li> <li>Medical and the service costs (see instructions)</li> <li>Medical program inpatient routine service costs (see instructions)</li> <li>Medical service costs (see instructions)</li> <li>Medic</li></ul>		Allowable Inpatient cost plus incentive payment (see instructions)						63.00
instructions)(title XVIII only)       0         65.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)       0         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for (CH, see instructions)       0         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0         68.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         70.00       Skilled nursing facility/other nursing facility/ICF/ID routine service cost (line 37)       0         71.00       Adjusted general inpatient routine service cost (line 70 + line 2)       0         72.00       Program routine service cost (line 9 x line 71)       73.00         73.00       Medically necessary private room cost applicable to Program (line 14 x line 35)       74.00         74.00       Total erelated costs (line 75 + line 2)       77.00         76.00       Per diem capital -related costs (line 75 + line 2)       77.00         77.00       Aggregate charges to beneficiaries for excess costs (from provider records)       76.00         78.00       Inpatien	4 <u>00</u>	PROGRAM INPATIENT ROUTINE SWING BED COST						64.00
65.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       0         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only); for CAH, see instructions       0         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0         68.00       Total Kitle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         69.00       Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         60.01       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         60.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         70.00       Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)       1         71.00       Adjusted general inpatient routine service cost per diem (line 74 + line 35)       1         71.00       Adjusted general inpatient routine service costs (line 72 + line 73)       1	04.00		is through becen		cost reporti	ng period (see	0	04.00
66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions       0         70.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0         68.00       Total Mitle V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)       0         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         70.00       Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)       0         71.00       Adjusted general inpatient routine service costs (line 70 + line 2)       0         72.00       Program routine service cost (line 9 x line 71)       70         73.00       Medicalty necessary private room cost applicable to Program (line 14 x line 35)       74         74.00       Total -related costs (line 75 + line 2)       75         75.00       Per diem capital -related costs (line 75 + line 2)       76         76.00       Program routine service cost for comparison to the cost limitation (line 78 minus line 79)       70         76.00       Per diem capital -related costs (line 75 + line 2)       77         77.00       Program routine service cost for comparison to the cost limitation (line 78 minus line 79)       70         77.00 <td< td=""><td>65.00</td><td></td><td>ts after Decembe</td><td>er 31 of the c</td><td>ost reporting</td><td>g period (See</td><td>0</td><td>65.00</td></td<>	65.00		ts after Decembe	er 31 of the c	ost reporting	g period (See	0	65.00
CAH, see instructions67.00Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)68.00Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)69.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)00Otal title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)01.01Otal title V or XIX swing-bed NF inpatient routine costs (line 7 + line 68)02.01Otal title V or XIX swing-bed NF inpatient routine costs (line 70 + line 2)03.02PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY04.03Usted general inpatient routine service cost per diem (line 70 + line 2)04.04Usted general inpatient routine service costs (line 72 + line 73)05.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)06.00Program capital -related costs (line 75 + line 2)07.00Program capital -related costs (line 75 + line 2)07.00Program capital -related costs (line 75 + line 2)07.00Aggregate charges to beneficiaries for excess costs (from provider records)08.00Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)08.00Inpatient routine service costs (see instructions)09.01Inpatient ancillary services (see instructions)09.02Program inpatient ancillary services (see instructions)09.03Rouge and the service costs (see instructions)	66 00	instructions)(title XVIII only)						66.00
(line 12 x line 19)68.00Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period(line 13 x line 20)69.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)00PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY00.00Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)01.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)72.00Program routine service cost (line 9 x line 71)73.00Medically necessary private room cost applicable to Program (line 14 x line 35)74.0075.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)75.0076.00Pred dem capital -related costs (line 75 + line 2)77.0077.00Program capital -related costs (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)80.0080.0010 Inpatient routine service costs (see instructions)81.0082.0084.00Program inpatient ancillary services (see instructions)84.0085.0086.000186.0002101010101010111213<	00.00							00.00
68.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period       0         (1ine 13 x line 20)       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         PART 111 - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY       0         70.00       Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)       0         71.00       Adjusted general inpatient routine service cost per diem (line 70 + line 2)       0         72.00       Program routine service cost (line 9 x line 71)       0         73.00       Medically necessary private room cost applicable to Program (line 14 x line 35)       0         74.00       Total related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)       0         76.00       Per diem capital -related costs (line 75 + line 2)       0         77.00       Program routine service cost for omparison to the cost limitation (line 78 minus line 79)       0         77.00       Program routine service cost for comparison to the cost limitation (line 78 minus line 79)       0         80.00       Total Program routine service cost (see instructions)       0         81.00       Reasonable inpatient routine service (see instructions)       0         82.00       Inpatient routine service costs (see instructions) <td< td=""><td>67.00</td><td>5 1</td><td>e costs through</td><td>December 31 o</td><td>f the cost re</td><td>eporting period</td><td>0</td><td>67.00</td></td<>	67.00	5 1	e costs through	December 31 o	f the cost re	eporting period	0	67.00
(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)0PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY0Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)0Adjusted general inpatient routine service cost per diem (line 70 + line 2)0Program routine service cost (line 9 x line 71)030.00Medically necessary private room cost applicable to Program (line 14 x line 35)74.00Total Program general inpatient routine service costs (line 72 + line 73)75.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.00Per diem capital -related costs (line 75 + line 2)77.00Program capital -related costs (line 76 + line 77)78.00Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)80.00Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)81.00Program inpatient routine service (see instructions)82.00Program inpatient ancillary services (see instructions)84.00Program inpatient ancillary services (see instructions)85.00Utilization review - physician compensation (see instructions)86.00Program inpatient outine services (see instructions)86.00Program inpatient of OBSERVATION BED PASS THROUGH COST	68 00		e costs after De	cember 31 of	the cost rend	orting period	0	68.00
PART 111 - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY         70.00       Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)         71.00       Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)         72.00       Program routine service cost (line 9 x line 71)         73.00       Medically necessary private room cost applicable to Program (line 14 x line 35)         74.00       Total Program general inpatient routine service costs (line 72 + line 73)         75.00       Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)         76.00       Per diem capital-related costs (line 75 ÷ line 2)         77.00       Program capital -related costs (line 74 minus line 77)         78.00       Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)         78.00       Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)         79.00       Program routine service cost per diem limitation         78.00       Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79)         79.00       Regregate charges to beneficiaries for excess costs (from provider records)         70.00       Inpatient routine service cost set or comparison to the cost limitation (line 78 minus line 79)         80.00       Inpatient routine service co								
<ul> <li>70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)</li> <li>71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)</li> <li>72.00 Program routine service cost (line 9 x line 71)</li> <li>73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)</li> <li>74.00 Total Program general inpatient routine service costs (line 72 + line 73)</li> <li>75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)</li> <li>76.00 Per diem capital-related costs (line 75 ÷ line 2)</li> <li>77.00 Program capital-related costs (line 74 minus line 77)</li> <li>78.00 Aggregate charges to beneficiaries for excess costs (from provider records)</li> <li>70.01 Inpatient routine service cost per diem limitation</li> <li>70.02 Inpatient routine service costs (see instructions)</li> <li>70.03 Reasonable inpatient routine services (see instructions)</li> <li>70.04 Program inpatient ancillary services (see instructions)</li> <li>71.05 Reasonable inpatient operating costs (sum of lines 83 through 85)</li> <li>71.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</li> </ul>	69.00						0	69.00
<ul> <li>Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)</li> <li>Program routine service cost (line 9 x line 71)</li> <li>Medically necessary private room cost applicable to Program (line 14 x line 35)</li> <li>Total Program general inpatient routine service costs (line 72 + line 73)</li> <li>Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)</li> <li>Per diem capital-related costs (line 75 ÷ line 2)</li> <li>Program capital -related costs (line 74 minus line 77)</li> <li>Aggregate charges to beneficiaries for excess costs (from provider records)</li> <li>Inpatient routine service cost per diem limitation</li> <li>Inpatient routine service cost (see instructions)</li> <li>Reasonable inpatient routine services (see instructions)</li> <li>Orogram inpatient ancillary services (see instructions)</li> <li>Otal Program inpatient operating costs (sum of lines 83 through 85)</li> <li>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</li> </ul>	70 00		•					70.00
<ul> <li>Program routine service cost (line 9 x line 71)</li> <li>Medically necessary private room cost applicable to Program (line 14 x line 35)</li> <li>Total Program general inpatient routine service costs (line 72 + line 73)</li> <li>Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)</li> <li>Per diem capital -related costs (line 75 + line 2)</li> <li>Program capital -related costs (line 74 minus line 77)</li> <li>Aggregate charges to beneficiaries for excess costs (from provider records)</li> <li>Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79)</li> <li>Inpatient routine service costs (see instructions)</li> <li>Reasonable inpatient routine services (see instructions)</li> <li>Program inpatient ancillary services (sem of lines 83 through 85)</li> <li>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</li> </ul>								71.0
<ul> <li>Total Program general inpatient routine service costs (line 72 + line 73)</li> <li>Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)</li> <li>Per diem capital -related costs (line 75 ÷ line 2)</li> <li>Program capital -related costs (line 74 minus line 77)</li> <li>Aggregate charges to beneficiaries for excess costs (from provider records)</li> <li>Total Program routine service cost per diem limitation</li> <li>Inpatient routine service cost per diem limitation</li> <li>Inpatient routine service cost service costs (see instructions)</li> <li>Reasonable inpatient routine services (see instructions)</li> <li>OPorgram inpatient operating costs (sum of lines 83 through 85)</li> <li>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</li> </ul>	72.00	Program routine service cost (line 9 x line 3	71)					72.00
<ul> <li>75.00 Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)</li> <li>76.00 Per diem capital -related costs (line 75 ÷ line 2)</li> <li>77.00 Program capital -related costs (line 74 minus line 76)</li> <li>78.00 Inpatient routine service cost (line 74 minus line 77)</li> <li>79.00 Aggregate charges to beneficiaries for excess costs (from provider records)</li> <li>30.00 Total Program routine service cost per diem limitation</li> <li>11.00 Inpatient routine service cost per diem limitation</li> <li>20.00 Inpatient routine service cost per diem limitation</li> <li>21.00 Inpatient routine service costs (see instructions)</li> <li>23.00 Reasonable inpatient ancillary services (see instructions)</li> <li>34.00 Program inpatient ancillary services (see instructions)</li> <li>35.00 Utilization review - physician compensation (see instructions)</li> <li>36.00 Total Program inpatient operating costs (sum of lines 83 through 85)</li> <li>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</li> </ul>			U U	•				73.0
26, line 45)76.00Per diem capital -related costs (line 75 ÷ line 2)77.00Program capital -related costs (line 74 minus line 76)78.00Inpatient routine service cost (line 74 minus line 77)79.00Aggregate charges to beneficiaries for excess costs (from provider records)30.00Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)81.00Inpatient routine service cost per diem limitation32.00Inpatient routine service costs (see instructions)33.00Reasonable inpatient routine services (see instructions)34.00Program inpatient ancillary services (see instructions)35.00Utilization review - physician compensation (see instructions)36.00Total Program inpatient operating costs (sum of lines 83 through 85)PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						Part II. column		75.00
77.00       Program capital-related costs (line 9 x line 76)         78.00       Inpatient routine service cost (line 74 minus line 77)         79.00       Aggregate charges to beneficiaries for excess costs (from provider records)         70.00       Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)         81.00       Inpatient routine service cost per diem limitation         82.00       Inpatient routine service cost limitation (line 9 x line 81)         83.00       Reasonable inpatient routine services (see instructions)         84.00       Program inpatient ancillary services (see instructions)         85.00       Utilization review - physician compensation (see instructions)         86.00       Total Program inpatient operating costs (sum of lines 83 through 85)         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
<ul> <li>78.00 Inpatient routine service cost (line 74 minus line 77)</li> <li>Aggregate charges to beneficiaries for excess costs (from provider records)</li> <li>70.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)</li> <li>71.00 Inpatient routine service cost per diem limitation</li> <li>72.00 Inpatient routine service cost limitation (line 9 x line 81)</li> <li>73.00 Reasonable inpatient routine services (see instructions)</li> <li>74.00 Program inpatient ancillary services (see instructions)</li> <li>75.00 Utilization review - physician compensation (see instructions)</li> <li>76.00 Total Program inpatient operating costs (sum of lines 83 through 85)</li> <li>77.10 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</li> </ul>								76.0
79.00       Aggregate charges to beneficiaries for excess costs (from provider records)         30.00       Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)         31.00       Inpatient routine service cost per diem limitation         32.00       Reasonable inpatient routine services costs (see instructions)         33.00       Reasonable inpatient ancillary services (see instructions)         35.00       Utilization review - physician compensation (see instructions)         36.00       Total Program inpatient operating costs (sum of lines 83 through 85)         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		6						77.0 78.0
1.00       Inpatient routine service cost per diem limitation         12.00       Inpatient routine service cost limitation (line 9 x line 81)         13.00       Reasonable inpatient routine service costs (see instructions)         14.00       Program inpatient ancillary services (see instructions)         15.00       Utilization review - physician compensation (see instructions)         15.00       Total Program inpatient operating costs (sum of lines 83 through 85)         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST			,	ovider record	s)			79.0
32.00       Inpatient routine service cost limitation (line 9 x line 81)         33.00       Reasonable inpatient routine service costs (see instructions)         34.00       Program inpatient ancillary services (see instructions)         35.00       Utilization review - physician compensation (see instructions)         36.00       Total Program inpatient operating costs (sum of lines 83 through 85)         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				ost limitation	(line 78 mir	nus line 79)		80.0
33.00       Reasonable inpatient routine service costs (see instructions)         34.00       Program inpatient ancillary services (see instructions)         35.00       Utilization review - physician compensation (see instructions)         36.00       Total Program inpatient operating costs (sum of lines 83 through 85)         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		•		1				81.0 82.0
34.00       Program inpatient ancillary services (see instructions)         35.00       Utilization review - physician compensation (see instructions)         36.00       Total Program inpatient operating costs (sum of lines 83 through 85)         PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								83.0
36.00         Total Program inpatient operating costs (sum of lines 83 through 85)           PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST	34.00	Program inpatient ancillary services (see ins	structions)					84.0
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								85.00
	00. UU			ougn 85)			1	86.00
	87.00	Total observation bed days (see instructions)	)				1, 201	
88.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)2,851.7089.00Observation bed cost (line 87 x line 88) (see instructions)3,424,892			•	line 2)				

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	702, 283	8, 332, 662	0. 08428	1 3, 424, 892	288, 653	90.00
91.00 Nursing Program cost	0	8, 332, 662	0.00000	3, 424, 892	0	91.00
92.00 Allied health cost	0	8, 332, 662	0.00000	3, 424, 892	0	92.00
93.00 All other Medical Education	0	8, 332, 662	0.00000	3, 424, 892	0	93.00

Health Financial Systems GREENE COUNTY GENE	ERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre 5/30/2023 1:0	pared:
	Title	xviii	Hospi tal	Cost	o pili
Cost Center Description	in the	Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
		··· ···· ··· ···	Charges	(col. 1 x col.	
			3	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			1		
30. 00 03000 ADULTS & PEDI ATRI CS			1, 336, 964		30.00
31. 00 03100 I NTENSI VE CARE UNI T			192, 816		31.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS		i .			
50. 00 05000 OPERATI NG ROOM		0. 3440			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3247		0	
53. 00 05300 ANESTHESI OLOGY		0. 4719		30, 505	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1048			
60. 00 O6000 LABORATORY		0. 1958		111, 960	
65. 00 06500 RESPI RATORY THERAPY		0. 3152			
66. 00 06600 PHYSI CAL THERAPY		0. 2805		32, 817	
67.00 06700 OCCUPATI ONAL THERAPY		0. 2834		5, 230	
68.00 O6800 SPEECH PATHOLOGY		0.4559		3, 220	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.2622			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1.0944			
73.00 07300 DRUGS CHARGED TO PATIENTS		0.2630		288, 454	
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON OUTPATI ENT SERVI CE COST CENTERS		0.0000	0 00	0	77.00
88. 00 08800 RURAL HEALTH CLINIC		0.0000	00	0	88.00
88. 01 08801 RURAL HEALTH CLINIC II		0.0000		0	
88. 02 08802 RURAL HEALTH CLINIC III		0.0000			1
88. 03 08803 RURAL HEALTH CLINIC IV		0.0000		0	
91. 00  09100  EMERGENCY		0. 2030		-	
91.00 09100 EMERGENCT 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 5867		0, 493	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		1. 5007	3, 803, 587	1, 156, 238	
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		3, 003, 367	1, 150, 250	200.00
202.00 Net charges (line 200 minus line 201)	5 (THE UT)		3, 803, 587		201.00
		I	5,005,007	I	1202.00

