This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1317 Worksheet S Period: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/28/2024 4: 36 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date:] Manually prepared cost report use only If this is an amended report enter the number of times the provider resubmitted this cost report Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENE COUNTY GENERAL HOSPITAL (15-1317) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	R CHECKBOX		
	1	2	SIGNATURE 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	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	799, 269	-666, 274	0	0	1.00
2.00	SUBPROVI DER - I PF	0	0	0		0	2.00
3.00	SUBPROVI DER - I RF	0	0	0		0	3.00
5.00	SWING BED - SNF	0	86, 372	0		0	5.00
6.00	SWING BED - NF	0				0	6.00
10.00	RURAL HEALTH CLINIC I	0		-10, 422		0	10.00
10.01	RURAL HEALTH CLINIC II	0		68, 861		0	10.01
10.02	RURAL HEALTH CLINIC III	0		-129, 838		0	10.02
10.03	RURAL HEALTH CLINIC IV	0		-606		0	10.03
200.00	TOTAL	0	885, 641	-738, 279	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 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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1317 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/28/2024 4:36 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: P0 Box: 1000 1.00 Street: R. R 1 1.00 Zip Code: 47441-9457 County: GREENE 2.00 City: LINTON State: IN 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, O, or N)

/ XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal GREENE COUNTY GENERAL 151317 99915 02/01/2003 Ν 0 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF GREENE COUNTY GENERAL 157317 99915 lo2/01/2003| N N 0 7.00 7 00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospital -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14 00 Hospi tal -Based Hospi ce 14 00 MY LINTON CLINIC 15.00 Hospital -Based Health Clinic - RHC 158535 99915 12/18/2018 Ν Ν Ν 15.00 Hospital-Based Health Clinic - RHC MY BLOOMFIELD CLINIC 158533 99915 12/18/2018 15.01 Ν Ν Ν 15.01 MY WESTGATE CLINIC 158534 99915 15.02 15 02 Hospital-Based Health Clinic - RHC 12/18/2018 Ν N N 1111 15.03 Hospital-Based Health Clinic - RHC MY WORTHINGTON CLINIC 158538 99915 12/12/2018 Ν Ν 15.03 Ν 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2023 12/31/2023 20.00 21.00 Type of Control (see instructions) 21.00 3. 00 1.00 2.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no N Ν 22.01 for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be determined at cost report settlement? (see instructions) Enter in column Ν Ν 22.02 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22.04 rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1. "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

Health Financial Systems GREENE CO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D.	UNTY GENERA ATA	AL HOSPITAL Provider CC		Period: From 01/0 To 12/3		Worksh Part I Date/T	rm CMS-2 neet S-2 ime Pre	pared:
			1.00	2.	00	3	00	
23.00 Which method is used to determine Medicaid days on I below? In column 1, enter 1 if date of admission, 2 if date of discharge. Is the method of identifying t reporting period different from the method used in t reporting period? In column 2, enter "Y" for yes or	if census on the days in the prior control of the prior control of the prior not be the pri	days, or 3 this cost ost o.		O				23. 00
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medica HMO da	ys Me	Other di cai d days	
24 00 If this provider is an LDDS best tall enter the	1.00	2.00	3.00	4. 00	5. 00	0	6. 00	24.00
24.00 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. 25.00 If this provider is an IRF, enter the in-state				0		0	0	24. 00
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		f Geogr 00	
26.00 Enter your standard geographic classification (not w	age) status	s at the be	eginning of		2	۷.	00	26. 00
cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban column the effective date of the geographic reclassification.	age) statu: r "2" for i	rural. If a		st	2			27. 00
35.00 If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			SCH status i	n Begi n	0 ni na:	End	i ng:	35. 00
				1.			00	
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat 37.00 If this is a Medicare dependent hospital (MDH), enter	es.	·			0			36. 00 37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for taccordance with FY 2016 OPPS final rule? Enter "Y" f	he MDH trai	nsitional p	payment in					37. 01
instructions) 38.00 If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.								38. 00
				Υ,			/N	
39.00 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 accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), on the mileago ii)? Enter	r (iii)? En e requireme in column	nter in colu ents in 2 "Y" for y	mn	I		00 N	39.00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octoon in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for					N 	40.00
					1. 00	2. 00		
Prospective Payment System (PPS)-Capital								
 45.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exceptions and the pursuant to 42 CFR §412.348(f)? If yes, complete Wks 	eption for	extraordi n	nary circums	tances	e N N	N N	N N	45. 00 46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS 48.00 Is the facility electing full federal capital paymen	capital? I	Enter "Y fo	or yes or "N	" for no.	N N	N N	N N	47. 00 48. 00
Teaching Hospitals						- '		
56.00 Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after Decembe the instructions. For column 2, if the response to involved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable "Y" for yes; otherwise, enter "N" for no in column 2	"Y" for yes er 27, 2020, column 1 is cams in the CRs) MA di	s or "N" fo , under 42 "Y", or if prior year	or no in col CFR 413.78(this hospi or penulti	umn 1. For b)(2), see tal was mate year,	- N			56. 00

Health Financial Systems GREENE COUL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATE		Provi der CC		Period: From 01/01/ To 12/31/	2023	of Form Worksheet Part I Date/Time 5/28/2024	t S-2 e Pre	pared:
		<u>'</u>			V	XVIII	XI X	
57.00 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 c "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 1f line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	reside cost re Works applic 413.7 on dut ete col	nts in approve n 1. If column porting period heet E-4. If c able. For cost 7(e)(1)(iv) a y, if the resp umn 2, and com nt for physici	d GME program 1 is "Y", di ? Enter "Y" olumn 2 is "N reporting pend (v), regan onse to line plete Workshe	ns trained d for yes or "", eriods rdless of 56 is "Y" eet E-4.	1. 00 N	2.00 3	3.00	57. 00
59.00 Are costs claimed on line 100 of Worksheet A? If yes			, Pt. I.		N			59. 00
			NAHE 413.85 Y/N	Li ne	#	Pass-Thro Qualifica Criteri Code	tion	
60.00 Are you claiming nursing and allied health education	(NAHE)	costs for	1. 00 N	2. 00		3. 00		60.00
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? (umn 1. CR) NAH	see If column 1						
	Y/N	I ME	Direct GME	IME		Direct (GME	
(4.00 0)	1.00	2. 00	3. 00	4. 00		5. 00	0.00	(1.00
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 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 instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,	N				0.00		0.00	61. 00 61. 01 61. 02
and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 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. 03
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. 04
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. 05
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)								61.06
	Pro	ogram Name	Program Code	Unweigh IME FTE 0	Count	Unweight Direct (FTE Cou 4.00	GME Int	
61.10 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. 61.20 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,		55	2.00	5.00	0.00	7. 00	0. 00	61. 20

Health Financial Systems	GREENE CO	UNTY GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA Pr	rovider CC		Period: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part I	pared:
						1. 00	
ACA Provisions Affecting the Hea 62.00 Enter the number of FTE resident	s that your hospital	trained in			eriod for which	0.00	62. 00
your hospital received HRSA PCRE 62.01 Enter the number of FTE resident during in this cost reporting pe	s that rotated from	a Teaching H			o your hospital	0.00	62. 01
Teaching Hospitals that Claim Re	esidents in Nonprovid	der Settings					
63.00 Has your facility trained reside "Y" for yes or "N" for no in col						N	63.00
				Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
				Nonprovi der Si te		col . 2))	
				1. 00	2.00	3. 00	
Section 5504 of the ACA Base Year period that begins on or after a				This base yea	ar is your cost	reporti ng	
64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to rosettings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (col	s yes, or your facili aber of unweighted no otations occurring in e number of unweighte our hospital. Enter i	ty trained ron-primary can all nonproved non-primar n column 3 t	residents re rider ry care he ratio	0. 0	0.00	0. 000000	64.00
or (cordiiir r drvrded by (cordiiir	Program Name	Program		Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))	
65.00 Enter in column 1, if line 63	1. 00	2.0	0	3. 00	4. 00	5. 00	
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				Unwei ghted	Unwei ghted	Ratio (col.	
				FTEs Nonprovi der Si te 1.00	FTEs in	1/ (col . 1 + col . 2))	
Section 5504 of the ACA Current		n Nonprovi de	er Setting				
beginning on or after July 1, 20 66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column	unweighted non-prima occurring in all nonp unweighted non-prima cal. Enter in column	provider sett ary care resi 3 the ratio	i ngs. dent	0. 0	0.00	0. 000000	66. 00
(Co. dim)	Program Name	Program		Unwei ghted FTEs Nonprovi der Si te	·	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2. 0	0	3. 00	4. 00	5. 00	

67. 66	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		0.00	0. 00000	0, 07. 00
	divided by (column 3 + column				
	4)). (see instructions)				
	Disease CME is Assessed as a width the EV 2022 LDDC Final Duly 07 ED 400/E 40072 (Assessed 1	2022)		1. 00	
	<u>Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-49072 (August 1 For a cost reporting period beginning prior to October 1, 2022, did you obtain permiss MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final Rule, 87 FI (August 10, 2022)?</u>	on from yo			68.00
	(again to a factor of the fac		4 00	0.00 0.00	
	Inpatient Psychiatric Facility PPS		1.00	2.00 3.00	
70. 00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF sul	provi der?	N		70.00
71. 00	Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in	the most		0	71.00
	recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new tear program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for Column 3: If column 2 is Y, indicate which program year began during this cost reportions (see instructions)	chi ng ` no.			
75 00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF		l N		75. 00
	subprovi der? Enter "Y" for yes and "N" for no.		IN IN		75.00
	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is indicate which program year began during this cost reporting period. (see instructions)	or "N" for e with 42 /,		0	76. 00
				1.00	
	Long Term Care Hospital PPS			1. 00	
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	g period? I	Enter	N N	80. 00 81. 00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(1)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(2)(1)(1)(1)(2)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)(1)		r no.	N	85. 00 86. 00
87.00	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87. 00
		Approved Permane Adjustm (Y/N)	ent ent)	Number of Approved Permanent Adjustments 2.00	
	Column 1: Is this hospital approved for a permanent adjustment to the TEFRA target amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 2 and line 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	N			0 88.00
					,

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co		Peri od:	u of Form CMS- Worksheet S-2	
			From 01/01/2023 To 12/31/2023	Date/Time Pre	
		Wkst. A Lin	e Effective	5/28/2024 4:3 Approved	36 pm
		No.	Date	Permanent	
				Adjustment Amount Per	
				Di scharge	
		1. 00	2. 00	3. 00	
89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A li		0.	00	(89.00
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	get amount				
per discharge. Column 3: Enter the amount of the approved permanent adjustme	ant to the				
TEFRA target amount per discharge.	in to the				
			V	XIX	1
Title V and XIX Services			1. 00	2. 00	
90.00 Does this facility have title V and/or XIX inpatient hospital	services? E	nter "Y" for	N	Υ	90.00
yes or "N" for no in the applicable column.					04.00
91.00 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			N	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dua	ıl certificat			N	92.00
instructions) Enter "Y" for yes or "N" for no in the applicab		-1 VIVO F-1	N	N.	02.00
93.00 Does this facility operate an ICF/IID facility for purposes o "Y" for yes or "N" for no in the applicable column.	or title v an	id XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for n	no in the	N	N	94.00
applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the appl	i cabla calum	an a	0.00	0.00	95.00
95.00 If line 94 is "Y", enter the reduction percentage in the appl 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			0.00 N	0.00 N	96.00
applicable column.					
97.00 If line 96 is "Y", enter the reduction percentage in the appl 98.00 Does title V or XIX follow Medicare (title XVIII) for the int			0. 00 N	0. 00 Y	97.00
stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo	or yes or "N"	for no in	IN	'	70.00
column 1 for title V, and in column 2 for title XIX.					
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				Y	98. 01
title XIX.	ire v, and ir	r corumni z ro	'		
98.02 Does title V or XIX follow Medicare (title XVIII) for the cal			N	Υ	98. 02
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.	"N" TOP NO	in column i			
98.03 Does title V or XIX follow Medicare (title XVIII) for a criti				N	98. 03
reimbursed 101% of inpatient services cost? Enter "Y" for yes for title V, and in column 2 for title XIX.	or "N" for	no in column	1		
98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH r	eimbursed 10)1% of	N	N	98. 04
outpatient services cost? Enter "Y" for yes or "N" for no in	column 1 for	title V, an	d		
in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add bac	rk the BCE di	sallowance o	n N		98. 05
Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				'	70.03
column 2 for title XIX.					
98.06 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			N	Y	98. 06
column 2 for title XIX.	T TOT LITTE	v, and in			
Rural Providers				T	105.00
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the all-i	nclusive met	hod of payme	nt Y		105. 00 106. 00
for outpatient services? (see instructions)	ner dar ve met	inod or payme			100.00
107.00 Column 1: If line 105 is Y, is this facility eligible for cos			N		107. 00
training 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	and/or IRF				
Enter "Y" for yes or "N" for no in column 2. (see instruction					107 01
107.01 If this facility is a REH (line 3, column 4, is "12"), is it reimbursement for I&R training programs? Enter "Y" for yes or					107. 01
instructions)			_		
108.00 s this a rural hospital qualifying for an exception to the C	KNA fee sche	edul e? See 4	2 Y		108. 00

108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42					108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupati onal	Speech	Respi ratory	
	1. 00	2. 00	3. 00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109.00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL			of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C	F	eriod: rom 01/01/2023 o 12/31/2023	Worksheet S Part I Date/Time P	repared:
			1.00	: 36 pm
110.00 Did this hospital participate in the Rural Community Hospital Demonstrati Demonstration) for the current cost reporting period? Enter "Y" for yes or complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lapplicable.	"N" for no. I	f yes,	N N	110.00
		1.00	2. 00	
111.00 If this facility qualifies as a CAH, did it participate in the Frontier (Health Integration Project (FCHIP) demonstration for this cost reporting "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, integration prong of the FCHIP demo in which this CAH is participating in Enter all that apply: "A" for Ambulance services; "B" for additional beds for tele-health services.	period? Enter enter the n column 2.	N		111.00
	1.00	2.00	3. 00	
112.00 Did this hospital participate in the Pennsylvania Rural Health Model (PARHM) demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112.00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y" for yes or	N			0115.00
"N" for no.				
117.00 s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1	Y			117. 00
if the policy is claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	Insurance	
	T T CIIII CIIIIS	203303	Trisur arice	
118 Ollist amounts of mal practice premiums and paid losses:	1.00	2.00	3. 00	0118 01
118.01 List amounts of malpractice premiums and paid losses:	1. 00	0		0118.01
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing and amounts contained therein.	444, 996 than the		3.00	118. 02
118.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless programmers of the State	than the cost centers ovision in ACA (" for yes or the Outpatient	1.00		118. 02
 118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless professional applicable amendments? (see instructions) Enter in column 1, "N" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable devices 	than the cost centers ovision in ACA (" for yes or the Outpatient tructions)	1.00 N	2.00	118. 02 119. 00 120. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro \$3121 and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA \$3121 and applicable amendments? (see instenter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in \$1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter	than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to 8(w)(3) of the	1.00 N	2.00	118. 02 119. 00 120. 00
 118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prosports and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instenter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903 	than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" n 50% of total ganizations	0 1.00 N N	2.00	118. 02 119. 00 120. 00 121. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prospectively said applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organization a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information	than the cost centers ovision in ACA " for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 sional and/or and, enter "Y" in 50% of total ganizations 'Y" for yes or	0 1.00 N	2. 00 N	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00
 118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless professional services or In column 1, "Note of the Professional School of the Professional School of the Outpatient Hold Harmless professional services expenses, for services patients? Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal theare related taxes as defined in \$1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 	than the cost centers ovision in ACA /" for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" n 50% of total ganizations 'Y" for yes	0 1.00 N N N Y N N Y	2. 00 N	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless programs and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal theare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organization? In column 1 is "Y", were the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.	than the cost centers ovision in ACA " for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" 1 50% of total panizations 'Y" for yes or	0 1.00 N N N Y N N Y	2. 00 N	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00 125. 00 126. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DN NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless professional applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instener in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater that professional services expenses, for services purchased from unrelated organization? In column 2, enter "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certific column 1 and termination date, if applicable, in column 2.	than the cost centers ovision in ACA " for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 sional and/or 1, enter "Y" in 50% of total ganizations "Y" for yes or "Y" for yes tification date fication date	0 1.00 N N N Y N N Y	2. 00 N	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00 125. 00 126. 00 127. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless programs and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated organizated in a CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the cert in column 1 and termination date, if applicable, in column 2.	than the cost centers ovision in ACA (" for yes or the Outpatient tructions) es charged to B(w)(3) of the er in column 2 sional and/or 1, enter "Y" n 50% of total ganizations 'Y" for yes or "Y" for yes or	0 1.00 N N N Y N N Y	2. 00 N	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00 125. 00 126. 00 127. 00 128. 00
118.02 Are mal practice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein. 119.00 DN NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless professal and applicable amendments? (see instructions) Enter in column 1, "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instended that the Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal theare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. 123.00 Did the facility and/or its subproviders (if applicable) purchase profess services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than professional services expenses, for services purchased from unrelated organization? In column 1 and CBSA outside of the main hospital CBSA? In column 2, enter "N" for no. Certified Transplant Center Information 125.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare-certified kidney transplant program, enter the certific column 1 and termination date, if applicable, in column 2.	than the cost centers ovision in ACA " for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 sional and/or 1, enter "Y" in 50% of total ganizations "Y" for yes or "Y" for yes or "Y" for date fication date fication date	0 1.00 N N N Y N N Y	2. 00 N	118. 02 119. 00 120. 00 121. 00 122. 00 123. 00 126. 00 127. 00 128. 00 129. 00 130. 00

Health Financial Systems		Y GENERAL HOSPITAL		1		u of Form CMS	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENIIFICATION DATA	Provi der CC	CN: 15-1317		: 01/01/2023 2/31/2023	Worksheet S- Part I Date/Time Pr 5/28/2024 4:	epared:
					1. 00	2.00	
131.00 If this is a Medicare-certified in date in column 1 and termination			certi fi cati	on	1.00	2.00	131.00
132.00 f this is a Medicare-certified i in column 1 and termination date,			fication da	nte			132.00
133.00 Removed and reserved 134.00 If this is a hospital-based organ in column 1 and termination date, All Providers			he OPO numb	oer			133. 00 134. 00
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	"N" for no in column 1	. If yes, and home mber. (see instruc	office cos		N		140.00
1.00 If this facility is part of a cha			ugh 143 th	e name ar	3.00 nd address	of the home	
office and enter the home office	contractor name and co Contractor's Name		Contra	ctor's Nu	ımher:		141. 00
142. 00 Street:	PO Box:	J.	Contra	, tor 3 m	alliber.		142.00
143. 00 Ci ty:	State:		Zip Co	de:			143.00
						1. 00	+
144.00 Are provider based physicians' co	sts included in Worksh	eet A?				Y	144.00
					1.00	2.00	
45.00 f costs for renal services are cinpatient services only? Enter "Y no, does the dialysis facility inperiod? Enter "Y" for yes or "N"	" for yes or "N" for n clude Medicare utiliza	o in column 1. If	column 1 is	5	1.00	2.00	145. 00
46.00 Has 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
						1. 00	\dashv
47.00 Was there a change in the statist						N	147.00
148.00 Was there a change in the order o 149.00 Was there a change to the simplif				or no		N N	148. 0
149.00 was there a change to the shiphin	rea cost irriarily illetilo	Part A	Part B		itle V	Title XIX	149.00
a		1.00	2. 00		3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
55. 00 Hospi tal		N	N		N	N	155. 0
56. 00 Subprovi der - IPF		N	N		N	N	156. 0
57. 00 Subprovi der - I RF 58. 00 SUBPROVI DER		N	N N		N	N	157. 0 158. 0
59. 00 SNF		N	N N		N	N	159. 0
160.00HOME HEALTH AGENCY		N	N N		N	N	160. 0
61. 00 CMHC			N N		N	N	161.0
						1.00	
Multicampus 165.00 Is this hospital part of a Multica	ampus hospital that ha	s one or more camp	uses in dit	ferent 0	CBSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
66.00 f 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						0.0	166. 00
column 5 (see instructions)							
Hoal th Information Tasked on (III)	T) inconting in the A-	ori can Pocovery	nd Doiny so	mont Ast		1. 00	
Health Information Technology (HI 167.00 s this provider a meaningful use 168.00 f this provider is a CAH (line 1	r under §1886(n)? Ent O5 is "Y") and is a me	er "Y" for yes or aningful user (lin	"N" for no.			Y	167. 00 168. 00
reasonable cost incurred for the 68.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii)	not a meaningful user,	does this provide			dshi p		168. 0
169.00 If this provider is a meaningful transition factor. (see instruction		and is not a CAH	(line 105 i	s "N"),	enter the	0.0	00169.0

Health Financial Systems	GREENE COUNTY GENE	RAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-1317	Peri od:	Worksheet S-2	
			From 01/01/2023 To 12/31/2023		narod.
			10 12/31/2023	Date/Time Pre 5/28/2024 4:3	
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					170. 00
			1. 00	2. 00	
171.00 If line 167 is "Y", does this provi	der have any days for indi	viduals enrolled in	N	0	171.00
section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter					
"Y" for yes and "N" for no in colum	n 1. If column 1 is yes, 🤅	enter the number of secti	on		
1876 Medicare days in column 2. (se	e instructions)				

### HIGSPITAL AND HOSPITAL PEACH CARE RELINDINGERENT QUESTI OMALIEE Provider CO2 15-1317	Heal th	Financial Systems GREENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
PART II - MORPITAL MID MORPITAL HEATHCREE CORRECT RELIGIOUS/PROJECTION/MAISE	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		From 01/01/2023	Part II Date/Time Pre	epared:
Bearer I I - HOSPITAL MAN HOSPITAL MEATHCREE COMPLEX RELINGUISESURED TOURISTIONALE RESIDENT STATEMENT YOUR AID WEST RESPONSES. Enter N for all NO responses. Enter all dates in the midd/Wyby Terman and Provide Organization and Operation. 1.00 Has the provider changed concretibly immediately prior to the beginning of the cost. 1.00 Has the provider changed concretibly immediately prior to the beginning of the cost. 2.00 Has the provider changed concretibly immediately prior to the beginning of the cost. 2.00 Has the provider changed concretibly immediately prior to the beginning of the cost. 2.00 Has the provider changed concretibly immediately prior to the beginning of the cost. 2.00 Has the provider terminated participation in the Medicare Program? If you 2.00 3.00 2.00 3.00 2.00 3.00 3.00 3.00					Y/N		36 pm
secretal Instruction. Enter Y for all YS responses. Enter N for all N0 responses. Enter all dates in the middy/wyor formul, some interest of the control of		DADT II. HOODITAL AND HOODITAL HEATHCADE COMDLEY DELMDHOC	EMENT OUESTLON	VALDE	1. 00	2. 00	
1.00 Pepertrup parted 71 Type, senter the date of the change in column 2, See Instructions) N		General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS			er all dates in	the	
2.00 Has the provider tensinated participation in the Medicare Program? IT. N.00 2.00 3.00 2.00 3.00 2.00 yes, enter in column 2 the date of termination and in column 3. "Y" for yes, enter in column 2 the date of termination and in column 3. "Y" for yes, enter in column 2 the date of termination and in column 3. "Y" for yes, enter in column 2 the date of termination and in column 3. "Y" for yes, enter in column 2 the date of termination and in column 3. "Y" for yes, enter in column 3. 3.00 contracts, with in dividuals or entit itse (e.g., chain home offices drug or redical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or femily and other similar rid attributions. For the instructions in the instructions of the instructions of the instructions of the column 2 femily and other similar rid attribution. For the instructions in the instructions of the column 3. (see Instructions) If no. see Instructions. 5.00 Are the cost report foul attribution in the seed of the cost report foul attribution in the cost report foul attribution. 5.00 For the legal operator of the program? If yes, submit reconciliation. 6.00 Column 1 Are costs claimed for a nursing program? Column 2: If yes, is the provider in the legal operator of the program? If yes, see instructions. 6.00 More nursing programs and/or allied health programs approved and/or renewed during the N 2.00 cost report in period? If yes, see instructions. 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 8.00 Work an approved International Column 2 is R in an Approved N 1.00 cost reporting period? If yes, see instructions. 10.00 Was an approved international column and Resident (MB) program intitiated or renewed during the N 2.00 period? If yes, see instructions. 10.00 If in left yes, see instructions. 10.00 If in left yes, yes, we read yet the provider's bed debts? If yes, see instructions. 10.00 If in left yes, see	1. 00	Has the provider changed ownership immediately prior to th					1.00
2.00 Has the provider terminated participation in the Medicare Program? IF yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary or or medical supply companies) that are related to the provider or list or file actionships" (See Instructions) V"/II Type Date The lationships" (See Instructions) V"/II Type Date The lationships (See Instructions) The lationships (See Instructions) V"/II Type Date The lationships (See Instructions)		reporting period? If yes, enter the date of the change in	column 2. (see			V/I	
2.00 last the provider terminated participation in the Medicare Program? IF N yes, exterin column 2 the date of remination and in column 3, "V" for voluntary or "I" for involuntary for for involu							
contracts, with individuals or entities (e.g., chain home offices, drug or nedical supply companies) that are related to the provideor or its officers, medical staff, management personnel, or members of the board of directors through ownership. Control, or family and other simil ar relationships of control, or family and other simil ar relationships of control. Financial Data and Reports		yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary.	mn 3, "V" for				
Financial Data and Reports	3. 00	contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the proviofficers, medical staff, management personnel, or members of directors through ownership, control, or family and oth	offices, drug der or its of the board	Y			3.00
Financial Data and Reports 4.00 Column 1: Were the financial statements prepared by a Certified Public							
4.00 Column 1: Were the financial statements prepared by a Certified Public Y A 4.00 Accountant? Column 2: If yes, enter "A" for Audited," (")" for Conjied, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see Instructions). If no. see Instructions. Solution 2. Sol		Financial Data and Reports		1.00	2.00	3.00	
those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper.		Column 1: Were the financial statements prepared by a Cer Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av	for Compiled,	Y	A		4.00
Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider the legal operator of the program? 7.00 Are costs claimed for Allied Heal th Programs approved and/or renewed during the costs reporting period? If yes, see instructions. 8.00 Were nursing programs and/or allied heal th programs approved and/or renewed during the cost reporting period? If yes, see instructions. 8.00 Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. 10.00 Was an approved Intern and Resident GWE program initiated or renewed in the current cost reporting period? If yes, see instructions. 11.00 Are GWE cost directly assigned to cost centers other than I & R in an Approved N 11.00 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts walved? If yes, see N 14.00 13.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts walved? If yes, see N 14.00 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. 16.00 Was the cost report prepared using the PS&R Report only? 17.00 Was the cost report prepared using the PS&R Report only? 18.00 If line 10 or 17 is yes, enter the pald-through date of the PS&R Report used to file this cost report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report data for additional claims that have been billed but are not included on the PS&R Report of of the report data for corre	5. 00			N			5. 00
Approved Educational Activities		those on the filed financial statements? If yes, submit re	conciliation.		Y/N	Legal Oper	
6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider N							
7.00 Are costs claimed for Allied Heal th Programs? If "Y" see instructions. N Robot		Column 1: Are costs claimed for a nursing program? Column	2: If yes, i	s the provide	r N		6. 00
9.00 Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions. 10.00 Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions. 11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00 Reaching Program on Worksheet A? If yes, see instructions. 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see instructions. 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. 16.00 Part A Part B P		Are costs claimed for Allied Health Programs? If "Y" see i		wed during th			
10.00 Was an approved Intern and Resident GME program Initiated or renewed in the current cost reporting period? If yes, see instructions. 11.00	9. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 00
11.00 Are GME cost directly assigned to cost centers other than I & R in an Approved N 11.00	10. 00	Was an approved Intern and Resident GME program initiated		the current	N		10.00
Bad Debts 1.00 1.	11. 00	Are GME cost directly assigned to cost centers other than	I & R in an Ap	proved	N		11. 00
12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 16.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 17.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 18.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 18.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 19.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 16.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 17.00 Was the cost report prepared using the PS&R Report only? 18.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 19.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 19.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 19.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 19.00 Did total beds available change from the prior cost reporting period? If yes, see instructions 19.00 Did tot		Teaching Program on worksheet A? IT yes, see Instructions.				Y/N	
12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting N 13.00 period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. Part A							
13.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy. 14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see			s soo instruc	tions		V	12.00
14.00 If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see N 14.00 instructions. Bed Complement	13. 00	If line 12 is yes, did the provider's bad debt collection	policy change	during this c	ost reporting	l .	
15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions. N 15.00		If line 12 is yes, were patient deductibles and/or coinsurinstructions.	ance amounts w	aived? If yes	, see	N	14.00
Part A Part B Y/N Date Y/N Date 1.00 2.00 3.00 4.00 PS&R Data 16.00 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) 17.00 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) 18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report used to file this cost report? If yes, see instructions. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report used to file this cost report? If yes, see instructions. 19.00 Report data for corrections of other PS&R Report			ing period2 lf	ves see ins	tructions	N	15 00
PS&R Data 16.00 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) 17.00 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) 18.00 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. 19.00 Report data for corrections of other PS&R Report	13.00	p. a total boas available change from the prior cost report	Par		Par		13.00
PS&R Data 16.00 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) 17.00 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) 18.00 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. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report							
16.00 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) 17.00 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) 18.00 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. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report		PS&R Data	1.00	2.00	3.00	4.00	
17.00 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) 18.00 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. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R N Report data for corrections of other PS&R Report		Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	Y	05/14/2024	Y	05/14/2024	16. 00
18.00 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. 19.00 If line 16 or 17 is yes, were adjustments made to PS&R N N 19.00 Report data for corrections of other PS&R Report	17. 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	N		N		17. 00
19.00 If line 16 or 17 is yes, were adjustments made to PS&R N N N 19.00 Report data for corrections of other PS&R Report	18. 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	N		N		18. 00
	19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report	N		N		19.00

Health Financial Systems GREENE COUNTY GE	NERAL HOSPITAL	L	In Lie	u of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-1317	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S- Part II Date/Time Pi 5/28/2024 4:	repared:
		iption	Y/N	Y/N	
00.00 10.11 44 47 1		0	1.00	3. 00	105 -
20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
	Y/N	Date	Y/N	Date	
	1.00	2.00	3. 00	4. 00	
21.00 Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
				1. 00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS	HOSPI TALS)		1.00	
Capital Related Cost		· ·			
22.00 Have assets been relifed for Medicare purposes? If yes, see	e instructions	5		N	22. 00
23.00 Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprai	sals made du	ring the cost	N	23. 00
24.00 Were new leases and/or amendments to existing leases entere	ed into durino	this cost r	eporting period?	N	24.00
If yes, see instructions 25.00 Have there been new capitalized leases entered into during	the cost repo	ortina period	? If ves. see	N	25.00
i nstructi ons.	·	0.			
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	he cost report	ing period?	If yes, see	N	26.00
27.00 Has the provider's capitalization policy changed during the	e cost reporti	ng period? I	f yes, submit	N	27. 00
copy. Interest Expense					
28.00 Were new Loans, mortgage agreements or Letters of credit er period? If yes, see instructions.	ntered into du	ıring the cos	t reporting	N	28. 00
29.00 Did the provider have a funded depreciation account and/or		ebt Service	Reserve Fund)	Υ	29. 00
treated as a funded depreciation account? If yes, see instr 30.00 Has existing debt been replaced prior to its scheduled matu		debt? If ye	s, see	N	30.00
instructions. 31.00 Has debt been recalled before scheduled maturity without is	ssuance of now	, dobt2 lf vo	5 500	N	31.00
instructions.	ssuance or new	debt: II ye	5, 500	IN	31.00
Purchased Services 32.00 Have changes or new agreements occurred in patient care ser	rvi cas furni sh	ed through c	ontractual	N	32.00
arrangements with suppliers of services? If yes, see instru		ied till odgir c	ontractual	IN.	32.00
33.00 If line 32 is yes, were the requirements of Sec. 2135.2 approximation, see instructions.	plied pertaini	ng to compet	itive bidding? If	F N	33.00
Provi der-Based Physi ci ans					
34.00 Were services furnished at the provider facility under an a	arrangement wi	th provider-	based physicians?	Y	34.00
If yes, see instructions. 35.00 If line 34 is yes, were there new agreements or amended exi		ents with the	provi der-based	N	35. 00
physicians during the cost reporting period? If yes, see in	nstructi ons.		Y/N	Date	
			1. 00	2. 00	
Home Office Costs					
36.00 Were home office costs claimed on the cost report?			N		36. 00
37.00 If line 36 is yes, has a home office cost statement been pr	repared by the	home office	? N		37.00
If yes, see instructions. 38.00 If line 36 is yes , was the fiscal year end of the home off			f N		38. 00
the provider? If yes, enter in column 2 the fiscal year end 39.00 If line 36 is yes, did the provider render services to other			s. N		39.00
see instructions.	•	,			
40.00 If line 36 is yes, did the provider render services to the instructions.	nome office?	it yes, see	N		40.00
	1	00	2	00	
Cost Report Preparer Contact Information	1.	. 00	2.	00	
	KERRY		BEJARANO		41.00
respecti vel y.	FORVIS LLP				42.00
preparer.			WEDS: :	- 500 // 5 - 5 - 5	
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317. 383. 4182		KERRY. BEJARANO	@FORVIS.COM	43.00

Heal th	Financial Systems GF	REENE COUNTY G	ENERA	L HOSPITAL		In Lieu	of Form (CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	F	Provider CCN	: 15-1317	eriod: rom 01/01/2023 o 12/31/2023		Pre	pared:
				3. 00)				
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the titl		DI RE	CTOR					41.00
	held by the cost report preparer in columns respectively.	1, 2, and 3,							
42. 00	Enter the employer/company name of the cost	report							42.00
43. 00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respecti								43. 00

Heal th	Financial Systems GREENE COUNTY GENE	RAL HOSPITAL		Non-CMS HFS Wo	rksheet
HFS Su	upplemental Information	Provi der CCN: 15-1317	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pro 5/28/2024 4::	epared:
			Title V	Title XIX	
			1. 00	2. 00	
	TITLES V AND/OR XIX FOLLOWING MEDICARE				
1. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Interstepdown adjustments on W/S B, Part I, column 25? Enter Y/N i and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98)	in column 1 for Title V	N	Y	1.00
2. 00	Do Title V or XIX follow Medicare (Title XVIII) for the report Part I (e.g. net of Physician's component)? Enter Y/N in coluin column 2 for Title XIX. (see S-2, Part I, line 98.01)	rting of charges on W/S (Y	2.00
3. 00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of the Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for 2 for Title XIX. (see S-2, Part I, line 98.02)			Y	3.00
3. 01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01
3. 02	Does Title XIX transfer managed care (HMO) days from Workshee	et S-3 Part L column 7		Y	3. 02
0.02	sum of lines 2, 3, and 4 to Worksheet E-4, column 2, line 26'			·	0.02
		•	I npati ent	Outpati ent	
			1. 00	2.00	
	CRITICAL ACCESS HOSPITALS				
4.00	Does Title V follow Medicare (Title XVIII) for Critical Acces	ss Hospitals (CAH) being	N	N	4.00
	reimbursed 101% of cost? Enter Y or N in column 1 for inpation outpatient. (see S-2, Part I, lines 98.03 and 98.04)				
5. 00	Does Title XIX follow Medicare (Title XVIII) for Critical Accrembursed 101% of cost? Enter Y or N in column 1 for inpation for outpatient. (see S-2, Part I, Lines 98.03 and 98.04)			N	5. 00
	To outpatrent. (see 5-2, rait 1, Tries 70.03 and 70.04)		Ti tle V	Title XIX	
			1.00	2.00	
	RCE DI SALLOWANCE		1.00	2.00	
6. 00	Do Title V or XIX follow Medicare and add back the RCE Disall column 4? Enter Y/N in column 1 for Title V and Y/N in column S-2, Part I, line 98.05)		N	Y	6. 00
7 00	PASS THROUGH COST				
7. 00	Do Title V or XIX follow Medicare when cost reimbursed (payme worksheets D, parts I through IV? Enter Y/N in column 1 for 2 for Title XIX. (see S-2, Part I, line 98.06)		N	Y	7.00
	RHC				
8. 00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Entitle V and Y/N in column 2 for Title XIX.	ter Y/N in column 1 for	N	N	8. 00
	FOHC				
9. 00	For fiscal year beginning on/after 10/01/2014, use M-series 1 XLX? Enter Y/N in column 1 for Title V and Y/N in column 2 for		N	N	9. 00
				ate 00	
	STATE MEDICALD FORMS				
10.00	Select the state when using state Medicaid forms.				 1 0.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Health Financial Systems GREENE COUNTY GENERAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC Provider CCN: 15-1317

				Т	o 12/31/2023	Date/Time Pre 5/28/2024 4:3	
						I/P Days /	O piii
						0/P Visits /	
	Component	Worksheet A	No. of Beds	Bed Days	CAH/REH Hours	Trips Title V	
	Component	Li ne No.	No. of beds	Avai I abl e	OAII/ KEII HOUI 3	TI LIC V	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	20	7, 300	36, 360. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		20	7, 300	36, 360. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31.00	5	1, 825	3, 000. 00	0	8.00
9. 00	CORONARY CARE UNIT	31.00	5	1, 023	3,000.00	U	9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14. 00	Total (see instructions)		25	9, 125	39, 360. 00	0	14.00
15.00	CAH visits				0.00	0	15.00
15. 10 16. 00	REH hours and visits SUBPROVIDER - IPF				0. 00	0	15. 10 16. 00
17. 00	SUBPROVIDER - IPF						17.00
18. 00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00 24. 10	HOSPICE	20.00					24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 01	RURAL HEALTH CLINIC II	88. 01				0	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02				0	26. 02
26. 03	RURAL HEALTH CLINIC IV	88. 03				0	26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		25			_	27. 00
28. 00	Observation Bed Days					0	28.00
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)						29. 00 30. 00
31.00	Employee discount days (see Histruction)						31.00
32. 00	Labor & delivery days (see instructions)		0	0			32.00
32. 01	Total ancillary labor & delivery room		Ĭ				32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33.00
33. 01	LTCH site neutral days and discharges			_		_	33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	30.00	0	0		0	34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1317

Period: Worksheet S-3 From 01/01/2023 Part I

33.01

34.00

Date/Time Prepared: 12/31/2023 5/28/2024 4: 36 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Title XIX Component Total ALL Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 PART I - STATISTICAL DATA 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 808 31 1, 515 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 103 2.00 3.00 HMO IPF Subprovider HMO IRF Subprovider 0 3 00 0 4.00 0 C 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 286 335 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 1,094 7.00 31 1,850 7.00 beds) (see instructions) 8.00 INTENSIVE CARE UNIT 38 125 8.00 9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11 00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 13 146 14.00 Total (see instructions) 1, 132 48 2, 121 0.00 332.26 14.00 15.00 CAH visits C 0 15.00 15. 10 REH hours and visits 0 0 15.10 SUBPROVIDER - IPF 16.00 16.00 17.00 SUBPROVIDER - IRF 17.00 18.00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22.00 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24.00 24.10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 RURAL HEALTH CLINIC 3.800 40.39 26 00 29 392 0 00 26 00 9, 001 10. 20 RURAL HEALTH CLINIC II 0 26.01 1, 671 0.00 26.01 26. 02 RURAL HEALTH CLINIC III 1, 974 0 7, 994 0.00 9. 92 26.02 26.03 RURAL HEALTH CLINIC IV 3, 349 0 9, 914 0.00 8.63 26.03 FEDERALLY QUALIFIED HEALTH CENTER 0.00 0.00 26. 25 C 26 25 0 0 Total (sum of lines 14-26) 27.00 0.00 401.40 27.00 Observation Bed Days 133 1, 359 28.00 29.00 Ambulance Trips 29.00 0 Employee discount days (see instruction) 30.00 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 24 54 32.00 32.00 Total ancillary labor & delivery room 32.01 32.01 0 outpatient days (see instructions) 33 00 LTCH non-covered days 33.00

0

0

0

LTCH site neutral days and discharges

34.00 | Temporary Expansion COVID-19 PHE Acute Care

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: Heal th Fi nancial SystemsGREENE COUHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-1317

				To	12/31/2023	Date/Time Pre 5/28/2024 4:3	
		Full Time		Di sch	arges	372072024 4.3	O piii
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		(291	14	638	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			26	0		2.00
3.00	HMO I PF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0 00	beds) (see instructions)						0 00
8. 00	INTENSIVE CARE UNIT						8.00
9. 00 10. 00	CORONARY CARE UNIT						9. 00 10. 00
11. 00	BURN INTENSIVE CARE UNIT						11.00
	SURGICAL INTENSIVE CARE UNIT						
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12.00
14. 00	· ·	0.00	(291	14	638	13. 00 14. 00
15. 00	CAH visits	0.00	(291	14	030	15.00
15. 10							15. 10
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	1						18.00
	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26. 03	RURAL HEALTH CLINIC IV	0.00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28. 00
29.00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
	LTCH non-covered days			0			33.00
33. 01	3			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care			1			34.00

		EENE COUNTY GE				eu of Form C		552-10
HOSPI 7	FAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1317	Period: From 01/01/2023	Worksheet	S-8	
			Component	CCN: 15-8535	To 12/31/2023	B Date/Time		
					RHC I	5/28/2024	4: 30	э рііі
					1	. 00		
1. 00	Clinic Address and Identification Street				1210 N. 1000 V	N		1. 00
1.00	Joth Cot		Ci	ty	State	ZIP Code	,	1.00
				00	2. 00	3. 00		
2. 00	City, State, ZIP Code, County		LINTON			47441		2.00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban			0	3.00
					nt Award	Date		
	Source of Federal Funds				1.00	2. 00		
4. 00	Community Health Center (Section 330(d), PHS	Act)				T		4.00
5.00	Migrant Health Center (Section 329(d), PHS A							5.00
6.00	Health Services for the Homeless (Section 34)	O(d), PHS Act)						6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes							7. 00 8. 00
9. 00	OTHER (SPECIFY)							9. 00
				•				
10.00	Does this facility operate as other than a h	ospi tal basad	DUC or FOUC2 F	ntor "V" for	1. 00 N	2.00	0	10.00
10.00	yes or "N" for no in column 1. If yes, indic. 2. (Enter in subscripts of line 11 the type o	ate number of	other operatio	ns in column			U	10.00
	hours.)	Sun	day	I N	 Monday	Tuesday		
		from	to	from	to	from		
		1. 00	2.00	3.00	4. 00	5. 00		
11 00	Facility hours of operations (1)					1		11. 00
11.00	CETIVIC							11.00
					1. 00	2. 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 columbur of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y N		0	12.00 13.00
13. 01	numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consolid separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH	for yes or "N" pings and comp Consolidated Cs in the grou	for no. If lete a RHC grouping			0	13. 01
					ider name	CCN		
14 00	RHC/FQHC name, CCN				1. 00	2. 00		14 00
14.00	KHO/T QUE Hallie, CON	Y/N	V	XVIII	XIX	Total Visi	ts	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

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 15-1317	Peri od:	Worksheet S-8	3
		Component (CCN: 15-8535	From 01/01/2023 To 12/31/2023		epared: 36 pm
				RHC I		
		Cou	nty			
		4.	00			
2.00 City, State, ZIP Code, County		GREENE				2.00
	Tuesday	Wedne	esday	Thur	sday	
	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
	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

HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1317	Peri od:	Worksheet	S-8	2552-1
			Component	CCN: 15-8533	From 01/01/2023 To 12/31/2023	3	Pre	pared:
					RHC II	37 207 2024	4. 30	о рііі
			<u>'</u>					
					1.	. 00		
00	Clinic Address and Identification				EE N. IUDOE CI		\blacksquare	1 00
. 00	Street		Ci	ty	55 N. JUDGE ST	ZIP Code	_	1.00
		-		00	2. 00	3.00		
2. 00	City, State, ZIP Code, County	В	LOOMFI ELD			N 47424		2.00
2 00	HOCDITAL DACED FOLICE ONLY. Designation. Fet	"D"	"!!" 6			1.00		2.00
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	or "U" for		nt Award	Date	0	3.00
					1. 00	2.00		
	Source of Federal Funds					1 2.00		
4. 00	Community Health Center (Section 330(d), PHS							4.00
5.00	Migrant Health Center (Section 329(d), PHS A							5.00
5. 00	Health Services for the Homeless (Section 34	O(d), PHS Act)				-		6.00
7. 00 8. 00	Appalachian Regional Commission Look-Alikes							7. 00 8. 00
9. 00	OTHER (SPECIFY)							9.00
	(5. 251. 1)							
					1. 00	2.00		
0.00	Does this facility operate as other than a h	•					0	10.00
	yes or "N" for no in column 1. If yes, indic 2.(Enter in subscripts of line 11 the type o							
	hours.)	i other operation	on(s) and the	operating				
	near of y	Sund	ay	N	londay	Tuesday		
		from	to	from	to	from		
		1. 00	2. 00	3. 00	4. 00	5. 00		
11 00	Facility hours of operations (1)						\blacksquare	11 00
11.00	CLINIC							11.00
					1. 00	2.00		
12. 00	Have you received an approval for an excepti	on to the produ	ctivity stand	ard?	Y	2.00	\neg	12.00
13. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col				N		0	13.00
	number of providers included in this report.	List the names	of all provi	ders and				
12 01	numbers below.	ing multiple co	noolidatad DU	Co (oo dofin	ed N		0	12.01
13. 01	If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2						۷	13.01
	yes, enter in column 2 the number of consoli							
	separate Worksheet S-8 for each consolidated	RHC grouping.	Consol i dated	RHC grouping	gs			
	are comprised exclusively of grandfathered c			oing or				
	comprised exclusively of new consolidated RH	<u>Cs in the group</u>	i ng.	Drov	idor namo	CCN		
					ider name 1.00	2. 00		
14. 00	RHC/FQHC name, CCN				1.00	2.00	\neg	14.00
		Y/N	V	XVIII	XIX	Total Visi	ts	
		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							15. 00
	XIX, as applicable. Enter in column 5 the number of total visits for this provider.							

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 15-1317	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8533	From 01/01/2023 To 12/31/2023		epared: 36 pm
				RHC II		
		Cou	nty			
		4.	00			
2.00 City, State, ZIP Code, County		GREENE				2.00
	Tuesday	Wedne	esday	Thur	sday	
	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
	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

	<i></i>	EENE COUNTY GE				eu of Form C		552-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1317	Period: From 01/01/2023	Worksheet	S-8	
			Component	CCN: 15-8534	To 12/31/2023	B Date/Time		
					RHC III	5/28/2024	4: 30	o pm
			· '					
					1	. 00		
1. 00	Clinic Address and Identification Street				1985 E. FREEDO	OM DB		1. 00
1.00	Juli Cot		Ci	ty	State	ZIP Code	,	1.00
			1.	00	2. 00	3. 00		
2. 00	City, State, ZIP Code, County		NEWBERRY		11	47449		2.00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban		1.00	0	3.00
	•				nt Award	Date		
	Course of Foderal Funda				1. 00	2. 00		
4. 00	Source of Federal Funds Community Health Center (Section 330(d), PHS	Act)		I		1		4. 00
5. 00	Migrant Health Center (Section 329(d), PHS A							5. 00
6.00	Health Services for the Homeless (Section 34							6.00
7.00	Appalachian Regional Commission							7.00
8. 00 9. 00	Look-Alikes OTHER (SPECIFY)							8. 00 9. 00
7. 00	Johner (or corresponding to the control of the corresponding to the corr							7. 00
	T- '				1.00	2. 00		
10. 00	Does this facility operate as other than a house or "N" for no in column 1. If yes, indical. (Enter in subscripts of line 11 the type of hours.)	ate number of	other operatio	ns in column			0	10. 00
	illoui 3.)	Sun	day	l N	londay	Tuesday		
		from	to	from	to	from		
	Facility house of energtions (1)	1. 00	2. 00	3.00	4. 00	5. 00		
11. 00	Facility hours of operations (1)							11.00
					1. 00	2. 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 columber of providers included in this report. In numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	N N		0	12. 00 13. 00
13. 01	If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RH)? Enter "Y" dated RHC grou RHC grouping. onsolidated RH	for yes or "N" pings and comp Consolidated Cs in the grou	for no. If lete a RHC grouping			0	13. 01
					ider name	CCN		
14 00	RHC/FQHC name, CCN				1. 00	2. 00		14.00
14.00	NITO/ I WITC HAIRE, CON	Y/N	V	XVIII	XIX	Total Visi	ts	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

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 15-1317	Peri od:	Worksheet S-8	3
		Component	CCN: 15-8534	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 4:3	epared: 36 pm
				RHC III		
		Cou	nty			
		4.	00			
2.00 City, State, ZIP Code, County		GREENE				2.00
	Tuesday	Wedne	esday	Thur	sday	
	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
	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	NERAL HOSPITAL		In Lie	eu of Form CM	S-25	52-10
HOSPI 7	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1317	Period: From 01/01/2023	Worksheet S	8-8	
			Component	CCN: 15-8538	To 12/31/2023	3 Date/Time F		
-					RHC I V	5/28/2024 4	1: 36	pm
					INTO TV			
					1	. 00		
1 00	Clinic Address and Identification				100 F MAIN C	TDEET		1 00
1.00	Street		Ci	tv	102 E. MAIN S	ZIP Code		1. 00
				00	2.00	3.00		
2.00	City, State, ZIP Code, County		WORTHI NGTON		11	V 47471		2.00
						1.00		
3. 00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rura	al or "U" for i	urban		1.00	0	3. 00
0.00	THOSE TIME BROCK TELL BOOK GREET ON ENG				nt Award	Date		0.00
					1. 00	2. 00		
4 00	Source of Federal Funds	· A - + \				T		4 00
4. 00 5. 00	Community Health Center (Section 330(d), PHS Migrant Health Center (Section 329(d), PHS A						ŀ	4. 00 5. 00
6. 00	Health Services for the Homeless (Section 34						l	6. 00
7.00	Appalachian Regional Commission							7.00
8.00	Look-Alikes							8.00
9. 00	OTHER (SPECIFY)							9. 00
					1. 00	2.00		
10.00	Does this facility operate as other than a h	•			N		0	10. 00
	yes or "N" for no in column 1. If yes, indic 2. (Enter in subscripts of line 11 the type of hours.)							
	11041 01 /	Sun	day	M	onday	Tuesday		
		from	to	from	to	from		
	Facility hours of operations (1)	1. 00	2. 00	3. 00	4. 00	5. 00		
								11 00
11.00	CLINIC							11.00
11.00	CLI NI C							11.00
					1.00	2.00		
12.00	Have you received an approval for an excepti				N	2.00		12. 00
12.00	Have you received an approval for an excepti Is this a consolidated cost report as define	d in CMS Pub. 1	100-04, chapte	r 9, section		2.00		12. 00
12. 00	Have you received an approval for an excepti	d in CMS Pub. 1 umn 1. If yes,	100-04, chapte enter in colu	n 9, section nn 2 the	N	2.00		12. 00
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes, List the names	100-04, chapted enter in coludes of all provid	r 9, section nn 2 the ders and	N N	2.00	0	12. 00 13. 00
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report	d in CMS Pub. 2 umn 1. If yes, List the names ing multiple co	100-04, chapted enter in coludes of all providence	r 9, section mn 2 the ders and Cs (as define	N N	2.00	0	12. 00 13. 00
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below.	d in CMS Pub. 2 umn 1. If yes, List the names ing multiple co)? Enter "Y" 1	100-04, chapte enter in colu s of all provio onsolidated RHO for yes or "N"	r 9, section mn 2 the ders and Cs (as define for no. If	N N	2.00	0	12. 00 13. 00
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC grouping. RHC grouping.	100-04, chapted enter in column s of all provide consolidated RHO for yes or "N" bings and compl Consolidated	r 9, section mn 2 the ders and Cs (as define for no. If lete a RHC grouping	N N	2.00	0	12. 00 13. 00
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered of	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. consolidated RHC	100-04, chapted enter in columns of all providence on solidated RHF for yes or "N" bings and compile Consolidated Cs in the group	r 9, section mn 2 the ders and Cs (as define for no. If lete a RHC grouping	N N	2.00	0	12. 00 13. 00
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. consolidated RHC	100-04, chapted enter in columns of all providence on solidated RHF for yes or "N" bings and compile Consolidated Cs in the group	r 9, section mn 2 the ders and Cs (as define for no. If ete a RHC groupino ping or	ed N	2. 00	0	12. 00 13. 00
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RF	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. consolidated RHC	100-04, chapted enter in columns of all providence on solidated RHF for yes or "N" bings and compile Consolidated Cs in the group	r 9, section mn 2 the ders and Cs (as define for no. If ete a RHC grouping oing or	N N		0	11. 00 12. 00 13. 00
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered of	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group	100-04, chapter enter in colurs of all provider consolidated RHF for yes or "N" bings and compile Consolidated Cs in the grouping.	r 9, section nn 2 the ders and Cs (as define for no. If ete a RHC groupine ping or Provi	N N N gs der name	CCN 2.00	0	12. 00 13. 00
12. 00 13. 00	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RF	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group	100-04, chapter enter in colurs of all provider on solidated RHG for yes or "N" bings and compiconsolidated Cs in the group bing.	r 9, section nn 2 the ders and Cs (as define for no. If ete a RHC grouping oing or Provi	N N N Sps der name	CCN 2.00 Total Visit	0	12. 00 13. 00
12. 00 13. 00 13. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoli separate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RFRHC/FQHC name, CCN	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group	100-04, chapter enter in colurs of all provider consolidated RHF for yes or "N" bings and compile Consolidated Cs in the grouping.	r 9, section nn 2 the ders and Cs (as define for no. If ete a RHC groupine ping or Provi	N N N gs der name	CCN 2.00	0	12. 00 13. 00 13. 01
12. 00 13. 00 13. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RF	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colurs of all provider on solidated RHG for yes or "N" bings and compiconsolidated Cs in the group bing.	r 9, section nn 2 the ders and Cs (as define for no. If ete a RHC grouping oing or Provi	N N N Sps der name	CCN 2.00 Total Visit	0	12. 00 13. 00 13. 01
12. 00 13. 00 13. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RHRC/FQHC name, CCN 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	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colurs of all provider on solidated RHG for yes or "N" bings and compiconsolidated Cs in the group bing.	r 9, section nn 2 the ders and Cs (as define for no. If ete a RHC grouping oing or Provi	N N N Sps der name	CCN 2.00 Total Visit	0	12. 00 13. 00 13. 01
12. 00 13. 00 13. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RFRHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colurs of all provider on solidated RHG for yes or "N" bings and compiconsolidated Cs in the group bing.	r 9, section nn 2 the ders and Cs (as define for no. If ete a RHC grouping oing or Provi	N N N Sps der name	CCN 2.00 Total Visit	0	12. 00 13. 00 13. 01
12. 00 13. 00 13. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RFRHC/FOHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colurs of all provider on solidated RHG for yes or "N" bings and compiconsolidated Cs in the group bing.	r 9, section nn 2 the ders and Cs (as define for no. If ete a RHC grouping oing or Provi	N N N Sps der name	CCN 2.00 Total Visit	0	12. 00 13. 00 13. 01
12. 00 13. 00 13. 01	Have you received an approval for an excepti Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report. numbers below. If line 13, column 1, is "Y", are you report in CMS Pub. 100-02, chapter 13, section 80.2 yes, enter in column 2 the number of consoliseparate Worksheet S-8 for each consolidated are comprised exclusively of grandfathered comprised exclusively of new consolidated RFRHC/FQHC name, CCN Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	d in CMS Pub. umn 1. If yes, List the names ing multiple cc)? Enter "Y" 1 dated RHC group RHC grouping. onsolidated RHC Cs in the group Y/N 1.00	100-04, chapter enter in colurs of all provider on solidated RHG for yes or "N" bings and compiconsolidated Cs in the group bing.	r 9, section nn 2 the ders and Cs (as define for no. If ete a RHC grouping oing or Provi	N N N Sps der name	CCN 2.00 Total Visit	0	12. 00 13. 00

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	CN: 15-1317	Peri od: From 01/01/2023	Worksheet S-8	3
			Component CCN: 15-8538		Date/Time Pre 5/28/2024 4:3	epared: 36 pm
				RHC IV		
		Cou	nty			
		4.	00			
2.00 City, State, ZIP Code, County		GREENE				2.00
	Tuesday	Wednesday		Thursday		
	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
	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

	Financial Systems GREENE COUNTY GENERAL HOSPITAL			u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Provider C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/28/2024 4:3	pared:
				1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA			1.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio				1
1. 00	Cost to charge ratio (see instructions)			0. 315676	1.00
	Medicaid (see instructions for each line)				1
2.00	Net revenue from Medicaid			3, 021, 105	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Υ	3.00	
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental paymen	ai d?	l N	4.00	
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medica			1, 198, 096	5.00
6.00	Medi cai d charges			35, 866, 470	
7.00	Medicaid cost (line 1 times line 6)			11, 322, 184	7.00
8.00	Difference between net revenue and costs for Medicaid program (see instr	uctions)		7, 102, 983	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each li	ne)			
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	
11. 00	Stand-alone CHIP cost (line 1 times line 10)			0	
12.00	Difference between net revenue and costs for stand-alone CHIP (see instr			0	12.00
	Other state or local government indigent care program (see instructions			1	
13.00	Net revenue from state or local indigent care program (Not included on I			0	
14. 00	Charges for patients covered under state or local indigent care program	(Not included	in lines 6 or	0	14.00
15. 00	10) State or local indigent care program cost (line 1 times line 14)			0	15.00
16. 00	Difference between net revenue and costs for state or local indigent car	o program (so	o instructions)		
10.00	Grants, donations and total unreimbursed cost for Medicaid, CHIP and sta				10.00
	instructions for each line)	te/rocar rnar	gent care progra	1113 (300	
17. 00	Private grants, donations, or endowment income restricted to funding cha	ri tv care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital of			0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent		s (sum of lines	7, 102, 983	19.00
	8, 12 and 16)				
		Uni nsured	Insured	Total (col. 1	
		pati ents	pati ents	+ col. 2)	
		1.00	2. 00	3. 00	
	Uncompensated care cost (see instructions for each line)		-1	07/ 0/5	
20.00	Charity care charges and uninsured discounts (see instructions)	276, 26		,	
21. 00	Cost of patients approved for charity care and uninsured discounts (see instructions)	87, 21	0	87, 210	21.00
22 00	Payments received from patients for amounts previously written off as		0		22 00
22. 00	charity care		0	0	22.00
23. 00	Cost of charity care (see instructions)	87, 21	0	87, 210	23 00
23.00	post of sharry said (see Histractions)	57,21	<u> </u>	07,210	23.00
				1. 00	
			6		24.00
24.00	Does the amount on line 20 col. 2, include charges for patient days beyo	na a renorn o	r stav limit	l N	Z4. U

imposed on patients covered by Medicaid or other indigent care program?