INPATLENT ANCILLARY SERVICE COST APPORTIONMENT         Provider CON: 15-1317         Period: To 12/31/2022         Period: To 12/31/2022         Worksheet D-3           Component CN: 15-2317         Swing Beds - SWF         Cost         Date/Time Prepared: 5/30/2023         Date/Time Prepared: 5/30/2023         Date/Time Prepared: 5/30/2023         Date/Time Prepared: 5/30/2023           Impatient         Cost Center Description         Ratio of Cost To Charges         Inpatient Program Costs (col 1 x col .         Inpatient Program Costs (col 1 x col .         Date/Time Prepared: 5/30/2023           30.00         03000 ADULTS & PEDIATRICS         1.00         2.00         3.00           31.00         03000 NURSERV MAKILLARY SERVICE COST CENTERS         30.00         31.00           MAKILLARY SERVICE COST CENTERS         0         0.52.00         52.00         52.00           52.00         052.00 DELIVERY ROOM & LABOR ROOM         0.324732         0         0         53.00           53.00         050.00 ADULTS & PEDIATRICS         0.144828         17.403         1.824 54.00           50.00         050.00 OEADOLARDROW         0.344082         0         0         53.00           60.00         06000 PRESTIRATORY THERAPY         0.315224         79.662         25.111         65.00           60.00         06000 PRESTIRATORY THERAPY<	Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	-	In Lie	u of Form CMS-:	2552-10
Component CCR: 15-2317         To         12/31/2022         Date/Time Prepared: 5/30/2023 1: 05 pm           Cost Center Description         Title XVIII         Swing Beds - SNF         Cost           1000         Cost         Inpatient Program         Program         Program           0:00         03000 ADULTS & PEDI ATRICS         1.00         2.00         3.00           30:00         03000 INTESS VE CARE UNIT         31.00         30.00           43:00         04300 NURSERY         43.00           ANOO ILARY SERVICE COST CENTERS         0.344082         0         55.00           50:00         05000 DELVERY ROM & L&B0R R00M         0.344082         0         55.00           50:00         05000 DELVERY ROM & L&B0R R00M         0.344732         0         0         53.00           51:00         05300 ANESTHESI 0LOGY         0.104828         17,403         1,824         54.00           60:00         065000 CLARDRATORY         0.2804550         11,202         22,22,23         67.00           60:00         065000 OPERTINC HATERAPY         0.283423         78,622         22,114         66.00           60:00         06500 OPHYSICAL HERAPY         0.280550         11,202         31,422         66.00           60:	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1317		Worksheet D-3	
Title XVIII         Swing Beds - SNF         Cost           Cost Center Description         Ratio of Cost To Charges         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Charges           30.00         03000 ADULTS & PEDIATRICS         1.00         2.00         3.00           31.00         031001 INTENSI VE CARE UNIT         30.00         31.00         31.00           31.00         031000 INTENSI VE CARE UNIT         31.00         31.00         31.00           320.00         05200 DELIVERY ROM & LABOR ROM         0.344082         0         0         55.00           0.00         05000 OPERATING ROM         0.324732         0         55.00         55.00           0.00         05000 DADULTS & LABOR ROM         0.324732         0         0         52.00           0.00         05000 OPERATING ROM         0.324732         0         0         52.00           0.00         05000 DESON RESPIRATORY THERAPY         0.315224         79.662         25.111         65.00           0.00         06000 LABORATORY         0.283423         78.622         22.28         67.00           0.00         06000 DELVERTACORDI LICEY         0.283423         78.622         22.28         67.			001 45 3043			
Title XVIII         Swing, Beds SNF         Cost           Ratio of Cost         Inpatient Program Charges         Inpatient Program (cost score)         Inpatient (cost score)         Inpatient (cost score)         Inpatient (cost cost score)		Component	CCN: 15-Z317	10 12/31/2022		
Cost Center Description         Ratio of Cost To Charges         Inpatient Program Charges         Inpatient Program Charges         Inpatient Program Charges           1.00         2.00         3.00           30.00         03000 ADULTS & PEDIATRICS         30.00           31.00         03100 INTENSI VE CABE UNIT         31.00           43.00         04300 NURSERY         31.00           ANCILLARY SERVICE COST CENTERS         0         50.00           50.00         05000 DEFLATI NG ROOM         0.344082         0           50.00         05300 ANESTHESI OLOGY         0.417988         0         0           51.00         06000 RESPICATORY THERAPY         0.15224         0         52.00           50.00         05300 ANESTHESI OLOGY         0.14428         17.403         1.824         54.00           60.00         06600 RESPICATORY THERAPY         0.35224         0         53.00           61.00         06600 RESPICATORY THERAPY         0.280550         112.002         31.422         66.00           62.00         06600 SPEECH PATHOLOGY         0.283423         78.622         22.238         67.00           63.00         06600 SPEECH PATHOLOGY         0.283423         78.622         22.208         67.00		Title	e XVIII	Swina Beds - SNF		<u>5 piii</u>
INPATEENT ROUTINE SERVICE COST CENTERS         To Charges         Program Costs (col. 1 x col. 2)           30.00         03000 ADULTS & PEDIATRICS         3.00         3.00           31.00         03100 INTENSI VE CARE UNI T         31.00         31.00           43.00         04300 NURSERY         4         43.00           ANCILLARY SERVICE COST CENTERS         0         50.00         050000 PERAITING ROOM         0.344082         0         50.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         52.00         53.00 <td>Cost Center Description</td> <td></td> <td></td> <td></td> <td></td> <td></td>	Cost Center Description					
INPATI ENT ROUTI NE SERVICE COST CENTERS         1.00         2.00         3.00           30.00         03000         ADULTS & PEDI ATRI CS         3.00         3.00           31.00         03100         INTENSION         3.00         3.00           43.00         04300         NURSERY         43.00         43.00           ANCLLARY SERVICE COST CENTERS         50.00         05000         005000         005000         005000         00520         00520         005200         005200         005200         005200         005200         005200         005200         005200         005200         005200         005200         0052000         005300			To Charges	Program		
INPATI ENT ROUTINE SERVICE COST CENTERS           30.00         03000/ ADULTS & PEDIATRICS         30.00           31.00         03100 INTENSIVE CARE UNIT         31.00           43.00         43.00         043000 NURSERY         43.00           ANCI LLARY SERVICE COST CENTERS         0         0.52.00         05200 DELIVERY ROOM & LABOR ROOM         0.344082         0         0           50.00         053000 ARDSTHESI OLOGY         0.417988         0         0         53.00           51.00         05300 ALDSTHESI OLOGY         0.104828         17.403         1.824         54.00           61.00         066000 PHYSI CAL THERAPY         0.315224         79.662         25.111         65.00           65.00         065000 CUPATI ONAL THERAPY         0.315224         79.662         25.111         65.00           66.00         06600 PHYSI CAL THERAPY         0.280555         12.002         31.422         66.00           67.00         06700 OCCUPATI ONAL THERAPY         0.280555         9.242         4.214         68.00           68.00         068000 SPEECH PATHOLOGY         0.455955         9.242         4.214         68.00           71.00         07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS         0.263035         133,703 <td< td=""><td></td><td></td><td></td><td>Charges</td><td>(col. 1 x col.</td><td></td></td<>				Charges	(col. 1 x col.	
INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00         330.00         330.00         330.00         330.00         330.00         331.00         330.00         330.00         330.00         330.00         320.00         320.00         320.00         320.00         320.00         320.00         320.00         330.00         <						
30. 00       03000 ADULTS & PEDIATRICS       30. 00         31. 00       03100 INTENSIVE CARE UNIT       31. 00         33. 00       04300 INTENSIVE CARE UNIT       30. 00         31. 00       03100 INTENSIVE CARE UNIT       30. 00         31. 00       04300 INTERSIVE CORE UNIT       30. 00         31. 00       04300 INTERSIVE CORE UNIT       0         30. 00       05000 INTENSIVE CORE UNIT       0. 344082       0       0         50. 00       05200 DELIVERY ROOM & LABOR ROOM       0. 324732       0       0       52. 00         51. 00       05300 ANESTHESI OLOGY       0. 471988       0       0       53. 00         52. 00       05300 ARESTHESI OLOGY       0. 104828       17, 403       1, 824       54. 00         60. 00       06000 LABORATORY       0. 195865       37, 694       7, 383       60. 00         60. 00       06600 PHYSI CAL THERAPY       0. 280550       112, 002       31, 422       66. 00         67. 00       06700 OCCUPATI ONAL THERAPY       0. 283423       78, 622       22, 283       67. 00         69. 00       06900 ELECTROCARDI OLOGY       0. 45555       9, 242       4, 214       68. 00         70. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS <td></td> <td></td> <td>1.00</td> <td>2.00</td> <td>3.00</td> <td></td>			1.00	2.00	3.00	
31.00       03100       INTENSIVE CARE UNIT       31.00         43.00       04300       NURSERY       43.00         AUCULARY SERVICE COST CENTERS       50.00       05000       OPERATING ROOM       0.344082       0       0       50.00         52.00       05200       DELIVERY ROOM & LABOR ROOM       0.324732       0       0       53.00         53.00       05300       ANESTHESI OLOGY       0.471988       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.104828       17.403       1.824       54.00         65.00       06500       ABORATORY       0.315224       79.662       25.111       65.00         66.00       06600       PHYSI CAL THERAPY       0.280550       112.002       31.422       66.00         66.00       06600       SPECH PATHOLOGY       0.455955       9.242       4.214       66.00         67.00       052000       SPECH PATHOLOGY       0.283423       78.622       22.83       67.00         68.00       06800       SPECH PATHOLOGY       0.263035       133.703       35,169       73.00         71.00       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.263035       133.703       35,169						
43.00       04300       NURSERY       43.00         ANCILLARY SERVICE COST CENTERS       43.00         ANCILLARY SERVING COM       0.344082       0       50.00         05000       DELIVERY ROOM & LABOR ROOM       0.324732       0       52.00         53.00       05300       AMESTHESI OLOGY       0.471988       0       53.00         64.00       5400       RAJ DLOGY-DI AGNOSTI C       0.104828       17.403       1.824       54.00         65.00       06500       RESPI RATORY THERAPY       0.195865       37.694       7.383       60.00         66.00       06500       RESPI RATORY THERAPY       0.280550       112.002       31.422       66.00       66.00       66.00       66.00       0.6900       LECINCARDI OLOGY       0.280555       9.242       4.214       68.00         67.00       06000       LECINCCARDI OLOGY       0.263035       133.703       35.169       73.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.262206       58.022       15.214       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0.000000       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS						
ANCILLARY SERVICE COST CENTERS           50. 00         05000         DELVERY ROOM & LABOR ROOM         0.344082         0         0         50. 00           52. 00         DS200         DELIVERY ROOM & LABOR ROOM         0.324732         0         0         52. 00           53. 00         DS300         ANESTHESI OLOGY         0.471988         0         0         53. 00           54. 00         D5400         RADI OLOGY-DI AGNOSTI C         0.104828         17, 403         1, 824         54. 00           0.00         OGOOL LABORATORY         0.195865         37, 694         7, 383         60. 00           65. 00         06500         RESPI RATORY THERAPY         0.315224         79, 662         25, 111         65. 00           06400         DAGORATORY         0.283423         78, 622         22, 283         67. 00           0.0700         OCUPATI ONAL THERAPY         0.283423         78, 622         22, 283         67. 00           0.06800         SPEECH PATHOLOGY         0.455955         9, 242         4, 214         68. 00           69. 00         OF100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.263035         133, 703         35, 169           17. 00         O7200         IMEGED TO PATI EN						•
50.00         05000         OPERATING ROOM         0.344082         0         0         50.00           52.00         052000         DELLVERY ROOM & LABOR ROOM         0.324732         0         0         52.00           53.00         05300         ANESTHESI OLOGY         0.471988         0         0         53.00           54.00         05400         RADIOLOGY-DI AGNOSTI C         0.104828         17,403         1,824         54.00           60.00         06600         LABORATORY         0.315224         79,662         25,111         65.00           65.00         06500         RESPI RATORY THERAPY         0.280550         112,002         31,422         66.00           66.00         06600         PHYSI CAL THERAPY         0.280550         112,002         31,422         66.00           67.00         06700 ELECTROCARDI OLOGY         0.455955         9,242         4,214         68.00         69.00           68.00         OF300 OLECTROCARDI OLOGY         0.0000000         0         0         69.00           71.00         07100         MEGED TO PATIENTS         0.262305         5133,703         35,169         73.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.263						43.00
52.00       05200       DELIVERY ROOM & LABOR ROOM       0.324732       0       0       52.00         53.00       05300       ANESTHESI OLOGY       0.471988       0       0       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.104828       17,403       1,824       54.00         60.00       06000       LABORATORY       0.195865       37,694       7,383       60.00         65.00       06500       RESPI RATORY THERAPY       0.315224       79,662       25,111       65.00         66.00       06600       PHYSI CAL THERAPY       0.280550       112,002       31,422       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.280555       9,242       4,214       68.00         68.00       06800       SPEECH PATHOLOGY       0.455955       9,242       4,214       68.00         69.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.262305       133,703       35,169       73.00         70.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0.000000       0       0       73.00         70.00       07300       DRUGS CHARGED TO PATIENTS       0.263305       133,703       35,169       73.00 <td></td> <td></td> <td></td> <td>1</td> <td></td> <td></td>				1		
53.00       05300       ANESTHESI OLOGY       0.471988       0       0       53.00         54.00       05400       RADI OLOCY-DI AGNOSTI C       0.104828       17,403       1,824       54.00         60.00       06000       LABORATORY       0.195865       37,694       7,383       60.00         65.00       06500       RESPI RATORY THERAPY       0.315224       79,662       25,111       65.00         66.00       06600       PHYSI CAL THERAPY       0.280550       112,002       31,422       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.283423       78,622       22,83       67.00         68.00       06800       SPEECH PATHOLOGY       0.455955       9,242       4,214       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       0       72.00         72.00       07100       MED LOKL CHARGED TO PATI ENTS       0.263035       133,703       35,169       73.00         77.00       07200       IMPL DEV. CHARGED TO PATI ENTS       0.000000       0       0       72.00         017041 ENT SERVICE COST CENTERS       0.263035       133,703       35,169       73.00       73.00       73.00       73.00					0	
54.00       05400       RADI OLOGY-DI AGNOSTI C       0.104828       17,403       1,824       54.00         60.00       06000       LABORATORY       0.195865       37,694       7,383       60.00         65.00       06500       RESPI RATORY THERAPY       0.315224       79,662       25,111       65.00         66.00       06600       PHYSI CAL THERAPY       0.280550       112,002       31,422       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.283423       78,622       22,283       67.00         68.00       06800       SPEECH PATHOLOGY       0.455955       9,242       4,214       88.00         69.00       O6900       ELECTROCARDI OLOGY       0.000000       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.262206       58,022       15,214       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.263035       133,703       35,169       73.00         77.00       07700       ALLOGENEI C HSCT ACOULISI TI ON       0.000000       0       0       77.00         017420       INRAL HEALTH CLINIC I       0.000000       0       0       0       88.00 <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td>					0	
60.00       06000       LABORATORY       0.195865       37,694       7,383       60.00         65.00       06500       RESPI RATORY THERAPY       0.315224       79,662       25,111       65.00         66.00       06600       PHYSI CAL THERAPY       0.280550       112,002       31,422       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.283423       78,622       22,283       67.00         68.00       06800       SPEECH PATHOLOGY       0.455955       9,242       4,214       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       0       69.00         71.00       MOI MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.262206       58,022       15,214       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.263035       133,703       35,169       73.00         77.00       07700       ALLOGENEI C HSCT ACQUI SI TI ON       0.000000       0       0       77.00         017PATI ENT SERVICE COST CENTERS       0.000000       0       0       0       77.00         88.01       08801       RURAL HEALTH CLINI C III       0.000000       0       88.01         88.03       08803						•
65.00       06500       RESPI RATORY THERAPY       0.315224       79,662       25,111       65.00         66.00       06600       PHYSI CAL THERAPY       0.280550       112,002       31,422       66.00         67.00       06700       0CUPATI ONAL THERAPY       0.283423       78,622       22,283       67.00         68.00       06800       SPEECH PATHOLOGY       0.455955       9,242       4,214       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.262206       58,022       15,214       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0.263035       133,703       35,169       73.00         77.00       07700       ALLOGENEI C HSCT ACQUI SI TI ON       0.000000       0       0       77.00         00TTAT ENT SERVICE COST CENTERS       0.000000       0       0       88.00       08801       88.01       88.00         88.00       08802       RURAL HEALTH CLINIC III       0.000000       0       88.01         88.03       08803       RURAL HEALTH CLINIC IV       0.000000       0       88.03 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
66.00       06600       PHYSI CAL THERAPY       0.280550       112,002       31,422       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.283423       78,622       22,283       67.00         68.00       06800       SPEECH PATHOLOGY       0.455955       9,242       4,214       68.00         69.00       06900       ELECTROCARDI OLOGY       0.000000       0       0       69.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.262206       58,022       15,214       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       1.094400       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.263035       133,703       35,169       73.00         77.00       0700 ALLOGENEI C HSCT ACQUI SITI ON       0.000000       0       0       77.00         01700 HURAL HEALTH CLINI C II       0.000000       0       0       88.01       88.01         88.00       08801       RURAL HEALTH CLINI C III       0.000000       0       88.01         88.01       08803       RURAL HEALTH CLINI C IV       0.000000       0       88.03         88.03       08803       RURAL						•
67.00       06700       0CCUPATIONAL THERAPY       0.283423       78,622       22,283       67.00         68.00       06800       SPEECH PATHOLOGY       0.455955       9,242       4,214       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       0       0       69.00         71.00       O7100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.262206       58,022       15,214       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       1.094400       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.263035       133,703       35,169       73.00         77.00       07700       ALLOGENEIC HSCT ACQUISITION       0.000000       0       0       77.00         07700       ALLOGENEI C HSCT ACQUISITION       0.000000       0       0       88.00         88.00       08800       RURAL HEALTH CLINIC III       0.000000       0       88.01         88.01       08803       RURAL HEALTH CLINIC IV       0.000000       0       88.03         88.03       08803       RURAL HEALTH CLINIC IV       0.000000       0       88.03         91.00       09100       EMERGENCY <td< td=""><td></td><td></td><td></td><td></td><td>25, 111</td><td></td></td<>					25, 111	
68.00       06800       SPEECH PATHOLOGY       0.455955       9,242       4,214       68.00         69.00       06900       ELECTROCARDIOLOGY       0.000000       0       69.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0.262206       58,022       15,214       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       1.094400       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.263035       133,703       35,169       73.00         77.00       0700       ALLOGENEIC CIST CENTERS       0.000000       0       0       0         001TPATIENT SERVICE COST CENTERS       0.000000       0       0       88.00       88.00         88.00       08800       RURAL HEALTH CLINIC III       0.000000       0       88.01         88.01       08801       RURAL HEALTH CLINIC III       0.000000       0       88.02         88.03       08803       RURAL HEALTH CLINIC IV       0.000000       0       88.03         91.00       09100       EMERGENCY       0.203032       0       0       91.00         92.00       OSERVATION BEDS (NON-DISTINCT PART)       0       0       92.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td>•</td></t<>						•
69.00         06900         ELECTROCARDIOLOGY         0.000000         0         69.00           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENTS         0.262206         58,022         15,214         71.00           72.00         07200         IMPL.         DEV. CHARGED TO PATIENTS         1.094400         0         72.00           73.00         07300         DRUGS CHARGED TO PATIENTS         0.263035         133,703         35,169         73.00           77.00         07700         ALLOGENEIC HSCT ACQUISITION         0.000000         0         0           0UTPATIENT SERVICE COST CENTERS         0.000000         0         0         88.00           88.00         08801         RURAL HEALTH CLINIC         0.000000         0         88.01           88.01         08801         RURAL HEALTH CLINIC III         0.000000         0         88.01           88.02         08802         RURAL HEALTH CLINIC III         0.000000         0         88.02           88.03         08803         RURAL HEALTH CLINIC IV         0         0.000000         0         88.03           91.00         09100         EMERGENCY         0.203032         0         0         92.00         92.00         92.00						
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0.262206       58,022       15,214       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       1.094400       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.263035       133,703       35,169       73.00         77.00       07700       ALLOGENEI C HSCT ACQUISITION       0.000000       0       0       77.00         0UTPATIENT SERVICE COST CENTERS       0.8000       RURAL HEALTH CLINIC       0.000000       0       88.00         88.00       08801       RURAL HEALTH CLINIC II       0.000000       0       88.01         88.01       08803       RURAL HEALTH CLINIC II       0.000000       0       88.02         88.03       08803       RURAL HEALTH CLINIC IV       0.000000       0       88.03         91.00       09100       EMERGENCY       0.203032       0       88.03         92.00       09SERVATION BEDS (NON-DISTINCT PART)       0.586771       0       92.00       92.00         92.00       DSERVATION BEDS (NON-DISTINCT PART)       1.586771       0       0       92.00       92.00       92.00       92.00       92.00       92.00       92.00 <td< td=""><td></td><td></td><td></td><td></td><td>4, 214</td><td></td></td<>					4, 214	
72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       1.094400       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.263035       133,703       35,169       73.00         77.00       07700       ALLOGENEIC HSCT ACQUISITION       0.000000       0       0       77.00         0UTPATIENT SERVICE COST CENTERS       0.000000       0       0       0       88.00         88.00       08800       RURAL HEALTH CLINIC II       0.000000       0       88.00         88.01       08801       RURAL HEALTH CLINIC III       0.000000       0       88.01         88.02       08802       RURAL HEALTH CLINIC III       0.000000       0       88.01         88.02       08803       RURAL HEALTH CLINIC IV       0.000000       0       88.03         91.00       09100       EMERGENCY       0.203032       0       0       91.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       1.586771       0       92.00       92.00       92.00       0       92.00       0       92.00       0       92.00       0       92.00       0       92.00       0       92.00       0       92.00       0       0						
73.00       07300       DRUGS CHARGED TO PATIENTS       0.263035       133,703       35,169       73.00         77.00       07700       ALLOGENEI C HSCT ACQUISITION       0.000000       0       0       77.00         0UTPATIENT SERVICE COST CENTERS       0.000000       0       0       88.00       88.00         88.01       08801       RURAL HEALTH CLINIC II       0.000000       0       88.01         88.02       08802       RURAL HEALTH CLINIC III       0.000000       0       88.01         88.02       08803       RURAL HEALTH CLINIC III       0.000000       0       88.02         88.03       08803       RURAL HEALTH CLINIC IV       0.000000       0       88.03         91.00       09100       EMERGENCY       0.203032       0       91.00         92.00       092200       OBSERVATION BEDS (NON-DISTINCT PART)       1.586771       0       92.00         200.00       Total (sum of lines 50 through 94 and 96 through 98)       526,350       142,620       200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00					15, 214	•
77.00         07700         ALLOGENEIC HSCT ACQUISITION         0.000000         0         0         77.00           0UTPATI ENT SERVICE COST CENTERS         0.000000         0         0         88.00         88.00         08800         RURAL HEALTH CLINIC         0         0.000000         0         88.00           88.01         08801         RURAL HEALTH CLINIC II         0.000000         0         88.01         88.01           88.02         08802         RURAL HEALTH CLINIC III         0.000000         0         88.02         88.03           91.00         09100         EMERGENCY         0.203032         0         91.00         91.00           92.00         0952RVATION BEDS (NON-DISTINCT PART)         1.586771         0         92.00         92.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00         201.00						
OUTPATI ENT_SERVICE_COST_CENTERS           88.00         08800         RURAL_HEALTH_CLINIC         0.000000         0         88.00           88.01         08801         RURAL_HEALTH_CLINIC_II         0.000000         0         88.01           88.02         08802         RURAL_HEALTH_CLINIC_III         0.000000         0         88.01           88.02         08803         RURAL_HEALTH_CLINIC_III         0.000000         0         88.02           88.03         08803         RURAL_HEALTH_CLINIC_IV         0.000000         0         88.03           91.00         09100         EMERGENCY         0.203032         0         91.00           92.00         0BSERVATION BEDS (NON-DISTINCT_PART)         0         0.203032         0         92.00           200.00         Total (sum of lines 50 through 94 and 96 through 98)         526, 350         142, 620         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00         201.00					35, 169	
88.00       08800       RURAL HEALTH CLINIC       0.000000       0       88.00         88.01       08801       RURAL HEALTH CLINIC II       0.000000       0       88.01         88.02       08802       RURAL HEALTH CLINIC III       0.000000       0       88.02         88.03       08803       RURAL HEALTH CLINIC III       0.000000       0       88.02         91.00       09100       EMERGENCY       0.000000       0       88.03         92.00       09200       0BSERVATI ON BEDS (NON-DI STINCT PART)       0       0.203032       0       91.00         200.00       Total (sum of lines 50 through 94 and 96 through 98)       526,350       142,620       200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201.00       201.00			0.0000	0 0	0	77.00
88.01       08801       RURAL HEALTH CLINIC II       0.000000       0       88.01         88.02       08802       RURAL HEALTH CLINIC III       0.000000       0       88.02         88.03       08803       RURAL HEALTH CLINIC III       0.000000       0       88.03         91.00       09100       EMERGENCY       0.000000       0       91.00         92.00       09200       085RVATI ON BEDS (NON-DISTINCT PART)       0       0       92.00         200.00       Total (sum of lines 50 through 94 and 96 through 98)       526,350       142,620       200.00         201.00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       0       201.00			1			
88. 02       08802       RURAL HEALTH CLINIC III       0.000000       0       88. 02         88. 03       08803       RURAL HEALTH CLINIC IV       0.000000       0       88. 03         91. 00       09100       EMERGENCY       0.203032       0       91. 00         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       1.586771       0       92. 00         200. 00       Total (sum of lines 50 through 94 and 96 through 98)       526, 350       142, 620       200. 00         201. 00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201. 00       201. 00					-	
88. 03       08803       RURAL HEALTH CLINIC IV       0.000000       0       88. 03         91. 00       09100       EMERGENCY       0.203032       0       91. 00         92. 00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       1.586771       0       92. 00         200. 00       Total (sum of lines 50 through 94 and 96 through 98)       526, 350       142, 620       200. 00         201. 00       Less PBP Clinic Laboratory Services-Program only charges (line 61)       0       201. 00       201. 00					•	
91.00         09100         EMERGENCY         0.203032         0         91.00           92.00         09200         OBSERVATI ON BEDS (NON-DISTINCT PART)         1.586771         0         92.00           200.00         Total (sum of lines 50 through 94 and 96 through 98)         526,350         142,620         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00					0	
92.00         09200         OBSERVATION         BEDS (NON-DISTINCT PART)         1.586771         0         92.00           200.00         Total (sum of lines 50 through 94 and 96 through 98)         526,350         142,620         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         0         201.00					0	
200.00         Total (sum of lines 50 through 94 and 96 through 98)         526,350         142,620         200.00           201.00         Less PBP Clinic Laboratory Services-Program only charges (line 61)         0         201.00					-	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			1. 58677			
				526, 350	142, 620	
202.00   Net charges (line 200 minus line 201)   526, 350  202.00				0		
	202.00   Net charges (line 200 minus line 201	)		526, 350		202.00