28.00 Non-Medicare bad debt amount (see instructions)
29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)

Charges for insured patients' liability (see instructions)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Medicare reimbursable bad debts (see instructions)

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)

Bad debt amount (see instructions)

27.01 Medicare allowable bad debts (see instructions)

If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of

0 25.00

26.00

27.00

27.01

28.00

29.00

30.00

5, 815, 113

5, 301, 828

1, 853, 310

1, 940, 520

9, 043, 503 31. 00

333, 635

513, 285

25.00

26.00

27.00

stay limit

	PART II - HOSPITAL DATA								
	Uncompensated and Indigent Care Cost-to-Charge Ratio								
1.00	Cost to charge ratio (see instructions)				1.00				
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				2.00				
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00				
4.00	00 If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?								
5.00									
6.00									
7.00	1 1 1 1 1 3 1								
8. 00	Difference between net revenue and costs for Medicaid program (see instru			7. 00 8. 00					
0.00	Children's Health Insurance Program (CHIP) (see instructions for each line			1	0.00				
9.00	Net revenue from stand-alone CHIP	10)			9.00				
10.00					10.00				
11. 00					11.00				
	Difference between net revenue and costs for stand-alone CHIP (see instru	uctions)			12.00				
12.00	· ·				12.00				
12 00	Other state or local government indigent care program (see instructions to			I	l 13.00				
	Net revenue from state or local indigent care program (Not included on li								
14. 00	Charges for patients covered under state or local indigent care program	(NOT LUCITAGE I	n lines 6 or		14.00				
45 00					45 00				
15.00					15.00				
16. 00	<u> </u>			L ,	16.00				
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state	te/local indige	ent care progra	ams (see					
	instructions for each line)			1					
	Private grants, donations, or endowment income restricted to funding chain			17. 00 18. 00					
18. 00	.00 Government grants, appropriations or transfers for support of hospital operations								
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent	care programs	(sum of lines		19.00				
	8, 12 and 16)								
		Uni nsured	Insured	Total (col. 1					
		pati ents	pati ents	+ col . 2)					
		1. 00	2. 00	3. 00					
	Uncompensated care cost (see instructions for each line)								
20.00	Charity care charges and uninsured discounts (see instructions)				20.00				
21.00	Cost of patients approved for charity care and uninsured discounts (see				21.00				
	instructions)								
22.00	Payments received from patients for amounts previously written off as				22.00				
	charity care								
23 00					23.00				
	Cost of charity care (see instructions)			1	23.UU				
20.00	Cost of charity care (see instructions)				23.00				
20.00	Cost of charity care (see instructions)			1.00	23.00				
24. 00		nd a Length of	stav limit	1.00	24.00				
	Does the amount on line 20 col. 2, include charges for patient days beyon	nd a length of	stay limit	1.00					
24. 00	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program?	o o	,	1.00	24. 00				
	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent	o o	,	1.00	24. 00				
24. 00 25. 00	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit	o o	,	1.00	24. 00 25. 00				
24. 00 25. 00 25. 01	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions)	o o	,	1.00	24. 00 25. 00 25. 01				
24. 00 25. 00 25. 01 26. 00	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions)	o o	,	1.00	24. 00 25. 00 25. 01 26. 00				
24. 00 25. 00 25. 01 26. 00 27. 00	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions)	o o	,	1.00	24. 00 25. 00 25. 01 26. 00 27. 00				
24. 00 25. 00 25. 01 26. 00 27. 00 27. 01	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions)	o o	,	1.00	24. 00 25. 00 25. 01 26. 00 27. 00 27. 01				
24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions)	t care program'	,	1.00	24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00				
24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00 29. 00	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	t care program'	,	1.00	24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00 29. 00				
24. 00 25. 00 25. 01 26. 00 27. 00 27. 01 28. 00 29. 00 30. 00	Does the amount on line 20 col. 2, include charges for patient days beyon imposed on patients covered by Medicaid or other indigent care program? If line 24 is yes, enter the charges for patient days beyond the indigent stay limit Charges for insured patients' liability (see instructions) Bad debt amount (see instructions) Medicare reimbursable bad debts (see instructions) Medicare allowable bad debts (see instructions) Non-Medicare bad debt amount (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see	t care program'	,	1.00					

Heal th	Financial Systems GR	EENE COUNTY GENE	ERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C		eri od:	Worksheet A	
				F	rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/28/2024 4:3	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassi fi ed	<u>Б</u>
	0001 0011101 20001 pti 011	00.0.100	01	+ col . 2)	i ons (See	Tri al Balance	
				' 00!! 2)	A-6)	(col. 3 +-	
					7. 07	col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		2.00	0.00	1. 00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT		3, 020, 360	3, 020, 360	69, 224	3, 089, 584	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		719, 957			719, 957	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 145, 632			6, 237, 914	4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	2, 926, 293	6, 157, 932			8, 922, 719	5.00
7. 00	00700 OPERATION OF PLANT	876, 578	1, 249, 771			2, 126, 349	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	0,0,0,0	0,217,771			242, 400	•
9. 00	00900 HOUSEKEEPI NG	450, 524	387, 027			595, 151	9.00
10.00	01000 DI ETARY	706, 589	415, 466			187, 046	•
11. 00	01100 CAFETERI A	0	0			935, 009	11.00
13. 00	01300 NURSING ADMINISTRATION	626, 453	168, 365	1		794, 818	•
14. 00	01400 CENTRAL SERVI CES & SUPPLY	020, 100	-28, 070			-28, 070	1
15. 00	01500 PHARMACY	706, 024	124, 871			830, 895	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	324, 635	44, 743			369, 378	1
17. 00	01700 SOCIAL SERVICE	248, 341	1, 825			250, 166	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	240, 341	1, 029			1, 045, 631	
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>			1, 043, 031	1,045,051	1 7.00
30. 00	03000 ADULTS & PEDIATRICS	3, 486, 469	1, 145, 038	4, 631, 507	603, 689	5, 235, 196	30.00
31.00	03100 I NTENSI VE CARE UNI T	520, 937	205, 398			726, 335	1
43. 00	04300 NURSERY	870	106			191, 498	
45.00	ANCILLARY SERVICE COST CENTERS	070	100	770	170, 322	171, 470	45.00
50.00	05000 OPERATING ROOM	813, 518	786, 495	1, 600, 013	0	1, 600, 013	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	271, 038	13			2, 435	1
53. 00	05300 ANESTHESI OLOGY	0	1, 057, 023			11, 392	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 189, 817	693, 695		·	1, 883, 512	•
60.00	06000 LABORATORY	1, 127, 140	2, 775, 625			3, 902, 765	
65. 00	06500 RESPI RATORY THERAPY	811, 223	106, 423			915, 107	65.00
66. 00	06600 PHYSI CAL THERAPY	599, 160	18, 837			617, 997	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	256, 103	0,007			256, 103	67.00
68. 00	06800 SPEECH PATHOLOGY	58, 727	0			58, 727	68.00
69. 00	06900 ELECTROCARDI OLOGY	00, 727	0	00,727		0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	ő	3, 128, 135		_		1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	ő	0, 120, 100			2, 475, 828	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	278, 581	2, 764, 511	1		3, 043, 092	•
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	270,001	0			0	•
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		_	Ö	78.00
, 0. 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>			J		70.00
88. 00	08800 RURAL HEALTH CLINIC	3, 392, 236	956, 509	4, 348, 745	-76, 804	4, 271, 941	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	940, 751	351, 443	.,		1, 332, 842	1
88. 02	08802 RURAL HEALTH CLINIC III	766, 651	338, 254			1, 126, 559	
88. 03	08803 RURAL HEALTH CLINIC IV	735, 778	310, 235			1, 060, 515	
	09100 EMERGENCY	2, 473, 757	1, 478, 725			3, 955, 021	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,,	1, 1,0, ,20	0,702,102	2,007	0,,00,02.	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						, , , , , , , , , , , , , , , , , , , ,
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102.00
.02.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			J		1.02.00
118.00		24, 588, 193	34, 524, 344	59, 112, 537	525, 595	59, 638, 132	118 00
	NONREI MBURSABLE COST CENTERS	2.,000,.70	31,021,011	07,1.2,007	323, 070	57,555,162	1
190 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	n	0	n	Ω	190. 00
	19200 PHYSI CI ANS PRI VATE OFFI CES	2, 953, 657	531, 007	3, 484, 664	-525, 595	2, 959, 069	
	07950 FOUNDATION / MOBS	2, 755, 557	0 0		0		194. 00
200.00	1 1	27, 541, 850	35, 055, 351		0	62, 597, 201	
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	, , 550	22, 300, 301	1, 5, 201	١		

Provi der CCN: 15-1317

Peri od: Worksheet A From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					127 017 2020	5/28/2024 4: 36 pm
	Cost Center Description	Adjustments	Net Expenses		'	
	·	(See A-8)	For			
			Allocation			
		6. 00	7. 00			
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT	-22, 365	3, 067, 219	9		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	719, 957	7		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 237, 914	•		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-3, 229, 588	5, 693, 131			5.00
7. 00	00700 OPERATION OF PLANT	-5, 685	2, 120, 664	1		7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	242, 400)		8.00
9. 00	00900 HOUSEKEEPI NG	0	595, 151			9.00
10.00	01000 DI ETARY	0	187, 046			10.00
11. 00	01100 CAFETERI A	-255, 445	679, 564			11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	794, 818	•		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	-28, 070	•		14.00
	01500 PHARMACY	0	830, 895	•		15.00
	01600 MEDICAL RECORDS & LIBRARY	-4, 738	364, 640	1		16. 00
17. 00	01700 SOCI AL SERVI CE	0	250, 166	1		17.00
19. 00		-1, 045, 631)		19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDI ATRI CS	-540, 732	4, 694, 464			30.00
	03100 INTENSIVE CARE UNIT	0	726, 335	1		31.00
43.00		0	191, 498	3		43.00
F0 00	ANCILLARY SERVICE COST CENTERS		4 (00 046	, I		
50.00	05000 OPERATING ROOM	0	1, 600, 013			50.00
52.00		0	2, 435	1		52.00
53. 00 54. 00	· ·	0	11, 392	1		53.00
60.00		0	1, 883, 512	1		54. 00 60. 00
65. 00	06500 RESPIRATORY THERAPY	-7, 200	3, 902, 765 907, 907			65. 00
66. 00	06600 PHYSI CAL THERAPY	-7, 200	617, 997	1		66.00
67. 00			256, 103	1		67.00
	06800 SPEECH PATHOLOGY		58, 727			68.00
69. 00			30, 727	•		69.00
71. 00		-71, 302	581, 005			71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	71,302	2, 475, 828	1		72.00
	07300 DRUGS CHARGED TO PATIENTS	-504, 396	2, 538, 696	•		73.00
77. 00		0	2, 330, 070	•		77.00
	07800 CAR T-CELL IMMUNOTHERAPY	o	C			78.00
70.00	OUTPATIENT SERVICE COST CENTERS	<u>ا</u>		21		70.00
88. 00	08800 RURAL HEALTH CLINIC	ol	4, 271, 941			88.00
88. 01	08801 RURAL HEALTH CLINIC II	l ol	1, 332, 842			88. 01
	08802 RURAL HEALTH CLINIC III	ol	1, 126, 559			88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	ol	1, 060, 515	1		88. 03
91. 00		-880, 697	3, 074, 324	1		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		-, -, -,			92.00
	OTHER REIMBURSABLE COST CENTERS			·		
102.00	10200 OPI OI D TREATMENT PROGRAM	0	C			102.00
	SPECIAL PURPOSE COST CENTERS			•		
118.00		-6, 567, 779	53, 070, 353	3		118. 00
	NONREI MBURSABLE COST CENTERS					
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	C			190. 00
	19200 PHYSICIANS PRIVATE OFFICES	-40, 214	2, 918, 855	5		192. 00
	07950 FOUNDATION / MOBS	0	C	1		194. 00
200.00	TOTAL (SUM OF LINES 118 through 199)	-6, 607, 993	55, 989, 208	3		200. 00

Period: Worksheet Non-CMS W Provider CCN: 15-1317

		To 12/31/2023 Date/Time 5/28/2024	
Cost Center Description	CMS Code	Standard Label For	
		Non-Standard Codes	
GENERAL SERVICE COST CENTERS	1.00	2.00	
1. 00 CAP REL COSTS-BLDG & FLXT	00100		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	00200		2.00
4. 00 EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5. 00 ADMI NI STRATI VE & GENERAL	00500		5.00
7. 00 OPERATION OF PLANT	00700		7.00
8. 00 LAUNDRY & LINEN SERVICE	00800		8.00
9. 00 HOUSEKEEPI NG	00900		9.00
10. 00 DI ETARY	01000		10.00
11. 00 CAFETERI A	01100		11.00
13. 00 NURSING ADMINISTRATION	01300		13.00
14.00 CENTRAL SERVICES & SUPPLY	01400		14.00
15. 00 PHARMACY	01500		15. 00
16. 00 MEDICAL RECORDS & LIBRARY	01600		16.00
17. 00 SOCI AL SERVI CE	01700		17. 00
19. 00 NONPHYSI CI AN ANESTHETI STS	01900		19. 00
INPATIENT ROUTINE SERVICE COST CENTERS			
30. 00 ADULTS & PEDIATRICS	03000		30.00
31. 00 INTENSIVE CARE UNIT	03100		31.00
43. 00 NURSERY	04300		43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 OPERATI NG 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 LABORATORY	06000		60.00
65. 00 RESPI RATORY THERAPY	06500		65.00
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 PATIENT	07100		71.00
72.00 IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00 DRUGS CHARGED TO PATIENTS	07300		73.00
77.00 ALLOGENEIC HSCT ACQUISITION	07700		77. 00
78. 00 CAR T-CELL IMMUNOTHERAPY	07800		78. 00
OUTPATIENT SERVICE COST CENTERS			
88.00 RURAL HEALTH CLINIC	08800		88.00
88. 01 RURAL HEALTH CLINIC II	08801		88. 01
88. 02 RURAL HEALTH CLINIC III	08802		88. 02
88. 03 RURAL HEALTH CLINIC IV	08803		88. 03
91. 00 EMERGENCY	09100		91.00
92. 00 OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS 102.00 OPIOID TREATMENT PROGRAM	10200		102.00
SPECIAL PURPOSE COST CENTERS] 10200		102.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)			118. 00
NONREI MBURSABLE COST CENTERS	<u> </u>	<u> </u>	1
190. 00 GIFT FLOWER COFFEE SHOP & CANTEEN	19000		190. 00
192. 00 PHYSI CI ANS PRI VATE OFFI CES	19200		192.00
194.00 FOUNDATION / MOBS	07950		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	1		200. 00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
RECLASSI FI CATI ONS	Provi der CCN: 15-1317	Peri od: Worksheet A-6

					From 01/01/2023 To 12/31/2023	Date/Time Pr 5/28/2024 4:	
		Increases		<u>'</u>			ļ
	Cost Center	Li ne #	Sal ary	Other			
	2.00	3. 00	4. 00	5. 00			
	A - CRNA RECLASS						
1.00	NONPHYSICIAN ANESTHETISTS	19. 00	0	1, 045, 631			1.00
	TOTALS			1, 045, 631			
	B - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30.00	268, 616	0			1.00
	TOTALS		268, 616				
	C - DIETARY RECLASS						
1.00	CAFETERI A	11. 00	588, 801	346, 208			1.00
	TOTALS		588, 801	346, 208			
	D - RHC ALLOCATION		· · · · · ·	•			
1.00	RURAL HEALTH CLINIC II	88. 01	40, 648	0			1.00
2.00	RURAL HEALTH CLINIC III	88. 02	21, 654	0			2.00
3.00	RURAL HEALTH CLINIC IV	88. 03	14, 502	0			3.00
	TOTALS		76, 804				
	E - INSURANCE RECLASS	,					1
1.00	CAP REL COSTS-BLDG & FLXT	1.00	0	69, 224			1.00
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	92, 282			2.00
	TOTALS			161, 506			
	F - LAUNDRY AND HOUSEKEEPING	RECLASS					Ī
1.00	LAUNDRY & LINEN SERVICE	8. 00	0	242, 400			1.00
	TOTALS			242, 400			
	G - IMPLANTABLE DEVICES RECLA	ISS					
1.00	IMPL. DEV. CHARGED TO	72.00	0	2, 475, 828			1.00
	PATI ENTS						
	TOTALS			2, 475, 828			
	I - HOSPITALIST RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	525, 595	0			1. 00
	TOTALS		525, 595				
	J - NURSERY RECLASS						
1.00	NURSERY	43. 00	190, 522	0			1.00
	TOTALS		190, 522	0			
	K - EKG RECLASSIFICATION						
1.00	EMERGENCY	91. 00	0	2, 539		·	1.00
	TOTALS		0	2, 539			
500.00	Grand Total: Increases		1, 650, 338	4, 274, 112			500.00

						To 12/31/2023	Date/Time Prepared: 5/28/2024 4:36 pm
		Decreases		•			
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref	.	
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CRNA RECLASS						
1.00	ANESTHESI OLOGY	53. 00	0	1, 045, 631		0	1.00
	TOTALS		0	1, 045, 631			
	B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52. 00	268, 616	0		0	1.00
	TOTALS		268, 616	0			
	C - DIETARY RECLASS						
1.00	DI ETARY	10.00	588, 801	346, 208	(0	1.00
	TOTALS	T	588, 801	346, 208		7	
	D - RHC ALLOCATION	<u>.</u>					
1.00	RURAL HEALTH CLINIC	88. 00	76, 804	0)	0	1.00
2.00		0.00	o	0	1	0	2.00
3.00		0.00	o	0	1	o	3.00
	TOTALS	- $ +$	76, 804			7	
	E - INSURANCE RECLASS	·	•				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	161, 506	1.	2	1.00
2.00		0.00	O	0	1	0	2. 00
	TOTALS			161, 506		7	
	F - LAUNDRY AND HOUSEKEEPING	RECLASS					
1.00	HOUSEKEEPI NG	9. 00	0	242, 400)	0	1.00
	TOTALS			242, 400		7	
	G - IMPLANTABLE DEVICES RECLA	ASS					
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	2, 475, 828	(0	1.00
	PATI ENT						
	TOTALS	- $ -$		2, 475, 828			
	I - HOSPITALIST RECLASS		<u> </u>			·	
1.00	PHYSICIANS PRIVATE OFFICES	192. 00	525, 595	0	1	0	1.00
	TOTALS		525, 595			7	
	J - NURSERY RECLASS					<u> </u>	
1.00	ADULTS & PEDIATRICS	30.00	190, 522	0	1	0	1.00
	TOTALS	- $ +$	190, 522			7	
	K - EKG RECLASSIFICATION					'	
1.00	RESPI RATORY THERAPY	65. 00	O	2, 539		0	1.00
	TOTALS	— — — †		2, 539		7	
500.00	Grand Total: Decreases		1, 650, 338	4, 274, 112			500.00
	,	'			1	1	,

Period: Worksheet A-6
From 01/01/2023 Non-CMS Worksheet
To 12/31/2023 Date/Time Prepared: Health Financial Systems RECLASSIFICATIONS Provi der CCN: 15-1317

Cost Center Line # Salary Other Cost Center Cost C							To	0 12/31/2023	Date/Time Pre 5/28/2024 4:3	epared:
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00										
A - CRMA RECLASS 1,00										
1.00			3.00	4.00	5. 00	6. 00	7.00	8. 00	9. 00	
AMESTHETISTS			10.00		4 045 (04	ANEGELEGIALON	1 50 00		1 015 (01	4 00
TOTALS	1.00		19.00	O	1, 045, 631	ANESTHEST OLOGY	53.00	O	1, 045, 631	1.00
B - LABOR & DELIVERY DELIVERY ROOM & LABOR 52.00 268.616 0 1.00					- 		-	+		
ADULTS & PEDIATRICS 30.00 268,616 O DELIVERY ROOM & LABOR 52.00 268,616 O TOTALS C DISTARY RECLASS C DISTA				<u> </u>	1, 045, 631	TUTALS		U	1, 045, 631	
TOTALS	1 00		30.00	268 616	٥	DELLVEDY DOOM & LABOR	52 00	268 616	0	1 00
TOTALS	1.00	ADOLTS & TEDIATRICS	30.00	200, 010			32.00	200, 010	O	1.00
C - DIETARY RECLASS 11.00 588,801 346,208 DIETARY 10.00 588,801 346,208 1.00		TOTALS — — —		268.616				268, 616	— — <u> </u>	
1.00				200, 0.0	<u>_</u>			200,010		
TOTALS	1.00		11. 00	588, 801	346, 208	DI ETARY	10.00	588, 801	346, 208	1.00
1.00		TOTALS		588, 801			-			
1		D - RHC ALLOCATION								
2. 00	1.00	RURAL HEALTH CLINIC	88. 01	40, 648	0	RURAL HEALTH CLINIC	88. 00	76, 804	0	1.00
11		1								
RURAL HEALTH CLINIC 88.03	2.00		88. 02	21, 654	0		0.00	0	0	2.00
IV		1:::								
TOTALS	3. 00	I .	88. 03	14, 502	0		0.00	0	0	3.00
1.00 CAP REL COSTS-BLDG & 1.00 0 69, 224 ADMINISTRATIVE & 5.00 0 161, 506 1.00						TOTAL C	<u> </u>			
1.00 CAP REL COSTS-BLDG & 1.00 0 69, 224 ADMINISTRATIVE & 5.00 0 161, 506 1.00 FIXT				76, 804	U	TUTALS		76, 804	0	
Columbrishment Colu	1 00		1 00	ما	40.224	ADMINISTRATIVE 0	E 00	٥	141 EO4	1 00
2. 00 EMPLOYEE BENEFITS 4. 00 0 92, 282 0. 00 0 0 0 2. 00	1.00		1.00	۷			5.00	٩	101, 300	1.00
DEPARTMENT	2 00		4 00	0		GENERAL	0 00	0	0	2.00
TOTALS	2.00		1. 00	Ĭ	72, 202		0.00	٩	o o	2.00
1.00					161, 506	TOTALS	-	$$ $\overline{}$	161, 506	
SERVICE		F - LAUNDRY AND HOUSEK	EEPING RI	ECLASS	,				. ,	
TOTALS	1.00	LAUNDRY & LINEN	8. 00	0	242, 400	HOUSEKEEPI NG	9.00	0	242, 400	1.00
1. 00 IMPL. DEV. CHARGED TO 72. 00 0 2, 475, 828 MEDI CAL SUPPLIES 71. 00 0 2, 475, 828 1. 00		SERVI CE								
1. 00 IMPL. DEV. CHARGED TO 72. 00 0 2, 475, 828 MEDI CAL SUPPLIES 71. 00 0 2, 475, 828 1. 00 PATI ENTS TOTALS 0 2, 475, 828 TOTALS 0 2, 575, 595 0 0 TOTALS 0 0 0 0 0 0 0 0 0				<u> </u>	242, 400	TOTALS		0	242, 400	
PATI ENTS										
TOTALS	1. 00		72. 00	0			71.00	0	2, 475, 828	1.00
I - HOSPITALIST RECLASS 30.00 525,595 0 PHYSICIANS PRIVATE 192.00 525,595 0 1.00 0FFICES 192.00 525,595 0 1.00 0FFICES 192.00 19										
1. 00 ADULTS & PEDI ATRI CS 30. 00 525, 595 0 PHYSI CI ANS PRI VATE 09. 00 525, 595 0 1. 00 OFFI CES TOTALS 525, 595 0 TOTALS 525, 595 0 TOTALS 525, 595 0 1. 00 OFFI CES 1. 00 NURSERY RECLASS 1. 00 NURSERY 43. 00 190, 522 0 ADULTS & PEDI ATRI CS 30. 00 190, 522 0 TOTALS 190, 522 0 TOTALS 190, 522 0 OTOTALS 190, 5				0	2, 475, 828	TOTALS		0	2, 475, 828	
OFFICES OFFICES OTOTALS 525, 595 OTOTALS 525, 595 OTOTALS 525, 595 OTOTALS O	1 00			E2E E0E	ما	DINCLOLANC DDINATE	1100 00	F2F F0F		1 00
TOTALS 525, 595 0 TOTALS 525, 595 0 J - NURSERY RECLASS 1. 00 NURSERY 43. 00 190, 522 0 ADULTS & PEDIATRICS 30. 00 190, 522 0 1. 00 TOTALS 190, 522 0 TOTALS 190, 522 0 K - EKG RECLASSIFICATION 1. 00 EMERGENCY 91. 00 0 2, 539 RESPIRATORY THERAPY 65. 00 0 2, 539 TOTALS 0 2, 539 TOTALS 0 2, 539 500. 00 Grand Total: 1, 650, 338 4, 274, 112 Grand Total: 1, 650, 338 4, 274, 112 500. 00	1.00	ADULTS & PEDIATRICS	30.00	525, 595			192.00	525, 595	Ü	1.00
1. 00 NURSERY RECLASS 190, 522 O ADULTS & PEDIATRICS 30. 00 190, 522 O 1. 00		TOTALS — — —					-	— — <u></u>	— — <u> </u>	
NURSERY 43.00 190, 522 O ADULTS & PEDIATRICS 30.00 190, 522 O 190, 522 O 1.00 TOTALS 190, 522 0 TOTALS 190, 522 0 K - EKG RECLASSIFICATION 1.00 EMERGENCY 91.00 0 2,539 RESPIRATORY THERAPY 65.00 0 2,539 TOTALS 500.00 Grand Total: 1,650,338 4,274,112 Grand Total: 1,650,338 4,274,112 500.00				525, 595	U _I	TOTALS		525, 595		
TOTALS 190, 522 0 TOTALS 190, 522 0 K - EKG RECLASSIFICATION 1. 00 EMERGENCY 91.00 0 2,539 RESPIRATORY THERAPY 65.00 0 2,539 TOTALS 0 2,539 TOTALS 0 2,539 500.00 Grand Total: 1,650,338 4,274,112 Grand Total: 1,650,338 4,274,112 500.00	1 00		43.00	190 522	0	ADULTS & PEDLATRICS	30.00	190 522	0	1 00
K - EKG RECLASSIFICATION 1. 00 EMERGENCY 91.00 0 2,539 RESPIRATORY THERAPY 65.00 0 2,539 T.00 1.00 0 2,539 TOTALS 0 0 2,539 TOTALS 0 0 2,539 TOTALS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00		13.00				30. 50		— — <u> </u>	1.00
1. 00 EMERGENCY 91. 00 0 2,539 RESPIRATORY THERAPY 65. 00 0 2,539 1. 00 TOTALS 0 2,539 TOTALS 0 2,539 500. 00 Grand Total: 1,650,338 4,274,112 Grand Total: 1,650,338 4,274,112 500.00			ON	170,022	<u> </u>			170,022		
TOTALS 0 2,539 TOTALS 0 2,539 500. 00 Grand Total: 1,650,338 4,274,112 Grand Total: 1,650,338 4,274,112 500.00	1. 00			O	2, 539	RESPIRATORY THERAPY	65, 00	O	2, 539	1.00
500.00 Grand Total: 1,650,338 4,274,112 Grand Total: 1,650,338 4,274,112 500.00				- - - -				— — o f		
Increases Decreases Decreases	500.00	Grand Total:		1, 650, 338				1, 650, 338		4
		Increases				Decreases				

In Lieu of Form CMS-2552-10
Period: Worksheet A-7
From 01/01/2023 Part I Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1317

				To	rom 01/01/2023 o 12/31/2023		
				Acqui si ti ons		3/20/2024 4.3	o piii
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	624, 598	0	0	0	3, 400	1.00
2.00	Land Improvements	3, 485, 761	0	0	0	20, 151	2.00
3.00	Buildings and Fixtures	11, 060, 650	0	0	0	151, 810	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	5, 119, 511	0	0	0	429, 148	5.00
6.00	Movable Equipment	4, 560, 920	690, 202	0	690, 202	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24, 851, 440	690, 202	0	690, 202	604, 509	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	24, 851, 440	690, 202	0	690, 202	604, 509	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		_				
1.00	Land	621, 198	0				1.00
2. 00	Land Improvements	3, 465, 610	0				2.00
3. 00	Buildings and Fixtures	10, 908, 840	0				3. 00
4. 00	Building Improvements	0	0				4.00
5. 00	Fi xed Equipment	4, 690, 363	0				5.00
6.00	Movable Equipment	5, 251, 122	0				6.00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	24, 937, 133	0				8.00
9. 00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	24, 937, 133	0				10.00

Heal th	Financial Systems GF	REENE COUNTY GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 01/01/2023 To 12/31/2023			
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FLXT	999, 079	1, 428, 902	592, 37	9 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	719, 957	0		0	0	2.00	
3.00	Total (sum of lines 1-2)	1, 719, 036	1, 428, 902	592, 37	9 0	0	3.00	
		SUMMARY 0	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14 00	15.00					

Heal th	n Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 01/01/2023 To 12/31/2023		pared:
		COMPUTATION OF RATIOS			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 CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	19, 686, 011	0	19, 686, 011			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5, 251, 122	l .	5, 251, 122			2.00
3. 00	Total (sum of lines 1-2)	24, 937, 133		24, 937, 133			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relat ed Costs	cols. 5 through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(976, 714		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	Ĭ	C	719, 957		
3.00	Total (sum of lines 1-2)	0	·	<u> </u>	1, 696, 671	1, 428, 902	3.00
		SUMMARY OF CAPITAL					
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
		11.00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12. 00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	592, 379	69, 224			3, 067, 219	1.00
2.00	CAP REL COSTS-BLDG & FIXT	392, 379	· ·				2.00
3.00	Total (sum of lines 1-2)	592, 379	ı	1		1	
3.00	10tal (3am 01 111163 1-2)	372,317	1 07, 224	1	, i	3,707,170	J 3.00

Peri od: From 01/01/2023 Provider CCN: 15-1317

				Fr Tc	om 01/01/2023 12/31/2023	Date/Time Pre	
				Expense Classification on	Worksheet A	5/28/2024 4: 3	6 pm
				To/From Which the Amount is t			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)				Ref.	
1. 00	Investment income - CAP REL	1. 00	2. 00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5. 00 0	1.00
	COSTS-BLDG & FLXT (chapter 2)						
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		0		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	Tel ephone services (pay	А	-5, 685	OPERATION OF PLANT	7. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-1, 428, 629			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0. 00	0	13. 00
14.00	Cafeteria-employees and guests		-224, 029	CAFETERI A	11. 00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	0	17. 00
18. 00	Sale of medical records and	В	-4, 738	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	abstracts Nursing and allied health		0		0. 00	0	19. 00
	education (tuition, fees,						
20. 00	books, etc.) Vendi ng machi nes	В	-11, 291	CAFETERI A	11. 00	0	20. 00
21. 00	Income from imposition of interest, finance or penalty		0		0. 00	0	21.00
	charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	A-0-3	J	RESPIRATORI IIIERAFI	05.00		23.00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of				33.33		
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FLXT Depreciation - CAP REL		n	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP					, and the second	28. 00
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
0	limitation (chapter 14)			ADULTO A DESCRIPTION			0.5 -
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDI ATRI CS	30. 00		30. 99
		. '	'	. '	'		-

Heal th	Financial Systems	GR	REENE COUNTY GE	ENERAL HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8		
					From 01/01/2023 To 12/31/2023	Date/Time Pre	nared·	
					10 12/01/2020	5/28/2024 4: 3		
				Expense Classification or				
				To/From Which the Amount is	to be Adjusted			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7		
		(2)				Ref.		
	T	1. 00	2. 00	3.00	4. 00	5. 00		
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00	
	pathology costs in excess of							
32. 00	limitation (chapter 14) CAH HIT Adjustment for		_		0.00	0	32.00	
32.00	Depreciation and Interest		0		0.00	U	32.00	
33. 00	CPR TRAINING	В	440	ADMINISTRATIVE & GENERAL	5. 00	0	33.00	
33. 01	MISC. REVENUE - ADMIN	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 01	
33. 02	AHA DUES	A	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02	
33. 03	I HA DUES	Α	-1, 641	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03	
33.04	MARKETING & ADVERTISING	Α	-179, 013	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04	
33. 05	RENTAL OF PROVIDER SPACE -	В	-32, 589	CAP REL COSTS-BLDG & FLXT	1. 00	9	33. 05	
	BENEFI TS							
33. 07	340B EXPENSE	A	· ·	DRUGS CHARGED TO PATIENTS	73. 00	0	00.07	
33. 08	CRNA ADJUSTMENT TO MARKET	Α		NONPHYSICIAN ANESTHETISTS	19. 00	0	33. 08	
33. 10	ORTHO CLINIC - START-UP COSTS	A	· ·	PHYSICIANS PRIVATE OFFICES	192. 00	0	33. 10	
33. 11	HOSPITAL ASSESSMENT FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 11	
33. 12	BOND AMORTIZATION EXPENSE	A	· ·	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 12	
33. 13	MISC. EXPENSE - ADMIN	A	-244	ADMINISTRATIVE & GENERAL	5. 00	0	33. 13	

-71, 302 MEDI CAL SUPPLI ES CHARGED TO

PATI ENT

-20, 125 CAFETERI A

-6, 607, 993

71.00

11.00

0.00

33.16

33.17

33. 18

50.00

В

TOTAL (sum of lines 1 thru 49)

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

33. 16 REBATES

(3)

33. 17

50.00

CATERING REVENUE

33. 18 OTHER ADJUSTMENTS (SPECIFY)

⁽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.

| Period: | Worksheet A-8-2 | From 01/01/2023 | To 12/21/2023 Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1317

Wist. A Line # Cost Center/Physician Identifier Remuneration Professional Component Component Component Component RCE Amount Physician Provider Component RCE Amount Physician							Γο 12/31/2023		
		Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount		
1.00				Remuneration	Component	Component		ider Component	
1.00 30. OADULTS & PEDIATRICS 594, 212 540, 732 52, 480 0 0 1.00						·		Hours	
2.00		1. 00	2. 00	3. 00	4. 00			7.00	
3.00	1. 00	30.00	ADULTS & PEDIATRICS	594, 212	540, 73	2 53, 480	0	0	1.00
4,00				7, 200				0	
S	3.00			1, 143, 762	880, 69	7 263, 065	0	0	3.00
Column C	4.00	0. 00		0		0	0	0	
7.00	5.00	0. 00		0		0	0	0	5.00
8.00 0.00				0	(0	0	0	6. 00
9,00	7. 00			0	(0	0	0	7. 00
10.00				0		0	0	0	
1.00				0	1	0	0	0	1
WKST. A Line # Cost Center/Physician Identifier Unadjusted RCE Limit Unadjusted RCE Limit Component Cost of Component Cost of Mal practice Cost of Mal		0. 00		0	1	0	0	0	
Identifier									
1.00		Wkst. A Line #							
1.00			l denti fi er	Limit					
1.00					Limit			Insurance	
1.00									
2. 00 65. 00 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 0 3. 00 3. 00 4. 00 5. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0									
3. 00					•	-			1
4.00				0		-	1	_	1
5. 00 0. 00 <td< td=""><td></td><td></td><td></td><td>0</td><td>1</td><td>0</td><td>0</td><td>0</td><td>1</td></td<>				0	1	0	0	0	1
6.00				0		0	0	0	
7. 00				0	1	0	0	0	1
8. 00				0	1	0	0	_	1
9.00				0	1	0	0	_	
10.00				0	1	0	0	_	
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14 Disallowance Adjusted RCE Limit Disallowance Adjustment Disallowance Adjustment Disallowance Disallowance Adjustment Disallowance Disal				0	1	0	0	_	
Wkst. A Line # Cost Center/Physician I dentifier Provider Component Share of col. 14 Disallowance Adjustment Disallowance Adjustment Disallowance Adjustment Disallowance Disallowance Adjustment Disallowance Adjustment Disallowance Adjustment Disallowance Disallowance Adjustment Disallowance Adjustment Disallowance Adjustment Disallowance Disallowance Adjustment Disallowance Disallowance Adjustment Disallowance Disallow		0.00		0	1	0	0	_	
Identifier Component Share of col. Li mi t Di sal I owance			0 1 0 1 (0)	0		0		0	200.00
Share of col. 14		Wkst. A Line #					Adjustment		
1.00 2.00 15.00 16.00 17.00 18.00			rdentifier		LIMIT	Di Sai i owance			
1.00 2.00 15.00 16.00 17.00 18.00 1.00 30.00 ADULTS & PEDI ATRI CS 0 0 540,732 1.00 2.00 65.00 RESPI RATORY THERAPY 0 0 0 7,200 2.00 3.00 91.00 EMERGENCY 0 0 0 880,697 3.00 4.00 0.00 0 0 0 0 4.00 5.00 0.00 0 0 0 0 4.00 6.00 0.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 7.00 8.00 0.00 0 0 0 0 9.00 9.00 0.00 0 0 0 0 9.00 10.00 0 0 0 0 0 0 10.00									
1.00 30.00 ADULTS & PEDIATRICS 0 0 540,732 1.00 2.00 65.00 RESPIRATORY THERAPY 0 0 0 7,200 2.00 3.00 91.00 EMERGENCY 0 0 0 880,697 3.00 4.00 0.00 0 0 0 0 4.00 5.00 0.00 0 0 0 0 4.00 6.00 0.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 0 6.00 7.00 0.00 0		1 00	3 00		14 00	17.00	19.00	-	
2. 00 65. 00 RESPI RATORY THERAPY 0 0 7, 200 2. 00 3. 00 91. 00 EMERGENCY 0 0 0 880, 697 3. 00 4. 00 0. 00 0 0 0 0 0 4. 00 5. 00 0. 00 0 0 0 0 0 5. 00 6. 00 0. 00 0 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 0 10. 00	1 00								1 00
3. 00 91. 00 EMERGENCY 0 0 0 880, 697 3. 00 4. 00 0. 00 0 0 0 0 4. 00 5. 00 0. 00 0 0 0 0 5. 00 6. 00 0. 00 0 0 0 0 0 6. 00 7. 00 0. 00 0 0 0 0 0 7. 00 8. 00 0. 00 0 0 0 0 0 8. 00 9. 00 0. 00 0 0 0 0 0 9. 00 10. 00 0 0 0 0 0 0 0 10. 00				-		-			
4.00 0.00 5.00 0.00 6.00 0.00 7.00 0.00 8.00 0.00 9.00 0.00 10.00 0.00 0 0 0									1
5.00 0.00 0 0 0 0 5.00 6.00 0.00 0 0 0 0 6.00 7.00 0.00 0 0 0 0 0 7.00 8.00 0.00 0 0 0 0 0 8.00 9.00 0.00 0 0 0 0 9.00 10.00 0 0 0 0 0 10.00								1	
6.00 0.00 7.00 0.00 8.00 0.00 9.00 0.00 10.00 0.00 0 0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>									
7. 00 0. 00 8. 00 0. 00 9. 00 0. 00 10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 10. 00									
8.00 0.00 9.00 0.00 10.00 0.00									
9. 00 0. 00 0 0 0 0 9. 00 10. 00 0 10. 00 0 10. 00									
10.00 0.00 0 0 10.00									
									1
	200.00	3.00		1 0			1 428 629		200.00

Health Financial Systems

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1317

Period:
From 01/01/2023
To 12/31/2023

CAPITAL RELATED COSTS

In Lieu of Form CMS-2552-10

Worksheet B
Part I
Date/Time Prepared:
5/28/2024 4: 36 pm

				To	12/31/2023	Date/Time Pre 5/28/2024 4:3	
			CAPI TAL REI	LATED COSTS		1 37 207 2024 4. 3	O pili
			07.1.1.1.1.2.1.2.1	21125 00010			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
	ENERAL OFFICE COOT OFFITERS	0	1. 00	2. 00	4. 00	4A	
	ENERAL SERVICE COST CENTERS 0100 CAP REL COSTS-BLDG & FIXT	3, 067, 219	3, 067, 219				1.00
	0200 CAP REL COSTS-BLDG & FIXT	719, 957	3,007,219	719, 957			2.00
	0400 EMPLOYEE BENEFITS DEPARTMENT	6, 237, 914	0		6, 237, 914		4.00
	0500 ADMINISTRATIVE & GENERAL	5, 693, 131	267, 607	-	662, 773	6, 674, 845	5.00
4	0700 OPERATION OF PLANT	2, 120, 664	394, 058		198, 535	2, 788, 848	7.00
4	0800 LAUNDRY & LINEN SERVICE	242, 400			0	267, 402	8.00
	0900 HOUSEKEEPI NG	595, 151	20, 937		102, 039	722, 143	9. 00
10.00 0	1000 DI ETARY	187, 046	113, 365	21, 747	26, 678	348, 836	10.00
11. 00 0	1100 CAFETERI A	679, 564	111, 662	21, 420	133, 357	946, 003	11.00
13.00 0	1300 NURSING ADMINISTRATION	794, 818	22, 308	4, 279	141, 885	963, 290	13.00
	1400 CENTRAL SERVICES & SUPPLY	-28, 070	142, 070		0	141, 253	
	1500 PHARMACY	830, 895	53, 339	10, 232	159, 907	1, 054, 373	15.00
	1600 MEDICAL RECORDS & LIBRARY	364, 640	· ·		73, 526	490, 944	1
	1700 SOCIAL SERVICE	250, 166			56, 247	320, 523	17. 00
	1900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
_	NPATIENT ROUTINE SERVICE COST CENTERS		70	105 100	00/ 0/0		
	3000 ADULTS & PEDIATRICS	4, 694, 464			926, 362	6, 460, 262	30.00
	3100 INTENSIVE CARE UNIT 4300 NURSERY	726, 335 191, 498			117, 987 43, 348	977, 008	1
	NCILLARY SERVICE COST CENTERS	191, 498	15, 744	3, 020	43, 348	253, 610	43.00
	5000 OPERATING ROOM	1, 600, 013	203, 717	39, 079	184, 253	2, 027, 062	50.00
	5200 DELIVERY ROOM & LABOR ROOM	2, 435	· ·		549	13, 183	52.00
4	5300 ANESTHESI OLOGY	11, 392	0		0	11, 392	1
4	5400 RADI OLOGY-DI AGNOSTI C	1, 883, 512	189, 178	36, 290	269, 480	2, 378, 460	
60.00 0	6000 LABORATORY	3, 902, 765	108, 463	20, 806	255, 285	4, 287, 319	60.00
65. 00 0	6500 RESPI RATORY THERAPY	907, 907	4, 860	932	183, 733	1, 097, 432	65.00
66.00 0	6600 PHYSI CAL THERAPY	617, 997	37, 511	7, 196	135, 703	798, 407	66.00
	6700 OCCUPATI ONAL THERAPY	256, 103	37, 511	7, 196	58, 005	358, 815	
4	6800 SPEECH PATHOLOGY	58, 727	20, 106		13, 301	95, 991	68. 00
	6900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	581, 005	0	0	0	581, 005	
	7200 IMPL. DEV. CHARGED TO PATIENTS	2, 475, 828	0	0	(2, 22)	2, 475, 828	
	7300 DRUGS CHARGED TO PATIENTS	2, 538, 696		6, 678	63, 096	2, 643, 281	73.00
	7700 ALLOGENEIC HSCT ACQUISITION 7800 CAR T-CELL IMMUNOTHERAPY	0	0	- 1	0 0	0	77. 00 78. 00
	JTPATIENT SERVICE COST CENTERS	U	0	<u> </u>	<u> </u>	0	76.00
	8800 RURAL HEALTH CLINIC	4, 271, 941	0	48, 155	750, 909	5, 071, 005	88. 00
	8801 RURAL HEALTH CLINIC II	1, 332, 842			222, 276	1, 583, 758	
	8802 RURAL HEALTH CLINIC III	1, 126, 559			178, 542	1, 329, 262	
	8803 RURAL HEALTH CLINIC IV	1, 060, 515	Ö		169, 930	1, 261, 069	
	9100 EMERGENCY	3, 074, 324	235, 870		560, 279	3, 915, 719	
92. 00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART					0	
	THER REIMBURSABLE COST CENTERS						
	0200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	PECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	53, 070, 353	2, 914, 432	690, 648	5, 687, 985	52, 338, 328	ji 18. 00
	ONREIMBURSABLE COST CENTERS 9000 GIFT FLOWER COFFEE SHOP & CANTEEN		11 F/O	2 215	ما	13, 763	100 00
	9200 PHYSICIANS PRIVATE OFFICES	2, 918, 855	11, 548 141, 239		549, 929	3, 637, 117	
	7950 FOUNDATION / MOBS	Z, 710, 000	141, 239		J47, 729		194.00
200.00	Cross Foot Adjustments				٩		200.00
201.00	Negative Cost Centers		0	0	n		201.00
202.00	TOTAL (sum lines 118 through 201)	55, 989, 208	3, 067, 219	-	6, 237, 914	55, 989, 208	
Ţ	, ,		•				•

Provider CCN: 15-1317

Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 5/28/2024 4:36 pm

						5/28/2024 4: 3	6 pm
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT					ı	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					1	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					1	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	6, 674, 845				1	5. 00
7. 00	00700 OPERATION OF PLANT	377, 479	3, 166, 327			1	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	36, 194	21, 486			1	8.00
9. 00	00900 HOUSEKEEPI NG	97, 744	21, 444		841, 331	1	9.00
10.00	01000 DI ETARY	47, 216	116, 110		2, 296	514, 458	
11. 00	01100 CAFETERI A	128, 044	114, 366		383	0 11, 100	11.00
13. 00	01300 NURSING ADMINISTRATION	130, 384	22, 848		765	Ö	
14. 00	01400 CENTRAL SERVICES & SUPPLY	19, 119	145, 510		383	0	
15. 00	01500 PHARMACY	142, 713	54, 630		9, 758	0	
16.00	01600 MEDICAL RECORDS & LIBRARY					0	
		66, 451	45, 355		1, 435		
17.00	01700 SOCIAL SERVICE	43, 384	12, 126		383	0	
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	074 440	704 077	70.004	004 750	0/0 407	00.00
30.00	03000 ADULTS & PEDIATRICS	874, 412	721, 377		281, 750	360, 107	30.00
31.00	03100 INTENSIVE CARE UNIT	132, 241	114, 025		78, 355	154, 351	31.00
43.00	04300 NURSERY	34, 327	16, 125	0	9, 376	0	43.00
	ANCILLARY SERVICE COST CENTERS	074.040	202 (12		407.400		
50.00	05000 OPERATING ROOM	274, 369	208, 649		107, 439	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 784	8, 765		13, 011	0	52.00
53.00	05300 ANESTHESI OLOGY	1, 542	0	-	3, 444	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	321, 932	193, 758		35, 207	0	1
60.00	06000 LABORATORY	580, 301	111, 089		34, 920	0	60.00
65.00	06500 RESPI RATORY THERAPY	148, 541	4, 978		16, 838	0	
66.00	06600 PHYSI CAL THERAPY	108, 067	38, 420	·	52, 906	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	48, 567	38, 420	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	12, 993	20, 593	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	78, 641	0	0	383	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	335, 111	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	357, 776	35, 654	0	0	0	73.00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	o	0	0	o	0	77.00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	o	0	0	o	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	686, 376	257, 110	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	214, 366	152, 913	0	o	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	179, 920	129, 002	0	o	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	170, 689	163, 507		o	0	88. 03
91.00	09100 EMERGENCY	530, 004	241, 580		161, 206	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		, , , , , , , , , , , , , , , , , , , ,		, , , , ,	-	92.00
	OTHER REIMBURSABLE COST CENTERS						
102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
118.00		6, 180, 687	3, 009, 840	325, 082	810, 238	514, 458	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	1, 863	11, 828	0	3, 635	0	190. 00
	19200 PHYSICIANS PRIVATE OFFICES	492, 295	144, 659		·	0	192.00
	07950 FOUNDATION / MOBS	l, _, o	0		277 130		194.00
200.00			O				200.00
201.00			0	0	ا	<u> </u>	201.00
202.00		6, 674, 845	3, 166, 327	ı	841, 331	514, 458	
202.00	1.577E (36m 11765 176 till 60gir 201)	0,074,040	5, 100, 327	1 323, 302	041, 001	314, 430	1-02.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1317

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/28/2024 4:36 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & RECORDS & **SUPPLY** LI BRARY Ν 15.00 11 00 13 00 14 00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 1, 188, 796 11.00 01300 NURSING ADMINISTRATION 1, 159, 948 13.00 13.00 42, 661 01400 CENTRAL SERVICES & SUPPLY 14.00 306, 265 14 00 15.00 01500 PHARMACY 49, 174 472 1, 311, 120 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 42, 986 176 647, 347 16.00 0 01700 SOCIAL SERVICE 17.00 18, 182 17.00 C 67 0 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 305.028 629, 196 111, 986 30.00 7. 255 0 03100 INTENSIVE CARE UNIT 31.00 37.016 76, 334 928 0 6, 169 31 00 04300 NURSERY 43.00 12, 212 2, 221 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 177, 190 50.00 85.918 1,960 68.010 50.00 6, 169 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 207 0 740 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 122, 011 36, 149 0 1.553 54.00 06000 LABORATORY 0 60.00 139, 651 Ω 87,681 84, 513 60 00 0 65.00 06500 RESPIRATORY THERAPY 64,045 C 4, 361 12, 338 65.00 06600 PHYSI CAL THERAPY 50, 802 o 20, 974 66.00 528 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 14.980 0 6.539 67.00 0 06800 SPEECH PATHOLOGY 1, 974 68.00 4, 342 C 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 0 38, 470 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 146, 015 0 72 00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 24, 967 0 182 1, 311, 120 0 73.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.00 0 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 6, 307 88.00 6, 307 08801 RURAL HEALTH CLINIC II 0 0 0 88.01 88.01 88 02 08802 RURAL HEALTH CLINIC III 0 0 0 0 6, 307 88.02 08803 RURAL HEALTH CLINIC IV 88.03 0 0 0 6, 307 88.03 09100 EMERGENCY 134, 386 277, 228 2, 565 0 249, 285 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 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 SUBTOTALS (SUM OF LINES 1 through 117) 1, 148, 361 1, 159, 948 292, 422 1, 311, 120 632, 295 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CANTEEN C 15, 052 190. 00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 40, 435 13,843 0 194.00 07950 FOUNDATION / MOBS ol 0 194.00 0 0 C 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 1, 188, 796 1, 159, 948 306, 265 1, 311, 120 647, 347 202. 00

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1317 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/28/2024 4: 36 pm Cost Center Description SOCI AL NONPHYSI CI AN Subtotal Intern & Total SERVI CE **ANESTHETISTS** Resi dents Cost & Post Stepdown Adjustments 17. 00 19.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11 00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 16.00 17.00 01700 SOCIAL SERVICE 394, 665 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 258, 876 10, 089, 173 10, 089, 173 30.00 03100 INTENSIVE CARE UNIT 1, 654, 245 1, 654, 245 31.00 53, 204 0 0 31.00 04300 NURSERY 11, 911 0 339, 784 0 339, 784 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 971, 702 0 2, 971, 702 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 3, 970 0 46,882 0 46, 882 52.00 0 17, 325 17, 325 53.00 05300 ANESTHESI OLOGY 0 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 3, 141, 023 3, 141, 023 54.00 60.00 06000 LABORATORY 0 5, 325, 474 0 5, 325, 474 60.00 06500 RESPIRATORY THERAPY 65.00 0 0 0 1, 348, 533 0 0 1, 348, 533 65.00 06600 PHYSI CAL THERAPY 1, 135, 129 66 00 Ω 1, 135, 129 66 00 06700 OCCUPATIONAL THERAPY 67.00 0 467, 321 467, 321 67.00 06800 SPEECH PATHOLOGY 0000 135, 893 0 135, 893 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 Ω 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 698, 499 698, 499 71.00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2, 956, 954 2, 956, 954 72.00 07300 DRUGS CHARGED TO PATIENTS 4, 372, 980 0 4, 372, 980 73.00 73.00 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 ol 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 6,020,798 0 6, 020, 798 88 00 08801 RURAL HEALTH CLINIC II 1, 957, 344 0 88.01 0 1, 957, 344 88.01 0 08802 RURAL HEALTH CLINIC III 88 02 0 Ω 1, 644, 491 1,644,491 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 0 1, 601, 572 0 1,601,572 88.03 09100 EMERGENCY o 91.00 66, 704 0 5, 662, 138 5, 662, 138 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 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 394, 665 0 51, 587, 260 0 51, 587, 260 118. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 46, 141 0 46, 141 190. 00 192. 00 19200 PHYSICIANS PRIVATE OFFICES 4, 355, 807 192. 00 0 0 0 4, 355, 807

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394, 665

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55, 989, 208

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ol

0 194.00

0 200.00

0 201.00

55, 989, 208 202. 00

194.00 07950 FOUNDATION / MOBS

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

200.00

201.00

202.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION STATISTICS	Provi der CCN: 15-1317	Period: Worksheet Non-CMS W From 01/01/2023
		To 12/31/2023 Date/Time Prepared:

			5/28/2024 4: 3	36 pm
	Cost Center Description	Statistics	Statistics Description	
		Code		
		1. 00	2. 00	
	GENERAL SERVICE COST CENTERS			
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	SQUARE FEET	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	2	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	3	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPI NG	4	HOURS OF SERVICE	9.00
10.00	DI ETARY	5	MEALS SERVED	10.00
11.00	CAFETERI A	6	HOURS	11.00
13.00	NURSI NG ADMI NI STRATI ON	7	DIRECT NRSING HRS	13.00
14.00	CENTRAL SERVICES & SUPPLY	8	COSTED REQUIS.	14.00
15.00	PHARMACY	9	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	10	TIME SPENT	16.00
17.00	SOCI AL SERVI CE	11	TIME SPENT	17.00
19.00	NONPHYSI CI AN ANESTHETI STS	12	ASSIGNED TIME	19. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To | 12/31/2023 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1317

				То	12/31/2023	Date/Time Pre 5/28/2024 4:3	
			CAPI TAL REI	LATED COSTS		37 207 2024 4.3	o piii
	Cost Center Description	Di rectly	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	_	_		_	_	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	1	0	0	4.00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	267, 607 394, 058		318, 941 469, 649	0	5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	20, 978		25, 002	0	8.00
9. 00	00900 HOUSEKEEPI NG	0	20, 773		24, 953	0	9. 00
10.00	01000 DI ETARY	0	113, 365		135, 112	0	10.00
11.00	01100 CAFETERI A	0	111, 662		133, 082	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	22, 308		26, 587	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	142, 070		169, 323	0	14.00
15.00	01500 PHARMACY	0	53, 339		63, 571	0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	44, 283		52, 778	0	16.00
17.00	01900 NONPHYSICIAN ANESTHETISTS	0	11, 839 0		14, 110 0	0	17. 00 19. 00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	<u> </u>	0	17.00
30. 00	03000 ADULTS & PEDIATRICS	0	704, 328	135, 108	839, 436	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0	111, 330	21, 356	132, 686	0	31.00
43.00	04300 NURSERY	0	15, 744	3, 020	18, 764	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	,		242, 796	0	50.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	8, 557 0		10, 199 0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	189, 178		225, 468	0	54.00
60. 00	06000 LABORATORY	0	108, 463		129, 269	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	4, 860		5, 792	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	37, 511	7, 196	44, 707	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	37, 511	7, 196	44, 707	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	20, 106		23, 963	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69.00
71. 00 72. 00	O7100 MEDICAL SUPPLIES CHARGED TO PATIENT O7200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	34, 811	6, 678	41, 489	0	73.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	Ō		Ö	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		48, 155	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	,,	28, 640	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	24, 161	24, 161	0	88. 02
88. 03 91. 00	O8803 RURAL HEALTH CLINIC IV O9100 EMERGENCY	0	235, 870	30, 624 45, 246	30, 624	0	88. 03 91. 00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	233, 670	45, 240	281, 116 0	U	92.00
72.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	2, 914, 432	690, 648	3, 605, 080	0	118. 00
190. 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0	11, 548	2, 215	13, 763	Ω	190. 00
	19200 PHYSI CI ANS PRI VATE OFFI CES	0	141, 239		168, 333		192.00
194.00	07950 FOUNDATION / MOBS	0	0		0	0	194. 00
200.00					0		200. 00
201.00		_	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	0	3, 067, 219	719, 957	3, 787, 176	0	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1317

Peri od: Worksheet B From 01/01/2023 Part II To 12/31/2023 Date/Time Prepared:

5/28/2024 4:36 pm

Cost Center Description ADMINISTRATIV OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY E & GENERAL **PLANT** LINEN SERVICE 9. 00 5.00 7.00 10.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00500 ADMINISTRATIVE & GENERAL 5.00 318, 941 5.00 7.00 00700 OPERATION OF PLANT 18, 038 487, 687 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 1,730 3, 309 30, 041 8.00 00900 HOUSEKEEPI NG 4, 671 3, 303 32, 927 9 00 9 00 0 10.00 01000 DI ETARY 2, 256 17,884 0 90 155, 342 10.00 01100 CAFETERI A 6, 119 17, 615 0 11.00 15 0 11.00 13.00 01300 NURSING ADMINISTRATION 6, 231 3, 519 0 30 0 13.00 01400 CENTRAL SERVICES & SUPPLY 914 22, 412 0 14 00 15 0 14.00 0 15.00 01500 PHARMACY 6,820 8, 414 382 0 15.00 6, 986 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 175 0 56 0 16.00 01700 SOCIAL SERVICE 2, 073 0 17.00 17.00 1,868 15 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 7, 293 30 00 41, 759 111, 106 11,025 108, 735 03100 INTENSIVE CARE UNIT 6, 319 31.00 2, 275 46, 607 31.00 17, 562 3,067 04300 NURSERY 43.00 1,640 2, 484 0 367 0 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 13, 111 32, 137 1, 950 4, 205 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 85 1, 350 0 509 0 52.00 53.00 05300 ANESTHESI OLOGY 74 0 135 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 384 29, 843 4, 801 1,378 0 54.00 06000 LABORATORY 60.00 27, 730 1, 367 60.00 17, 110 0 0 06500 RESPIRATORY THERAPY 65.00 7, 098 767 \cap 659 0 65.00 06600 PHYSI CAL THERAPY 5, 164 5, 918 6,009 2,071 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 5, 918 67.00 2, 321 0 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 621 3, 172 0 0 0 68.00 0 69.00 06900 ELECTROCARDI OLOGY Ω (0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 3, 758 0 15 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 16, 014 0 0 0 72.00 C 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 17,097 5, 492 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 78.00 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 32, 799 39, 601 0 0 0 08801 RURAL HEALTH CLINIC II 23, 552 88.01 10, 244 0 0 0 88.01 08802 RURAL HEALTH CLINIC III 8, 598 88.02 19,869 0 0 0 88.02 88 03 08803 RURAL HEALTH CLINIC IV 8. 157 25, 184 O Ω 88 03 0 09100 EMERGENCY 91.00 25, 327 37, 209 7,713 6, 309 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 0 SPECIAL PURPOSE COST CENTERS 30, 041 SUBTOTALS (SUM OF LINES 1 through 117) 295, 327 463, 584 31, 710 155, 342 118. 00 NONREI MBURSABLE COST CENTERS 0 190, 00 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 89 1 822 142 192.00 19200 PHYSICIANS PRIVATE OFFICES 23, 525 22, 281 0 1,075 0 192.00 194.00 07950 FOUNDATION / MOBS 0 0 194.00 0 0 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 318, 941 487, 687 30, 041 32, 927 155, 342 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-1317

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 Part II | To 12/31/2023 Date/Time Prepared: 5/28/2024 4:36 pm

						5/28/2024 4: 3	6 pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	•		ADMI NI STRATI O	SERVICES &		RECORDS &	
			N	SUPPLY		LI BRARY	
		11. 00	13. 00	14.00	15.00		
	CENEDAL CEDALCE COCT CENTEDO	11.00	13.00	14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
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						5.00
7. 00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
							1
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	156, 831					11.00
13.00	01300 NURSING ADMINISTRATION	5, 628	41, 995				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	176, 488			14.00
15.00	01500 PHARMACY	6, 487	0	272	85, 946		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 671	0		0	68, 768	1
17. 00	01700 SOCIAL SERVICE	2, 399	0		o	00,700	1
19.00			0		-		
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	40, 241	22, 779		0	11, 896	1
31.00	03100 INTENSIVE CARE UNIT	4, 883	2, 764	535	0	655	31.00
43.00	04300 NURSERY	1, 611	0	1	0	236	43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	11, 335	6, 415	1, 130	0	7, 225	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	, 000	0,		Ö	655	1
53. 00	05300 ANESTHESI OLOGY	0	0	-	ő	79	
		1/ 00/			-		
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 096	0		0	3, 840	1
60.00	06000 LABORATORY	18, 423	0	,	0	8, 978	1
65.00	06500 RESPI RATORY THERAPY	8, 449	0	-,	0	1, 311	65.00
66.00	06600 PHYSI CAL THERAPY	6, 702	0	304	0	2, 228	66.00
67.00	06700 OCCUPATI ONAL THERAPY	1, 976	0	0	0	695	67.00
68.00	06800 SPEECH PATHOLOGY	573	0	0	o	210	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	_	ő	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
		0 004			-		1
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 294	0		85, 946	0	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	670	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	0	0	o	670	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	0	0	0	670	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	٥	0	0	670	
91. 00	09100 EMERGENCY	17, 729	10, 037	1, 478	0	26, 481	1
		17, 729	10,037	1,470	U	20, 401	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						1
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	151, 497	41, 995	168, 511	85, 946	67, 169	118.00
	NONREI MBURSABLE COST CENTERS						1
190. 00	19000 GIFT FLOWER COFFEE SHOP & CANTEEN	Ω	0	0	0	1. 599	190. 00
	19200 PHYSI CI ANS PRI VATE OFFI CES	5, 334	l o		Ö		192.00
	07950 FOUNDATION / MOBS	J, JJ4		0	0		194.00
200.00		U		١	۷	U	200.00
	1 1	^		1/ 17/		_	
201.00	1 1 9	15. 55:	1	16, 176	0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	156, 831	41, 995	192, 664	85, 946	68, 768	202. 00