Health Financial Systems GREENE COUNTY GEN	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet D-3 Date/Time Pre 5/30/2023 1:0	epared:
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
		_	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-		
30. 00 03000 ADULTS & PEDI ATRI CS			117, 212		30.00
31. 00 03100 I NTENSI VE CARE UNI T			24, 102		31.00
43. 00 04300 NURSERY			126, 795		43.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATING ROOM		0.3440			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 32473			
53. 00 05300 ANESTHESI OLOGY		0. 4719			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 10482			
60. 00 06000 LABORATORY		0. 1958			•
65. 00 06500 RESPI RATORY THERAPY		0. 3152			
66. 00 06600 PHYSI CAL THERAPY		0. 2805		873	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 28342		0	
68.00 06800 SPEECH PATHOLOGY		0. 4559		0	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26220			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 09440		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2630		24, 161	
77.00 07700 ALLOGENEI C HSCT ACQUI SI TI ON		0.0000	0 00	0	77.00
OUTPATIENT SERVICE COST CENTERS		0.0750	- /		1
88.00 08800 RURAL HEALTH CLINIC		0. 9752		0	
88.01 08801 RURAL HEALTH CLINIC II		0. 9004		0	
88. 02 08802 RURAL HEALTH CLINIC III		1. 1249		0	
88.03 08803 RURAL HEALTH CLINIC IV		1.4423		0	
91.00 09100 EMERGENCY		0. 2030		28, 959	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 5867		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)			599, 348	151, 784	
201.00 Less PBP Clinic Laboratory Services-Program only charg	jes (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			599, 348		202.00

ALCUL	Financial Systems GREENE COUNTY GENER ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1317	Period: From 01/01/2022	u of Form CMS-2 Worksheet E Part B	
			To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
		Title XVIII	Hospi tal	Cost	
				1.00	
00	PART B - MEDICAL AND OTHER HEALTH SERVICES			7 077 404	1.00
. 00 . 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	tions)		7, 077, 496 0	
. 00	OPPS payments			0	
. 00 . 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
. 00	Enter the hospital specific payment to cost ratio (see instruct	ctions)		0.000	
. 00 . 00	Line 2 times line 5			0 0.00	
. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV, col. 13, line 200		0	
0.00 1.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 7, 077, 496	10.00 11.00
1.00	COMPUTATION OF LESSER OF COST OR CHARGES			, , , , , , , , , , , , , , , , , , , ,	11.00
2 00	Reasonable charges Ancillary service charges			0	12.00
2.00 3.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ine 69)		0	
4.00	Total reasonable charges (sum of lines 12 and 13)	,		0	14.00
5.00	Customary charges Aggregate amount actually collected from patients liable for p	navment for services on	a charge basis	0	15.00
6.00	Amounts that would have been realized from patients liable for			0	
7 00	had such payment been made in accordance with 42 CFR §413.13(e	e)	-	0,000000	17.00
7.00 8.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000	
9.00	Excess of customary charges over reasonable cost (complete onl	ly if line 18 exceeds li	ne 11) (see	0	
0. 00	instructions) Excess of reasonable cost over customary charges (complete onl	ly if line 11 exceeds li	no 19) (soo	0	20.00
0.00	instructions)	Ty IT THE IT exceeds IT	Tie To) (See	0	20.00
1.00	Lesser of cost or charges (see instructions)			7, 148, 271	
2.00 3.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instr	ructions)		0	
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	
E 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u></u>		60,460	1 25 00
5.00 6.00	Deductibles and coinsurance amounts (for CAH, see instructions Deductibles and Coinsurance amounts relating to amount on line	-	ructions)	60, 469 4, 802, 832	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			2, 284, 970	
8. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	ine 50)		0	28.00
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
0.00	Subtotal (sum of lines 27 through 29)			2, 284, 970	
1.00 2.00	Primary payer payments Subtotal (line 30 minus line 31)			299 2, 284, 671	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 504, 130	
5.00	Adjusted reimbursable bad debts (see instructions)			327, 685	
6.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		381, 321	
7.00 8.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 612, 356 0	
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39.50
9.75	N95 respirator payment adjustment amount (see instructions)			0	
9.97 9.98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	red devices (see instru	tions)	0	
9.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
0.00	Subtotal (see instructions)			2, 612, 356	
0. 01 0. 02	Sequestration adjustment (see instructions)			32, 916 0	
0.02	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM or CHART pass-throughs			0	40. 02 40. 03
1.00	Interim payments			2, 861, 357	
1.01	Interim payments-PARHM or CHART				41.01
2.00 2.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM or CHART (for contractor use only)			0	42.00 42.01
3.00	Balance due provider/program (see instructions)			-281, 917	
3.01	Balance due provider/program-PARHM (see instructions)		-h	_	43.01
4.00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	cnapter 1,	0	44.00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
1.00 2.00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0	91.00 92.00
2.00 3.00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1317	Period: From 01/01/2022 To 12/31/2022		epared: )5 pm
	Title XVIII	Hospi tal	Cost	
			Overri des	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00 Override of Ancillary service charges (li	ne 12)		C	112.00
			1.00	
MEDICARE PART B ANCILLARY COSTS				
200.00 Part B Combined Billed Days			C	200.00

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2022 To 12/31/2022		
		Title		Hospi tal	Cost	
		I npati ent	E Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		2, 948, 59	7	2, 861, 357	1. (
00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	0	2. (
00	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)					3. (
	Program to Provider					
01	ADJUSTMENTS TO PROVIDER	10/17/2022	63, 70		0	3.0
02 03				0	0	3. ( 3. (
03				0	0	3.
05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		63, 70	-	0	3.
	3. 50-3. 98)		,		_	-
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3, 012, 29	7	2, 861, 357	4.
	TO BE COMPLETED BY CONTRACTOR	<u> </u>				
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03				0	0	5.
	Provider to Program	<u>г</u>				-
50 51	TENTATIVE TO PROGRAM			0	0	5. 5.
51 52				0	0	5. 5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.
00	5.50-5.98) Determined net settlement amount (balance due) based on					6.
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER		746, 53		0	6.
02	SETTLEMENT TO PROGRAM		2 750 02	0	281, 917 2, 579, 440	6.
00	Total Medicare program liability (see instructions)		3, 758, 82	Contractor	2,579,440 NPR Date	7
				Number	(Mo/Day/Yr)	
		0		1.00	2.00	-

VALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2022		
		component (	CCN: 15-Z317	To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
		Title	XVIII	Swing Beds - SN	F Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider 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,		549, 6	36 0	0	
00	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)					3. (
	Program to Provider					1
01	ADJUSTMENTS TO PROVIDER	10/17/2022	64, 4		0	
02				0	0	
03 04				0	0	
04				0	0	
00	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	
51				0	0	
52				0	0	
53 54				0	0	
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		64, 4	-	0	
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		614, 0	36	0	4.
	TO BE COMPLETED BY CONTRACTOR				1	
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
)1 )2	ILMATIVE TO PROVIDER			0	0	
)3				0	0	
	Provider to Program				1	
50	TENTATIVE TO PROGRAM			0	0	5
51 52				0	0	
92 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
0	5. 50-5. 98)					,
0	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		217, 9		0	
)2	SETTLEMENT TO PROGRAM		001 0	0	0	
00	Total Medicare program liability (see instructions)		831, 9	Contractor	0 NPR Date	7
				Number	(Mo/Day/Yr)	
		(		1.00	2.00	

Heal th	Financial Systems GREENE COUNTY GEN	ERAL HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1317	Peri od:	Worksheet E-1	
			From 01/01/2022 To 12/31/2022		narad
			10 12/31/2022	5/30/2023 1:0	
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATIO				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst	. S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days (see instructions)				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days (see instructions)				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1.1			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified Hil technology	WKST. 5-2, PT. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)			l	30.00
	Other Adjustment (specify)			l	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	is)		32.00
				Overri des	
				1.00	
	CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			i.	108.00

ALCULA	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Provider CCN: 15-	1317 Period:	Worksheet E-2	2552-
	Component CCN: 15-	-Z317 From 01/01/2022 To 12/31/2022	2 Date/Time Pre	
	Title XVIII	Swing Beds - SN	5/30/2023 1:0 F Cost	is pili
		Part A	Part B	
	CONDUCATION OF NET COST OF CONFEED OF DUILOFS	1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions)	699, 893	3 0	1.(
	Inpatient routine services - swing bed-NF (see instructions)	077, 07.		2.0
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst.	st. D, 144,040	6 0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through			
	instructions)			
	Nursing and allied health payment-PARHM or CHART (see instructions)			3.
	Per diem cost for interns and residents not in approved teaching program (see instructions)		0.00	4.
1	Program days	243	3 0	5.
	Interns and residents not in approved teaching program (see instructions)	2.0	0	
	Utilization review - physician compensation - SNF optional method only	(	)	7.
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	843, 93		
	Primary payer payments (see instructions)	(	0 0	
	Subtotal (line 8 minus line 9)	843, 93		
	Deductibles billed to program patients (exclude amounts applicable to physician professional services)		0 0	11.
	Subtotal (line 10 minus line 11)	843, 939	9 0	12.
	Coinsurance billed to program patients (from provider records) (exclude coinsura			
	for physician professional services)			
	80% of Part B costs (line 12 x 80%)		0	
	Subtotal (see instructions)	842, 57		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)		0 0	16. 16.
	Rural community hospital demonstration project (§410A Demonstration) payment			16.
	adjustment (see instructions)			
6. 99	Demonstration payment adjustment amount before sequestration	(	0 0	16.
	Allowable bad debts (see instructions)	(	0 0	
	Adjusted reimbursable bad debts (see instructions)		0 0	
	Allowable bad debts for dual eligible beneficiaries (see instructions) Total (see instructions)	842, 57		
	Sequestration adjustment (see instructions)	10, 610		
	Demonstration payment adjustment amount after sequestration)		0 0	
9. 03	Sequestration adjustment-PARHM or CHART pass-throughs			19.
	Sequestration for non-claims based amounts (see instructions)		0 0	
	Interim payments	614, 030	6 0	
	Interim payments-PARHM or CHART Tentative settlement (for contractor use only)		0 0	20.
	Tentative settlement-PARHM or CHART (for contractor use only)			21.
	Balance due provider/program (line 19 minus lines 19.01, 19.02, 19.25, 20, and 2	21) 217, 92	5 0	
	Balance due provider/program-PARHM or CHART (see instructions)			22.
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub.	15-2, (	0 0	23.
	chapter 1, §115.2 Dural Community Versital Demonstration Device (C4104 Demonstration) Adjustment			-
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21s		1	200.
	Century Cures Act? Enter "Y" for yes or "N" for no.	L .		200.
-	Cost Reimbursement			
	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II,	line		201.
	66 (title XVIII hospital))	o 1.		
	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3 200 (title XVIII swing-bed SNF))	3, line		202.
	Total (sum of lines 201 and 202)			203.
	Medicare swing-bed SNF discharges (see instructions)			204.
	Computation of Demonstration Target Amount Limitation (N/A in first year of the	current 5-year demons	tration	
	period)			1005
	Medicare swing-bed SNF target amount Medicare swing bod SNF impatient routine cost can (line 205 times line 204)			205. 206.
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204) Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement		1	200.
	Program reimbursement under the §410A Demonstration (see instructions)			207.
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of	lines 1		208.
	and 3)			
	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)			209.
	Reserved for future use Comparision of PPS versus Cost Reimbursement			210.
	COMPATISTUT OF FES VEISUS COST REFINDULSEMENT			