	THATCHAR SYSTEMS ON	ELNE GOONTT GE	Provi der C	CN: 15-1317	Period: From 01/01/2023 To 12/31/2023		pared:
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17. 00	19. 00	24. 00	25. 00	26.00	
	GENERAL SERVICE COST CENTERS		Г	T		Г	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 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						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						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	20, 504					17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	l				19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	13, 450	l	1, 211, 90			
31.00	03100 NTENSI VE CARE UNI T	2, 764	l e	220, 11			1
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	619		25, 72	2 0	25, 722	43.00
50.00	05000 OPERATING ROOM	0		320, 30	4 0	320, 304	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	206	l .	13, 00		13, 004	1
53.00	05300 ANESTHESI OLOGY	0		40		407	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		297, 70		297, 705	1
60.00	06000 LABORATORY	0		253, 40		253, 404	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0		26, 58 73, 10		26, 589 73, 103	1
67.00	06700 OCCUPATI ONAL THERAPY	0		55, 61		55, 617	1
68. 00	06800 SPEECH PATHOLOGY	0		28, 53		28, 539	1
69. 00	06900 ELECTROCARDI OLOGY	0		1	0 0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		25, 94		25, 942	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		100, 15		100, 155	1
73. 00 77. 00	07300 DRUGS CHARGED TO PATIENTS 07700 ALLOGENEIC HSCT ACQUISITION	0		153, 42	3 0 0	153, 423 0	1
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0		•	0 0		1
70.00	OUTPATIENT SERVICE COST CENTERS			I.	<u> </u>	<u> </u>	70.00
88. 00	08800 RURAL HEALTH CLINIC	0		121, 22	5 0	121, 225	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0		63, 10		63, 106	1
88. 02	08802 RURAL HEALTH CLINIC III	0		53, 29		53, 298	1
88. 03 91. 00	08803 RURAL HEALTH CLINIC IV 09100 EMERGENCY	0 3, 465		64, 63 416, 86		64, 635 416, 864	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 403		410, 80	0	l '	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPIOID TREATMENT PROGRAM	0			0 0	0	102.00
	SPECIAL PURPOSE COST CENTERS						
118.00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	20, 504	0	3, 525, 06	0 0	3, 525, 060	118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CANTEEN	0		17, 41	5 0	17 /15	190. 00
	19000 BIFT FLOWER COFFEE SHOP & CANTEEN	0		228, 52		228, 525	1
	07950 FOUNDATION / MOBS	0]	0		194. 00
200.00	Cross Foot Adjustments		0		0 0	0	200.00
201.00		0	0				201. 00
202.00	TOTAL (sum lines 118 through 201)	20, 504	0	3, 787, 17	6 0	3, 787, 176	202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1317 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/28/2024 4: 36 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS F & GENERAL n DEPARTMENT (ACCUM. COST) (GROSS SALARIES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 73.836 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 90, 348 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 27, 541, 850 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 2, 926, 293 5.00 6.442 6.442 -6, 674, 845 49, 314, 363 5.00 7.00 00700 OPERATION OF PLANT 9,486 9, 486 876, 578 2, 788, 848 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 505 505 267, 402 8.00 00900 HOUSEKEEPI NG 450, 524 0 9 00 504 504 722, 143 9 00 10.00 01000 DI ETARY 2,729 2,729 117, 788 0 348, 836 10.00 11.00 01100 CAFETERI A 2,688 2, 688 588, 801 946,003 11.00 13.00 01300 NURSING ADMINISTRATION 537 537 626, 453 0 0 963, 290 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 3 420 3 420 141 253 14 00 0 15.00 01500 PHARMACY 1, 284 1, 284 706, 024 1,054,373 15.00 01600 MEDICAL RECORDS & LIBRARY 324, 635 0 490, 944 16.00 1.066 1.066 16.00 ol 01700 SOCIAL SERVICE 17.00 17.00 285 285 248, 341 320, 523 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 16, 955 16, 955 4, 090, 158 6, 460, 262 30.00 03100 INTENSIVE CARE UNIT 2, 680 977, 008 31 00 2,680 520 937 0 31 00 43.00 04300 NURSERY 379 379 191, 392 0 253, 610 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 904 4, 904 813, 518 0 2, 027, 062 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 206 206 2, 422 13, 183 52 00 53.00 05300 ANESTHESI OLOGY 0 11, 392 53.00 2, 378, 460 05400 RADI OLOGY-DI AGNOSTI C 1, 189, 817 0 54.00 4.554 4,554 54.00 06000 LABORATORY 1, 127, 140 0 0 4, 287, 319 60.00 2,611 2,611 60.00 06500 RESPIRATORY THERAPY 65.00 117 117 811, 223 1, 097, 432 65 00 66.00 06600 PHYSI CAL THERAPY 903 903 599, 160 798, 407 66.00 06700 OCCUPATI ONAL THERAPY 0 67 00 903 903 256, 103 358, 815 67 00 0 06800 SPEECH PATHOLOGY 484 484 58, 727 95, 991 68.00 68.00 69 00 06900 ELECTROCARDI OLOGY 0 C 0 Λ 69 00 581, 005 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 71.00 0 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 2, 475, 828 72.00 07300 DRUGS CHARGED TO PATIENTS 0 278, 581 73.00 838 2, 643, 281 73.00 838 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 88 00 0 6,043 3, 315, 432 0 5,071,005 88.01 08801 RURAL HEALTH CLINIC II 0 3, 594 981, 399 0 1, 583, 758 88.01 88.02 08802 RURAL HEALTH CLINIC III 0 3, 032 788, 305 0 1, 329, 262 88.02 o 08803 RURAL HEALTH CLINIC IV 750, 280 88.03 0 3.843 1, 261, 069 88.03 09100 EMERGENCY 0 91.00 5, 678 5, 678 2, 473, 757 3, 915, 719 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00 0 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 70, 158 86, 670 25, 113, 788 -6, 674, 845 45, 663, 483 118. 00 NONREI MBURSABLE COST CENTERS 13, 763 190. 00 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 278 278 192.00 19200 PHYSICIANS PRIVATE OFFICES 3,400 3,400 2, 428, 062 0 3, 637, 117 192. 00 194.00 07950 FOUNDATION / MOBS 0 194.00 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 3, 067, 219 719, 957 6, 237, 914 6, 674, 845 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 135353 203. 00 41.540969 7.968710 0. 226489 204.00 Cost to be allocated (per Wkst. B, 318, 941 204. 00 Part II) Unit cost multiplier (Wkst. B, Part 0.006468 205.00 205.00 0.000000 II) NAHE adjustment amount to be allocated 206.00 206 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

	•	REENE COUNTY GE	NERAL HOSPITAL	N. 15 1017		Warkshaat B 1	
C0S1 F	NLLOCATION - STATISTICAL BASIS		Provi der CO	F	Period: From 01/01/2023 Fo 12/31/2023	Worksheet B-1 Date/Time Pre 5/28/2024 4:3	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS)	
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 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	74, 420 505 504 2, 729 2, 688 537 3, 420 1, 284 1, 066 285	29, 096 0 0 0 0 0 0 0	219, 850 600 100 200 100 2, 550 377 100	11, 489 0 0 0 0 0 0 0 0	21, 903 786 0 906 792 335 0	13.00 14.00 15.00 16.00 17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1			_		
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	16, 955 2, 680 379	2, 203	73, 625 20, 475 2, 450	3, 447	5, 620 682 225	31.00
10.00	ANCILLARY SERVICE COST CENTERS	3,,	<u> </u>	2, 100	<u> </u>	220	10.00
50. 00 52. 00 53. 00 54. 00 60. 00 65. 00 66. 00	O5000 OPERATI NG ROOM O5200 DELIVERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY O5400 RADI OLOGY-DI AGNOSTI C O6000 LABORATORY O6500 RESPI RATORY THERAPY O6600 PHYSI CAL THERAPY	4, 904 206 0 4, 554 2, 611 117 903	0 0 4, 650 0	28, 075 3, 400 900 9, 200 9, 125 4, 400 13, 825	0 0 0 0 0 0 0 0	1, 583 0 0 2, 248 2, 573 1, 180 936	52.00 53.00 54.00 60.00 65.00
67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 77. 00 78. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS	903 484 0 0 0 838 0	0 0 0 0 0	((((((0 0 0 0 0 0	276 80 0 0 0 460 0	68. 00 69. 00 71. 00 72. 00 73. 00 77. 00
88. 00 88. 01 88. 02 88. 03 91. 00 92. 00	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 08802 RURAL HEALTH CLINIC III 08803 RURAL HEALTH CLINIC IV 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	6, 043 3, 594 3, 032 3, 843 5, 678	0 0 0	(((42, 125	0 0	0 0 0 0 2,476	88. 00 88. 01 88. 02 88. 03 91. 00 92. 00
102 00	OTHER REIMBURSABLE COST CENTERS 10200 OPIOID TREATMENT PROGRAM	0	0	(0	0	102.00
118. 00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)	70, 742					118.00
192.00	1 1	278 3, 400 0	0	950 7, 179 (745	190. 00 192. 00 194. 00 200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	3, 166, 327		841, 331		1, 188, 796	202. 00
203. 00 204. 00		42. 546721 487, 687		3. 82684 ² 32, 92 ⁷		54. 275487 156, 831	1
205. 00	1 1 '	6. 553171	1. 032479	0. 149770	13. 520933	7. 160252	205. 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Heal th Fina	ncial Systems G	REENE COUNTY GEN	NERAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO	F	Period: From 01/01/2023 To 12/31/2023	Worksheet B-1 Date/Time Pre 5/28/2024 4:3	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	Ş
OFNE	ALL OFFICE OF COST OFFITTED	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00	RAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT DEMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY CAFETERIA NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY D SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	215, 506 0 0 0 0	5, 193, 050 8, 000 2, 992 1, 137 0	100) 131, 173) 0	497 0	1
	FIENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	116, 898	123, 022	(22, 692	326	30.00
31. 00 03100 43. 00 04300	INTENSIVE CARE UNIT NURSERY LLARY SERVICE COST CENTERS	14, 182	15, 730 35	(1, 250	67 15	31.00
52. 00 05200 53. 00 05300 54. 00 05400 60. 00 06000	OPERATING ROOM DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY RADIOLOGY-DIAGNOSTIC LABORATORY	32, 920 0 0 0 0	33, 237 0 3, 502 26, 341 1, 486, 731	((((1, 250 150 7, 325 17, 125	0 5 0 0	52. 00 53. 00 54. 00 60. 00
66. 00 06600 67. 00 06700 68. 00 06800 69. 00 06900	RESPIRATORY THERAPY) PHYSICAL THERAPY) OCCUPATIONAL THERAPY) SPEECH PATHOLOGY) ELECTROCARDIOLOGY) MEDICAL SUPPLIES CHARGED TO PATIENT	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	73, 943 8, 948 0 0 0 652, 307	((((0 4, 250 1, 325 400 0 0	0 0 0 0 0	69.00
72. 00 07200 73. 00 07300 77. 00 07700 78. 00 <u>07800</u>	DIMPL DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS ALLOGENEIC HSCT ACQUISITION CAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS	0 0 0 0	2, 475, 828 3, 092 0	(100 (0 0	0 0 0 0	72. 00 73. 00 77. 00
	RURAL HEALTH CLINIC	0	0	(1, 278	0	88. 00
88. 02 08802 88. 03 08803 91. 00 09100		0 0 0 51, 506	0 0 0 43, 488	(((1, 278 1, 278	0 0 0 84	88. 02 88. 03 91. 00
	OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS						92.00
102. 00 10200 SPECI	OPIOID TREATMENT PROGRAM AL PURPOSE COST CENTERS	0	0				102. 00
118. 00 NONRE	SUBTOTALS (SUM OF LINES 1 through 117) HIMBURSABLE COST CENTERS	215, 506	4, 958, 333	100	128, 123	497	118.00
190. 00 19000 192. 00 19200	D GIFT FLOWER COFFEE SHOP & CANTEEN D PHYSICIANS PRIVATE OFFICES D FOUNDATION / MOBS Cross Foot Adjustments Negative Cost Centers	0 0 0	0 234, 717 0	((0	0	190. 00 192. 00 194. 00 200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 159, 948	306, 265	1, 311, 120	647, 347	394, 665	
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B, Part II)	5. 382439 41, 995	0. 058976 192, 664			794. 094567 20, 504	203. 00 204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 194867	0. 033985	859. 460000	0. 524254	41. 255533	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1317 Period: Worksheet B-1

From 01/01/2023 12/31/2023 Date/Time Prepared: 5/28/2024 4: 36 pm Cost Center Description NONPHYSI CI AN **ANESTHETI STS** (ASSI GNED TIME) 19.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 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 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 53.00 0000000000 53.00 54 00 05400 RADI OLOGY-DI AGNOSTI C 54 00 06000 LABORATORY 60.00 60.00 65. 00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68. 00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 88.01 08801 RURAL HEALTH CLINIC II 88.01 08802 RURAL HEALTH CLINIC III 88 02 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 88.03 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 118.00 0 190. 00 19000 GIFT FLOWER COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS PRIVATE OFFICES 0 192.00 194.00|07950|FOUNDATION / MOBS 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 202.00 Cost to be allocated (per Wkst. B, 0 Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 204.00 Part II) Unit cost multiplier (Wkst. B, Part 0.000000 205.00 205.00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

Health Financial Systems	GREENE COUNTY GENERAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Pro	rovider CCN: 15-1317	From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Prepared: 5/28/2024 4:36 pm

				o 12/31/2023	Date/Time Pre 5/28/2024 4:3	pared: 6 pm
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.	Adj .		Di sal I owance		
	B, Part I,					
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	10, 089, 173		10, 089, 173		0	
31.00 03100 INTENSIVE CARE UNIT	1, 654, 245		1, 654, 245		0	31.00
43. 00 04300 NURSERY	339, 784		339, 784	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 971, 702		2, 971, 702		0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	46, 882		46, 882		0	
53. 00 05300 ANESTHESI OLOGY	17, 325		17, 325		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	3, 141, 023		3, 141, 023		0	54.00
60. 00 06000 LABORATORY	5, 325, 474		5, 325, 474	ا ا	0	60.00
65. 00 06500 RESPIRATORY THERAPY	1, 348, 533	0	1, 348, 533		0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 135, 129	0	1, 135, 129	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	467, 321	0	467, 321	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	135, 893	0	135, 893	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	698, 499		698, 499	o o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 956, 954		2, 956, 954	ا ا	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	4, 372, 980		4, 372, 980	0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		(0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0		(0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	6, 020, 798		6, 020, 798	0	0	
88.01 08801 RURAL HEALTH CLINIC II	1, 957, 344		1, 957, 344	· 0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	1, 644, 491		1, 644, 491	0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	1, 601, 572		1, 601, 572	0	0	88. 03
91. 00 09100 EMERGENCY	5, 662, 138		5, 662, 138	0	0	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	4, 272, 723		4, 272, 723	3	0	92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOID TREATMENT PROGRAM	0		(102.00
200.00 Subtotal (see instructions)	55, 859, 983	0	,,			200. 00
201.00 Less Observation Beds	4, 272, 723		4, 272, 723	3		201.00
202.00 Total (see instructions)	51, 587, 260	0	51, 587, 260	0	. 0	202. 00

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/28/2024 4: 36 pm Title XVIII Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent **TFFRA** I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 2, 999, 091 2, 999, 091 03000 ADULTS & PEDIATRICS 30.00 03100 INTENSIVE CARE UNIT 366, 947 366, 947 31.00 254, 716 254, 716 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 0.000000 1, 516, 050 8, 732, 592 10, 248, 642 0 289961 50.00 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 217, 340 11, 057 228, 397 0. 205265 0.000000 52.00 05300 ANESTHESI OLOGY 281, 397 792, 326 1,073,723 0.016135 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 33, 840, 067 0.091082 645, 625 34, 485, 692 0.000000 54.00 06000 LABORATORY 0. 183612 0.000000 60.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	u of Form CMS-2552-10	
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-13	From 01/01/2023	Worksheet C Part I Date/Time Prepared: 5/28/2024 4:36 pm
	Title XVIII	Hospi tal	Cost

				5/28/2024 4: 36 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING 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 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	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
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00
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
	,			•

Health Financial Systems	GREENE COUNTY GE	ENERAL HOSPITAL		In Lieu of Form CMS-2			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1317	Peri od: From 01/01/2023 Part To 12/31/2023 Date/Time Pre 5/28/2024 4:30			
		Ti tl	e XIX	Hospi tal	Cost		
		·		Costs			
Cost Center Description	Total Cost	Therapy Limit	Total Costs	s RCF	Total Costs		

				'	0 12/31/2023	5/28/2024 4: 3	6 pm
			Ti tl	e XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.	Adj .		Di sal I owance		
		B, Part I,					
		col. 26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDIATRICS	10, 089, 173		10, 089, 173		10, 089, 173	
	03100 INTENSIVE CARE UNIT	1, 654, 245		1, 654, 245		1, 654, 245	
	04300 NURSERY	339, 784		339, 784	. 0	339, 784	43.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 971, 702		2, 971, 702		2, 971, 702	
	D5200 DELIVERY ROOM & LABOR ROOM	46, 882		46, 882		46, 882	
	D5300 ANESTHESI OLOGY	17, 325		17, 325		17, 325	
	D5400 RADI OLOGY-DI AGNOSTI C	3, 141, 023		3, 141, 023		3, 141, 023	
	D6000 LABORATORY	5, 325, 474		5, 325, 474		5, 325, 474	
	06500 RESPI RATORY THERAPY	1, 348, 533	0	1, 348, 533		1, 348, 533	
	D6600 PHYSI CAL THERAPY	1, 135, 129	0	1, 135, 129		1, 135, 129	
	06700 OCCUPATI ONAL THERAPY	467, 321	0	467, 321		467, 321	67.00
	D6800 SPEECH PATHOLOGY	135, 893	0	135, 893	0	135, 893	
	D6900 ELECTROCARDI OLOGY	0		C		0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	698, 499		698, 499		698, 499	
	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 956, 954		2, 956, 954		2, 956, 954	
	D7300 DRUGS CHARGED TO PATIENTS	4, 372, 980		4, 372, 980	0	4, 372, 980	
	07700 ALLOGENEIC HSCT ACQUISITION	0		C	0	0	77.00
	07800 CAR T-CELL IMMUNOTHERAPY	0		C	0	0	78. 00
	DUTPATIENT SERVICE COST CENTERS						
	D8800 RURAL HEALTH CLINIC	6, 020, 798		6, 020, 798		6, 020, 798	
	D8801 RURAL HEALTH CLINIC II	1, 957, 344		1, 957, 344	0	1, 957, 344	
	D8802 RURAL HEALTH CLINIC III	1, 644, 491		1, 644, 491	0	1, 644, 491	
	D8803 RURAL HEALTH CLINIC IV	1, 601, 572		1, 601, 572	. 0	1, 601, 572	
	09100 EMERGENCY	5, 662, 138		5, 662, 138	0	5, 662, 138	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 272, 723		4, 272, 723		4, 272, 723	92.00
	OTHER REIMBURSABLE COST CENTERS						
	10200 OPIOID TREATMENT PROGRAM	0		C			102.00
200.00	Subtotal (see instructions)	55, 859, 983	0	55, 859, 983	0	55, 859, 983	
201.00	Less Observation Beds	4, 272, 723		4, 272, 723		4, 272, 723	
202. 00	Total (see instructions)	51, 587, 260	0	51, 587, 260	0	51, 587, 260	202. 00

	STATION OF WITHOUT OF GOODS TO STANGED		Trovider ox	0.4. 10 1017	From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/28/2024 4:3	
		_	Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent		Cost or Other	TEFRA	
				+ col . 7)	Ratio	I npati ent	
		4 00	7.00	0.00	0.00	Ratio	
	INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
30. 00		2, 999, 091		2, 999, 09	1		30.00
31. 00	I I	366, 947		366, 94		I	31.00
43. 00		254, 716		254, 71		I	43.00
43.00	ANCILLARY SERVICE COST CENTERS	254, 710		254,71	O _I		45.00
50. 00		1, 516, 050	8, 732, 592	10, 248, 64	2 0. 289961	0.000000	50.00
52. 00	0 05200 DELIVERY ROOM & LABOR ROOM	217, 340	11, 057			0. 000000	52.00
53.00	0 05300 ANESTHESI OLOGY	281, 397	792, 326	1, 073, 72	3 0. 016135	0. 000000	53.00
54.00	0 05400 RADI OLOGY-DI AGNOSTI C	645, 625	33, 840, 067			0. 000000	54.00
60.00	06000 LABORATORY	1, 117, 194	27, 886, 710	29, 003, 90	4 0. 183612	0.000000	60.00
65.00	06500 RESPIRATORY THERAPY	1, 172, 578	4, 004, 559	5, 177, 13	7 0. 260479	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	351, 492	4, 124, 564	4, 476, 05	6 0. 253600	0. 000000	66.00
67.00	0 06700 OCCUPATI ONAL THERAPY	168, 710	1, 454, 451	1, 623, 16	1 0. 287908	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	49, 971	305, 496	355, 46	7 0. 382294	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0. 000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 213, 968	4, 390, 867	5, 604, 83	5 0. 124624	0. 000000	71.00
72.00		763, 487	1, 968, 073	2, 731, 56		0.000000	
73.00		2, 411, 734	16, 755, 650	19, 167, 38		0. 000000	
77.00		0	0		0. 000000		
78. 00		0	0		0. 000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS				-1		
88. 00		0	7, 210, 480			0. 000000	
88. 0		0	2, 395, 276			0.000000	
88. 02		0	1, 916, 385			0.000000	
88. 0		770 700	1, 262, 939			0.000000	
91.00		773, 789	29, 507, 821			0.000000	
92. 00	O 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	296, 155	2, 259, 076	2, 555, 23	1 1. 672147	0. 000000	92.00
102 (00 10200 OPI OI D TREATMENT PROGRAM	0	0		0		102.00
200. (14, 600, 244	148, 818, 389		<u> </u>	I	200.00
200. (14, 000, 244	140, 010, 307	103, 410, 03	5	I	201.00
201. (I I	14, 600, 244	148, 818, 389	163, 418, 63	3	1	202.00
	()	1	, ,		- 1		1

Health Financial Systems	GREENE COUNTY GENE	RAL 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 Prepared: 5/28/2024 4:36 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Innatient			

			T' 11 . VI V	11	3/20/2024 4. 30 pill
			Title XIX	Hospi tal	Cost
	Cost Center Description	PPS Inpatient			
		Ratio			
		11. 00			
	NPATIENT ROUTINE SERVICE COST CENTERS				
	3000 ADULTS & PEDIATRICS				30.00
	3100 INTENSIVE CARE UNIT				31.00
	4300 NURSERY				43.00
A٨	NCILLARY SERVICE COST CENTERS				
50.00 05	5000 OPERATING ROOM	0. 000000			50.00
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53.00 05	5300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60.00 06	6000 LABORATORY	0. 000000			60.00
65. 00 06	6500 RESPIRATORY THERAPY	0. 000000			65.00
66. 00 06	6600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06	6700 OCCUPATI ONAL THERAPY	0. 000000			67.00
	6800 SPEECH PATHOLOGY	0. 000000			68.00
1	6900 ELECTROCARDI OLOGY	0. 000000			69.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
1	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
	7700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77.00
	7800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78.00
	JTPATIENT SERVICE COST CENTERS				
	8800 RURAL HEALTH CLINIC	0. 000000			88.00
	8801 RURAL HEALTH CLINIC II	0. 000000			88. 01
	8802 RURAL HEALTH CLINIC III	0. 000000			88. 02
	8803 RURAL HEALTH CLINIC IV	0. 000000			88. 03
	9100 EMERGENCY	0. 000000			91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
	THER REIMBURSABLE COST CENTERS	0. 000000			72.00
	D200 OPIOID TREATMENT PROGRAM				102.00
200. 00	Subtotal (see instructions)				200. 00
200.00	Less Observation Beds				201. 00
201.00	Total (see instructions)				202. 00
202.00	Total (see Histractions)				202.00

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	TAL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023		pared: 6 pm
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	320, 304				· ·	
52.00 05200 DELIVERY ROOM & LABOR ROOM	13, 004		1		0	52.00
53. 00 05300 ANESTHESI OLOGY	407	1, 073, 723				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	297, 705		1			54.00
60. 00 06000 LABORATORY	253, 404			·		
65. 00 06500 RESPI RATORY THERAPY	26, 589				· ·	
66. 00 06600 PHYSI CAL THERAPY	73, 103		1	·	· ·	
67. 00 06700 OCCUPATI ONAL THERAPY	55, 617					
68. 00 06800 SPEECH PATHOLOGY	28, 539	1	1			
69. 00 06900 ELECTROCARDI OLOGY	0	1	0.0000		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	25, 942			·	· ·	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	100, 155			·	· ·	
73. 00 07300 DRUGS CHARGED TO PATIENTS	153, 423	19, 167, 384		· · ·	8, 195	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 00000		0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	121, 225		1		0	
88. 01 08801 RURAL HEALTH CLINIC II	63, 106				0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III	53, 298				0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	64, 635				0	88. 03
91. 00 09100 EMERGENCY	416, 864				· ·	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	513, 235				176	
200.00 Total (lines 50 through 199)	2, 580, 555	159, 797, 879	1	4, 215, 054	61, 567	200.00

THROUGH COSTS

			'	0 12/31/2023	5/28/2024 4: 3	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
		ost-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0	C	0	0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	C	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	C	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	0	0	54.00
60. 00 06000 LABORATORY	0	0	C	0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0	C	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	O	0	C	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	O O	0	C	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	O O	0	C	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	-NT 0	0	C		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	ENT O	0	C		0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	l ol	0			0	72. 00 73. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	٥	0			0	73. 00 77. 00
78. 00 07700 ALLOGENETC HSCT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0			0	77.00 78.00
OUTPATIENT SERVICE COST CENTERS	I	U) U	U	76.00
88. 00 08800 RURAL HEALTH CLINIC		0		0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		0			0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III		0			0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	١	0			0	88. 03
91. 00 09100 EMERGENCY		0			0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PA	ART 0	Ŭ			0	92.00
200.00 Total (lines 50 through 199)	0	0	C	0	· · · · · · · · · · · · · · · · · · ·	200.00
in any		-1	_	-1	- 1	

THROUGH COSTS

			Т	o 12/31/2023	Date/Time Pre 5/28/2024 4:30	
		Title	xVIII	Hospi tal	Cost	<u> </u>
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col . 7)	
			and 4)		(see	
					instructions)	
ANOULLARY OFRIGOR ORDER OFFITTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS				10 040 (40	0.000000	F0 00
50. 00 05000 OPERATING ROOM	0	0	0			
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		228, 397		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		1, 073, 723		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		34, 485, 692		
60. 00 06000 LABORATORY	0	0		29, 003, 904		
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	0		5, 177, 137		
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		4, 476, 056 1, 623, 161		
68.00 06800 SPEECH PATHOLOGY	0	0		355, 467		
69. 00 06900 ELECTROCARDI OLOGY	0	0		333, 407	0.000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			5, 604, 835		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			2, 731, 560		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			19, 167, 384		
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0			17, 107, 304	0.000000	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0	0. 000000	
OUTPATIENT SERVICE COST CENTERS					0.000000	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	7, 210, 480	0.000000	88. 00
88. 01 08801 RURAL HEALTH CLINIC II	0	0	d	2, 395, 276		
88.02 08802 RURAL HEALTH CLINIC III	0	0	0	1, 916, 385		88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0	0	o c	1, 262, 939	0.000000	88. 03
91. 00 09100 EMERGENCY	0	0	O	30, 281, 610		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	o	2, 555, 231	0.000000	92.00
200.00 Total (lines 50 through 199)	0	0	o c	159, 797, 879		200. 00

Health Financial Systems	GREENE COUNTY GENEI	RAL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1317		Worksheet D
TUDQUEU COSTS			From 01/01/2023	Part IV

THROUGH COSTS	KVI OL OTTIEK TAOC	J TTOVIGET 6		From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/28/2024 4:3	
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷		Costs (col. 8		Costs (col. 9	
	col . 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	T		T	Т		
50. 00 05000 OPERATING ROOM	0. 000000	472, 696		0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	(0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	79, 985	•	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	340, 408	•	0	0	54.00
60. 00 06000 LABORATORY	0. 000000	519, 576		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	458, 678	•	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	131, 740		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	25, 216	•	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	15, 730	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	495, 668		0	0	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	568, 949	(0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 023, 847	(0	0	73.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0	(0	0	77.00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	(0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0	(0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0	(0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0	(0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0. 000000	0	(0	0	88. 03
91. 00 09100 EMERGENCY	0. 000000	81, 683		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	878		0	0	92.00
200.00 Total (lines 50 through 199)		4, 215, 054	(0	0	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1317

THROUGH COSTS

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL IN Lieu of Form CMS-2552-10

Provider CCN: 15-1317

Period: From 01/01/2023 Part IV To 12/31/2023 Date/Time Prepared:

					10 12/31/2023	Date/lime Pro 5/28/2024 4:3	
			Title	XVIII	Hospi tal	Cost	00 p
	Cost Center Description	PSA Adj. Non	PSA Adj. All	<u> </u>	<u> </u>		
	·	Physi ci an	Other Medical				
		Anesthetist	Educati on				
		Cost	Cost				
		21. 00	24. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	C	0				50.00
	05200 DELIVERY ROOM & LABOR ROOM	C	0				52.00
	05300 ANESTHESI OLOGY	C	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	C	0				54.00
	06000 LABORATORY	C	0				60.00
	06500 RESPI RATORY THERAPY	C	0				65.00
	06600 PHYSI CAL THERAPY	C	0				66.00
	06700 OCCUPATI ONAL THERAPY	C	0				67.00
	06800 SPEECH PATHOLOGY	C	0				68. 00
	06900 ELECTROCARDI OLOGY	C	0				69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	C	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	C	0				73.00
	07700 ALLOGENEIC HSCT ACQUISITION	C	0				77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	C	0				78. 00
	OUTPATIENT SERVICE COST CENTERS	_					
	08800 RURAL HEALTH CLINIC	0	0				88. 00
	08801 RURAL HEALTH CLINIC II	0	0				88. 01
	08802 RURAL HEALTH CLINIC III		0				88. 02
	08803 RURAL HEALTH CLINIC IV		0				88. 03
	09100 EMERGENCY		0				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0				92.00
200.00	Total (lines 50 through 199)	[C	미				200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1317 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/28/2024 4:36 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 5.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 541, 405 50.00 0. 289961 05200 DELIVERY ROOM & LABOR ROOM 0 0. 205265 52.00 0 52.00 0 0 05300 ANESTHESI OLOGY 53.00 0.016135 0 65, 213 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.091082 8, 868, 961 0 0 0 0 54.00 60.00 06000 LABORATORY 0.183612 6, 818, 268 0 60.00 06500 RESPIRATORY THERAPY 1, 019, 927 65.00 0.260479 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 253600 1, 493, 440 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 287908 416, 681 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.382294 29, 556 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.124624 808, 851 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1. 082515 0 0 72.00 663, 525 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73 00 0 228147 6, 437, 243 305 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 0 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 88.01 88.01 88.02 08802 RURAL HEALTH CLINIC III 88.02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 6, 392, 116 91 00 09100 EMERGENCY 0. 186983 88 Ω 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.672147 569,083 0 92.00

35, 124, 269

35, 124, 269

393

393

0

0 200.00

0 202.00

201.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/28/2024 4: 36 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 7. 00 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 446, 947 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0 1, 052 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 807, 803 0 54.00 60.00 06000 LABORATORY 1, 251, 916 0 60.00 06500 RESPIRATORY THERAPY 0 65.00 265, 670 65.00 0 66.00 06600 PHYSI CAL THERAPY 378, 736 66.00 67.00 06700 OCCUPATI ONAL THERAPY 119, 966 67.00 11, 299 0 68.00 06800 SPEECH PATHOLOGY 68.00 0 06900 ELECTROCARDI OLOGY 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 100,802 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 718, 276 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 70 73.00 73 00 1, 468, 638 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 88.01 88.01 88.02 08802 RURAL HEALTH CLINIC III 88.02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 91 00 09100 EMERGENCY 1, 195, 217 16 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 951, 590 92.00 200.00 Subtotal (see instructions) 7, 717, 912 86 200.00 Less PBP Clinic Lab. Services-Program

7, 717, 912

86

201.00

202.00

201.00

202.00

Only Charges

Net Charges (line 200 - line 201)

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1317 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 Part V Date/Time Prepared: 5/28/2024 4:36 pm Title XIX Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 4.00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 964, 991 50.00 0. 289961 05200 DELIVERY ROOM & LABOR ROOM 3, 686 0 0. 205265 52.00 52.00 0 0 53. 00 | 05300 | ANESTHESI OLOGY 0 0.016135 8, 947 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.091082 2, 924, 944 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0.183612 3, 582, 330 0 60.00 06500 RESPIRATORY THERAPY 65.00 0.260479 363, 344 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 253600 190, 941 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 287908 106, 022 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.382294 186, 885 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.124624 230, 787 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1. 082515 0 0 72.00 81,673 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 73 00 0 228147 1, 550, 532 0 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0.000000 0 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 88.01 88.01 88.02 08802 RURAL HEALTH CLINIC III 88.02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 91 00 09100 EMERGENCY 0. 186983 4, 308, 918 Ω 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART o 1.672147 0 165, 670 0 92.00 200.00 Subtotal (see instructions) 0 0 200.00 14, 669, 670 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges

14, 669, 670

0 202.00

202.00

Net Charges (line 200 - line 201)

					То	12/31/2023	Date/Time Pr 5/28/2024 4:	
			Ti tl	e XIX		Hospi tal	Cost	
		Cos						
	Cost Center Description	Cost	Cost					
		Rei mbursed	Rei mbursed					
		Servi ces	Services Not					
		Subject To	Subject To					
			Ded. & Coins.					
		(see inst.)	(see inst.)					
		6. 00	7. 00					
	LLARY SERVICE COST CENTERS							
	O OPERATING ROOM	279, 810	0					50.00
	ODELIVERY ROOM & LABOR ROOM	757	0					52.00
	O ANESTHESI OLOGY	144	0					53.00
	O RADI OLOGY-DI AGNOSTI C	266, 410	0					54.00
	O LABORATORY	657, 759	0					60.00
	O RESPI RATORY THERAPY	94, 643	0					65. 00
	O PHYSI CAL THERAPY	48, 423	0					66. 00
	O OCCUPATI ONAL THERAPY	30, 525	0					67. 00
	SPEECH PATHOLOGY	71, 445	0					68. 00
	O ELECTROCARDI OLOGY	0	0					69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	28, 762	0					71. 00
	O IMPL. DEV. CHARGED TO PATIENTS	88, 412	0					72.00
	DRUGS CHARGED TO PATIENTS	353, 749	0					73. 00
	O ALLOGENEIC HSCT ACQUISITION	0	0					77. 00
	O CAR T-CELL IMMUNOTHERAPY	0	0					78. 00
	ATLENT SERVICE COST CENTERS							
	O RURAL HEALTH CLINIC							88.00
	1 RURAL HEALTH CLINIC II							88. 01
	2 RURAL HEALTH CLINIC III							88. 02
	3 RURAL HEALTH CLINIC IV							88. 03
	O EMERGENCY	805, 694	0					91.00
	O OBSERVATION BEDS (NON-DISTINCT PART	277, 025	0					92.00
200. 00	Subtotal (see instructions)	3, 003, 558	0					200.00
201. 00	Less PBP Clinic Lab. Services-Program	0						201.00
	Only Charges	0 000 550						
202. 00	Net Charges (line 200 - line 201)	3, 003, 558	0					202.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-	1317 Peri od: From 01/01/2023	Worksheet D-1		
		To 12/31/2023			
	Title XVIII	Hospi tal	Cost		
Cost Center Description					
			1.00		
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS				1	
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn) 3,209					
2.00 Inpatient days (including private room	m days, excluding swing-bed and newborn o	days)	2, 874	2.00	
1_ 1				1	

	Cost Center Description	COST	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 209	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	2, 874 0	2. 00 3. 00
	do not complete this line.		
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	1, 515	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	808	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	286	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13. 00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	10, 089, 173 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)		23. 00
24. 00	X line 18) 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) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	1, 053, 247	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	9, 035, 926	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Pri vate room charges (excluding swing-bed charges)	0	
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
	Average per diem private room charge differential (line 32 minus line 33) (see instructions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35. 00 36. 00
37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line		37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	3, 144. 02	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	2, 540, 368	
	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 2, 540, 368	40. 00 41. 00

	Financial Systems GR ATION OF INPATIENT OPERATING COST	REENE COUNTY GE	NERAL HOSPITAL Provider C	CN: 15-1317 F	eriod: rom 01/01/2023	u of Form CMS-2 Worksheet D-1	
				Т	o 12/31/2023	Date/Time Pre 5/28/2024 4:3	
	Cost Contar Decement on	Total		XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3. 00	4.00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	1, 654, 245	125	13, 233. 96	38	502, 890	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 (Wk	st. D-3, col. 3	3, line 200)			1, 358, 914	48. 00
48. 01	Program inpatient cellular therapy acquisiti				column 1)	4 402 172	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.0	or)(see instru	ctions)		4, 402, 172	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51. 00	 Pass through costs applicable to Program inp	atient ancillar	rv services (f	rom Wkst D s	um of Parts II	0	51.00
01.00	and IV)		y 361 VI 663 (1	rom with b, s	um or rures rr		01.00
52. 00 53. 00	Total Program excludable cost (sum of lines		alated non ph	vei ei an anaeth	otist and	0	52. 00 53. 00
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		erated, non-ph	ysician anestn	etist, and	0	53.00
E 4 00	TARGET AMOUNT AND LIMIT COMPUTATION	•					
54. 00 55. 00	Program discharges Target amount per discharge					0 0. 00	
55. 01	Permanent adjustment amount per discharge					0.00	
55. 02	Adjustment amount per discharge (contractor					0.00	1
56. 00 57. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus	line 53)	0	56. 00 57. 00
58.00	Bonus payment (see instructions)	o .			ŕ	0	58.00
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)		n the cost rep	orting period	endi ng 1996,	0.00	59.00
60.00	Expected costs (lesser of line 53 ÷ line 54,		om prior year	cost report, u	pdated by the	0.00	60.00
61. 00	<pre>market basket) Continuous improvement bonus payment (if lin</pre>	o 52 · lino 54	is loss than	the lowest of	linge 55 plue	0	61.00
01.00	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of t	the amount by	which operatin	g costs (line	0	01.00
62. 00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	899, 190	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oor 21 of the	cost roporting	pariod (Saa	0	65.00
05.00	instructions)(title XVIII only)	ts after beceilik	bei 31 of the	cost reporting	perrou (see	0	05.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only); for	899, 190	66.00
67. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost re	porting period	0	67.00
	(line 12 x line 19)		2				
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter l	becember 31 of	the cost repo	ring period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient		`			0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service c	ost per diem (I					71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	,	m (line 14 v l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv		•				74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line	76)					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		orovider recor	ds)			78. 00 79. 00
80.00	Total Program routine service costs for comp				us line 79)		80.00
81.00	Inpatient routine service cost per diem limi		1)				81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (•				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PAS		Jugii 00 <i>)</i>				
87.00	Total observation bed days (see instructions					1, 359	
88. UU	Adjusted general inpatient routine cost per	urem (TINE 27 -	- IIIIe 2)			3, 144. 02	88. UU

Health Financial Systems GR	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)			4, 272, 723	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 211, 901	10, 089, 173	0. 12011	9 4, 272, 723	513, 235	90.00
91.00 Nursing Program cost	0	10, 089, 173	0.00000	0 4, 272, 723	0	91.00
92.00 Allied health cost	0	10, 089, 173	0.00000	0 4, 272, 723	0	92.00
93.00 All other Medical Education	0	10, 089, 173	0. 00000	0 4, 272, 723	0	93.00

Heal th	Financial Systems	GREENE COUNTY GENER	AL HOSPITAL	In Lie	u of Form CMS-2	552-10
COMPUT	TATION OF INPATIENT OPERATING COST		Provi der CCN: 15-1317	Peri od: From 01/01/2023	Worksheet D-1	
				To 12/31/2023	Date/Time Prep 5/28/2024 4:36	
			Title XIX	Hospi tal	Cost	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	INPATIENT DAYS					
1.00	Inpatient days (including private room da	ys and swing-bed day	s, excluding newborn)		3, 209	1.00
2.00	Inpatient days (including private room da	ys, excluding swing-	bed and newborn days)		2, 874	2.00
3. 00	Private room days (excluding swing-bed an do not complete this line.	nd observation bed day	ys). If you have only p	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-b	ed and observation b	ed days)		1, 515	4.00

	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 209	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	2, 874 0	2. 00 3. 00
3.00	do not complete this line.	١	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	1, 515	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	335	5.00
,	reporting period		,
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
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
0.00	reporting period (if calendar year, enter 0 on this line)	31	9. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	اد	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	o	12. 00
12.00	through December 31 of the cost reporting period	١	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		44.00
14. 00 15. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	0 146	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)	13	16.00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
18. 00	reporting period		18. 00
16.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		16.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
	reporting period		
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	10, 089, 173	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22.00
00.00	5 x line 17)		00.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)	1, 053, 247	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 035, 926	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00		0	29.00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0. 00	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	33. 00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0. 00	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35)	0 025 024	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	9, 035, 926	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	3, 144. 02	38.00
39. 00 40. 00	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)	97, 465 0	39. 00 40. 00
41. 00		97, 465	
	· · · · · · · · · · · · · · · · · · ·		

4. 00	Semi-private room days (excluding swing-bed and observation bed days)	1, 515	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	335	5.00
3.00	report in g peri od	333	3.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	J	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	report in g per ind	J	7.00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	o l	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	31	9. 00
7. 00	newborn days) (see instructions)	31	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructions)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	o l	11.00
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	o l	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	O	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	146	
16. 00	Nursery days (title V or XIX only)		16.00
10.00	SWING BED ADJUSTMENT	13	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
10.00	reporting period		10.00
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)	10, 089, 173	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		
22.00	5 x line 17)	U	22.00
23. 00		^	23. 00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	U	23.00
24. 00	, and the second	0	24. 00
24.00	17 x line 19)	U	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
25.00	Swing-bed cost applicable to writing services after beceined 31 of the cost reporting period (fine 8)	U	25.00
26. 00	Total swing-bed cost (see instructions)	1, 053, 247	26 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9, 035, 926	
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	7, 033, 720	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	
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. 000000	
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)		33.00
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
35. 00	Average per diem private room cost differential (line 34 x line 31)		35.00
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line		
37.00	27 minus line 36)	7, 033, 720	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00		3, 144. 02	38 00
39.00		3, 144. 02 97, 465	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	97, 465	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	97, 465	
41.00	Total Frogram general impatrent routine service cost (Title 37 + Title 40)	71,400	41.00

Cost Center Description		Financial Systems GR ATION OF INPATIENT OPERATING COST	EENE COUNTY GEN	Provi der Co	CN: 15-1317 F	Peri od:	worksheet D-1	
Cost Center Description						From 01/01/2023 To 12/31/2023	Date/Time Pre	
Injustment				Ti tl	e XIX	Hospi tal		
Cost		Cost Center Description			9	Program Days		
1.00 NURSPEY (111e V a XIX only) 339,78e 146 2,377,79 13 30,795 146 2,377,79 13 30,795 146 2,377,79 13 30,795 146 2,377,79 13 30,795 146 2,377,79 13 30,795 146 2,377,79 13 30,795 146 2,377,79 13 30,795 146 2,377,79 13 30,795 146 2,377,79 13 30,795 146 2,377,79 147 30,795 147 3			•	•	7		7	
MINISTRY (11 He V X XIX poly) 339, 786 146 2,377.79 13 30,786 Intensive Core Type Inpatient Nospital Units 1,654,246 125 13,233.96 4 52,396 4						4.00		
Attended to Care type Inpatient Hospital Writs Intrinsive CARE Writ	42 00	NURSERY (title V & XIX only)						42 00
Milipsi Cape Milipsi Cape Milipsi Cape Milipsi Cape Milipsi Cape Milipsi Milipsi Cape Milipsi Milipsi Cape Milipsi Milip	42.00		337, 704	140	2, 321. 2	/ 13	30, 233	42.00
44.00 (CORONARY CARE UNIT 45.00 (RIMEN TRESSIVE CARE UNIT 46.00 (SURGICAL INTERSIVE CARE UNIT 46.00 (SURGICAL INTERSIVE CARE UNIT 47.00 (THER SYCIAL CARE CONTENT DESCRIPTION 48.00 (Program inpatient callular therapy acquisition cost (Glocksheet D-6, Part III, line 10, column 1) 48.00 (Program inpatient callular therapy acquisition cost (Glocksheet D-6, Part III, line 10, column 1) 49.00 (Program inpatient callular therapy acquisition cost (Glocksheet D-6, Part III, line 10, column 1) 40.081 40.01 (Program inpatient costs (Sum of Tines 4) through 48 (01) (see Instructions) 40.081 40.08	43.00		1, 654, 245	125	13, 233, 90	5 4	52, 936	43.00
44.00 OTHER SPECIAL CARE (DNIT) 7.00 OTHER SPECIAL CARE (DNIT			, ,		,		,	44.00
### Offines SPECIAL CARE (SPECIPY) Cost Center Description 1.00	45.00	BURN INTENSIVE CARE UNIT						45.00
Cost Center Description 1.00 1.00 1.00 1.00 1.00 1.00 279.725 48.00 Program Inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 1.00 279.725 48.01 Program Inpatient collular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 49.00 Total Program inpatient costs (sun of lines 41 through 48 0)(see instructions) 460.381 460.381 51.00 Pass through costs applicable to Program Inpatient routine services (from Wkst. D, sun of Parts I and and IV) 51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sun of Parts II and IV) 52.00 Fotal Program excludable cost (sun of lines 50 and 51) 53.00 Fotal Program excludable cost (sun of lines 50 and 51) 54.00 Forgram inpatient operating cost excluding capital related, non-physician anesthetist, and octave and incomplete the cost of	46.00	SURGICAL INTENSIVE CARE UNIT						46.00
1.00 Program inpatient ancillary service cost (Wkst. B-3, col. 3, line 200) 279, 225 48.01 Program inpatient collular therapy acquisition cost (Worksheet D-6, Part III, line 10, column 1) 279, 225 40.01 1012 Program inpatient costs (sum or lines 41 through 48 01)(see instructions) 460, 381 400, 481 400, 4	47. 00							47. 00
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instructions)(itile XVIII only) 65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(itile XVIII only) 66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 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) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total litle V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) 60.00 Part III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 70.00 Skilled nursing facility/other nursing facility/CF/IID routine service cost (line 37) 71.00 Adjusted general inpatient routine service costs (line 70 + line 70) 72.00 Program general inpatient routine service costs (line 72 + line 73) 73.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 74.00 Total Program general inpatient routine service costs (from provider records) 75.00 Aggregate charges to beneficiaries for excess costs (from provider records) 76.00 Inpatient routine service cost for comparison to the cost limitation (line 78 minus line 79) 77.00 Inpa								
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instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only); for CAH, see instructions 67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) 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) 69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY 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 (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 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) 80.00 Total Program routine service cost per diem limitation 10.10	65 00		ts after Decemb	or 31 of the (rost reporting	neriod (See		65.00
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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)								82. 00 83. 00
85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				,				84.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)				ons)				85.00
								86.00
		PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					1
87.00 Total observation bed days (see instructions) 1,359 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 3,144.02 8								

Health Financial Systems GR	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023		
		Ti tl e	e XIX	Hospi tal	Cost	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions))			4, 272, 723	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
				·	instructions)	
	1. 00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	1, 211, 901	10, 089, 173	0. 12011	9 4, 272, 723	513, 235	90.00
91.00 Nursing Program cost	0	10, 089, 173	0.00000	0 4, 272, 723	0	91.00
92.00 Allied health cost	0	10, 089, 173	0.00000	0 4, 272, 723	0	92.00
93.00 All other Medical Education	o	10, 089, 173	0. 00000	0 4, 272, 723	0	93.00

NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT Pr	ovider C	CN: 15-1317	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-3 Date/Time Pre 5/28/2024 4:3	eparec
		Ti tl e	: XVIII	Hospi tal	Cost	
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
LNDA	TIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	_
	OO ADULTS & PEDIATRICS		I	1 227 224		30.0
	OO INTENSIVE CARE UNIT			1, 336, 334 104, 842		31. (
	NURSERY			104, 042		43. (
	LLARY SERVICE COST CENTERS					45.
	OO OPERATING ROOM		0. 2899	61 472, 696	137, 063	50.
	DO DELIVERY ROOM & LABOR ROOM		0. 2052	. ,	0	
	OO ANESTHESI OLOGY		0. 0161		1, 291	53.
	DO RADI OLOGY-DI AGNOSTI C		0. 0910		31, 005	
0.00 0600	DO LABORATORY		0. 1836	12 519, 576	95, 400	60.
5.00 0650	OO RESPIRATORY THERAPY		0. 2604	79 458, 678	119, 476	65.
	DO PHYSI CAL THERAPY		0. 2536		33, 409	
	OO OCCUPATI ONAL THERAPY		0. 2879		7, 260	
	OO SPEECH PATHOLOGY		0. 3822		6, 013	
	00 ELECTROCARDI OLOGY		0.0000		0	
	DO MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1246		61, 772	
	OO IMPL. DEV. CHARGED TO PATIENTS		1. 0825		615, 896	
	DO DRUGS CHARGED TO PATIENTS		0. 2281		233, 588	
	OO ALLOGENEIC HSCT ACQUISITION		0.0000		0	
	OO CAR T-CELL IMMUNOTHERAPY PATIENT SERVICE COST CENTERS		0.0000	00 0	0	78.
	NO RURAL HEALTH CLINIC		0.0000	00	0	88.
	1 RURAL HEALTH CLINIC II		0.0000		0	
	22 RURAL HEALTH CLINIC III		0.0000		0	
	3 RURAL HEALTH CLINIC IV		0.0000		0	
	00 EMERGENCY		0. 1869		15, 273	
	OO OBSERVATION BEDS (NON-DISTINCT PART		1. 6721		1, 468	
00.00	Total (sum of lines 50 through 94 and 96 through 98)			4, 215, 054	1, 358, 914	
01.00	Less PBP Clinic Laboratory Services-Program only charges (ine 61)		0		201.
202. 00	Net charges (line 200 minus line 201)	,		4, 215, 054		202.

	ancial Systems GREENE COUNTY GENERAL ARRONT				u of Form CMS-2	
INPAILENI A	ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1317	Peri od: From 01/01/2023	Worksheet D-3	
		Component	CCN: 15-Z317	To 12/31/2023	Date/Time Pre	
					5/28/2024 4: 3	6 pm
		Title		Swing Beds - SNF		
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2.00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	0.00	
	O ADULTS & PEDIATRICS					30.00
31.00 0310	O INTENSIVE CARE UNIT					31.00
43.00 0430						43.00
ANCI	LLARY SERVICE COST CENTERS					1
50. 00 0500	O OPERATING ROOM		0. 2899	61 1, 734	503	50.00
52.00 0520	DELIVERY ROOM & LABOR ROOM		0. 2052	65 0	0	52.00
53.00 0530	O ANESTHESI OLOGY		0. 01613			53.00
	O RADI OLOGY-DI AGNOSTI C		0. 09108		1, 607	54.00
	O LABORATORY		0. 1836	12 40, 752	7, 483	60.00
	O RESPI RATORY THERAPY		0. 2604			
	O PHYSI CAL THERAPY		0. 25360			
	O OCCUPATI ONAL THERAPY		0. 28790			
	O SPEECH PATHOLOGY		0. 3822		i .	
	O ELECTROCARDI OLOGY		0.00000		0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 1246		5, 231	71.00
	O IMPL. DEV. CHARGED TO PATIENTS		1. 0825		0	72.00
	O DRUGS CHARGED TO PATIENTS		0. 2281		20, 318	
	O ALLOGENEIC HSCT ACQUISITION		0.0000			77.00
	OCAR T-CELL IMMUNOTHERAPY ATIENT SERVICE COST CENTERS		0.0000	00 0	0	78.00
	O RURAL HEALTH CLINIC		0.0000	20	0	88.00
	1 RURAL HEALTH CLINIC II		0.0000		0	88.0
	2 RURAL HEALTH CLINIC III		0.0000		0	88.0
	3 RURAL HEALTH CLINIC IV		0.0000		0	88. 03
	O EMERGENCY		0. 18698		1	91.0
	O OBSERVATION BEDS (NON-DISTINCT PART		1, 6721		Ö	92.0
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1.0721	533, 462		
201.00	Less PBP Clinic Laboratory Services-Program only charge	s (Line 61)	1	0 0		201.00
202. 00	Net charges (line 200 minus line 201)	(1110 01)	1	533, 462	l	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Health Financial Systems GREENE COUNTY GENERAL MARKET AND ALL ARY CERTAIN OF A COUNTY OF THE COUNTY				u of Form CMS-	
To 12/31/20/32 Title XIX Hospital Cost	INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1317	Peri od:	Worksheet D-3	3
Ratio of Cost Inpatient Inpatient Program Charges Program Charges Program Charges Cost X Col 2 X C						
NPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.		Ti tl	e XIX	Hospi tal	Cost	
NPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
NAME			To Charges			
INPATI ENT ROUTINE SERVICE COST CENTERS 193, 315 30.00 31.00				Charges		
NPATI ENT ROUTI NE SERVI CE COST CENTERS 193, 315 30. 00 3						
30. 00			1.00	2. 00	3. 00	
31.00 03100 INTENSIVE CARE UNIT 27, 590 160, 438 343.00 04300 NURSERY 160, 438 43.00 NURSERY 160, 438 160, 4						
43.00				· ·	l .	
ANCILLARY SERVICE COST CENTERS				· ·	l .	
50. 00				160, 438		43.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 205265 66, 340 13, 617 52. 00 53. 00 05300 AMESTHESI OLOGY 0. 016135 2, 814 45 53. 00 64. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 091082 24, 909 2, 269 54. 00 65. 00 06500 RESPI RATORY THERAPY 0. 260479 78, 534 20, 456 65. 00 66. 00 06500 RESPI RATORY THERAPY 0. 253600 5, 126 1, 300 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0. 287908 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0. 382294 380 145 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0. 000000 0 0 67. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1. 082515 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 1. 082515 0 0 72. 00 73. 00						
53. 00 05300 ANESTHESI OLOGY 0.016135 2,814 45 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.091082 24,909 2,269 54. 00 60. 00 06000 LABORATORY 0.183612 107,605 19,758 60. 00 65. 00 06500 RESPI RATORY THERAPY 0.260479 78,534 20,456 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.287908 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.287908 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.382294 380 145 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.124624 58,893 7,339 73. 30 73. 30 0 72. 00 0 72. 00 0 72. 00 0 72. 00 0 72. 00 0 72. 01 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.091082 24,909 2,269 54.00 60. 00 06000 LABORATORY 0.183612 107,605 19,758 60.00 65. 00 06500 RESPIRATORY THERAPY 0.260479 78,534 20,456 65.00 66. 00 06600 PHYSI CAL THERAPY 0.253600 5,126 1,300 66.00 67. 00 06700 OCCUPATI ONAL THERAPY 0.287908 0 0 67.00 68. 00 06800 SPEECH PATHOLOGY 0.382294 380 145 68.00 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69.00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.124624 58,893 7,339 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1.082515 0 0 72.00 77. 00 07300 DRUGS CHARGED TO PATI ENTS 0.228147 122,034 27,842 73.00 77. 00 07500 ALLOGENEI C HSCT ACQUI SI TI ON 0.000000 0 0 0 77.00 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0.000000 0 0			•	· ·		
60. 00 06000 LABORATORY 0.183612 107, 605 19, 758 60. 00 65. 00 RESPI RATORY THERAPY 0.260479 78, 534 20, 456 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.253600 5, 126 1, 300 66. 00 06700 000000 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0.287908 0 0 0 0 0.287908 0 0 0 0 0.287908 0 0 0 0 0 0 0 0 0 0 0						
65.00 06500 RESPIRATORY THERAPY 0.260479 78,534 20,456 65.00 66.00 06600 PHYSI CAL THERAPY 0.287908 0 0.6700 06CUPATI ONAL THERAPY 0.287908 0 0 67.00 06700 0CCUPATIONAL THERAPY 0.287908 0 0 67.00 069000 06900 06900 06900 06900			•	· ·		
66. 00			•	· ·		1
67. 00			•	· ·		
68. 00			•	· ·	1	
69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.124624 58, 893 7, 339 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1.082515 0 0 72. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 0.228147 122, 034 27, 842 73. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0.000000 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 78. 00 0000000 0 0 0 0 0 0						
71. 00					l .	
72. 00						
73. 00 07300 DRUGS CHARGED TO PATIENTS 0.228147 122,034 27,842 73. 00 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 0 0 0 0						1
77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0.000000 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 78. 00 0 0 0 0 0 0 0 0 0			•			
78. 00			•			1
SERVICE COST CENTERS					l .	
88. 00			0.00000	0		78.00
88. 01 08801 RURAL HEALTH CLINIC II 0.817168 0 0 0 88. 01			0.83500	07		88 00
88. 02 08802 RURAL HEALTH CLINIC III 0 88. 02 88. 03 08803 RURAL HEALTH CLINIC IV 1. 268131 0 0 88. 03 09100 09100 EMERGENCY 0. 186983 164, 023 30, 670 91. 00 92. 00 09200 085ERVATION BEDS (NON-DISTINCT PART 1. 672147 86, 634 144, 865 92. 00 201. 00 201. 00 Cess PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201. 00 201. 00 201. 00 0. 858121 0 0 88. 02 0 88. 02 0 88. 02 0 88. 03 0 88. 02 0 88. 03 0 88. 03 0 88. 03 0 88. 03 0 88. 03 0 88. 03 0 88. 03 0 88. 03 0 88. 03 0 88. 03 0 0 88. 03 0 0 88. 03 0 0 0 0 0 0 0 0 0					1	
88. 03						
91. 00 09100 EMERGENCY 0. 186983 164, 023 30, 670 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 1. 672147 86, 634 144, 865 92. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00 201.			1			
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 1.672147 86, 634 144, 865 92. 00 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201. 00			1			
200.00 Total (sum of lines 50 through 94 and 96 through 98) 756,674 279,725 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			•			1
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00			1.0/21			
		(Line 61)			217, 123	
		(Tric OI)		_		

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1317	From 01/01/2023 P To 12/31/2023 D	Worksheet E Part B Date/Time Prepared: 5/28/2024 4:36 pm

		Ti +Lo. VVIII	Hospi tal	5/28/2024 4: 3	6 pm_
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)	-l ana)		7, 717, 998	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instruct OPPS or REH payments	.10115)		0	2. 00 3. 00
4. 00	Outlier payment (see instructions)			0	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5.00
6.00	Line 2 times line 5			0	6.00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7. 00 8. 00
9. 00	Ancillary service other pass through costs including REH direc	ct graduate medical educ	ation costs from	-	9.00
	Wkst. D, Pt. IV, col. 13, line 200	g			
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			7, 717, 998	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			0	12.00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0	14.00
45.00	Customary charges				45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pamounts that would have been realized from patients liable for			0	15. 00 16. 00
10.00	had such payment been made in accordance with 42 CFR §413.13(e		ni a chai gebasi s	O	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			0	18.00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	instructions) Excess of reasonable cost over customary charges (complete onl	v if line 11 exceeds li	ne 18) (see	0	20.00
20.00	instructions)	y II IIIIc II cxccccc II	110 10) (300	· ·	20.00
21.00	Lesser of cost or charges (see instructions)			7, 795, 178	21.00
22. 00	Interns and residents (see instructions)			0	22.00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00 24. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions			49, 073	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line	24 (for CAH, see instr	ructions)	5, 667, 058	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	2 and 23] (see	2, 079, 047	27. 00
28. 00	instructions) Direct graduate medical education payments (from Wkst. E-4, li	no 50)		0	28. 00
28. 50	REH facility payment amount (see instructions)	Tie 30)		U	28.50
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.00
30.00	Subtotal (sum of lines 27, 28, 28.50 and 29)			2, 079, 047	30.00
31.00	Primary payer payments			1, 567	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVIC	FS)		2, 077, 480	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		0	33.00
34.00	Allowable bad debts (see instructions)			478, 691	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			311, 149	
	Allowable bad debts for dual eligible beneficiaries (see instr	ructi ons)		326, 159	36.00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			2, 388, 629 0	37. 00 38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)			39. 50
39. 75	N95 respirator payment adjustment amount (see instructions)			0	39. 75
39. 97	Demonstration payment adjustment amount before sequestration	and doubless (see the t))	0	39. 97
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ceu devices (see instruc	cu ons)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			2, 388, 629	40.00
40. 01	Sequestration adjustment (see instructions)			47, 773	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM pass-throughs			0 007 400	40. 03
41. 00 41. 01	Interim payments Interim payments-PARHM			3, 007, 130	41. 00 41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)			· ·	42. 01
43.00	Balance due provider/program (see instructions)			-666, 274	43.00
43. 01	Balance due provider/program-PARHM (see instructions)			_	43.01
44. 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				
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92. 00 93. 00
93. 00	Time Value of Money (see instructions)			0	73.00

Health Financial Systems	GREENE COUNTY GENERA	AL HOSPITAL	In Lieu	of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1317	Peri od: From 01/01/2023 To 12/31/2023		pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94.00
				Overri des	
				1. 00	
WORKSHEET OVERRIDE VALUES					
112.00 Override of Ancillary service charges (li	ne 12)			0	112.00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200.00

Health Financial Systems GREENE
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | | To | 12/31/2023 | Date/Time Prepared: | Provi der CCN: 15-1317

				10 12/31/2023	5/28/2024 4: 36	
		Ti tl e	e XVIII	Hospi tal	Cost	
		Inpatier	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4. 00	
1. 00	Total interim payments paid to provider		2, 911, 45	7	3, 007, 130	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVI DER	09/26/2023	326, 80		0	3. 01
3. 02			l	0	0	3. 02
3. 03			l	0	0	3. 03
3. 04			l	0	0	3. 04
3. 05				0	0	3. 05
	Provider to Program			_	_	
3. 50	ADJUSTMENTS TO PROGRAM		1	0	0	3.50
3. 51			1	0	0	3. 51
3. 52			l	0	0	3. 52
3.53			1	0	0 0	3.53
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		1	-	0	3. 54 3. 99
3. 99	3. 50-3. 98)		326, 80	U	l 'I	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 238, 25	7	3, 007, 130	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		3, 230, 23	'	3,007,130	4.00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		1			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			<u>'</u>		
5. 01	TENTATI VE TO PROVI DER		(0	0	5. 01
5.02			(0	0	5.02
5.03			(0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		II.	0	0	5. 50
5. 51			II.	0	0	5. 51
5. 52			1	0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		1	0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		799, 26	9	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			ol	666, 274	6. 02
7. 00	Total Medicare program liability (see instructions)		4, 037, 52	6	2, 340, 856	7. 00
	, and the state of		, ., ., , .=	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8.00	Name of Contractor					8. 00

Health Financial Systems GREENE
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	CCN. 13-2317	0 12/31/2023	5/28/2024 4: 3	
		Title	XVIII S	wing Beds - SNF		
	<u> </u>	Inpatien	nt Part A	Par	rt B	
			1		1	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Takal i akasis asamaka sai dika saasi dan	1. 00	2.00	3. 00	4.00	1 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		804, 272		0	
2.00	submitted or to be submitted to the contractor for			,		2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					-
3. 01	ADJUSTMENTS TO PROVIDER	09/26/2023	122, 700		0	3. 01
3. 02	TABSOSTWENTS TO TROVIDER	0772072023	122, 700		0	
3. 03					0	
3. 04					0	3. 04
3.05			()	0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		(0	
3. 51					0	
3. 52					0	
3. 53 3. 54					0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		122, 700		0	
0. 77	3. 50-3. 98)		122,700			0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		926, 972	2	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					1
г оо	TO BE COMPLETED BY CONTRACTOR	I	1		I	- 00
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		()	0	5.01
5.02					0	
5.03			()	0	5.03
	Provi der to Program	1	1		1	
5. 50	TENTATIVE TO PROGRAM				0	
5. 51 5. 52					0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	
0. 77	5. 50-5. 98)		`			0. , ,
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		86, 372		0	
6. 02	SETTLEMENT TO PROGRAM		(1	0	
7. 00	Total Medicare program liability (see instructions)		1, 013, 344		0 NDD Doto	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2. 00	
8. 00	Name of Contractor					8. 00
	•	•		•	•	•