	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1317	Period: From 01/01/2022 To 12/31/2022	Worksheet E-3 Part V Date/Time Prep 5/30/2023 1:05	pare
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COST	F REIMBURSEMENT		
00	Inpatient services			4, 053, 271	
00	Nursing and Allied Health Managed Care payment (see instruc	ctions)		0	
00	Organ acqui si ti on			0	
01	Cellular therapy acquisition cost (see instructions)			0	
00	Subtotal (sum of lines 1 through 3.01)			4, 053, 271	4
00 00	Primary payer payments			0	
00	Total cost (line 4 less line 5). For CAH (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES	)		4, 093, 804	0
	Reasonable charges				1
00	Routine service charges			0	1 7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	9
. 00	Total reasonable charges			0	
	Customary charges				
. 00	Aggregate amount actually collected from patients liable for	or payment for services on	a charge basis	0	111
. 00	Amounts that would have been realized from patients liable	for payment for services of	on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413.13	3(e)	_		
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	13
00	Total customary charges (see instructions)			0	
. 00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	15
~ ~	instructions)				
. 00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	ne 14) (see	0	16
. 00	instructions) Cost of physicians' services in a teaching hospital (see in	nstructions)		0	17
. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	1 ''
. 00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	1 18
. 00	Cost of covered services (sum of lines 6, 17 and 18)			4, 093, 804	19
. 00	Deductibles (exclude professional component)			304, 976	20
. 00	Excess reasonable cost (from line 16)			0	21
. 00	Subtotal (line 19 minus line 20 and 21)			3, 788, 828	22
. 00	Coinsurance			1, 556	23
. 00	Subtotal (line 22 minus line 23)			3, 787, 272	
. 00	Allowable bad debts (exclude bad debts for professional ser	rvices) (see instructions)		30, 032	
. 00	Adjusted reimbursable bad debts (see instructions)			19, 521	
. 00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		14, 344	
. 00	Subtotal (sum of lines 24 and 25, or line 26)			3, 806, 793	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instruction	i ons)		0	
. 98	Recovery of accelerated depreciation.			0	
. 99	Demonstration payment adjustment amount before sequestration	on		2 904 703	
00	Subtotal (see instructions) Sequestration adjustment (see instructions)			3, 806, 793 47, 966	
01		n			30
. 02	Sequestration adjustment-PARHM or CHART			0	30
00	Interim payments			3, 012, 297	
. 01	Interim payments-PARHM or CHART			5, 512, 271	31
	Tentative settlement (for contractor use only)			0	
. 00	Tentative settlement-PARHM or CHART (for contractor use onl	Ι y)		0	32
. 00 . 01	Balance due provider/program (line 30 minus lines 30.01, 30	57		746, 530	
. 01	Balance due provider/program-PARHM or CHART (lines 2, 3, 18 32.01)	8, and 26, minus lines 30.(	03, 31.01, and		33

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1317	Period: From 01/01/2022	Worksheet E-3 Part VII	6
			To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
		Title XIX	Hospi tal	Cost	
			Inpatient 1.00	Outpatient 2.00	-
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR X		2100	
~~	COMPUTATION OF NET COST OF COVERED SERVICES		477.004		
00	Inpatient hospital/SNF/NF services		477, 931	2 404 042	1
00 00	Medical and other services Organ acquisition (certified transplant programs only)		0	2, 484, 862	2
00	Subtotal (sum of lines 1, 2 and 3)		477, 931	2, 484, 862	
00	Inpatient primary payer payments		477,731	2, 404, 002	5
00	Outpatient primary payer payments		Ū	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		477, 931	2, 484, 862	
	COMPUTATION OF LESSER OF COST OR CHARGES			, ,	
	Reasonabl e Charges				
. 00	Routine service charges		0		8
00	Ancillary service charges		599, 348	11, 106, 559	
	Organ acquisition charges, net of revenue		0		10
	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		599, 348	11, 106, 559	12
. 00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for	services on a charge	0	0	13
	basis	6			
4.00	Amounts that would have been realized from patients liable for		n 0	0	14
- 00	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)	0,000000	0,00000	11
	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		0. 000000 599, 348	0.000000 11, 106, 559	
	Excess of customary charges over reasonable cost (complete onl	vifling 16 exceeds	121, 417	8, 621, 697	
. 00	line 4) (see instructions)	y IT THE TO EXCEEds	121,417	0, 021, 077	''
3. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lir	e 0	0	18
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	
1	Cost of physicians' services in a teaching hospital (see instr		0	0	
	Cost of covered services (enter the lesser of line 4 or line 1 PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be		477, 931 ders.	2, 484, 862	
	Other than outlier payments		0	0	22
	Outlier payments		0	0	
	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0		25
	Routine and Ancillary service other pass through costs		0		26
	Subtotal (sum of lines 22 through 26)		0	0	1
	Customary charges (title V or XIX PPS covered services only)		0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		477, 931	2, 484, 862	29
0. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		477, 931	2, 484, 862	
	Deducti bl es		0	2, 101, 002	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	
	Utilization review		0		35
6. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	477, 931	2, 484, 862	36
. 00	TO ZERO OUT MEDICALD		-477, 931	-2, 484, 862	37
	Subtotal (line 36 ± line 37)		0	0	
	Direct graduate medical education payments (from Wkst. E-4)		0		39
	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
	Interim payments		0	0	
	Balance due provider/program (line 40 minus line 41)		0	0	
3. 00	Protested amounts (nonallowable cost report items) in accordan	CE WITH CMS PUB 15-2,	0	0	43
	chapter 1, §115.2 OVERRI DES				1
					1

	Financial Systems GREENE COUNTY GE SHEET (If you are nonproprietary and do not maintain	Provider C		Peri od:	Worksheet G	
und-ty nly)	ype accounting records, complete the General Fund column			rom 01/01/2022 o 12/31/2022		par
		General Fund	Speci fi c	Endowment Fund	5/30/2023 1:0 Plant Fund	15 pi
		General Tunu	Purpose Fund		Franciscula	
1	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	3, 471, 847	'l C	ol	0	1
	Temporary investments	C			0	
	Notes receivable	C	) C	0 0	0	:
00	Accounts receivable	6, 443, 554	C	0 0	0	.
00	Other receivable	2, 430, 393	C C	0 0	0	
	Allowances for uncollectible notes and accounts receivable	C	) C	0 0	0	
	Inventory	546, 449		0	0	
	Prepaid expenses	295, 516		0	0	
	Other current assets Due from other funds				0	
	Total current assets (sum of lines 1-10)	13, 187, 759		-	0	
	FIXED ASSETS	13, 107, 733	1 <u></u>	л <u> </u>	0	ť i
	Land	624, 598	c c	) O	0	1:
	Land improvements	3, 485, 761		0	0	
. 00	Accumulated depreciation	-126, 396	) C	0 0	0	1
5.00	Buildings	11, 060, 650	) C	0 0	0	1
	Accumulated depreciation	-2, 167, 877	'  C	0	0	
	Leasehold improvements	C	) C	0 0	0	
	Accumulated depreciation	C		-	0	
	Fixed equipment	5, 119, 511		-	0	1
	Accumulated depreciation	-2, 273, 029		-	0	
	Automobiles and trucks			-	0	
	Accumulated depreciation Major movable equipment	4, 560, 920		0	0	
	Accumul ated depreciation	-1, 589, 209			0	1 -
	Mi nor equipment depreciable	-1, 309, 209			0	
	Accumulated depreciation	C		0	0	
	HIT designated Assets	C		0	0	
	Accumulated depreciation	C		0	0	
9.00	Mi nor equi pment-nondepreci abl e	C	) C	0 0	0	2
D. 00	Total fixed assets (sum of lines 12-29)	18, 694, 929	) C	0 0	0	30
	OTHER ASSETS		1			
	Investments	1, 206, 428			0	
	Deposits on Leases	C	0	0	0	
	Due from owners/officers	0 007 50/		0	0	
	Other assets	2,927,586		0	0	
	Total other assets (sum of lines 31-34)	4, 134, 014 36, 016, 702			0	
	Total assets (sum of lines 11, 30, and 35)  CURRENT LIABILITIES	30, 010, 702	. <u> </u>		0	- 3
- F	Accounts payable	1, 155, 467	' C	ol	0	3
	Salaries, wages, and fees payable	2, 463, 286			0	
	Payroll taxes payable	338, 164			0	
	Notes and Loans payable (short term)	1, 847, 296		0	0	
	Deferred income	C	) C	0 0	0	
2.00	Accelerated payments	C				42
3.00	Due to other funds	C	) C	0 0	0	4:
	Other current liabilities	2, 108, 159			0	
H	Total current liabilities (sum of lines 37 thru 44)	7, 912, 372	2 C	0 0	0	4
	LONG TERM LIABILITIES	-	-			4
	Mortgage payable	17 044 050		0	0	
	Notes payable	17, 246, 058			0	
	Unsecured Loans Other Long term Liabilities				0	
	Total long term liabilities (sum of lines 46 thru 49)	17, 246, 058			0	
	Total liabilities (sum of lines 45 and 50)	25, 158, 430			0	
+	CAPITAL ACCOUNTS	20, 100, 400		· <u> </u>	0	ſ
	General fund balance	10, 858, 272	,			15
	Specific purpose fund	,				5
	Donor created - endowment fund balance - restricted			0		5
	Donor created - endowment fund balance - unrestricted			0		5
5.00	Governing body created - endowment fund balance			0		5
	Plant fund balance - invested in plant				0	
8. 00	Plant fund balance - reserve for plant improvement,				0	5
	replacement, and expansion	40				_
	Total fund balances (sum of lines 52 thru 58)	10, 858, 272		0	0	
0.00	Total liabilities and fund balances (sum of lines 51 and	36, 016, 702	() C	ין 0	0	6

Heal th	Financial Systems G	REENE COUNTY GENI	ERAL HOSPITAL			In Lie	u of Form CMS-	2552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-1317		eriod: com 01/01/2022 0 12/31/2022	Worksheet G-7 Date/Time Pre 5/30/2023 1:0	epared:
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
							5 00	
1.00	Fund balances at beginning of period	1.00	2.00	3.00		4.00	5.00	1.00
$\begin{array}{c} 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	1, 389, 754 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 389, 754 1, 389, 754 10, 858, 272			0 0 0 0		$\begin{array}{c} 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10, 858, 272			0		19.00
		Endowment Fund	Pl ant	Fund				
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) INTERCOMPANY TRANSFERS	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	000000000000000000000000000000000000000	0 0 0 0 0 0		0 0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATE		AL HOSPITAL Provider CO		Peri od:	eu of Form CMS-: Worksheet G-2	
UTTE.				From 01/01/2022 To 12/31/2022	Parts I & II	pared:
	Cost Center Description		Inpatient 1.00	Outpatient 2.00	Total 3.00	
	PART I – PATIENT REVENUES		1.00	2.00	0.00	
	General Inpatient Routine Services					]
1.00	Hospi tal		2, 709, 0	18	2, 709, 018	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		2 700 0	10	2 700 010	9.00
10.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		2, 709, 0	10	2, 709, 018	10.00
11.00	INTENSIVE CARE UNIT		375, 0	76	375, 076	11.00
12.00	CORONARY CARE UNIT		375,0	/0	373,070	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of )	ines	375, 0	76	375, 076	
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		3, 084, 0	94	3, 084, 094	17.00
18.00	Ancillary services		10, 582, 0	29 119, 236, 306	129, 818, 335	18.00
19.00	Outpatient services			0 0	0	19.00
20.00	RURAL HEALTH CLINIC			0 5, 637, 963	5, 637, 963	20.00
20. 01	RURAL HEALTH CLINIC II			0 2, 092, 472		
20. 02	RURAL HEALTH CLINIC III			0 987, 263		
20. 03	RURAL HEALTH CLINIC IV			0 594, 537		
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE					25.00
26.00 27.00	OTHER (SPECIFY)			0	0	
27.00	Total patient revenues (sum of lines 17-27)(transfer column 3 *	to Wkst	13, 666, 1	23 128, 548, 541		•
20.00	G-3, line 1)	to wkst.	13,000,1	23 120, 340, 341	142, 214, 004	20.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			52, 989, 677		29.00
30.00	EXPENSES NOT INCLUDED ON WORKSHEET A		1, 238, 5			30.00
31.00				0		31.00
32.00				0		32.0
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			1, 238, 583		36.0
37.00	DEDUCT (SPECIFY)			0		37.0
38.00				0		38.00
39.00				0		39.00
40.00				0		40.0
41.00				0		41.00
42.00 43.00	Total deductions (sum of lines 37-41)	(there C				42.00
	Total operating expenses (sum of lines 29 and 36 minus line 42)	utransfer	1	54, 228, 260	1	43.00

Heal th	Financial Systems GREENE COUNTY GENE	RAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN: 15-1317	Period:	Worksheet G-3	
			From 01/01/2022 To 12/31/2022	Date/Time Prep	pared:
				5/30/2023 1:0	5 pm
1 00	Tatal anti-ant movement (from What C.O. Dant L. Jaluma O. Lin	- 20)		1.00	1 00
1.00 2.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin Less contractual allowances and discounts on patients' accoun			142, 214, 664 94, 318, 776	1.00 2.00
2.00	Net patient revenues (line 1 minus line 2)	its		47, 895, 888	2.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		54, 228, 260	4.00
5.00	Net income from service to patients (line 3 minus line 4)	43)		-6, 332, 372	5.00
0.00	OTHER I NCOME			0,002,012	0.00
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	servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00				0	14.00
15.00	<b>J J J J J J J J J J</b>			0	15.00
	Revenue from sale of medical and surgical supplies to other t	nan patients		0	16.00 17.00
	Revenue from sale of drugs to other than patients Revenue from sale of medical records and abstracts			0	17.00
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	18.00
	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
	Rental of vending machines			0	21.00
22.00				0	22.00
23.00				0	23.00
24.00				2, 287, 212	
24.50	COVID-19 PHE Funding			464, 353	24.50
25.00	Total other income (sum of lines 6-24)			2, 751, 565	
26.00	Total (line 5 plus line 25)			-3, 580, 807	26.00
	OTHER EXPENSES (SPECIFY)			0	27.00
	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, 580, 807	29.00

		COUNTY GE	NERAL HOSPITAL			u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1317	Peri od:	Worksheet M-1	
			Component	CCN: 15-8535	From 01/01/2022 To 12/31/2022		
						5/30/2023 1:0	5 pm
					RHC I		
		Compensati on	Other Costs	· ·	1 Reclassificati		
				+ 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	5.00	4.00	5.00	
1.00	Physi ci an	3, 053, 231	0	3, 053, 23	-1, 731, 569	1, 321, 662	1.00
2.00	Physician Assistant	0,000,201	0	0,000,20	0 0	0	2.00
3.00	Nurse Practitioner	0	0		0 749, 391	749, 391	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	0	0		0 0	0	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 88, 353	88, 353	
8.00	Laboratory Techni ci an	0	0		0 0	0	
9.00	Other Facility Health Care Staff Costs	0	0		0 852, 857	852, 857	9,00
10.00	Subtotal (sum of lines 1 through 9)	3, 053, 231	0	3, 053, 23			10.00
11.00	Physician Services Under Agreement	0	0	.,,	0 0	0	11.00
12.00	Physician Supervision Under Agreement	0	0		0 0	0	12.00
13.00	Other Costs Under Agreement	0	875, 768	875, 76	0 8	875, 768	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	875, 768	875, 76	0 8	875, 768	14.00
15.00	Medical Supplies	0	196, 559	196, 55	59 0	196, 559	15.00
16.00	Transportation (Health Care Staff)	0	26, 826	26, 82	26 0	26, 826	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	223, 385	223, 38	35 0	223, 385	
22.00	Total Cost of Health Care Services (sum of	3, 053, 231	1, 099, 153	4, 152, 38	-40, 968	4, 111, 416	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	_	_	1	-	-	
23.00	Pharmacy	0	0		0 0	-	
24.00	Dental	0	0		0 0	0	
25.00	Optometry	0	0		0 0	0	
25.01	Tel eheal th	0	0		0 0	0	
25.02	Chronic Care Management All other nonreimbursable costs	0	0		0 0	0	
26.00 27.00	Nonallowable GME costs	0	0		0 0	0	26.00
27.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	
20.00	through 27)	0	0		0	0	20.00
	FACILITY OVERHEAD			1			
29.00	Facility Costs	0	101, 731	101, 73	31 0	101, 731	29.00
30.00	Admi ni strati ve Costs	0	49, 497				
31.00	Total Facility Overhead (sum of lines 29 and	0	151, 228				1
	30)	Ū	, 220			,	
32.00	Total facility costs (sum of lines 22, 28	3, 053, 231	1, 250, 381	4, 303, 61	2 0	4, 303, 612	32.00
	and 31)			1			

		EENE COUNTY GEN				u of Form CMS	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CC	N: 15-1317	Period: From 01/01/2022	Worksheet M-	-1
			Component C	CN: 15-8535	To 12/31/2022	Date/Time Pr 5/30/2023 1:	
					RHC I		
		Adjustments	Net Expenses				
			or Allocation				
		(	col. 5 + col.				
		(	6)				
		6.00	7.00				
1 00	FACILITY HEALTH CARE STAFF COSTS	220 540	002 112				1 1 0
1.00 2.00	Physician Physician Assistant	-339, 549	982, 113 0				1.0
2.00 3.00	Nurse Practitioner	-37, 482	711, 909				3.0
4.00	Visiting Nurse	-37, 402	/11, 202				4.0
4.00 5.00	Other Nurse	0	0				5.0
5.00 5.00	Clinical Psychologist	0	0				6.0
7.00	Clinical Social Worker	-77, 398	10, 955				7.0
B. 00	Laboratory Techni ci an	0	10, 700				8.0
9.00	Other Facility Health Care Staff Costs	0	852, 857				9.0
10.00	Subtotal (sum of lines 1 through 9)	-454, 429	2, 557, 834				10.0
11.00	Physician Services Under Agreement	0	0				11.0
12.00	Physician Supervision Under Agreement	0	0				12.0
13.00	Other Costs Under Agreement	0	875, 768				13.0
14.00	Subtotal (sum of lines 11 through 13)	0	875, 768				14.0
15.00	Medical Supplies	0	196, 559				15.0
16.00	Transportation (Health Care Staff)	0	26, 826				16.0
17.00	Depreciation-Medical Equipment	0	0				17.0
18.00	Professional Liability Insurance	0	0				18.0
19.00	Other Health Care Costs	0	0				19.0
20. 00	Allowable GME Costs						20.0
21.00	Subtotal (sum of lines 15 through 20)	0	223, 385				21.0
22.00	Total Cost of Health Care Services (sum of	-454, 429	3, 656, 987				22.0
	lines 10, 14, and 21)						_
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00 24.00	Pharmacy Dental	0	0				23.0
		0	0				
25.00 25.01	Optometry Telehealth	0	0				25.0 25.0
25.01	Chronic Care Management	0	0				25.0
26.02	All other nonreimbursable costs	0	0				25.0
27.00	Nonallowable GME costs	0	0				20.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.0
20.00	through 27)	0	Ŭ				20.0
	FACILITY OVERHEAD						
29.00	Facility Costs	0	101, 731				29.0
30.00	Administrative Costs	0	90, 465				30.0
31.00	Total Facility Overhead (sum of lines 29 and	0	192, 196				31.0
	30)						
32.00	Total facility costs (sum of lines 22, 28	-454, 429	3, 849, 183				32.0
	and 31)						