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL In Lieu of Form (2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1317 Period:				
			To 12/31/2023	Date/Time Pre 5/28/2024 4:3	
		Title XVIII	Hospi tal	Cost	
	TO DE COMPLETED DV CONTRACTOR FOR MONOTANDARD COST REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				-
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		0.14		1.00
2. 00	Medicare days (see instructions)	3-3, Pt. 1 Col. 15 1111	E 14		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				5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c		Wkst. S-2, Pt. I		7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH		T		
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	ns)	0	32.00
				Overri des 1.00	
	CONTRACTOR OVERRIDES			1.00	
108.00	Override of HIT payment				108. 00
100.00	Tover 1 de or 111 i payment		ı		1100.00

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1317	Peri od:	Worksheet E-2
			From 01/01/2023	
		Component CCN: 15-Z317	To 12/31/2023	Date/Time Prepared:
		,		5/28/2024 4:36 pm

		Component CCN: 15-Z317	To 12/31/2023	Date/Time Pre 5/28/2024 4:3	
		Title XVIII	Swing Beds - SNF		о ріп
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES			_	
1.00	Inpatient routine services - swing bed-SNF (see instructions) Inpatient routine services - swing bed-NF (see instructions)		908, 182	0	
2. 00 3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par	t A and sum of Wkst D	130, 243	0	2.00
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swi			U	3.00
	instructions)	ng bed pass thi bugh, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teach	ing program (see		0.00	4.00
	instructions)				
5.00	Program days		286	0	
6. 00	Interns and residents not in approved teaching program (see i			0	
7.00	Utilization review - physician compensation - SNF optional me	thod only	1 020 425		7.00
8. 00 9. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7) Primary payer payments (see instructions)		1, 038, 425	0	
10.00	Subtotal (line 8 minus line 9)		1, 038, 425	0	1
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	1, 030, 423	0	
	professional services)	east of to project or an		Ū	
12.00	Subtotal (line 10 minus line 11)		1, 038, 425	0	12.00
13.00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	4, 400	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (see instructions)		1, 034, 025	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
16. 50 16. 55	Pioneer ACO demonstration payment adjustment (see instruction Rural community hospital demonstration project (§410A Demonst		0		16. 50 16. 55
10. 55	adjustment (see instructions)	ration) payment	U		10.55
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
	Allowable bad debts (see instructions)		0	0	1
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18.00
	Total (see instructions)		1, 034, 025	0	
	Sequestration adjustment (see instructions)		20, 681	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
19. 03	Sequestration adjustment-PARHM pass-throughs			0	19. 03 19. 25
	Sequestration for non-claims based amounts (see instructions) Interim payments		926, 972	0	1
	Interim payments-PARHM		720, 712	O	20.01
	Tentative settlement (for contractor use only)		0	0	1
	Tentative settlement-PARHM (for contractor use only)				21.01
22.00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	86, 372	0	22.00
	Balance due provider/program-PARHM (see instructions)				22. 01
23. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2	+:>			-
200 00	Rural Community Hospital Demonstration Project (§410A Demonst Is this the first year of the current 5-year demonstration pe				200. 00
200.00	Century Cures Act? Enter "Y" for yes or "N" for no.	TIOG UNGOL THE ZIST			200.00
	Cost Reimbursement		1		1
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1, Pt. II, line			201.00
	66 (title XVIII hospital))				
202. 00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, lin	e		202. 00
000 00	200 (title XVIII swing-bed SNF))				000 00
	Total (sum of lines 201 and 202)				203. 00 204. 00
204.00	Medicare swing-bed SNF discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demons	tration	J204. 00
	period)	Thist year of the curre	iit 3-year demons	iti ati on	
205.00	Medicare swing-bed SNF target amount				205.00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t	imes line 204)			206.00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs	sement			
	Program reimbursement under the §410A Demonstration (see inst				207. 00
208. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	2, col. 1, sum of lines	1		208. 00
200 22	and 3)	ati ana)			200 00
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	CTIONS)			209. 00 210. 00
∠10.00	Reserved for future use Comparision of PPS versus Cost Reimbursement				J≥ 10. 00
215 00	Total adjustment to Medicare swing-bed SNF PPS payment (line	209 plus line 210) (see			215. 00
5. 50	instructions)	p. as 210) (300			[
			1		1

Health Financial Systems	GREENE COUNTY GENERAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			From 01/01/2023 To 12/31/2023	Worksheet E-3 Part V Date/Time Prepared: 5/28/2024 4:36 pm
		Title XVIII	Hospi tal	Cost

				5/28/2024 4: 3	6 pm
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	Inpatient services			4, 402, 172	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2.00
3. 00	Organ acquisition	,		0	3.00
3. 01	Cellular therapy acquisition cost (see instructions)			0	3. 01
4. 00	Subtotal (sum of lines 1 through 3.01)			4, 402, 172	4.00
5. 00	Primary payer payments			0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 446, 194	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			1, 110, 171	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			0	8.00
9. 00	Organ acquisition charges, net of revenue			0	9.00
10. 00	Total reasonable charges			0	10.00
10.00	Customary charges			U	10.00
11. 00	Aggregate amount actually collected from patients liable for	nayment for sorvices on	a chargo basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable fo				12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	. 3	ili a charge basis	0	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000))		0. 000000	13. 00
14. 00	Total customary charges (see instructions)			0.000000	14.00
15. 00	Excess of customary charges over reasonable cost (complete on	ly if line 14 evenede li	no () (coo	0	15.00
15.00	instructions)	ry ii iine 14 exceeds ii	ne o) (see	U	15.00
16. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 eyecods lin	0 14) (600	0	16. 00
10.00	instructions)	ry ii iiile 6 exceeds iii	le 14) (See	U	10.00
17. 00	· · · · · · · · · · · · · · · · · · ·	rustions)		0	17. 00
17.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		U	17.00
10 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet E-	4 Line 40)		0	18. 00
18. 00 19. 00	Cost of covered services (sum of lines 6, 17 and 18)	4, TITIE 49)		4, 446, 194	
	l · · · · · · · · · · · · · · · · · · ·				
20.00	Deductibles (exclude professional component)			348, 756	
21. 00	Excess reasonable cost (from line 16)			4 007 430	21.00
22. 00	Subtotal (line 19 minus line 20 and 21)			4, 097, 438	
23. 00	Coinsurance			0	23.00
24.00	Subtotal (line 22 minus line 23)			4, 097, 438	
25. 00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		34, 594	
26.00	Adjusted reimbursable bad debts (see instructions)			22, 486	
27. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		21, 312	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			4, 119, 924	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instruction	5)		0	29. 50
29. 98	Recovery of accelerated depreciation.			0	29. 98
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30.00	Subtotal (see instructions)			4, 119, 924	30.00
30. 01	Sequestration adjustment (see instructions)			82, 398	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03	Sequestration adjustment-PARHM				30. 03
31.00	Interim payments			3, 238, 257	
31. 01	Interim payments-PARHM				31.01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.0.			799, 269	33.00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, m				33. 01
34.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
	§115. 2				

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1317	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prep 5/28/2024 4:30	pared:
	Title XIX	Hospi tal	Cost	
		1 12 1	0 1	

		'	0 12/31/2023	5/28/2024 4: 3	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SE	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient hospital/SNF/NF services		460, 381		1. 00
2. 00	Medical and other services			3, 003, 558	2. 00
3. 00	Organ acquisition (certified transplant programs only)		0		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		460, 381	3, 003, 558	4.00
5. 00	Inpatient primary payer payments		0		5.00
6. 00	Outpatient primary payer payments		4/0 001	0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		460, 381	3, 003, 558	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
8. 00	Reasonable Charges				8.00
9. 00	Routine service charges		756, 674	14 440 470	9.00
10. 00	Ancillary service charges Organ acquisition charges, net of revenue		730, 074	14, 669, 670	10.00
11. 00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		756, 674	14, 669, 670	12.00
12.00	CUSTOMARY CHARGES		730, 074	14, 007, 070	12.00
13. 00	Amount actually collected from patients liable for payment for	r services on a charge	0	0	13.00
10.00	basis	. Ser vi des en a enarge	Ĭ	Ü	10.00
14.00	Amounts that would have been realized from patients liable for	r pavment for services on	o	0	14.00
	a charge basis had such payment been made in accordance with	. 3			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		756, 674	14, 669, 670	16.00
17.00	Excess of customary charges over reasonable cost (complete on	ly if line 16 exceeds	296, 293	11, 666, 112	17.00
	line 4) (see instructions)		·		
18.00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds line	o	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line		460, 381	3, 003, 558	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.		
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26.00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		460, 381	3, 003, 558	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	460, 381	3, 003, 558	
32.00	Deducti bl es		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review	>	0		35.00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	460, 381	3, 003, 558	
	ZERO OUT MEDICALD		-460, 381	-3, 003, 558	
38. 00	Subtotal (line 36 ± line 37)		0	0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	! +L ONG D L 45 C	0	0	42.00
43. 00	Protested amounts (nonallowable cost report items) in accordance to the state of th	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115. 2 OVERRI DES				
100 00	Override Ancillary service charges (line 9)		0	0	109. 00
107.00	povertide Americally service charges (Title 7)		١	U	109.00

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

Provider CCN: 15-1317

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/28/2024 4:36 pm

General Fund Speci fi c Endowment Plant Fund Purpose Fund Fund 1.00 2.00 4.00 3.00 CURRENT ASSETS 1.00 Cash on hand in banks 843, 780 0 0 0 1.00 0 0 2.00 Temporary investments 1,849,016 0 2.00 0 3 00 Notes receivable 0 0 3 00 0 4.00 Accounts receivable 7, 540, 601 0 4.00 5.00 2, 852, 749 0 0 0 5.00 Other receivable ol 6.00 Allowances for uncollectible notes and accounts receivable 0 0 6.00 o 529 859 0 7 00 7 00 0 Inventory 0 8.00 Prepaid expenses 327, 489 0 0 8.00 0 9.00 Other current assets 0 9.00 10.00 Due from other funds 0 ol 0 10.00 Total current assets (sum of lines 1-10) 13, 943, 494 11.00 0 0 0 11.00 FIXED ASSETS 12.00 Land 923, 204 0 0 0 12.00 Land improvements 0 0 13.00 3, 465, 610 0 13.00 οĺ 14.00 Accumulated depreciation -282.4520 14.00 Bui I di ngs o 15.00 11, 681, 329 0 0 15.00 0 16.00 Accumulated depreciation -2, 414, 956 0 0 16.00 0 0 0 Leasehold improvements 17.00 17.00 C 0 0 18 00 Accumulated depreciation 0 18 00 Fixed equipment 7, 776, 249 19.00 19.00 0 0 20.00 Accumulated depreciation -2, 795, 984 0 0 0 20.00 0 21.00 Automobiles and trucks 0 21.00 22.00 Accumulated depreciation 0 22.00 23.00 Major movable equipment 5, 251, 122 0 0 0 0 23.00 Accumulated depreciation 0 24.00 -1, 564, 259 0 24.00 0 25.00 Minor equipment depreciable 0 25.00 Accumulated depreciation 0 0 26.00 26.00 C 0 0 27.00 HIT designated Assets 0 0 0 27.00 0 28.00 Accumulated depreciation 0 0 28.00 0 0 29.00 Mi nor equi pment-nondepreci abl e 0 29.00 Total fixed assets (sum of lines 12-29) 30.00 22, 039, 863 0 0 0 30.00 OTHER ASSETS 31 00 31.00 Investments 1, 262, 605 0 0 0 0 32.00 Deposits on Leases 0 0 32.00 0 0 33.00 Due from owners/officers 0 33.00 ol 34.00 Other assets 2, 825, 170 0 34.00 0 Total other assets (sum of lines 31-34) 0 0 35.00 4, 087, 775 0 35.00 Total assets (sum of lines 11, 30, and 35) 36.00 40, 071, 132 0 0 0 36.00 CURRENT LIABILITIES 37 00 1 707 097 0 0 n 37 00 Accounts payable 0 0 38.00 Salaries, wages, and fees payable 3,073,696 0 38.00 Payroll taxes payable 717, 186 0 0 0 39.00 39.00 40.00 Notes and Loans payable (short term) 0 0 0 40.00 2,048,652 o Deferred income 0 41 00 41 00 0 42.00 Accelerated payments C 42.00 43.00 Due to other funds 0 0 0 43.00 Other current liabilities ol 44.00 1,022,600 0 0 44.00 0 Total current liabilities (sum of lines 37 thru 44) 45.00 8, 569, 231 0 0 45.00 ONG TERM LIABILITIES Mortgage payable 0 0 0 46.00 46,00 0 19, 210, 053 0 47.00 Notes payable 0 47.00 48.00 Unsecured Loans 0 0 0 48.00 Other long term liabilities 0 0 49.00 49.00 0 Total long term liabilities (sum of lines 46 thru 49) 19, 210, 053 0 ol 0 50.00 50.00 51.00 Total liabilities (sum of lines 45 and 50) 27, 779, 284 0 0 0 51.00 CAPITAL ACCOUNTS 52.00 General fund balance 12, 291, 848 52.00 0 Specific purpose fund 53.00 53.00 54 00 Donor created - endowment fund balance - restricted 0 54 00 Donor created - endowment fund balance - unrestricted 0 55.00 56.00 Governing body created - endowment fund balance 0 56.00 Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement, 57.00 57.00 0 58.00 0 58.00 replacement, and expansion Total fund balances (sum of lines 52 thru 58) 12, 291, 848 0 0 0 59.00 60.00 Total liabilities and fund balances (sum of lines 51 and 40, 071, 132 0 0 0 60.00

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1 From 01/01/2023 Provi der CCN: 15-1317

					To 12/31/202	3 Date/Time Pre 5/28/2024 4:3	pared: 6 pm
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1. 00	2.00	3. 00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	13, 967, 886 -1, 676, 038 12, 291, 848		0	0 0	1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00 9. 00 10. 00	Total additions (sum of line 4-9)	0 0 0 0	0		0 0 0 0	0 0 0	6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0	12, 291, 848		0 0 0 0 0	0 0 0 0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00
17. 00 18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 12, 291, 848		0	0	17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8. 00			
1. 00 2. 00 3. 00 4. 00 5. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0		0		1. 00 2. 00 3. 00 4. 00 5. 00
6. 00 7. 00 8. 00 9. 00			0 0 0 0				6. 00 7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	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	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0		18. 00 19. 00

Health Financial Systems GREE STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1317

			To 12/31/2023	Date/Time Pre 5/28/2024 4:3	pared: 6 pm
	Cost Center Description	Inpatient	Outpati ent	Total	O pili
	300 t 301101 B3331 pt 311	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				
1.00	Hospi tal	4, 577, 0	28	4, 577, 028	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	4, 577, 0	28	4, 577, 028	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	366, 9	47	366, 947	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	366, 9	47	366, 947	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	4, 943, 9		4, 943, 975	17. 00
18. 00	Ancillary services	9, 916, 4			
19. 00	Outpati ent services	840, 5		33, 417, 818	
20.00	RURAL HEALTH CLINIC		0 7, 210, 480	7, 210, 480	
20. 01	RURAL HEALTH CLINIC II		0 2, 395, 276	2, 395, 276	20. 01
20. 02	RURAL HEALTH CLINIC III		0 1, 916, 385	1, 916, 385	20. 02
20. 03	RURAL HEALTH CLINIC IV		0 1, 262, 939	1, 262, 939	20. 03
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26.00
27.00	PHYSI CI ANS		0 6, 356, 027	6, 356, 027	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to WA	kst. 15, 701, 0	21 163, 354, 437	179, 055, 458	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		62, 597, 201		29. 00
30.00	ADD (SPECIFY)		0		30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33.00
34.00			0		34.00
35.00			0		35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)		0		37.00
38.00			0		38. 00
39.00			0		39.00
40.00			0		40.00
41.00			0		41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tra	ansfer	62, 597, 201		43.00
	to Wkst. G-3, line 4)				

Heal th	n Financial Systems GREENE COUN	ITY GENERAL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1317	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 4:3	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column			179, 055, 458	1.00
2. 00	Less contractual allowances and discounts on patients	' accounts		121, 373, 868	2.00
3.00	Net patient revenues (line 1 minus line 2)			57, 681, 590	3.00
4. 00	Less total operating expenses (from Wkst. G-2, Part I			62, 597, 201	4.00
5. 00	Net income from service to patients (line 3 minus line	e 4)		-4, 915, 611	5. 00
	OTHER I NCOME				
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 commun	nication services		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
10.00				0	10.00
11. 00				0	11.00
12. 00				0	12.00
13. 00	J			0	13.00
14. 00	1			0	14.00
15. 00	3 1			0	15.00
	Revenue from sale of medical and surgical supplies to	other than patients		0	16.00
	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	1	n		0	20.00
21. 00	Rental of vending machines			0	21.00
22. 00				0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER REVENUES			3, 239, 573	24.00
24. 50	COVI D-19 PHE Funding			0	24.50
25.00	Total other income (sum of lines 6-24)			3, 239, 573	25.00
26.00	Total (line 5 plus line 25)			-1, 676, 038	
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29 00	Net income (or loss) for the period (line 26 minus lin	ne 28)		-1, 676, 038	29. 00

Heal th	Financial Systems	GREENE COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
ANALYS	SIS OF HOSPITAL-BASED RHC/FOHC COSTS		Provider C	CN: 15-1317	Peri od: From 01/01/2023	Worksheet M-1	
			Component	CCN: 15-8535	To 12/31/2023	Date/Time Pre 5/28/2024 4:3	
					RHC I		
	·	Compensati on	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
		· ·		+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS	·		•			
1.00	Physi ci an	1, 184, 465	C	1, 184, 4	65 0	1, 184, 465	1.00
0 00		1 6	۱ .	.1			

		Compensation	Other Costs	lotal (col. 1 + col. 2)	Reclassificat ions	Reclassified 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	1, 184, 465	0	1, 184, 465		1, 184, 465	1.00
2. 00 3. 00	Physician Assistant Nurse Practitioner	0 851, 755	0			0 851, 755	2. 00 3. 00
4. 00	Visiting Nurse	851, 755	0	851, 755	0	851, 755	4.00
5. 00	Other Nurse	515, 668	0	515, 668	0	515, 668	5.00
6. 00	Clinical Psychologist	313, 000	0	313,000	0	0	6.00
7. 00	Clinical Social Worker	18, 259	0	18, 259	0	18, 259	7.00
7. 10	Marriage and Family Therapist	10, 207	0	10, 20,		10, 20,	7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Technician	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)	2, 570, 147	0	2, 570, 147	0	2, 570, 147	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	520, 375			520, 375	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	520, 375			520, 375	
15.00	Medical Supplies	0	220, 662			220, 662	15.00
16.00	Transportation (Health Care Staff)	0	22, 546	22, 546	0	22, 546	16.00
17. 00 18. 00	Depreciation-Medical Equipment Professional Liability Insurance	U	0	0	0	0	17. 00 18. 00
19. 00	Other Health Care Costs	0	0		0	0	19.00
20.00	Allowable GME Costs	U	0		0	0	20.00
21.00	Subtotal (sum of lines 15 through 20)	0	243, 208	243, 208	0	243, 208	21.00
22. 00	Total Cost of Health Care Services (sum of	2, 570, 147	763, 583			3, 333, 730	22.00
22.00	lines 10, 14, and 21)	2,070,117	, 55, 555	0,000,700		0,000,700	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
23.00	Pharmacy	0	0	0	0	0	23.00
24.00	Dental	0	0	0	0	0	24. 00
25.00	Optometry	0	0	0	0	0	25. 00
25. 01	Tel eheal th	0	0	0	0	0	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	0	0	0	26. 00
27. 00	Nonallowable GME costs		•				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23 through 27)	0	0	0	0	0	28. 00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	136, 784	136, 784	0	136, 784	29. 00
30.00	Administrative Costs	822, 089	56, 142				30.00
31. 00	Total Facility Overhead (sum of lines 29 and		192, 926			1, 015, 015	31.00
	30)	, , , , , ,	, , , ===]		
32.00	Total facility costs (sum of lines 22, 28	3, 392, 236	956, 509	4, 348, 745	0	4, 348, 745	32.00
	and 31)						

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		From 01/01/2023	
	Component CCN: 15-8535	To 12/31/2023	Date/Time Prepared: 5/28/2024 4:36 pm

			Component	CCN. 13-0333	10 12/31/202	5/28/2024	
					RHC I	0, 20, 2021	оо р
		Adjustments	Net Expenses				
		.,	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	-16, 597	1, 167, 868	3			1.00
2.00	Physician Assistant	0	C				2.00
3. 00	Nurse Practitioner	61, 595	913, 350				3.00
4.00	Visiting Nurse	0	C				4.00
5. 00	Other Nurse	0	515, 668	3			5.00
6. 00	Clinical Psychologist	0	(6.00
7. 00	Clinical Social Worker	-121, 802	-103, 543	3			7.00
7. 10	Marriage and Family Therapist	,					7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	0	C				8.00
9. 00	Other Facility Health Care Staff Costs	0	Č				9.00
10.00	Subtotal (sum of lines 1 through 9)	-76, 804	2, 493, 343	S S			10.00
11. 00	Physician Services Under Agreement	70,001	2, 170, 010	á			11.00
12. 00	Physician Supervision Under Agreement	0	Č				12.00
13. 00	Other Costs Under Agreement	0	520, 375	1			13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	520, 375				14.00
15. 00	Medical Supplies	0	220, 662	1			15.00
16. 00	Transportation (Health Care Staff)	0	22, 546				16.00
17. 00	Depreciation-Medical Equipment	0	22, 540	1			17. 00
18. 00		0		1			18.00
19. 00	Other Health Care Costs	0		1			19.00
20. 00	Allowable GME Costs	O		ή			20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	243, 208				21.00
22. 00	Total Cost of Health Care Services (sum of	-76, 804	3, 256, 926	•			22.00
22.00	lines 10, 14, and 21)	-70, 804	3, 230, 920	'			22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			1			
23. 00		0	C	1			23.00
24. 00	Dental	0	C	•			24.00
25. 00	Optometry	0		1			25.00
25. 00	Tel eheal th	0					25. 01
25. 01	Chronic Care Management	0					25. 02
26. 00	All other nonreimbursable costs	0					26.00
27. 00	Nonallowable GME costs	U		ή			27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C				28.00
20.00	,	U		ή			20.00
	through 27) FACILITY OVERHEAD			1			
20 00	Facility Costs	0	136, 784	1			29. 00
30.00	Administrative Costs	0	878, 231				30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	1, 015, 015	•			31.00
31.00	30)	U	1,015,015	'			31.00
32. 00	Total facility costs (sum of lines 22, 28	-76, 804	4, 271, 941	1			32.00
32.00	and 31)	-70,004	4, 211, 941	'			32.00
	Julia 31)		I	1			ı

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Period: Worksheet M-1
	Component CCN: 15-8533	From 01/01/2023 Date/Time Prepared:

			Component		rom 01/01/2023 o 12/31/2023	Date/Time Pre 5/28/2024 4:3	
					RHC II		•
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	320, 330	0	320, 330	0	320, 330	1.00
2.00	Physician Assistant	0	0) (0	0	2.00
3.00	Nurse Practitioner	218, 938	0	218, 938	0	218, 938	3.00
4.00	Visiting Nurse	0	0) (0	0	4.00
5.00	Other Nurse	291, 501	0	291, 501	0	291, 501	5.00
6.00	Clinical Psychologist	0	0) (0	0	6.00
7.00	Clinical Social Worker	70, 806	0	70, 806	0	70, 806	7.00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7. 11
8.00	Laboratory Techni ci an	0	0) (0	0	8.00
9.00	Other Facility Health Care Staff Costs	o	0) (0	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	901, 575	0	901, 575	0	901, 575	10.00
11.00	Physician Services Under Agreement	o	0) (0	0	11.00
12.00	Physician Supervision Under Agreement	o	0) (0	0	12.00
13.00	Other Costs Under Agreement	o	192, 277	192, 277	0	192, 277	13.00
14.00	Subtotal (sum of lines 11 through 13)	o	192, 277	192, 277	0	192, 277	14.00
15.00	Medical Supplies	o	107, 294	107, 294	. 0	107, 294	15.00
16.00	Transportation (Health Care Staff)	o	1, 422	1, 422	0	1, 422	16.00
17.00	Depreciation-Medical Equipment	o	0		0	0	17.00
18.00	Professional Liability Insurance	o	0) (0	0	18. 00
19.00	Other Health Care Costs	ol	0) c	0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	o	108, 716	108, 716	0	108, 716	21.00
22.00	Total Cost of Health Care Services (sum of	901, 575	300, 993	1, 202, 568	0	1, 202, 568	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						1
23.00	Pharmacy	0	0)	0	0	23. 00
24.00	Dental	0	0) (0	0	24.00
25.00	Optometry	0	0) (0	0	25. 00
25. 01	Tel eheal th	0	0) (0	0	25. 01
25.02	Chronic Care Management	0	0) (0	0	25. 02
26.00	All other nonreimbursable costs	0	0) (0	0	26.00
27.00	Nonallowable GME costs						27.00
28.00	Total Nonreimbursable Costs (sum of lines 23	o	0) (0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	40, 750			40, 750	29. 00
30.00	Administrative Costs	39, 176	9, 700	48, 876	0	48, 876	30.00
31.00	Total Facility Overhead (sum of lines 29 and	39, 176	50, 450	89, 626	0	89, 626	31.00
	30)			1			
32.00	Total facility costs (sum of lines 22, 28	940, 751	351, 443	1, 292, 194	1 0	1, 292, 194	32.00
	and 31)			1			

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Peri od: From 01/01/2023			
	Component CCN: 15-8533	10 12/31/2023	5/28/2024 4: 36 pm		

			Component	CCN. 13-0555	10	12/31/2023	5/28/2024	
						RHC II	0, 20, 202 :	т оо р
	·	Adjustments	Net Expenses		•			
		.,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00	1				
	FACILITY HEALTH CARE STAFF COSTS			-				
1.00	Physi ci an	-7, 910	312, 420					1.00
2. 00	Physician Assistant	., , 0	0.2, .20					2.00
3. 00	Nurse Practitioner	-22, 248	196, 690					3.00
4. 00	Vi si ti ng Nurse	22, 240	170,070					4.00
5. 00	Other Nurse		291, 501	'				5.00
6. 00	Clinical Psychologist	0	271, 301					6.00
7. 00	Clinical Social Worker	70, 806	141, 612	()				7.00
	1	70, 806	141, 012	-				
7. 10	Marriage and Family Therapist							7. 10
7. 11	Mental Health Counselor							7. 11
8.00	Laboratory Techni ci an	0	C	1				8.00
9. 00	Other Facility Health Care Staff Costs	0	C	1				9. 00
10.00	Subtotal (sum of lines 1 through 9)	40, 648	942, 223	1				10.00
11. 00	Physician Services Under Agreement	0	C	1				11. 00
12.00	Physician Supervision Under Agreement	0	C					12.00
13.00	Other Costs Under Agreement	0	192, 277					13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	192, 277	'				14.00
15.00	Medical Supplies	0	107, 294					15. 00
16.00	Transportation (Health Care Staff)	0	1, 422	!				16.00
17.00	Depreciation-Medical Equipment	0	C					17. 00
18.00	Professional Liability Insurance	o	C					18. 00
19.00	Other Health Care Costs	ol	C					19.00
20.00	Allowable GME Costs							20.00
21. 00	Subtotal (sum of lines 15 through 20)	ol	108, 716	,				21.00
22. 00	Total Cost of Health Care Services (sum of	40, 648	1, 243, 216	1				22. 00
	lines 10, 14, and 21)	,	., = , =					
	COSTS OTHER THAN RHC/FQHC SERVICES			·				
23. 00	Pharmacy	0	C					23. 00
24. 00	Dental	ol	C	•				24.00
25. 00	Optometry	n o	C	1				25. 00
25. 01	Tel eheal th	ol Ol	C	1				25. 01
25. 02	1	ol Ol	C	1				25. 02
26. 00	All other nonreimbursable costs	0	0	1				26.00
27. 00	Nonal Lowable GME costs	ď	C	'				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23		C					28.00
26.00		٩	C	'				20.00
	through 27) FACILITY OVERHEAD							
20 00	Facility Overhead Facility Costs	O	40, 750	<u> </u>				29.00
	1 -	O O		•				30.00
30.00	Administrative Costs	O O	48, 876	1				
31. 00	Total Facility Overhead (sum of lines 29 and	٥	89, 626	<u>'</u>				31.00
22 00	30)	40 440	1 222 042	.[22.00
32. 00	Total facility costs (sum of lines 22, 28	40, 648	1, 332, 842	-				32.00
	and 31)	I		I				I

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Peri od: From 01/01/2023	Worksheet M-1		
	Component CCN: 15-8534	To 12/31/2023	Date/Time Prepared: 5/28/2024 4:36 pm		
		RHC III			

			ooportorre			5/28/2024 4:36 pm	
					RHC III		
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2.00	3.00	4.00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS			•			
1.00	Physi ci an	329, 091	0	329, 09	0	329, 091	1.00
2.00	Physician Assistant	o	0		0	0	2.00
3.00	Nurse Practitioner	165, 996	0	165, 996	0	165, 996	3.00
4.00	Visiting Nurse	0	0	(0	4.00
5. 00	Other Nurse	153, 346	0	153, 346	0	153, 346	5.00
6. 00	Clinical Psychologist	0	0	100,010		0	6. 00
7. 00	Clinical Social Worker	24, 105	0	24, 105	-	24, 105	7. 00
7. 10	Marriage and Family Therapist	21, 100	O	21,100		21, 100	7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	0	0		0	0	8.00
9. 00	Other Facility Health Care Staff Costs	0	0		-	0	9.00
10.00	Subtotal (sum of lines 1 through 9)	672, 538	0	672, 538	,	672, 538	
11. 00	Physician Services Under Agreement	072, 330	0	072, 330	0	072, 330	11.00
12. 00	Physician Supervision Under Agreement	0	0		0	0	12.00
13. 00	Other Costs Under Agreement	0	195, 653	195, 653	-	195, 653	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	195, 653			195, 653	14.00
15. 00	Medical Supplies	0	75, 015			75, 015	
16. 00	Transportation (Health Care Staff)	0	3, 335			3, 335	
17. 00	Depreciation-Medical Equipment	0	ა, ააა			3, 333	17.00
18.00	Professional Liability Insurance	0	0		,	0	18.00
19. 00	Other Health Care Costs	0	0		,	0	19.00
20.00	Allowable GME Costs	۷	U)	U	20.00
		0	70 250	78, 350	0	70 250	21.00
21. 00	Subtotal (sum of lines 15 through 20)	472 F20	78, 350			78, 350	
22. 00	Total Cost of Health Care Services (sum of	672, 538	274, 003	946, 54	0	946, 541	22. 00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00		٥	0		0	0	23. 00
	Pharmacy Dental	0	0			0	24.00
24. 00		0	0			0	
25. 00	Optometry	U	0	`	<u> </u>		25. 00
25. 01	Tel eheal th	0	0	(0	0	25. 01
25. 02	Chronic Care Management	0	0		0	0	25. 02
26.00	All other nonreimbursable costs	0	0	(0	0	26.00
27. 00	Nonallowable GME costs	_	_		_	_	27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	(0	0	28. 00
	through 27)						
	FACILITY OVERHEAD	_			_		
29. 00	Facility Costs	0	53, 686			53, 686	
30.00	Administrative Costs	94, 114	10, 565			104, 679	30.00
31. 00	Total Facility Overhead (sum of lines 29 and	94, 114	64, 251	158, 365	0	158, 365	31. 00
	30)						
32. 00	Total facility costs (sum of lines 22, 28	766, 652	338, 254	1, 104, 906	0	1, 104, 906	32. 00
	and 31)			I			