		EENE COUNTY GE	NERAL HOSPITAL	N 45 4047		u of Form CMS-2	
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	JN: 15-1317	Period: From 01/01/2022	Worksheet M-1	
			Component (	CCN: 15-8533	To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
					RHC II		
		Compensation	Other Costs	Total (col.	1 Reclassi ficati	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	782, 555	0	782, 5	-367, 504	415, 051	1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	0	0		0 169, 376	169, 376	3.00
4.00	Visiting Nurse	0	0	1	0 0	0	4.00
5.00	Other Nurse	0	0		0 0	0	5.00
6.00	Clinical Psychologist	0	0		0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	
8.00	Laboratory Techni ci an	0	0		0 0	0	
9.00	Other Facility Health Care Staff Costs	0	0		0 198, 128	-	
10.00	Subtotal (sum of lines 1 through 9)	782, 555	0	782, 5		782, 555	
11.00	Physician Services Under Agreement	,02,000	0	702, 5	0 0	02,000	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
13.00	Other Costs Under Agreement	0	155, 505	155, 50		155, 505	
14.00	Subtotal (sum of lines 11 through 13)	0					
		0	155, 505			155, 505	
15.00	Medical Supplies	0	94, 043			94, 043	•
16.00	Transportation (Health Care Staff)	0	864	80	64 0	864	
17.00	Depreciation-Medical Equipment	0	0		0 0	0	
	Professional Liability Insurance	0	0		0 0	0	
19.00	Other Health Care Costs	0	0		0 0	0	
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	94, 907	94, 90		94, 907	
22.00	Total Cost of Health Care Services (sum of	782, 555	250, 412	1, 032, 90	67 0	1, 032, 967	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	
24.00	Dental	0	0		0 0	0	
25.00	Optometry	0	0		0 0	0	
25.01	Tel eheal th	0	0		0 0	0	
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)						
	FACILITY OVERHEAD						1
29.00	Facility Costs	0	71, 053	71, 0	53 0	71, 053	29.00
30.00	Administrative Costs	0	12, 665	12, 60	65 0	12, 665	30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	83, 718	83, 7	18 0	83, 718	31.00
	30)						
32.00	Total facility costs (sum of lines 22, 28	782, 555	334, 130	1, 116, 68	35 0	1, 116, 685	32.00
							1

NAL YS	Financial Systems GR IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CC	CN: 15-1317	Peri od:	Worksheet N	S-2552- I-1
IN LET O				CCN: 15-8533	From 01/01/2022 To 12/31/2022	Date/Time F 5/30/2023 1	repare
					RHC II		
			Net Expenses for Allocation (col. 5 + col.				
	-	6.00	6) 7.00				
	FACILITY HEALTH CARE STAFF COSTS	6.00	7.00		<u> </u>		_
. 00	Physi ci an	54, 513	469, 564				1.
. 00	Physi ci an Assi stant	01,010	0				2.
. 00	Nurse Practitioner	46, 563	215, 939				3.
. 00	Visiting Nurse	.0,000	2.0, 707				4.
. 00	Other Nurse	0	0				5.
. 00	Clinical Psychologist	0	0				6.
. 00	Clinical Social Worker	35, 390	35, 390				7.
. 00	Laboratory Techni ci an	33, 370	55, 570				8.
. 00	Other Facility Health Care Staff Costs	0	198, 128				9.
. 00 D. 00	Subtotal (sum of lines 1 through 9)	136, 466	919, 021				10.
	5,						111.
1.00	Physician Services Under Agreement	0	0				
2.00	Physician Supervision Under Agreement	0					12
3.00	Other Costs Under Agreement	0	155, 505				13
4.00	Subtotal (sum of lines 11 through 13)	0	155, 505				14
5.00	Medical Supplies	0	94, 043				15
6.00	Transportation (Health Care Staff)	0	864				16
7.00	Depreciation-Medical Equipment	0	0				17
B. 00	Professional Liability Insurance	0	0				18
9.00	Other Health Care Costs	0	0				19
0.00	Allowable GME Costs						20
1.00	Subtotal (sum of lines 15 through 20)	0	94, 907				21
2.00	Total Cost of Health Care Services (sum of	136, 466	1, 169, 433				22
	lines 10, 14, and 21)						
3. 00	COSTS OTHER THAN RHC/FQHC SERVICES Pharmacy	0	0				23
4.00	Dental	0	0				23
		0	0				
5.00	Optometry	0	0				25
5.01	Tel eheal th	0	0				
5.02	Chronic Care Management	0	0				25
6.00	All other nonreimbursable costs	0	0				26
7.00	Nonallowable GME costs						27
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.
	through 27)						
0 00	FACILITY OVERHEAD		71 050				- 20
9.00	Facility Costs	0	71, 053				29.
0.00	Administrative Costs	0	12, 665				30.
1.00	Total Facility Overhead (sum of lines 29 and	0	83, 718				31
2.00	30) Tatal facility costs (com of lines 22, 20	10/ 1//	1 050 454				
1 (1(1)	Total facility costs (sum of lines 22, 28	136, 466	1, 253, 151				32.

near th	Financial Systems GR	EENE COUNTY GE	NERAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1317	Peri od:	Worksheet M-1	
			Company	20N 15 0504	From 01/01/2022		
			Component	CCN: 15-8534	To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
					RHC III	5/30/2023 1.0	
		Compensation	Other Costs	Total (col	1 Recl assi fi cati	Recl assi fi ed	
		compensation	01101 00313	+ col. 2)	ons	Trial Balance	
					0113	$(col \cdot 3 + col \cdot$	
						4)	
		1.00	2.00	3.00	4,00	5.00	
	FACILITY HEALTH CARE STAFF COSTS	1100	2100	0.00		0.00	
1.00	Physi ci an	490, 874	0	490, 8	74 - 339, 966	150, 908	1 1.00
2.00	Physician Assistant	0	0	.,,,,,	0 104, 680		•
3.00	Nurse Practitioner	0	0		0 235, 286		•
4.00	Visiting Nurse	0	0		0 200, 200	0	•
5.00	Other Nurse	0	0			0	•
6.00	Clinical Psychologist	0	0			0	
7.00	Clinical Social Worker	0	0			0	
7.00 8.00	Laboratory Techni ci an	0	0			0	
		0	0				•
9.00	Other Facility Health Care Staff Costs	0	0	100.0		-	
10.00	Subtotal (sum of lines 1 through 9)	490, 874	0	490, 8		490, 874	
11.00	Physician Services Under Agreement	0	0		0 0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
13.00	Other Costs Under Agreement	0	98, 834			98, 834	•
14.00	Subtotal (sum of lines 11 through 13)	0	98, 834	98, 8		98, 834	
15.00	Medical Supplies	0	70, 476			70, 476	•
16.00	Transportation (Health Care Staff)	0	2, 474	2, 4	74 C	2, 474	16.00
17.00	Depreciation-Medical Equipment	0	0		0 0	0	17.00
18.00	Professional Liability Insurance	0	0		0 0	0	18.00
19.00	Other Health Care Costs	0	0		0 0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	72, 950	72, 9	50 C	72, 950	21.00
22.00	Total Cost of Health Care Services (sum of	490, 874	171, 784	662, 6	58 C	662, 658	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0		0 0	0	23.00
24.00	Dental	0	0		0 0	0	24.00
25.00	Optometry	0	0		0 0	0	25.00
25.01	Tel eheal th	0	0		0 0	0	25.01
25.02	Chronic Care Management	0	0		0 0	0	25.02
26.00	All other nonreimbursable costs	0	0		0 0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)	-			-		
	FACILITY OVERHEAD			I			
29.00	Facility Costs	0	54, 833	54, 8	33 C	54, 833	29.00
30.00	Administrative Costs	o	12, 832				•
31.00	Total Facility Overhead (sum of lines 29 and	0	67,665			67,665	•
21.00	30)	Ű	0.,000			.,	
	Total facility costs (sum of lines 22, 28	490, 874	239, 449	730, 32	23 0	730, 323	32.00
32.00							

	Financial Systems GR IS OF HOSPITAL-BASED RHC/FQHC COSTS	EENE COUNTY GE	Provi der C		Peri od:	u of Form CMS Worksheet M	
ANALYS	TS OF HUSPITAL-BASED RHC/FUHC CUSTS		Provider C	JN: 15-1317	From 01/01/2022	worksneet M	- 1
			Component (	CCN: 15-8534	To 12/31/2022	Date/Time Pr 5/30/2023 1:	
					RHC III	373072023 1	. 03 piii
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
		6.00	6) 7.00				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00				
. 00	Physi ci an	-10,239	140, 669				1.
2.00	Physician Assistant	0	104, 680				2.
. 00	Nurse Practitioner	-9, 081	226, 205				3.
. 00	Visiting Nurse	0	0				4.
5.00	Other Nurse	0	0				5.
. 00	Clinical Psychologist	0	0				6.
7.00	Clinical Social Worker	5, 870	5, 870				7.
8.00	Laboratory Techni ci an	0	0				8.
. 00	Other Facility Health Care Staff Costs	0	0				9.
0.00	Subtotal (sum of lines 1 through 9)	-13, 450	477, 424				10.
1.00	Physician Services Under Agreement	0	0				11.
2.00	Physician Supervision Under Agreement	0	0				12.
3.00	Other Costs Under Agreement	0	98, 834				13.
4.00	Subtotal (sum of lines 11 through 13)	0					14.
5.00	Medical Supplies	0	70, 476				15.
6.00	Transportation (Health Care Staff)	0	2, 474				16.
7.00	Depreciation-Medical Equipment	0	0				17.
8.00	Professional Liability Insurance	0	0				18.
9.00	Other Health Care Costs	0	0				19.
0.00	Allowable GME Costs	-					20.
1.00	Subtotal (sum of lines 15 through 20)	0	,				21.
2.00	Total Cost of Health Care Services (sum of	-13, 450	649, 208				22.
	Li nes 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
3. 00	Pharmacy	0	0				23.
4.00	Dental	0	-				23.
5.00	Optometry	0					25.
5.01	Tel eheal th	0	0				25.
5.02	Chronic Care Management	0	-				25.
6.00	All other nonreimbursable costs	0	0				26.
7.00	Nonallowable GME costs						27.
8.00	Total Nonreimbursable Costs (sum of lines 23	0	0				28.
	through 27)						
	FACILITY OVERHEAD					-	
9.00	Facility Costs	0					29.
0.00	Administrative Costs	0					30.
1.00	Total Facility Overhead (sum of lines 29 and	0	67, 665				31.
_	30)						
32.00	Total facility costs (sum of lines 22, 28	-13, 450	716, 873				32.
	and 31)						

		EENE COUNTY GE	NERAL HOSPITAL			u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provider C	CN: 15-1317	Period: From 01/01/2022	Worksheet M-1	
			Component (	CCN: 15-8538	To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
					RHC IV	0,00,2020 110	o p
		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, 271	0	342, 2	71 -218, 672	123, 599	1.00
2.00	Physician Assistant	0	0		0 0	0	2.00
3.00	Nurse Practitioner	0	0		0 218, 672	218, 672	3.00
4.00	Visiting Nurse	0	0		0 0	0	4.00
5.00	Other Nurse	0	0		0 0	0	5.00
6.00	Clinical Psychologist	0	0	1	0 0	0	6.00
7.00	Clinical Social Worker	0	0		0 0	0	7.00
8.00	Laboratory Techni ci an	0	0		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	0		0 0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	342, 271	0	342, 2	71 0	342, 271	10.00
11.00	Physician Services Under Agreement	0	0		0 0	0	
12.00	Physician Supervision Under Agreement	0	0		0 0	0	
13.00	Other Costs Under Agreement	0	79,047	79, 04	0	79,047	
14.00	Subtotal (sum of lines 11 through 13)	0	79,047	79, 04		79,047	
15.00	Medical Supplies	0	32, 705			32, 705	
16.00	Transportation (Health Care Staff)	0	3, 051	3, 05		3, 051	
17.00	Depreciation-Medical Equipment	0	3,031	5, 0,		0	
	Professional Liability Insurance	0	0			0	
19.00	Other Health Care Costs	0	0			0	
20.00	Allowable GME Costs	0	0		0 0	0	20.00
		0	25 754	25 71		25 754	
21.00	Subtotal (sum of lines 15 through 20)	0	35, 756			35, 756	
22.00	Total Cost of Health Care Services (sum of	342, 271	114, 803	457, 0	/4 0	457, 074	22.00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						-
23.00	Pharmacy	0	0		0 0	0	23.00
23.00	Dental	0	0		0 0	0	
24.00	Optometry	0	0		0 0	0	
25.00	Tel eheal th	0	0		0 0	0	
25.01	Chronic Care Management	0	0		0 0	0	
	5	0	0		0 0	0	
26.00	All other nonreimbursable costs	0	0		0 0	0	
27.00	Nonallowable GME costs		0				27.0
28.00	Total Nonreimbursable Costs (sum of lines 23	0	0		0 0	0	28.00
	through 27)						-
20.00	FACILITY OVERHEAD	0	24.000	24.00	03 0	24.202	20.00
29.00	Facility Costs	0	34, 203			,	
30.00	Administrative Costs	0	8, 979			8, 979	
31.00	Total Facility Overhead (sum of lines 29 and	0	43, 182	43, 18	32 0	43, 182	31.0
22.00	30) Tatal facility costs (sum of lines 22, 20	242 274	457 005	F00 0		F00 05/	22.0
32.00	Total facility costs (sum of lines 22, 28	342, 271	157, 985	500, 25	0 0	500, 256	32.00
	and 31)			I	I		I

		EENE COUNTY GE				u of Form CMS	
ANALYSIS	S OF HOSPITAL-BASED RHC/FQHC COSTS		Provider CC	CN: 15-1317	Period: From 01/01/2022	Worksheet M-	-1
			Component (	CCN: 15-8538	To 12/31/2022	Date/Time Pr 5/30/2023 1:	
					RHC IV		
		Adjustments	Net Expenses				
			for Allocation				
			(col. 5 + col.				
			6)				
		6.00	7.00				
	ACILITY HEALTH CARE STAFF COSTS	-35,021	00 570				1.0
	Physician Physician Assistant	-35, 021	88, 578 0				2.0
	Nurse Practitioner	0	218, 672				3.0
	Visiting Nurse	0	210,072				4.0
	Other Nurse	0	0				5.0
	Clinical Psychologist	0	0				6.0
	Clinical Social Worker	36, 138	36, 138				7.0
1	Laboratory Techni ci an	30, 130	0				8.0
	Other Facility Health Care Staff Costs	0	0				9.0
	Subtotal (sum of lines 1 through 9)	1, 117	343, 388				10.
	Physician Services Under Agreement	1, 117	043, 500				111.0
	Physician Supervision Under Agreement	0	0				12.0
	Other Costs Under Agreement	0	79.047				13.
	Subtotal (sum of lines 11 through 13)	0	79,047				14.
	Medical Supplies	0	32, 705				15.0
	Transportation (Health Care Staff)	0	3, 051				16.
	Depreciation-Medical Equipment	0	0,001				17.0
	Professional Liability Insurance	0	0				18.
	Other Health Care Costs	0	0				19.0
	Allowable GME Costs	Ū	U				20.0
	Subtotal (sum of lines 15 through 20)	0	35, 756				21.0
	Total Cost of Health Care Services (sum of	1, 117	458, 191				22. (
	lines 10, 14, and 21)	.,					
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00 F	Pharmacy	0	0				23. (
24.00 [0	Dental	0	0				24. (
25.00 0	Optometry	0	0				25.
5. 01 T	Tel eheal th	0	0				25.
25.02 0	Chronic Care Management	0	0				25.
. 00 A	All other nonreimbursable costs	0	0				26.
27.00 N	Nonallowable GME costs						27.
	Total Nonreimbursable Costs (sum of lines 23	0	0				28. (
	through 27)						_
	ACILITY OVERHEAD						
	Facility Costs	0	34, 203				29.
	Administrative Costs	0	8, 979				30.
	Total Facility Overhead (sum of lines 29 and	0	43, 182				31.0
	30)						
	Total facility costs (sum of lines 22, 28	1, 117	501, 373				32.0
a	and 31)						

	Financial Systems	GREENE COUNTY GE				u of Form CMS-2	
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre	nared
			component	CCN. 13-0333	10 12/31/2022	5/30/2023 1:0	
					RHC I		•
		Number of FTE	Total Visits	Producti vi ty	Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
. 00	Physi ci an	3. 55			1 4		1.00
. 00	Physician Assistant	0.00			1 0		2.00
8.00	Nurse Practitioner	6. 03			1 6		3.00
. 00	Subtotal (sum of lines 1 through 3)	9. 58			10		
. 00	Visiting Nurse	0.00				0	5.0
. 00	Clinical Psychologist	0.00				0	6.0
. 00	Clinical Social Worker	0. 13				79	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
. 02	Diabetes Self Management Training (FQHC	0.00	0	)		0	7.02
	onl y)						
8.00	Total FTEs and Visits (sum of lines 4	9. 71	25, 028	8		25, 028	8.00
	through 7)					_	
9.00	Physician Services Under Agreements		C	)		0	9.00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPI TAL-BASE	D RHC/FQHC SEF	RVI CES		1.00	
0. 00	Total costs of health care services (from )					3, 656, 987	10.00
1.00	Total nonreimbursable costs (from Wkst. M-	1, col. 7, line 2	28)				11.0
2.00	Cost of all services (excluding overhead)	(sum of lines 10	and 11)			3, 656, 987	12.00
3.00	Ratio of hospital-based RHC/FQHC services					1.000000	
4.00	Total hospital-based RHC/FQHC overhead - (1			ne 31)		192, 196	
5.00	Parent provider overhead allocated to facil					1, 649, 274	15.00
6.00	Total overhead (sum of lines 14 and 15)	5.	-			1, 841, 470	
7.00	Allowable GME overhead (see instructions)					0	17.0
8.00	Enter the amount from line 16					1, 841, 470	18.0
9.00	Overhead applicable to hospital-based RHC/I	-QHC services (li	ne 13 x line 1	8)		1, 841, 470	19.00
~ ~~		(FOUR 1	<u> </u>				0.0.00

 20.00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 5, 498, 457
 20.00

	Financial Systems	GREENE COUNTY GE				eu of Form CMS-2	
<b>ALLOCA</b>	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Peri od:	Worksheet M-2	
			Component		From 01/01/2022 To 12/31/2022	Date/Time Pre	nared
			component	CON. 13 0333	10 12/31/2022	5/30/2023 1:0	
					RHC II		
		Number of FTE	Total Visits	Producti vi ty	/ Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons		•				
. 00	Physi ci an	1. 51			1 2		1.0
. 00	Physician Assistant	0.00			1 0		2.0
. 00	Nurse Practitioner	1. 41			1 1		3.0
. 00	Subtotal (sum of lines 1 through 3)	2. 92			3	8, 589	4.C
. 00	Visiting Nurse	0.00				0	5. C
. 00	Clinical Psychologist	0.00				0	6.0
. 00	Clinical Social Worker	0. 54		1		426	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.C
. 02	Diabetes Self Management Training (FQHC	0.00	0 0			0	7.0
	only)						
8.00	Total FTEs and Visits (sum of lines 4	3.46	9, 015			9, 015	8.0
	through 7)						
. 00	Physician Services Under Agreements		0			0	9.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL-BASE	ED RHC/FOHC SER	VICES		1.00	
0.00	Total costs of health care services (from					1, 169, 433	10.0
	Total nonreimbursable costs (from Wkst. M-		. ,				11.0
	Cost of all services (excluding overhead)		,			1, 169, 433	12.0
3.00	Ratio of hospital -based RHC/FQHC services					1.000000	
4.00	Total hospital-based RHC/FQHC overhead - (			ne 31)		83, 718	14.0
5.00	Parent provider overhead allocated to faci			,		630, 936	
6.00	Total overhead (sum of lines 14 and 15)					714, 654	
7.00	Allowable GME overhead (see instructions)					0	
8.00	Enter the amount from line 16					714, 654	18.0
9.00	Overhead applicable to hospital-based RHC/	FQHC services (li	ne 13 x line 1	8)		714, 654	19.0
	Total allowable east of been tal based DUC					1 004 007	

 20.00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 1,884,087
 20.00

	Financial Systems	GREENE COUNTY GE				u of Form CMS-2	
LLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQH	C SERVI CES	Provider C		Period: From 01/01/2022	Worksheet M-2	
			Component (		To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
					RHC III		
	·	Number of FTE	Total Visits	Productivity	/ Minimum Visits	Greater of	
		Personnel		Standard (1)	(col. 1 x col. 3)	col. 2 or col. 4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons						
. 00	Physi ci an	0.44	984		1 0		1.00
2.00	Physician Assistant	0.37	0		1 0		2.00
. 00	Nurse Practitioner	1.65	3, 495		1 2		3.00
. 00	Subtotal (sum of lines 1 through 3)	2.46	4, 479		2	4, 479	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
. 00	Clinical Psychologist	0.00	0			0	6.0
. 00	Clinical Social Worker	0.10	58			58	7.0
. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	7.0
. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7.02
. 00	Total FTEs and Visits (sum of lines 4 through 7)	2.56	4, 537			4, 537	8. 0
. 00	Physician Services Under Agreements		0			0	9.0
. 00			0			0	7.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE	TO HOSPITAL-BASE	D RHC/FQHC SER	VICES			
0.00	Total costs of health care services (from	Wkst. M-1, col. 7	7, line 22)			649, 208	10.0
1.00	Total nonreimbursable costs (from Wkst. M	-1, col. 7, line 2	28)			0	11.0
2.00	Cost of all services (excluding overhead)	(sum of lines 10	and 11)			649, 208	12.0
3.00	Ratio of hospital-based RHC/FQHC services	(line 10 divided	by line 12)			1.000000	13.0
4.00	Total hospital-based RHC/FQHC overhead -	(from Worksheet. N	<i>I</i> -1, col. 7, li	ne 31)		67, 665	14.0
5.00	Parent provider overhead allocated to faci	lity (see instruc	ctions)			393, 771	15.0
6.00	Total overhead (sum of lines 14 and 15)					461, 436	16. 0
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					461, 436	
	Overhead applicable to hospital-based RHC.					461, 436	
20.00	Total allowable cost of hospital-based RHG	C/FQHC services (s	sum of lines 10	and 19)		1, 110, 644	20.00

	Financial Systems	GREENE COUNTY GE				eu of Form CMS-2	
<b>ALLOCAT</b>	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Peri od:	Worksheet M-2	
			Component	CCN: 15-8538	From 01/01/2022 To 12/31/2022	Date/Time Pre	narodi
			component	CON. 15 0550	10 12/31/2022	5/30/2023 1:0	
					RHC IV		
		Number of FTE	Total Visits		/ Minimum Visits		
		Personnel		Standard (1)	(col. 1 x col.	col. 2 or col.	
					3)	4	
		1.00	2.00	3.00	4.00	5.00	
	VISITS AND PRODUCTIVITY						-
	Posi ti ons		1	1	-		
	Physi ci an	0. 90			1		1.0
	Physician Assistant	0.00			1 0		2.0
	Nurse Practitioner	2. 21			1 2		3.0
	Subtotal (sum of lines 1 through 3)	3. 11		1	3	2, 143	
	Visiting Nurse	0.00				0	
	Clinical Psychologist	0.00				0	6.0
	Clinical Social Worker	0.52		1		435	
	Medical Nutrition Therapist (FQHC only)	0.00					
	Diabetes Self Management Training (FQHC only)	0.00		,		0	/.0
	Total FTEs and Visits (sum of lines 4	3. 63	2, 578			2, 578	8.0
	through 7)	5.05	2,370			2, 370	0.0
	Physician Services Under Agreements		0			0	9.0
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE			VI CES			
0.00	Total costs of health care services (from	Wkst. M-1, col. 7	7, line 22)			458, 191	10. C
1.00	Total nonreimbursable costs (from Wkst. M-	1, col. 7, line 2	28)			0	11. C
	Cost of all services (excluding overhead)	•	,			458, 191	
	Ratio of hospital-based RHC/FQHC services	•	,			1.000000	
	Total hospital-based RHC/FQHC overhead - (			ne 31)		43, 182	
	Parent provider overhead allocated to faci	lity (see instruc	ctions)			356, 144	
	Total overhead (sum of lines 14 and 15)					399, 326	
	Allowable GME overhead (see instructions)						17.0
	Enter the amount from line 16			- >		399, 326	
	Overhead applicable to hospital-based RHC/					399, 326	

 20.00
 Total allowable cost of hospital-based RHC/FQHC services (sum of lines 10 and 19)
 857, 517
 20.00

LCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1317	Peri od:	Worksheet M-3	
RVICES	Component CCN: 15-8535	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
	Title XVIII	RHC I	0/00/2020 110	<u> </u>
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES	n Wkat M 2 Lina 20)		E 400 4E7	1 1.
OO Total Allowable Cost of hospital-based RHC/FQHC Services (from OC Cost of injections/infusions and their administration (from Ww			5, 498, 457 305, 844	
00 Total allowable cost excluding injections/infusions (line 1 mi	· · · · ·		5, 192, 613	
00 Total Visits (from Wkst. M-2, column 5, line 8)	nus i ne z)		25, 028	
00 Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 9)		20, 020	
00 Total adjusted visits (line 4 plus line 5)			25, 028	
00 Adjusted cost per visit (line 3 divided by line 6)			207.47	7
		Cal cul ati on		
		Rate Period	Rate Period 1	
		N/A	(01/01/2022	
			through	
			12/31/2022)	
		1.00	2.00	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	220.63	
00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	207.47	9
.00 Program covered visits excluding mental health services (from	contractor records)	0	3, 672	10
.00 Program cost excluding costs for mental health services (line	-	0	761, 830	
.00 Program covered visits for mental health services (from contra	-	0	0	
.00 Program covered cost from mental health services (line 9 x lir		0	0	13
.00 Limit adjustment for mental health services (see instructions)	)	0	0	14
.00 Graduate Medical Education Pass Through Cost (see instructions	5)			15
.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	761, 830	16
.01 Total program charges (see instructions)(from contractor's rec	-		704, 137	
.02 Total program preventive charges (see instructions)(from provi	-		95, 307	
.03 Total program preventive costs ((line 16.02/line 16.01) times			103, 116	
. 04 Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		465, 715	16
(Titles V and XIX see instructions.)		0	E40 021	14
.05 Total program cost (see instructions) .00 Primary payer amounts		0	568, 831 0	
.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		76, 570	
records)			70, 370	
.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		106, 544	19
records) .00 Net Medicare cost excluding vaccines (see instructions)			568, 831	20
.00 Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		92, 447	
.00 Total reimbursable Program cost (line 20 plus line 21)	M 4, 1111C 10)		661, 278	
. 00 Allowable bad debts (see instructions)			001,270	23
.01 Adjusted reimbursable bad debts (see instructions)			0	
.00 Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25
.50 Pioneer ACO demonstration payment adjustment (see instructions	5)		0	25
.99 Demonstration payment adjustment amount before sequestration			0	
.00 Net reimbursable amount (see instructions)			661, 278	
. 01 Sequestration adjustment (see instructions)			8, 332	
. 02 Demonstration payment adjustment amount after sequestration			0	
.00 Interim payments			600, 181	27
.00 Tentative settlement (for contractor use only)	22 and $20$			
.00 Balance due component/program (line 26 minus lines 26.01, 26.0 .00 Protested amounts (nonallowable cost report items) in accordar			52, 765 0	
.00  Protested amounts (nonallowable cost report items) in accordar	ICE WILLI GWS PUD. 15-11,		0	30

S (from Wkst om Wkst. M e 1 minus I n 5, line 9 §20.6 or	your contractor) actor records) ne 10) records) ) * records)	RHC II	Date/Time Pre 5/30/2023 1:0 1.00 1,884,087 286,310 1,597,777 9,015 07,015 177.24 of Limit (1) Rate Period 1 (01/01/2022 through 12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 298,649 357,713 10,417	5 pm 1.0 2.0 3.0 3.0 4.0 5.0 6.0 7.0 7.0 10.0 11.0 12.0 10.0 11.0 12.0 10.0 11.0 12.0 10.0 11.0 10.
(from Wkst om Wkst. M 1 minus I 5, line 9 §20.6 or \$20.6 or tine 9 x I contractor x line 12) ions) 1, 2 and 3 s records) provider's imes line	your contractor) actor records) ne 10) records) * records)	Cal cul ati on Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	1.00 1,884,087 286,310 1,597,777 9,015 0 9,015 177.24 of Limit (1) Rate Period 1 (01/01/2022 through 12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 298,649 357,713 10,417	1. (2. () 3. () 4. () 5. () 6. () 7.
(from Wkst om Wkst. M 1 minus I 5, line 9 §20.6 or \$20.6 or tine 9 x I contractor x line 12) ions) 1, 2 and 3 s records) provider's imes line	-4, line 15) ine 2) ) your contractor) actor records) ine 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	1, 884, 087 286, 310 1, 597, 777 9, 015 0 9, 015 177. 24 of Li mi t (1) Rate Peri od 1 (01/01/2022 through 12/31/2022) 2. 00 185. 01 177. 24 1, 685 298, 649 0 0 298, 649 357, 713 10, 417	2. 3. 4. 5. 6. 7. 7. 8. 9. 9. 10. 11. 12. 13. 14. 15. 16. 16.
(from Wkst om Wkst. M 1 minus I 5, line 9 §20.6 or \$20.6 or tine 9 x I contractor x line 12) ions) 1, 2 and 3 s records) provider's imes line	-4, line 15) ine 2) ) your contractor) actor records) ine 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	1, 884, 087 286, 310 1, 597, 777 9, 015 0 9, 015 177. 24 of Li mi t (1) Rate Peri od 1 (01/01/2022 through 12/31/2022) 2. 00 185. 01 177. 24 1, 685 298, 649 0 0 298, 649 357, 713 10, 417	2. 3. 4. 5. 6. 7. 7. 8. 9. 9. 10. 11. 12. 13. 14. 15. 16. 16.
(from Wkst om Wkst. M 1 minus I 5, line 9 §20.6 or \$20.6 or tine 9 x I contractor x line 12) ions) 1, 2 and 3 s records) provider's imes line	-4, line 15) ine 2) ) your contractor) actor records) ine 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	286, 310 1, 597, 777 9, 015 0 9, 015 177. 24 of Limit (1) Rate Period 1 (01/01/2022 through 12/31/2022) 2.00 185.01 177. 24 1, 685 298, 649 0 0 0 298, 649 357, 713 10, 417	2. 3. 4. 5. 6. 7. 7. 8. 9. 9. 10. 11. 12. 13. 14. 15. 16. 16.
\$20.6 or \$20.6 or \$20.6 or from contra- line 9 x l contractor x line 12) ions) 1, 2 and 3 s records) provider's imes line	-4, line 15) ine 2) ) your contractor) actor records) ine 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	286, 310 1, 597, 777 9, 015 0 9, 015 177. 24 of Limit (1) Rate Period 1 (01/01/2022 through 12/31/2022) 2.00 185.01 177. 24 1, 685 298, 649 0 0 0 298, 649 357, 713 10, 417	2. 3. 4. 5. 6. 7. 7. 10. 11. 12. 13. 14. 15. 16. 16.
\$20.6 or \$20.6 or \$20.6 or tine 9 x l contractor x line 12) ions) tions) 1, 2 and 3 s records) provider's imes line	your contractor) actor records) ne 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	1, 597, 777 9, 015 0 9, 015 177. 24 of Limit (1) Rate Period 1 (01/01/2022) through 12/31/2022) 2. 00 185. 01 177. 24 1, 685 298, 649 0 0 0 0 298, 649 357, 713 10, 417	3.4. 5.6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 16.
\$20.6 or \$20.6 or from contra line 9 x l contractor x line 12) ions) 1, 2 and 3 s records) provider's imes line	your contractor) actor records) ne 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	9,015 0 9,015 177.24 of Limit (1) Rate Period 1 (01/01/2022 through 12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 0 298,649 357,713 10,417	4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 16.
\$20.6 or from contr line 9 x l contractor x line 12) ions) tions) 1, 2 and 3 s records) provider's imes line	your contractor) actor records) ine 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	0 9,015 177.24 of Limit (1) Rate Period 1 (01/01/2022 through 12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 298,649 357,713 10,417	5. 6. 7. 10. 11. 12. 13. 14. 15. 16. 16.
\$20.6 or from contr line 9 x l contractor x line 12) ions) tions) 1, 2 and 3 s records) provider's imes line	your contractor) actor records) ine 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	177.24 of Limit (1) Rate Period 1 (01/01/2022 through 12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 298,649 357,713 10,417	6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 16.
from contra- line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's imes line	actor records) ne 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	of Limit (1) Rate Period 1 (01/01/2022 through 12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 298,649 357,713 10,417	8 9 10 11 12 13 14 15 16 16
from contra- line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's imes line	actor records) ne 10) records) ) * records)	Rate Peri od N/A 1.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	Rate Period 1 (01/01/2022 through 12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 0 298,649 357,713 10,417	9 10 11 12 13 14 15 16 16
from contra- line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's imes line	actor records) ne 10) records) ) * records)	N/A 1.00 0.000 0.00	(01/01/2022 through 12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 298,649 357,713 10,417	9 10 11 12 13 14 15 16 16
from contra- line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's imes line	actor records) ne 10) records) ) * records)		through 12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 0 298,649 357,713 10,417	9. 10. 11. 12. 13. 14. 15. 16. 16.
from contra- line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's imes line	actor records) ne 10) records) ) * records)		12/31/2022) 2.00 185.01 177.24 1,685 298,649 0 0 0 298,649 357,713 10,417	9. 10. 11. 12. 13. 14. 15. 16. 16.
from contra- line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's imes line	actor records) ne 10) records) ) * records)		2.00 185.01 177.24 1,685 298,649 0 0 0 0 298,649 357,713 10,417	9 10 11 12 13 14 15 16 16
from contra- line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's imes line	actor records) ne 10) records) ) * records)		185. 01 177. 24 1, 685 298, 649 0 0 0 298, 649 357, 713 10, 417	9 10 11 12 13 14 15 16 16
from contra- line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's imes line	actor records) ne 10) records) ) * records)	0.00 0 0 0 0 0 0 0 0 0 0 0 0 0	177. 24 1, 685 298, 649 0 0 298, 649 298, 649 357, 713 10, 417	9 10 11 12 13 14 15 16 16
line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's cimes line	records)		1, 685 298, 649 0 0 298, 649 298, 649 357, 713 10, 417	10 11 12 13 14 15 16
line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's cimes line	records)		298, 649 0 0 298, 649 357, 713 10, 417	11 12 13 14 15 16 16
line 9 x l contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's cimes line	records)		298, 649 0 0 298, 649 357, 713 10, 417	11 12 13 14 15 16 16
contractor x line 12) cions) tions) 1, 2 and 3 s records) provider's cimes line	records) ) * records)	C C	0 0 298, 649 357, 713 10, 417	12 13 14 15 16 16
ions) tions) 1, 2 and 3 s records) provider's imes line	records)	C	0 298, 649 357, 713 10, 417	14 15 16 16
tions) 1, 2 and 3 s records) provider's imes line	records)	C	298, 649 357, 713 10, 417	15 16 16
1, 2 and 3 s records) provider's imes line	records)	O	357, 713 10, 417	16 16
s records) provider's imes line	records)	C	357, 713 10, 417	16
provider's imes line	,		10, 417	
imes line	,			
	16)			
10.03 200	10) +: mag 00)		8, 697	
	18) times . 80)		194, 274	16
		0	202, 971	16
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ons) (from	contractor		47, 110	
, ,				
uctions) (f	rom contractor		60, 036	19
			202, 971	20
/kst. M-4,	ine 16)		89, 476	
			292, 447	
			0	23
			0	23
instructio	ns)		0	
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ion				
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			207, 040	
26.02,27	and 28)		79, 116	
uc at	ation	uctions) ation	uctions) ation	Lion 00 uctions) 00 292, 447 3, 685 0 209, 646

LCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1317	Peri od:	Worksheet M-3	
RVICES	Component CCN: 15-8534	From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 1:09	
	Title XVIII	RHC III		
			1.00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES			1 110 / 11	
Total Allowable Cost of hospital-based RHC/FQHC Services (from			1, 110, 644	
Cost of injections/infusions and their administration (from W			57,635	
00  Total allowable cost excluding injections/infusions (line 1 mi 00  Total Visits (from Wkst. M-2, column 5, line 8)	nus i i ne 2)		1, 053, 009 4, 537	
00 Physicians visits under agreement (from Wkst. M-2, column 5, I	ine 0)		4, 537	
Total adjusted visits (line 4 plus line 5)	The 9)		4, 537	6.
00 Adjusted cost per visit (line 3 divided by line 6)			232.09	
The survice by the of		Cal cul ati on		/.
		Rate Period	Rate Period 1	
		N/A	(01/01/2022	
			through	
			12/31/2022)	
		1.00	2.00	
20 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	6 or your contractor)	0.00	303.50	
00 Rate for Program covered visits (see instructions) CALCULATION OF SETTLEMENT		0.00	232.09	9.
.00 Program covered visits excluding mental health services (from	contractor records)	0	971	10.
.00 Program cost excluding costs for mental health services (line	-	0	225, 359	
.00 Program covered visits for mental health services (from contra		0	223, 337	
.00 Program covered cost from mental health services (line 9 x lin	<i>,</i>	0	0	
.00 Limit adjustment for mental health services (see instructions)	-	0	0	
.00 Graduate Medical Education Pass Through Cost (see instructions			-	15
.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	225, 359	
.01 Total program charges (see instructions)(from contractor's red	cords)		221, 918	16
.02 Total program preventive charges (see instructions)(from provi	der's records)		11, 573	16
.03 Total program preventive costs ((line 16.02/line 16.01) times	line 16)		11, 752	16
.04 Total Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		161, 447	16
(Titles V and XIX see instructions.)				
.05 Total program cost (see instructions)		0	173, 199	
00 Primary payer amounts	· · · ·		0	
.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		11, 798	18
records)	) (from contractor		20 700	10
.00 Beneficiary coinsurance for RHC/FQHC services (see instruction records)	is) (from contractor		39, 709	19.
.00 Net Medicare cost excluding vaccines (see instructions)			173, 199	20
.00 Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		20, 841	
.00 Total reimbursable Program cost (line 20 plus line 21)			194, 040	
.00 Allowable bad debts (see instructions)			0	23
.01 Adjusted reimbursable bad debts (see instructions)			0	23
.00 Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		0	24
. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	25
.50 Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
.99 Demonstration payment adjustment amount before sequestration			0	
.00 Net reimbursable amount (see instructions)			194, 040	
.01 Sequestration adjustment (see instructions)			2, 445	
02 Demonstration payment adjustment amount after sequestration			0	
00 Interim payments			225, 322	
.00 Tentative settlement (for contractor use only) .00 Balance due component/program (line 26 minus lines 26.01, 26.0	$12 \ 27 \ and \ 29$		0 דרד ככ	
.00 Balance due component/program (line 26 minus lines 26.01, 26.0 .00 Protested amounts (nonallowable cost report items) in accordar			-33, 727 0	
. So processed amounts (nonarrowable cost report ritems) Th accordin	ice with ows rup. 13-11,		0	1 30.

	OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1317	Peri od:	Worksheet M-3	
ERVI CES		Component CCN: 15-8538	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
		Title XVIII	RHC IV		
				1.00	
DETER	MINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
00 Total	Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst. M-2, line 20)		857, 517	1.
	of injections/infusions and their administration (from W			98, 257	
	allowable cost excluding injections/infusions (line 1 mi	inus line 2)		759, 260	
	Visits (from Wkst. M-2, column 5, line 8)			2, 578	
	cians visits under agreement (from Wkst. M-2, column 5, I	line 9)		0	
	adjusted visits (line 4 plus line 5)			2, 578	6
00 Adjus	sted cost per visit (line 3 divided by line 6)		Coloulation	294.52	7
			Cal cul ati on	OF LIMIT (I)	
			Rate Period	Rate Period 1	
			N/A	(01/01/2022	
				through	
				12/31/2022)	
00 0	isit summat light (from CNC Dub 100.04 shorter 0, 500		1.00	2.00	
1	visit payment limit (from CMS Pub. 100-04, chapter 9, §20.	. 6 or your contractor)	0.00	163.22	
	for Program covered visits (see instructions) LATION OF SETTLEMENT		0.00	163.22	9
	am covered visits excluding mental health services (from	contractor records)	0	539	1 10
	ram cost excluding costs for mental health services (line		0	87.976	
5	am covered visits for mental health services (from contra	<i>,</i>	0	0,,,,0	
	am covered cost from mental health services (line 9 x lin	-	0	0	
	adjustment for mental health services (see instructions)	-	0	0	
1	ate Medical Education Pass Through Cost (see instruction	-		-	15
. 00   Total	Program cost (sum of lines 11, 14, and 15, columns 1, 2	and 3) *	0	87, 976	16
. 01   Total	program charges (see instructions) (from contractor's real	cords)		105, 086	16
02 Total	program preventive charges (see instructions)(from provi	ider's records)		1, 954	16
. 03   Total	program preventive costs ((line 16.02/line 16.01) times	line 16)		1, 636	16
	Program non-preventive costs ((line 16 minus lines 16.03	3 and 18) times .80)		53, 784	16
	es V and XIX see instructions.)				
1	program cost (see instructions)		0	55, 420	
1	iry payer amounts			0	
. 00 Less: recor	Beneficiary deductible for RHC only (see instructions)	(from contractor		19, 110	18
	us) Ficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		16, 804	19
recor	· · · · · · · · · · · · · · · · · · ·				
	ledicare cost excluding vaccines (see instructions)			55, 420	
	ram cost of vaccines and their administration (from Wkst.	M-4, line 16)		40, 163	
	reimbursable Program cost (line 20 plus line 21)			95, 583	
	vable bad debts (see instructions) sted reimbursable bad debts (see instructions)			0	
	vable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
1	ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	er ACO demonstration payment adjustment (see instructions	s)		0	
	istration payment adjustment amount before sequestration	- /		0	
	reimbursable amount (see instructions)			95, 583	
	estration adjustment (see instructions)			1, 204	
. 02 Demor	stration payment adjustment amount after sequestration			0	26
.00 Inter	im payments			54, 100	27
	tive settlement (for contractor use only)			0	
	nce due component/program (line 26 minus lines 26.01, 26.0			40, 279	
). 00   Prote	ested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II.		0	30

	Financial Systems GREENE COUNTY GE			In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CO Component (	CN: 15-1317 CCN: 15-8535	Period: From 01/01/2022 To 12/31/2022		pared:
		Ti ti o	XVIII	RHC I	5/30/2023 1:0	5 pm
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCINES	VACCI NES	VACCINES	ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2, 557, 834	2, 557, 8			1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 001532	0.0064	0. 000000	0. 000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	3, 919	16, 5	49 0	0	3.00
4.00	Injections/infusions and related medical supplies costs (from your records)	92, 195	90, 7	52 0	0	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	96, 114	107, 3	0 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	3, 656, 987	3, 656, 9	3, 656, 987	3, 656, 987	6.00
7.00	Total overhead (from Wkst. M-2, line 19)	1, 841, 470	1, 841, 4	70 1, 841, 470	1, 841, 470	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 026282	0. 0293	41 0. 000000	0. 000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	48, 398	54, 0	31 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	144, 512	161, 3	32 0	0	10. 00
11.00	Total number of injections/infusions (from your records)	500	2, 1	11 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	289.02	76.	42 0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	93	8	58 0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	26, 879	65, 5	68 0	0	14.00
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATION	
				1.00	2.00	
15.00	Total cost of injections/infusions and their administration	n costs (sum of	columns 1	1.00	305, 844	15.00
16.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)				
	Total Program cost of injections/infusions and their admini	stration costs	(SUM OT		92.44/	16.00

	Financial Systems GREENE COUNTY GE TATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider C	N. 15 1017	Peri od:	u of Form CMS-2 Worksheet M-4	
COMPU	ATTON OF HUSPITAL-BASED RHC/FUHC VALUTNE CUST	Provider CC	N: 15-1317	From 01/01/2022	worksneet M-4	
		Component (	CCN: 15-8533	To 12/31/2022	Date/Time Pre 5/30/2023 1:0	
		Title	XVIII	RHC II	0,00,2020 110	<u> </u>
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	919, 021	919, 0	21 919, 021	919, 021	1.00
2.00	Ratio of injection/infusion staff time to total health care staff time	0. 006259	0. 0232	0. 000000	0. 000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line 2)	5, 752	21, 3	43 0	0	3. 00
4.00	Injections/infusions and related medical supplies costs (from your records)	78, 011	72, 6	03 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	83, 763	93, 9	46 0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 169, 433	1, 169, 4	33 1, 169, 433	1, 169, 433	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	714, 654	714, 6	54 714, 654	714, 654	7.00
8.00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 071627	0. 0803	35 0. 000000	0. 000000	8.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	51, 189	57,4	12 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	134, 952	151, 3	58 0	0	10. 00
11.00	Total number of injections/infusions (from your records)	463	1, 7			11.00
12.00	Cost per injection/infusion (line 10/line 11)	291.47	88.	10 0.00	0.00	12.00
13.00	Number of injection/infusion administered to Program beneficiaries	122	6	12 0		13.00
13.01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13.01
14.00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	35, 559	53, 9	17 0		14.00
					COST OF INJECTIONS / INFUSIONS AND	
					ADMI NI STRATI ON	
15 00	Total cost of injections/infusions and their administration	a coste (sum of	columns 1	1.00	2.00 286,310	15 00
	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)				
16.00	Total Program cost of injections/infusions and their admini	stration costs	(sum of		89, 476	16.00

		NERAL HOSPITAL			u of Form CMS-2	
COMPUI	ATION OF HOSPITAL-BASED RHC/FOHC VACCINE COST	Provider CC	CN: 15-1317	Period: From 01/01/2022	Worksheet M-4	
		Component (	CCN: 15-8534	To 12/31/2022	Date/Time Pre	pared:
				5110 111	5/30/2023 1:0	5 pm
			XVIII	RHC III		
		PNEUMOCOCCAL	INFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2, 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	477, 424			477, 424	1.00
2.00	Ratio of injection/infusion staff time to total health	0.001175				
2.00	care staff time	0.001170	0.0002	0.000000	0.000000	2.00
3.00	Injection/infusion health care staff cost (line 1 x line	561	3, 9	35 0	0	3.00
	2)					
4.00	Injections/infusions and related medical supplies costs	9, 053	20, 1	41 0	0	4.00
	(from your records)					
5.00	Direct cost of injections/infusions (line 3 plus line 4)	9, 614			0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from	649, 208	649, 2	08 649, 208	649, 208	6.00
	Worksheet M-1, col. 7, line 22)					
7.00	Total overhead (from Wkst. M-2, line 19)	461, 436				
8.00	Ratio of injection/infusion direct cost to total direct	0. 014809	0. 0370	85 0. 000000	0.00000	8.00
0 00	cost (line 5 divided by line 6)	( 000	47.4	10		0.00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	6, 833			0	1.00
10.00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	16, 447	41, 1	88 0	0	10.00
11.00	Total number of injections/infusions (from your records)	60	4	21 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	274. 12				12.00
12.00	Number of injection/infusion administered to Program	15		71 0.00	0.00	
15.00	beneficiaries	15		0	0	13.00
13.01	Number of COVID-19 vaccine injections/infusions			0	0	13.01
	administered to MA enrollees					
14.00	Program cost of injections/infusions and their	4, 112	16, 7	29 0	0	14.00
	administration costs (line 12 times the sum of lines 13					
	and 13.01, as applicable)					
					COST OF	
					INJECTIONS /	
					INFUSIONS AND	
				1.00	ADMI NI STRATI ON	
15.00	Total cost of injections/infusions and their administration	a coste (sum of	columps 1	1.00	2.00 57,635	15 00
13.00	2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		COLUMNIS I,		57,035	15.00
16.00	Total Program cost of injections/infusions and their admini		(sum of		20, 841	16 00
10.00	protein rogram cost of rig cetrons/rin asions and there admini	nt to Wkst. M-3	(Sum Of		20,041	1 10.00

	inancial Systems GREENE COUNTY GE TON OF HOSPITAL-BASED RHC/FQHC VACCINE COST	NERAL HOSPITAL Provider CO	CN: 15-1317	Peri od:	u of Form CMS-2 Worksheet M-4	
		Component (	CCN: 15-8538	From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 1:09	
		Title	XVIII	RHC IV		
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2.02	
	ealth care staff cost (from Wkst. M-1, col. 7, line 10)	343, 388	343, 3	88 343, 388	343, 388	1.00
	atio of injection/infusion staff time to total health are staff time	0. 000630	0.0097	0. 000000	0. 000000	2.00
3.00 I	njection/infusion health care staff cost (line 1 x line )	216	3, 3	31 0	0	3.00
1.00 I	, njections/infusions and related medical supplies costs from your records)	10, 567	38, 3	87 0	0	4.00
	irect cost of injections/infusions (line 3 plus line 4)	10, 783	41, 7	18 0	0	5.0
	otal direct cost of the hospital-based RHC/FQHC (from orksheet M-1, col. 7, line 22)	458, 191	458, 1	91 458, 191	458, 191	6.0
	otal overhead (from Wkst. M-2, line 19)	399, 326	399, 3	26 399, 326	399, 326	7.0
	atio of injection/infusion direct cost to total direct ost (line 5 divided by line 6)	0. 023534	0. 0910	49 0.000000	0. 000000	8.0
9.00 0 <sup>,</sup>	verhead cost - injection/infusion (line 7 x line 8)	9, 398	36, 3	58 0	0	9.0
	otal injection/infusion costs and their administration osts (sum of lines 5 and 9)	20, 181	78, 0	76 0	0	10. 0
	otal number of injections/infusions (from your records)	59		09 0	-	
	ost per injection/infusion (line 10/line 11)	342.05	85.	89 0.00	0.00	
b	umber of injection/infusion administered to Program eneficiaries	22	3	80 0	0	
a	umber of COVID-19 vaccine injections/infusions dministered to MA enrollees			0	0	13.0
a	rogram cost of injections/infusions and their dministration costs (line 12 times the sum of lines 13 nd 13.01, as applicable)	7, 525	32, 6	38 0	0	14.0
					COST OF	
					INFUSIONS AND	
				1.00	ADMI NI STRATI ON	
15.00 T	otal cost of injections/infusions and their administration	costs (sum of	columps 1	1.00	2.00 98,257	15.0
2	, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)				
	otal Program cost of injections/infusions and their admini olumns 1, 2, 2.01, and 2.02, line 14) (transfer this amour				40, 163	16. (

Heal th	Financial Systems GREENE COUNTY GEN	VERAL HOSPITAL	Inlie	u of Form CMS-2	2552-10
	SIS OF PAYMENTS TO HOSPITAL-BASED RHC/FQHC PROVIDER FOR	Provi der CCN: 15-1317	Peri od:	Worksheet M-5	
	ES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8535	From 01/01/2022 To 12/31/2022	Date/Time Prep 5/30/2023 1:05	
			RHC I	575072025 1.00	
				t B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			600, 181	1.00
2.00	Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting p "NONE" or enter a zero			0	2.00
3.00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period. payment. If none, write "NONE" or enter a zero. (1)				3.00
	Program to Provider				
3.01				0	3.01
3.02				0	3.02
3.03				0	3.03
3.04				0	3.04
3.05				0	3.05
	Provider to Program			-	
3.50				0	3.50
3.51				0	3.51
3.52 3.53				0	3. 52 3. 53
3.53				0	3.53
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.4	98)		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transport			600, 181	4.00
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desl each payment. If none, write "NONE" or enter a zero. (1)	k review. Also show date of	f		5.00
F 01	Program to Provider			0	F 01
5.01 5.02				0	5. 01 5. 02
5.02				0	5.02
5.05	Provider to Program			0	5.05
5.50				0	5.50
5.51				0	5.51
5.52				0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.4			0	5.99
6.00	Determined net settlement amount (balance due) based on the	cost report. (1)			6.00
6.01	SETTLEMENT TO PROVIDER			52, 765	6.01
6.02	SETTLEMENT TO PROGRAM			0	6.02
7.00	Total Medicare program liability (see instructions)		Contract	652, 946	7.00
			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor		1.00	2.00	8.00
			1	I I	

AMALYSIS OF PAYMENTS TO HOSPITAL-BASED REC/FORC PROVIDER FOR SERVICES RENDERED TO PROGRAW BENEFICIARIES     Provider COX: 15-853     Period: Component CCX: 15-853     Period: To 01/01/2022     Deterfine Prepared: Date/Time Prepared: S/20/2023     Deterfine Prepared: To 01/01/202     Deterfine Prepared: Date/Time Prepared: S/20/2023     Deterfine Prepared: S/20/2023     Deterfine Prepared: To 01/01/202     Deterfine Prepared: S/20/2023     Deterfine Prepared: S/20/202	Heal th	Financial Systems GREENE COUNTY GEI	NERAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
SERVICES RENDERED TO PROGRAM BENEFICIARIES       Component CCN: 15-8533       From 01/01/2022 To 12/31/2022       Date/Time Prepared: 5/30/2023 1: 05 pm         1.00       Total interim payments paid to hospital-based PBC/FDK:       Imm/dd/yuyy       Amount       Imm/dd/yuyy         2.00       Interim payments paid to hospital-based PBC/FDK:       Interim payments paymble 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       Interim payments paymble on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       0       3.00         0.01       Ust separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       0       3.00         0.02       0       3.01       0       3.04         3.04       0       3.05       0       3.05         3.05       0       3.01       3.04       0       3.05         3.04       0       3.04       0       3.05         3.05       0       3.51       0       3.53         3.54       0       3.51       0       3.51         5.00       11 mes						
Image: constraint of the second sec					Date/Time Prep	
Pert B         Pert B           1.00         Total interim payments paid to hospital-based RHC/FOHC         1.00         2.00           1.00         Interim payments payable on individual bills, either submitted or to be submitted to the cortractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero         2.00         2.00           3.00         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)         0         3.00           Program to Provider         0         3.01         0         3.03           3.01         0         3.03         0         3.03           3.04         0         3.05         0         3.05           Provider to Program         0         3.05         0         3.50           3.51         0         3.52         0         3.52           3.52         0         3.52         0         3.52           3.54         0         0         3.54         0         3.54           3.54         0         0         3.54         0         3.54           3.55         0         0         5.50         0         5.50 <td< td=""><td></td><td></td><td></td><td>RHC LL</td><td>575072025 1.00</td><td><u>5 pili</u></td></td<>				RHC LL	575072025 1.00	<u>5 pili</u>
mm/dd/yyyy         Amount           1.00         Total interim payments paid to hospital-based RHC/FOHC         1.00         2.00           2.00         Interim payments payable on individual bills, either submitted ro to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.         209,646         1.00         209,646         1.00           3.00         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)         0         3.00           Program to Provider         0         3.00         0         3.00           3.01         0         3.02         0         3.00           3.02         0         3.00         0         3.00           3.01         0         3.01         0         3.02           3.02         0         3.02         0         3.03           3.04         0         3.04         0         3.04           3.05         0         3.04         0         3.64           3.04         0         3.54         0         3.54           3.05         0         3.54         0         3.54           3.99					T B	
1.00     Total interim payments paid to hospital-based RHC/FOHC     1.00     2.00       2.00     Interim payments payable on individual bills, either submitted to to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero     2.00     2.00       3.00     Uist 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)     0     3.00       3.01     0     0     3.01       3.02     0     3.02       3.03     0     3.03       3.04     0     3.04       3.05     0     3.05       Provider to Program     0     3.50       3.52     0     3.52       3.54     0     3.54       3.05     0     3.54       3.06     0     3.54       3.07     0     3.54       3.52     0     3.52       3.54     0     3.54       3.00     0     3.54       3.01     0     0       0     0     0       1.00     2.00,466     4.00       0     0     0     5.01       5.01     0     0     5.01       5.02 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
1:00       Total interim payments payable on individual bills, either submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.       2:00       Interim payments payable on individual bills, either submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.       3:00       2:00         3:00       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)       0       3:00         Program to Provider       0       3:02         3:01       0       3:02         3:03       0       3:02         3:04       0       3:03         3:05       0       3:04         3:06       0       3:04         3:07       0       3:04         3:08       0       3:04         3:09       0       3:04         3:01       0       3:04         3:02       0       3:04         3:04       0       3:04         3:05       0       3:51         3:53       0       3:53         3:54       0       3:53         3:59       0       3:59 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
2.00       Interim payments payable on individual bills, either submitted to to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NORE" or enter a zero.       0       2.00         3.00       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 "NORE" or enter a zero. (1)       0       3.00         9       Program to Provider       0       3.01         3.01       0       3.03       3.03         3.02       0       3.03       3.03         3.01       0       3.04       3.04         3.02       0       3.04       3.04         3.05       0       0       3.05         9       Provider to Program       0       3.50         3.05       0       3.51       0       3.51         3.06       0       3.51       0       3.51         3.53       4       0       3.53       3.54       0       3.53         3.54       0       3.59       0       3.51       3.54       3.54         3.55       4       0       3.51       3.55       3.54       3.54       3.54         3.55       550	1.00	Total interim payments paid to hospital-based RHC/FQHC				1.00
3.00         List separately each retroactive lump sum adjustment amount based on subsequent payment. If none, write "NONE" or enter a zero. (1)         3.00           9         Program to Provider         0         3.01           3.01         3.01         3.01         3.01           3.02         0         3.01         3.01           3.03         0.03         0.03         3.03           3.04         0         3.01         3.02           3.05         0         0         3.03           3.04         0         3.04         0         3.04           3.05         0         0         3.03         3.04         0         3.04           3.05         0         0.05         0         3.04         0         3.04           3.05         0         0.05         0         3.05         0         3.53           3.50         0         0.05         0         3.53         0.05         3.54           0.00         total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line         209, 646         4.00           2/1         0         15.00         1st separately each fentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a ze		Interim payments payable on individual bills, either submit the contractor for services rendered in the cost reporting				
Program to Provider         0         3.01           3.02         0         3.02           3.03         0         3.02           3.04         0         3.02           3.04         0         3.04           3.05         0         3.04           3.06         0         3.04           3.04         0         3.04           3.05         0         3.04           3.06         0         3.04           3.06         0         3.04           3.05         0         3.05           70         5.00         0         3.51           3.53         3.54         0         3.53           3.99         Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)         0         3.94           0.00         Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line         209, 646         4.00           27)         0         5.01         0         5.01           10         BE COMPLETED BY CONTRACTOR         0         5.00           5.01         0         5.01         0         5.01           5.02         0         5.01         0         5.02	3.00	List separately each retroactive lump sum adjustment amount revision of the interim rate for the cost reporting period.				3. 00
3.01       0       3.02         3.02       0       3.02         3.04       0       3.03         3.04       0       3.03         3.04       0       3.03         3.04       0       3.03         3.04       0       3.03         3.05       0       3.05         Provider to Program       0       3.50         3.51       0       3.51         3.52       0       3.52         3.53       0       3.52         3.54       0       3.52         3.55       0       3.52         3.54       0       3.52         3.55       0       3.52         3.54       0       3.53         3.59       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       0       3.54         5.00       Expanzle (sum of lines 1, 2, and 3.99) (transfer to Worksheet M=3, line       209,646       4.00         27)       0       Expanzle (sum of lines 1, 2, and 3.99)       0       5.00         10       Expanzle (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.50         5.50       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)						
3.02       0       3.02         3.03       0       3.02         3.04       0       3.03         3.04       0       3.03         3.05       0       3.05         Provider to Program       0       3.50         3.50       0       3.51         3.52       0       3.53         3.54       0       3.53         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       0       3.54         3.99       Subtotal interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       209,646       4.00         27)       TO BE COMPLETED BY CONTRACTOR       5.00       5.00       5.00       5.00         5.00       Lis separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00       5.00         Program to Provider       0       5.01       5.02       5.02         5.01       5.02       0       5.03       5.02       5.02         5.03       Provider to Program       0       5.03       5.51       5.02       5.52         5.04       0       5.52       0       5.51       5.52       5.52       5.55	3 01				0	3 01
3.03       0       3.03       0       3.03         3.04       0       3.04       0       3.04         Provider to Program       0       3.05       0       3.05         1.50       0       0       3.51       0       3.52         3.51       0       3.52       0       3.52         3.52       0       3.53       3.54       0       3.53         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       0       3.54       0       3.54         3.99       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       209,646       4.00       3.99         70       BE COMPLETED BY CONTRACTOR       5.00       5.00       5.01       5.00       5.01       5.00       5.01       5.00       5.01       5.01       5.01       5.01       5.01       5.01       5.01       5.01       5.01       5.01       5.01       5.01       5.01       5.01       5.03       5.50       5.51       5.99       5.02       5.52       5.99       5.52       5.99       5.52       5.99       5.52       5.99       5.52       5.99       5.52       5.52       5.52       5.52       5.52						
3.04         0         3.04           3.05         Provider to Program         0         3.04           3.50         0         3.51         3.52         0         3.51           3.52         0         3.51         3.52         0         3.52           3.54         0         3.54         0         3.54           3.99         Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)         0         3.54           3.90         Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 209, 646         4.00           27)         To BE COMPLETED BY CONTRACTOR         5.00         5.00           5.00         List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)         5.00           Program         0         5.01         0         5.02           5.03         0         5.03         5.03         5.03           5.50         0         0         5.50         5.52         5.59         5.50           5.51         0         5.52         5.59         5.59         5.59         5.59           6.00         Determined net settlement amount (balance due) based on the cost report. (1)         7.01						
3.05       Provider to Program       0       3.05         7.00       Provider to Program       0       3.50         3.51       0       3.52       0       3.53         3.53       0       3.53       0       3.53         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       0       0       3.99         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)       0       3.99         5.00       List separately each tentative settlement payment after desk review. Also show date of exch payment. If none, write "NONE" or enter a zero. (1)       5.00       5.01         7.01       Program to Provider       0       5.00       5.01         5.50       0       5.50       0       5.50         5.51       0       5.50       5.52       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52<					0	
3.50       0       3.50         3.51       0       3.51         3.52       0       3.53         3.54       0       3.53         3.54       0       3.53         3.54       0       3.54         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       0       3.54         0       0       3.51       0       3.53         3.99       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 209, 646       4.00         27)       TO BE COMPLETED BY CONTRACTOR       5.00       5.00         Each payment. If none, write "NONE" or enter a zero. (1)       5.00       5.01         Program to Provider       0       5.01       5.02         5.00       5.01       0       5.50         5.50       0       5.51       0         5.50       0       5.52       5.99         Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.50       5.52       5.99       5.52       5.99         Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         6.00       Determined net settlement amount (balance due) based on the cost repo	3.05				0	3.05
3.51       0       3.51         3.52       0       3.53         3.54       0       3.53         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       0       3.54         0.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       209,646         27)       TO BE COMPLETED BY CONTRACTOR       5.00         1.51 separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00         Program to Provider       0       5.01         5.01       0       5.02         0       5.01       0       5.02         5.00       0       5.50         0       5.50       0       5.51         5.50       0       5.52         0       5.51       0       5.52         5.52       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         6.00       SETTLEMENT TO PROVIDER       7.00       5.00       6.00         6.01       SETTLEMENT TO PROGRAM		Provider to Program				
3.52       0       3.52         3.53       0       3.54         3.54       0       3.54         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       0       3.99         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27)       0       3.54         TO       BE COMPLETED BY CONTRACTOR       5.00       5.00       5.00         Program to Provider       0       5.00       5.00         S.01       Frowider to Program       0       5.00         5.02       0       5.01       5.02         5.03       Provider to Program       0       5.03         5.50       5.51       0       5.51         5.52       0       5.51       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.59         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       5.99         6.01       SETTLEMENT TO PROGRAM       79, 116       6.01         6.02       SETTLEMENT TO PROGRAM       288, 762       7.00         7.00       Total Medicare program liability (see instructions)       0       1.00       2.00	3.50				0	3.50
3.53       0       3.53         3.54       0       3.53         3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       0       3.99         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 209,646       0       3.99         70       DBE COMPLETED BY CONTRACTOR       209,646       4.00         27)       To BE COMPLETED BY CONTRACTOR       5.00         Program to Provider       0       5.01         5.01       5.02       0       5.02         5.03       0       5.03       0       5.00         Provider to Program       0       5.50       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.59         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       5.99         6.01       SETTLEMENT TO PROGRAM       79,116       6.00         6.02       SETTLEMENT TO PROGRAM       79,116       6.02         7.00       Total Medicare program liability (see instructions)       0       1.00       2.00	3.51				0	3.51
3.54	3.52				0	3. 52
3.99       Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)       0       3.99         4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       209,646       4.00         27)       10       ECOMPLETED BY CONTRACTOR       5.00       5.00       5.00       5.00         Program to Provider       0       5.01       5.01       5.01       5.01       5.01         5.02       0       0       5.02       0       5.03       5.03         Provider to Program       0       5.51       0       5.52       5.52       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52       5.99         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       5.99         6.01       SETTLEEMENT TO PROVIDER       79, 116       6.01       0       5.02         7.00       Total Medicare program liability (see instructions)       288,762       7.00       0       1.00       208,762       7.00						
4.00       Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line       209,646       4.00         27)       TO BE COMPLETED BY CONTRACTOR       5.00       5.00       5.00       5.00         List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00       5.00       5.00         Program to Provider       0       5.01       5.00       5.01         5.02       0       5.02       0       5.02         7.00       Provider to Program       0       5.50       5.50         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.59       5.99         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.02       5.99         6.01       SETTLEMENT TO PROGRAM       0       6.02       288,762       7.00         7.00       Total Medicare program liability (see instructions)       0       1.00       2.00						
27)         TO BE COMPLETED BY CONTRACTOR           5.00         List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)         5.00           Program to Provider         0         5.01           5.01         0         5.01           5.02         0         5.01           5.03         0         5.01           7.04         0         5.01           5.05         0         5.03           9         Provider to Program         0         5.50           5.50         0         5.51           5.52         0         5.52           5.99         Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)         0         5.52           5.99         Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)         0         5.99           6.00         Determined net settlement amount (balance due) based on the cost report. (1)         79, 116         6.01           6.01         SETTLEMENT TO PROVIDER         0         6.02           6.02         SETTLEMENT TO PROGRAM         0         6.02           7.00         Total Medicare program liability (see instructions)         288, 762         7.00           0 <td< td=""><td></td><td></td><td></td><td></td><td>-</td><td></td></td<>					-	
5.00       List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)       5.00       5.01       0       5.01         9       Provider       0       5.01       0       5.02       0       5.03         9       Provider to Program       0       5.03       0       5.00       5.50         5.50       0       0       5.50       0       5.50         5.51       0       0       5.51       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.90         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       5.90         6.01       SETTLEMENT TO PROVIDER       7.00       7.01 Total Medicare program liability (see instructions)       288, 762       7.00         7.00       Total Medicare program liability (see instructions)       0       1.00       2.00       1.00	4.00	27)	fer to Worksheet M-3, line		209, 646	4.00
each payment. If none, write "NONE" or enter a zero. (1)         Program to Provider           5.01         0         5.01           5.02         0         0         5.02           5.03         0         5.03           Provider to Program         0         5.03           5.50         0         0         5.50           State         0         5.50         0           5.51         0         0         5.52           5.99         Subtotal (sum of Lines 5.01-5.49 minus sum of Lines 5.50-5.98)         0         0         5.52           5.99         Subtotal (sum of Lines 5.01-5.49 minus sum of Lines 5.50-5.98)         0         0         5.59           6.00         Determined net settlement amount (balance due) based on the cost report. (1)         6.00         5.99           6.01         SETTLEMENT TO PROVIDER         79, 116         6.01           6.02         SETTLEMENT TO PROGRAM         0         6.02           7.00         Total Medicare program Liability (see instructions)         288, 762         7.00           0         1.00         2.00         1         0         2.00				-		
Program to Provider         0         5.01           5.01         0         5.01           5.02         0         0           5.03         0         5.02           9         Provider to Program         0         5.50           5.50         0         0         5.50           5.51         0         0         5.51           5.52         0         0         5.52           5.99         Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)         0         5.52           5.99         Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)         0         5.59           6.00         Determined net settlement amount (balance due) based on the cost report. (1)         6.00         6.00           6.01         SETTLEMENT TO PROVIDER         79, 116         6.01           6.02         SETTLEMENT TO PROGRAM         0         6.02           7.00         Total Medicare program Liability (see instructions)         288, 762         7.00           0         1.00         2.00         1.00         2.00	5.00		k review. Also show date o	f		5.00
5.02       .03       .00       5.02         9       Provider to Program       .00       5.03         5.50       .01       .00       5.50         5.50       .01       .00       5.50         5.51       .00       .00       5.51         5.52       .00       .00       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       .00       .00         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       .00       6.00         6.01       SETTLEMENT TO PROVIDER       .00       .00       6.02         6.02       SETTLEMENT TO PROGRAM       .00       6.02         7.00       Total Medicare program liability (see instructions)       .288,762       7.00         Contractor NPR Date (Mo/Day/Yr)         0       1.00       2.00						
5.03       Provider to Program       0       5.03         5.50       0       5.50       0       5.50         5.51       0       5.51       0       5.51         5.52       0       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       0         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       0       6.02         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       288,762       7.00         Contractor NPR Date (Mo/Day/Yr)         0       1.00       2.00	5.01				0	5.01
Provider to Program         0         5.50           5.50         0         0         5.50           5.51         0         0         5.51           5.52         0         0         5.52           5.99         Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)         0         5.99           6.00         Determined net settlement amount (balance due) based on the cost report. (1)         6.00         6.00           6.01         SETTLEMENT TO PROVIDER         79,116         6.01           6.02         SETTLEMENT TO PROGRAM         0         6.02           7.00         Total Medicare program liability (see instructions)         288,762         7.00           Contractor NUMber (Mo/Day/Yr)           0         1.00         2.00	5.02					5.02
5.50       0       5.50         5.51       0       5.51         5.52       0       5.51         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       5.99         6.01       SETTLEMENT TO PROVIDER       6.00       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       288,762       7.00         Contractor Number (Mo/Day/Yr)         0       1.00       2.00	5.03				0	5.03
5.51       .52         5.52       .59         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00         6.01       SETTLEMENT TO PROVIDER       6.01         6.02       SETTLEMENT TO PROGRAM       79,116         7.00       Total Medicare program liability (see instructions)       288,762         Contractor NUMBER         0       1.00       2.00		Provider to Program		- 1		
5.52       5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.52         5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       5.99         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       79,116       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       288,762       7.00         Contractor NUMBER         0       1.00       2.00						
5.99       Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)       0       0       5.99         6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       79,116       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       288,762       7.00         Contractor NUMBER         0       1.00       2.00						
6.00       Determined net settlement amount (balance due) based on the cost report. (1)       6.00       6.00         6.01       SETTLEMENT TO PROVIDER       79,116       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       288,762       7.00         Contractor NPR Date (Mo/Day/Yr)         0       1.00       2.00			22)			
6.01       SETTLEMENT TO PROVIDER       79,116       6.01         6.02       SETTLEMENT TO PROGRAM       0       6.02         7.00       Total Medicare program liability (see instructions)       288,762       7.00         Contractor NUMber (Mo/Day/Yr)         0       1.00       2.00					0	
6.02       SETTLEMENT TO PROGRAM       6.02         7.00       Total Medicare program liability (see instructions)       288,762       7.00         Contractor NUMber (Mo/Day/Yr)         0       1.00       2.00			cost report. (1)		70.14/	
7.00         Total Medicare program liability (see instructions)         288,762         7.00           L         Contractor Number         NPR Date (Mo/Day/Yr)         (Mo/Day/Yr)           0         1.00         2.00						
Contractor         NPR Date           Number         (Mo/Day/Yr)           0         1.00         2.00						
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00			Contractor		7.00
0 1.00 2.00						
			0			
	8.00	Name of Contractor				8.00

Heal th	Financial Systems GREENE COUNTY GEI	NERAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10	
ANALYSI'S OF PAYMENTS TO HOSPITAL-BASED RHC/FOHC PROVIDER FOR Provider CCN: 15-131			Period: Worksheet M-5			
SERVIO	ES RENDERED TO PROGRAM BENEFICIARIES	Component CCN: 15-8534	From 01/01/2022 To 12/31/2022			
-			RHC III	5/50/2025 1.00	5 pm	
				t B		
			mm/dd/yyyy	Amount		
			1.00	2.00		
1.00	Total interim payments paid to hospital-based RHC/FQHC			225, 322	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero			0	2.00	
3.00	List separately each retroactive lump sum adjustment amount	based on subsequent			3.00	
5.00	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)				5.00	
	Program to Provider					
3.01				0	3. 01	
3.02				0	3. 02	
3.03				0	3.03	
3.04				0	3.04	
3.05				0	3.05	
	Provider to Program			-		
3.50				0	3.50	
3.51				0	3.51	
3.52 3.53				0	3. 52 3. 53	
3.53				0	3.53	
3.99						
4.00					3. 99 4. 00	
	TO BE COMPLETED BY CONTRACTOR					
5.00						
	each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
5.01				0	5.01	
5.02				0	5.02	
5.03				0	5.03	
F F0	Provider to Program				F F0	
5.50				0	5. 50 5. 51	
5. 51 5. 52				0	5.51	
5.92					5.99	
6.00					6.00	
6.01					6. 01	
6.02	SETTLEMENT TO PROGRAM			0 33, 727	6. 02	
7.00	Total Medicare program liability (see instructions)			191, 595	7.00	
			Contractor	NPR Date		
			Number	(Mo/Day/Yr)		
		0	1.00	2.00		
8.00	Name of Contractor				8.00	

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL	Inlie	u of Form CMS-2	2552-10			
	Period: Worksheet M-5					
	01/01/2022 12/31/2022	Date/Time Prep 5/30/2023 1:05				
	RHC IV	0/00/2020 1:00	<u> </u>			
	Par	t B				
m	nm/dd/yyyy	Amount				
	1.00	2.00				
1.00 Total interim payments paid to hospital-based RHC/FQHC		54, 100	1.00			
2.00 Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	0	2. 00				
3.00 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			3.00			
payment. If none, write "NONE" or enter a zero. (1) Program to Provider						
3.01		0	3. 01			
3.02		Ő	3. 02			
3.03		0	3.03			
3.04		0	3.04			
3.05		0	3.05			
Provider to Program						
3.50		0	3.50			
3. 51		0	3. 51			
3. 52		0	3.52			
3.53		0	3.53			
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3.54 3.99			
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)0Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line54,10027)						
TO BE COMPLETED BY CONTRACTOR	·					
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	List separately each tentative settlement payment after desk review. Also show date of					
Program to Provider						
5. 01		0	5.01			
5.02		0	5.02			
5.03		0	5.03			
Provider to Program						
5. 50		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 5.50-5.98)		0	5. 52 5. 99			
6.00 Determined net settlement amount (balance due) based on the cost report. (1)		0	6.00			
6.01 SETTLEMENT TO PROVIDER	40, 279	6.01				
6.02 SETTLEMENT TO PROGRAM		0	6. 02			
7.00 Total Medicare program liability (see instructions)		94, 379	7.00			
	Contractor Number	NPR Date (Mo/Day/Yr)				
0	1.00	2.00				
8.00 Name of Contractor			8.00			