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-1			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Peri od: From 01/01/2023	Worksheet M-1		
	Component CCN: 15-8534		Date/Time Prepared: 5/28/2024 4:36 pm		

						5/28/2024 4:	36 pm
					RHC III		
		Adjustments	Net Expenses				
		-	for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	24, 505	353, 596				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	-26, 957	139, 039				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	153, 346				5. 00
6.00	Clinical Psychologist	0	0				6.00
7.00	Clinical Social Worker	24, 105	48, 210				7. 00
7. 10	Marriage and Family Therapist						7. 10
7. 11	Mental Health Counselor						7.11
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	0				9. 00
10.00	Subtotal (sum of lines 1 through 9)	21, 653	694, 191				10.00
11.00	Physician Services Under Agreement	0	0				11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13. 00		0	195, 653	1			13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	195, 653				14.00
15. 00	,	0	75, 015				15.00
16.00	Transportation (Health Care Staff)	0	3, 335				16.00
17. 00		0	0	1			17. 00
18. 00	The second secon	0	Ö				18.00
19. 00		0	0	•			19.00
20. 00	Allowable GME Costs	_	_				20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	78, 350				21.00
22. 00		21, 653					22.00
22.00	lines 10, 14, and 21)	2.7000	,00, . , .				22.00
	COSTS OTHER THAN RHC/FQHC SERVICES			I.			
23. 00	Pharmacy	0	0				23.00
24. 00	Dental	0		1			24.00
25. 00	Optometry	0	Ö				25. 00
25. 01	Tel eheal th	0	0				25. 01
25. 02	4	0	0				25. 02
26. 00	All other nonreimbursable costs	0	0				26.00
27. 00	Nonallowable GME costs	ū					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0				28. 00
20.00	through 27)	ū					20.00
	FACILITY OVERHEAD			I.			
29.00	Facility Costs	0	53, 686				29.00
30.00	Admi ni strati ve Costs	0	104, 679	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	0	158, 365				31.00
300	30)	J					000
32. 00	Total facility costs (sum of lines 22, 28	21, 653	1, 126, 559				32.00
	and 31)	_ : , 000	.,,				
	· · · · ·	'	•				•

Health Financial Cyatama	CDEENE COUNTY OF	NEDAL HOCDLEAL		la Lia	of Form CMC 3	NEED 10	
Health Financial Systems	GREENE COUNTY GE	NERAL HUSPITAL	_	III LI e	In Lieu of Form CMS-2552-10		
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	Provi der CCN: 15-1317 Peri od: From 01/01/2023		Worksheet M-1		
		Component	CCN: 15-8538	To 12/31/2023	Date/Time Pre 5/28/2024 4:3		
				RHC IV			
	Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed		
			+ col 2)	i ons	Trial Balance		

					DUC 11/	37 207 2024 4. 3	о рііі
		0	011	Total Cost 4	RHC IV	Deal and Chal	
		Compensation	Other Costs		Recl assi fi cat		
				+ col . 2)	i ons	Tri al Bal ance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	221, 656	0	221, 656	0	221, 656	1.00
2.00	Physician Assistant	0	0	0	0	0	2.00
3.00	Nurse Practitioner	268, 003	0	268, 003	0	268, 003	3.00
4.00	Visiting Nurse	0	0	0	0	0	4. 00
5.00	Other Nurse	110, 905	0	110, 905	0	110, 905	5.00
6.00	Clinical Psychologist	o	0	o c	0	0	6. 00
7.00	Clinical Social Worker	26, 891	0	26, 891	0	26, 891	7. 00
7. 10	Marriage and Family Therapist	, , ,				,	7. 10
7. 11	Mental Health Counselor						7. 11
8. 00	Laboratory Techni ci an	ol	0	0	0	0	8.00
9. 00	Other Facility Health Care Staff Costs	ol	0		0	0	9. 00
10.00	Subtotal (sum of lines 1 through 9)	627, 455	0	627, 455	0	627, 455	10.00
11. 00	Physician Services Under Agreement	027, 100	0	027, 100		027, 100	11.00
12. 00	Physician Supervision Under Agreement	ol Ol	0		0	0	12.00
13. 00	Other Costs Under Agreement	0	166, 756	166, 756	0	166, 756	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	166, 756			166, 756	14.00
15. 00	Medical Supplies		41, 506			41, 506	15.00
16. 00	Transportation (Health Care Staff)	0	36, 939			36, 939	16.00
17. 00	Depreciation-Medical Equipment	0	30, 737	30, 434		30, 434	17. 00
18. 00		0	0		0	0	18.00
19. 00	,	0	0		0	0	19.00
20.00	Allowable GME Costs	٩	U		U	U	20.00
21.00	Subtotal (sum of lines 15 through 20)		78, 445	78, 445	0	78, 445	
21.00		(27.455	•			· ·	
22.00	Total Cost of Health Care Services (sum of	627, 455	245, 201	872, 656	U	872, 656	22.00
	lines 10, 14, and 21) COSTS OTHER THAN RHC/FQHC SERVICES						
22 00		O	0	0	0	0	23. 00
23. 00		U	0	-	-	0	
24.00	Dental	U	0		0	-	24.00
25.00	Optometry	U	U		0	0	25. 00
25. 01	Tel eheal th	O	0	1	0	0	25. 01
25. 02	Chronic Care Management	0	0	0	0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	0	0	0	26. 00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27)						
	FACILITY OVERHEAD						
29. 00	19 11111	0	47, 557		-	47, 557	29. 00
30.00	Administrative Costs	108, 323	17, 477	125, 800	0	125, 800	30. 00
31.00	Total Facility Overhead (sum of lines 29 and	108, 323	65, 034	173, 357	0	173, 357	31. 00
	30)						
32.00	Total facility costs (sum of lines 22, 28	735, 778	310, 235	1, 046, 013	0	1, 046, 013	32.00
	and 31)						

Health Financial Systems GREENE	COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1317 Component CCN: 15-8538	Peri od: From 01/01/2023 To 12/31/2023			

			Component	CCN. 13-0530	10	12/31/2023	5/28/2024	
						RHC IV	0, 20, 202 :	оо р
	·	Adjustments	Net Expenses					
		.,	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6, 00	7. 00	1				
	FACILITY HEALTH CARE STAFF COSTS			1				
1.00	Physi ci an	0	221, 656					1.00
2.00	Physician Assistant	0						2.00
3. 00	Nurse Practitioner	-12, 388	255, 615					3.00
4. 00	Visiting Nurse	0						4.00
5. 00	Other Nurse	0	110, 905					5. 00
6. 00	Clinical Psychologist	0	, , , , ,					6. 00
7. 00	Clinical Social Worker	26, 890	53, 781	1				7.00
7. 10	Marriage and Family Therapist	20,070	00, 701					7. 10
7. 13	Mental Health Counselor							7. 11
8. 00	Laboratory Techni ci an	0	(8.00
9. 00	Other Facility Health Care Staff Costs	0		1				9. 00
10.00	Subtotal (sum of lines 1 through 9)	14, 502	641, 957	1				10.00
11. 00	Physician Services Under Agreement	14, 302	041, 937	1				11.00
12. 00	Physician Supervision Under Agreement	0	(1				12.00
13. 00	Other Costs Under Agreement	0	166, 756	1				13.00
14.00		0		1				14.00
	Subtotal (sum of lines 11 through 13)	0	166, 756	1				15.00
15.00	Medical Supplies	0	41, 506	•				16.00
16.00	1 ' '	0	36, 939	1				
17.00	Depreciation-Medical Equipment	U	C	1				17.00
18.00	1	U	C	1				18.00
19.00		U	C	'				19.00
20.00	Allowable GME Costs		70.445					20.00
21.00	Subtotal (sum of lines 15 through 20)	14 500	78, 445	1				21.00
22. 00	Total Cost of Health Care Services (sum of	14, 502	887, 158	•				22. 00
	lines 10, 14, and 21)							
22.00	COSTS OTHER THAN RHC/FQHC SERVICES	ما						22.00
	Pharmacy	0	C	•				23.00
24. 00	Dental	0	-	1				24.00
25. 00	Optometry	0	C	1				25. 00
25. 01	Tel eheal th	0	C	1				25. 01
25. 02	Chronic Care Management	0	C	1				25. 02
26.00	All other nonreimbursable costs	O	C	'				26.00
27. 00	Nonallowable GME costs		_					27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	C	9				28. 00
	through 27) FACILITY OVERHEAD				_			
20 00	Facility Costs	O	47, 557					29. 00
30.00	Administrative Costs	0	125, 800					30.00
30.00	1	0		1				30.00
31.00	Total Facility Overhead (sum of lines 29 and 30)	۷	173, 357					31.00
32. 00	Total facility costs (sum of lines 22, 28	14, 502	1, 060, 515					32.00
32.00	and 31)	14, 302	1,000,010	Ί				32.00
	lana 31)	I		1				I

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component	CCN: 15-8535	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 4:3	
					RHC I		
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
		1. 00	2.00	3.00	1 x col . 3) 4.00	col . 4 5.00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	Posi ti ons						
1.00	Physi ci an	3. 09	7, 126		1 3		1.00
2.00	Physician Assistant	0.00	0	2, 10	00		2.00
3.00	Nurse Practitioner	5. 63	22, 266	2, 10	11, 823		3.00
4.00	Subtotal (sum of lines 1 through 3)	8. 72			11, 826	29, 392	4. 00
5.00	Visiting Nurse	8. 40	l e			0	
6.00	Clinical Psychologist	0.00				0	
7. 00	Clinical Social Worker	0. 68	l .			0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	
7. 02	Diabetes Self Management Training (FQHC only)	0.00	0			0	7. 02
7. 03	Marriage and Family Therapist						7. 03
7. 03	Mental Health Counselor						7.03
8. 00	Total FTEs and Visits (sum of lines 4	17. 80	29, 392			29, 392	8.00
0.00	through 7)	.,	2,,0,2			27,072	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HUSDITAL BASE	ED DUC/ENUC SEI	DVI CES		1. 00	
10. 00	Total costs of health care services (from Wk			TVICLS		3, 256, 926	10 00
11. 00	Total nonreimbursable costs (from Wkst. M-1,	·	. ,				11.00
12. 00	Cost of all services (excluding overhead) (s					3, 256, 926	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. !	M-1, col. 7, li	ine 31)		1, 015, 015	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			1, 748, 857	15.00
16.00	Total overhead (sum of lines 14 and 15)					2, 763, 872	
17.00	Allowable GME overhead (see instructions)					0	
18. 00	Enter the amount from line 16					2, 763, 872	
19.00	the second secon					2, 763, 872	
20.00	Total allowable cost of hospital-based RHC/F	UHC SERVICES (sum of lines 10	J and 19)	l	6, 020, 798	20.00

		REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC :	SERVI CES	Provi der Co		Peri od:	Worksheet M-2	!
			Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 4:3	
					RHC II		
	·	Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						1
	Positions		T	T	-T		
1.00	Physi ci an	1. 05			1 1		1.00
2.00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	1. 52					3.00
4.00	Subtotal (sum of lines 1 through 3)	2. 57		•	3, 193	9, 001	4.00
5.00	Visiting Nurse	4. 28				0	
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0.50				0	
7. 01 7. 02	Medical Nutrition Therapist (FQHC only) Diabetes Self Management Training (FQHC	0. 00 0. 00				0	
7.02	only)	0.00	0			0	7.02
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7.03
8. 00	Total FTEs and Visits (sum of lines 4	7. 35	9, 001			9, 001	8.00
0.00	through 7)	7.00	7,001			7,001	0.00
9. 00	Physician Services Under Agreements		0			0	9.00
	<u> </u>			•			
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEF	RVI CES			
10.00	Total costs of health care services (from Wk					1, 243, 216	
11.00	Total nonreimbursable costs (from Wkst. M-1,					0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			1, 243, 216	
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		89, 626	
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			624, 502	
16.00	Total overhead (sum of lines 14 and 15)					714, 128	
17. 00	Allowable GME overhead (see instructions)					0	1
18.00	Enter the amount from line 16			4.0)		714, 128	
19.00	Overhead applicable to hospital-based RHC/FC					714, 128	
20.00	Total allowable cost of hospital-based RHC/F	·UHC services (sum of lines 10	u and 19)		1, 957, 344	20.00

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 4:3	
					RHC III		
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	7	col. 2 or	
		1.00	0.00	0.00	1 x col . 3)	col . 4	
	VISITS AND PRODUCTIVITY	1. 00	2. 00	3. 00	4. 00	5. 00	
	Positions						
1. 00	Physi ci an	1, 09	4, 814	4, 20	0 4, 578		1.00
2. 00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	1. 22					3.00
4. 00	Subtotal (sum of lines 1 through 3)	2. 31			7, 140	7, 994	4.00
5.00	Visiting Nurse	2. 89		1	,	0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0. 20	0			0	7.00
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	0			0	7. 01
7. 02	Diabetes Self Management Training (FQHC	0.00	0)		0	7. 02
	onl y)						
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7.04
8. 00	Total FTEs and Visits (sum of lines 4	5. 40	7, 994			7, 994	8. 00
9. 00	through 7) Physician Services Under Agreements		0			0	9. 00
7.00	Triysi ci air Servi ces Under Agreements			1		0	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			968, 194	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s					968, 194	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1.000000	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		158, 365	14.00
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			517, 932	
16. 00						676, 297	
17.00	Allowable GME overhead (see instructions)					0	
18.00	Enter the amount from line 16	NIC (1	! 10 I ! · ·	10)		676, 297	
19.00	Overhead applicable to hospital-based RHC/FC Total allowable cost of hospital-based RHC/FC					676, 297 1, 644, 491	
20.00	Tiotal allowable cost of hospital-based RHC/F	runc services (Sum Of TitleS I	U anu 19)	l	1, 044, 491	∠∪. ∪∪

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 4:3	
					RHC IV		
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)		col. 2 or	
		1. 00	2.00	3.00	1 x col . 3) 4.00	col . 4 5.00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	3.00	
	Posi ti ons						
1.00	Physi ci an	0. 81	5, 966	4, 20	00 3, 402		1.00
2.00	Physician Assistant	0.00		_,			2.00
3.00	Nurse Practitioner	1. 81					3. 00
4.00	Subtotal (sum of lines 1 through 3)	2. 62			7, 203		
5.00	Visiting Nurse	2. 19				0	
6.00	Clinical Psychologist	0.00				0	
7.00	Clinical Social Worker	0. 38				0	
7. 01 7. 02	Medical Nutrition Therapist (FQHC only) Diabetes Self Management Training (FQHC	0. 00 0. 00	l .			0	
7.02	only)	0.00	0			U	7.02
7. 03	Marriage and Family Therapist						7. 03
7. 04	Mental Health Counselor						7.04
8. 00	Total FTEs and Visits (sum of lines 4	5. 19	9, 914			9, 914	8.00
	through 7)						
9. 00	Physician Services Under Agreements		0			0	9. 00
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	FD RHC/FOHC SE	RVICES		1. 00	
10.00	Total costs of health care services (from Wk					887, 158	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			887, 158	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					1. 000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		173, 357	1
15. 00	Parent provider overhead allocated to facili	ty (see instru	ctions)			541, 057	1
16. 00	,					714, 414	1
17. 00	Allowable GME overhead (see instructions)					714 414	
18. 00 19. 00	Enter the amount from line 16	NIC comilege (1	ino 12 v lino :	10)		714, 414	
	Overhead applicable to hospital-based RHC/FQ Total allowable cost of hospital-based RHC/FQ					714, 414 1, 601, 572	
20.00	Tiotal allowable cost of hospital-based knc/r	CITO SELVICES (Juli DI TITICS II	J anu 17)		1,001,372	20.00

ealth Financial Systems GREENE COUNTY GENER ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CES	Component CCN: 15-8535	From 01/01/2023 To 12/31/2023		pared
	Title XVIII	RHC I	3/20/2024 4.3	о рііі
			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
Total Allowable Cost of hospital-based RHC/FQHC Services (from Williams) Total allowable cost excluding injections/infusions (line 1 magnetic Total Visits (from Wkst. M-2, column 5, line 8) Physicians visits under agreement (from Wkst. M-2, column 5,	/kst. M-4, line 15) ninus line 2)		6, 020, 798 404, 616 5, 616, 182 29, 392 0	2. 3. 4.
.00 Total adjusted visits (line 4 plus line 5)			29, 392	
.00 Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	191.08 of Limit (1)	7.
		Carcuration	OI LIMIT (I)	
		Rate Period N/A	Rate Peri od 1 (01/01/2023 through 12/31/2023)	
00 D 111 11 (C 2010 D 1 400 04 1 1 1 0 000		1.00	2. 00	
Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20 Rate for Program covered visits (see instructions)	0.6 or your contractor)	0. 00 0. 00	229. 01 191. 08	8. 9.
CALCULATION OF SETTLEMENT Program covered visits excluding mental health services (from Program covered visits for mental health services (line Program covered visits for mental health services (from control 3.00 Program covered visits for mental health services (from control 3.00 Program covered cost from mental health services (see instructions Graduate Medical Education Pass Through Cost (see instructions Graduate Medical Education Pass Through Cost (see instructions Graduate Medical Education Pass Through Cost (see instructions Total Program cost (sum of lines 11, 14, and 15, columns 1, 2 Total program charges (see instructions)(from contractor's records) Total program preventive charges (see instructions) (from proval Total program preventive costs ((line 16.02/line 16.01) times Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)) Total program cost (see instructions) Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions) records) Beneficiary coinsurance for RHC/FQHC services (see instructions)	e 9 x line 10) ractor records) ne 12) si) sis) e and 3) * ecords) rider's records) siline 16) 33 and 18) times .80) (from contractor ons) (from contractor	0 0 0 0 0 0	3, 746 715, 786 54 10, 318 10, 318 726, 104 771, 851 33, 570 31, 580 486, 633 518, 213 0 86, 233	11. 12. 13. 14. 15. 16. 16. 16. 16. 17. 18.
Net program cost excluding injections/infusions (see instruct Program cost of vaccines and their administration (from Wkst. Total program IOP OPPS payments (see instructions) 1.55 Total program IOP Costs (see instructions) 1.60 Program IOP deductible and coinsurance (see instructions) 1.60 Total reimbursable Program cost (sum of lines 20, 21, 21.50, and lowable bad debts (see instructions) 1.60 Allowable bad debts (see instructions) 1.60 Allowable bad debts for dual eligible beneficiaries (see instructions) 1.60 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 1.60 Pioneer ACO demonstration payment adjustment (see instructions) 1.60 Net reimbursable amount (see instructions) 1.60 Sequestration adjustment (see instructions) 1.60 Demonstration payment adjustment amount after sequestration Interim payments 1.60 Demonstration payment (for contractor use only) 1.60 Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accordance chapter 1, §115. 2	M-4, line 16) minus line 21.60) cructions) as)		518, 213 91, 023 609, 236 0 0 0 0 0 609, 236 12, 185 0 607, 473 0 -10, 422 0	21. 21. 21. 22. 23. 23. 24. 25. 25. 26. 26. 26. 27. 28.

LCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQ	NERAL HOSPITAL OHC Provider CCN: 15-1317	Peri od:	u of Form CMS-2 Worksheet M-3	
RVI CES	Component CCN: 15-8533	From 01/01/2023 To 12/31/2023	Date/Time Pre	pare
	Title XVIII	RHC II	5/28/2024 4: 3	о рііі
		Ture 11	1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			11.00	
Total Allowable Cost of hospital-based RHC/FQHC Services (Cost of injections/infusions and their administration (from	The state of the s		1, 957, 344 309, 667	
Total allowable cost excluding injections/infusions (line Total Visits (from Wkst. M-2, column 5, line 8)	ŕ		1, 647, 677 9, 001	4.
OD Physicians visits under agreement (from Wkst. M-2, column ! Total adjusted visits (line 4 plus line 5)	5, line 9)		9, 001	5. 6.
00 Adjusted cost per visit (line 3 divided by line 6)			183. 05	1
50 naj ustou 5551 poi 1751 t (17116 5 al 17145a b) 17116 5/		Cal cul ati on	of Limit (1)	,
			Rate Period 1	
		N/A	(01/01/2023 through 12/31/2023)	
		1.00	2. 00	
OO Per visit payment limit (from CMS Pub. 100-04, chapter 9, 9 Rate for Program covered visits (see instructions)	§20.6 or your contractor)	0. 00 0. 00	192. 04 183. 05	1
CALCULATION OF SETTLEMENT On O Program covered visits excluding mental health services (fi	rom contractor records)	0	1, 633	10.
.00 Program cost excluding costs for mental health services (Ii		0	298, 921	
.00 Program covered visits for mental health services (from co	•	0	38	
0 Program covered cost from mental health services (line 9 x line 12) 0 Limit adjustment for mental health services (see instructions)			6, 956 6, 956	
.00 Limit adjustment for mental health services (see instruction Graduate Medical Education Pass Through Cost (see instruction Cost (see instruc	*	0	0, 730	15
.00 Total Program cost (sum of lines 11, 14, and 15, columns 1,	•	0	305, 877	16
0.01 Total program charges (see instructions)(from contractor's			366, 468	
o. 02 Total program preventive charges (see instructions)(from post. 03 Total program preventive costs ((line 16.02/line 16.01) time	•		8, 004 6, 681	
7.04 Total Program non-preventive costs ((Time 16.027) The 16.01) the 16.027 The 16.01) the 16.027 The 16.01) the 16.027			203, 230	
0.05 Total program cost (see instructions)		0		1
7.00 Primary payer amounts	no) (from contractor		0 45 150	
Less: Beneficiary deductible for RHC only (see instruction records)			45, 159	
Beneficiary coinsurance for RHC/FQHC services (see instructive records)	, ,		62, 611	
 .00 Net program cost excluding injections/infusions (see instruction) .00 Program cost of vaccines and their administration (from Wkstanton) 	,		209, 911 77, 449	1
.50 Total program IOP OPPS payments (see instructions)	st. W-4, Time 10)		77,447	21
.55 Total program IOP Costs (see instructions)				21
.60 Program IOP deductible and coinsurance (see instructions)				21
.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50 Allowable bad debts (see instructions)	0, minus line 21.60)		287, 360 0	
.01 Adjusted reimbursable bad debts (see instructions)			0	
.00 Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		0	
.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
.50 Pioneer ACO demonstration payment adjustment (see instruction).99 Demonstration payment adjustment amount before sequestration			0	1
.00 Net reimbursable amount (see instructions)	OI I		287, 360	
.01 Sequestration adjustment (see instructions)			5, 747	26
0.02 Demonstration payment adjustment amount after sequestration	n		0	
7.00 Interim payments 8.00 Tentative settlement (for contractor use only)			212, 752 0	1
2.00 Balance due component/program (line 26 minus lines 26.01, 2	26. 02, 27, and 28)		68, 861	
	rdance with CMS Pub. 15-II		0	1

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	AL HOSPITAL Provider CCN: 15-1317	Peri od:	u of Form CMS-2 Worksheet M-3	
RVI CES	Component CCN: 15-8534	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared
	Title XVIII	RHC III	5/28/2024 4: 3	ь рт
	THE AVIII	KIIC III	1 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
00 Total Allowable Cost of hospital-based RHC/FQHC Services (from	m Wkst M_2 line 20)		1, 644, 491	1.
OO Cost of injections/infusions and their administration (from W			108, 870	1
OD Total allowable cost excluding injections/infusions (line 1 m			1, 535, 621	
OO Total Visits (from Wkst. M-2, column 5, line 8)			7, 994	1
00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	1
00 Total adjusted visits (line 4 plus line 5)			7, 994	6.
00 Adjusted cost per visit (line 3 divided by line 6)			192. 10	7.
		Cal cul ati on	of Limit (1)	
		Rate Period	Rate Period 1	
		N/A	(01/01/2023	
			through	
		1.00	12/31/2023)	
00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	4 or your contractor)	1.00	2. 00 315. 03	8.
00 Rate for Program covered visits (see instructions)	. 6 or your contractor)	0.00		1
CALCULATION OF SETTLEMENT		0.00	172.10	· /·
0.00 Program covered visits excluding mental health services (from	contractor records)	0	1, 969	10.
.00 Program cost excluding costs for mental health services (line		0	378, 245	
2.00 Program covered visits for mental health services (from contra	actor records)	0	5	12.
8.00 Program covered cost from mental health services (line 9 x li	ne 12)	0	961	13.
.00 Limit adjustment for mental health services (see instructions)	0	961	14.
5.00 Graduate Medical Education Pass Through Cost (see instruction	•			15.
5.00 Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	•	0	379, 206	1
o.01 Total program charges (see instructions) (from contractor's re			421, 104	
0.02 Total program preventive charges (see instructions)(from prov	•		14, 166	1
o. 03 Total program preventive costs ((line 16.02/line 16.01) times o. 04 Total Program non-preventive costs ((line 16 minus lines 16.0			12, 756	
.04 Total Program non-preventive costs ((line 16 minus lines 16.0 (Titles V and XIX see instructions.)	s and real times . eta		258, 470	10.
5. 05 Total program cost (see instructions)		0	271, 226	16.
7.00 Primary payer amounts			0	I
8.00 Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		43, 362	
records)	·			
0.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		72, 710	19.
records)				
0.00 Net program cost excluding injections/infusions (see instruct	,		271, 226	
.00 Program cost of vaccines and their administration (from Wkst.	M-4, line 16)		28, 937	
.50 Total program IOP OPPS payments (see instructions) .55 Total program IOP Costs (see instructions)				21.
.55 Total program IOP Costs (see instructions).60 Program IOP deductible and coinsurance (see instructions)				21
2.00 Total reimbursable Program cost (sum of lines 20, 21, 21.50,	minus line 21 60)		300, 163	
8.00 Allowable bad debts (see instructions)			0	
8.01 Adjusted reimbursable bad debts (see instructions)				23.
1.00 Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	•		0	25.
5.50 Pioneer ACO demonstration payment adjustment (see instructions	s)		0	25.
5.99 Demonstration payment adjustment amount before sequestration			0	25.
0.00 Net reimbursable amount (see instructions)			300, 163	
o. 01 Sequestration adjustment (see instructions)			6, 003	
0.02 Demonstration payment adjustment amount after sequestration			422,000	
7.00 Interim payments			423, 998	
8.00 Tentative settlement (for contractor use only)	02 27 and 29)		120 020	
0.00 Balance due component/program (line 26 minus lines 26.01, 26.0 0.00 Protested amounts (nonallowable cost report items) in accorda	· · · · · · · · · · · · · · · · · · ·		-129, 838 0	1
	HOC WITH OWS FUD. 13-11	'	U	I 30.

CALCULATION OF	II Systems GREENE COUNTY GENER REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	RAL HOSPITAL Provider CCN: 15-1317	Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES		Component CCN: 15-8538	From 01/01/2023 To 12/31/2023	Date/Time Pre	pared
		Title XVIII	RHC IV	5/28/2024 4: 3	6 pm
	-	THE AVIII	I I I I I I I I I I I I I I I I I I I		
				1. 00	
	ATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES				
	lowable Cost of hospital-based RHC/FQHC Services (fro			1, 601, 572	1
1	injections/infusions and their administration (from W			117, 432	
	lowable cost excluding injections/infusions (line 1 m	ninus line 2)		1, 484, 140	1
1	sits (from Wkst. M-2, column 5, line 8) uns visits under agreement (from Wkst. M-2, column 5,	line 0)		9, 914 0	1
	ljusted visits (line 4 plus line 5)	11116 9)		9, 914	
1	cost per visit (line 3 divided by line 6)			149. 70	1
1.139 5.5 5.5			Cal cul ati on		
				Rate Period 1	
			N/A	(01/01/2023	
				through	
			1. 00	12/31/2023) 2. 00	
.00 Per vi si	t payment limit (from CMS Pub. 100-04, chapter 9, §20), 6 or your contractor)	0.00	169. 42	8.
	Program covered visits (see instructions)	, , , , , , , , , , , , , , , , , , , ,	0.00	149. 70	
CALCULAT	ION OF SETTLEMENT				
0.00 Program	covered visits excluding mental health services (from	contractor records)	0	3, 339	10.
	cost excluding costs for mental health services (line	*	0	499, 848	
1 0	covered visits for mental health services (from contr		0	10	1
, ,	covered cost from mental health services (line 9 x li	•	0	1, 497	1
1	ljustment for mental health services (see instructions • Medical Education Pass Through Cost (see instruction	•	0	1, 497	14. 15.
4	rogram cost (sum of lines 11, 14, and 15, columns 1, 2		0	501, 345	1
1	ogram charges (see instructions)(from contractor's re	•		540, 086	1
	ogram preventive charges (see instructions)(from prov	•		6, 971	
6.03 Total pr	rogram preventive costs ((line 16.02/line 16.01) times	line 16)		6, 471	16.
16.04 Total Pr	rogram non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		352, 750	16.
	V and XIX see instructions.)				
	rogram cost (see instructions)		0	359, 221	
	payer amounts Beneficiary deductible for RHC only (see instructions)	(from contractor		0 53, 936	
records)	,	(Troil Contractor		33, 930	10.0
	ary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		95, 778	19. (
records)	·	, (
20.00 Net pro	ram cost excluding injections/infusions (see instruct	i ons)		359, 221	20. (
	cost of vaccines and their administration (from Wkst.	M-4, line 16)		50, 421	21.
	rogram IOP OPPS payments (see instructions)				21.
	ogram IOP Costs (see instructions)				21.
	IOP deductible and coinsurance (see instructions) simbursable Program cost (sum of lines 20, 21, 21.50,	minus Line 21 40)		400 442	21.
	e bad debts (see instructions)	minus irne 21.60)		409, 642 0	1
	reimbursable bad debts (see instructions)			0	
	e bad debts for dual eligible beneficiaries (see inst	ructions)		0	
	JUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,		0	1
	ACO demonstration payment adjustment (see instruction	ıs)		0	1
5.99 Demonstr	ration payment adjustment amount before sequestration			0	25.
	bursable amount (see instructions)			409, 642	
	ration adjustment (see instructions)			8, 193	
	ration payment adjustment amount after sequestration			402.055	
7.00 Interim	payments re settlement (for contractor use only)			402, 055	1
1	due component/program (line 26 minus lines 26.01, 26.	02 27 and 28)		0 -606	
	ed amounts (nonallowable cost report items) in accorda	•		-000	1
	(1 000. 10 11	'	ı	١ ٥٠.

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od: From 01/01/2023	Worksheet M-4	
		Component (To 12/31/2023	Date/Time Pre 5/28/2024 4:30	
			XVIII	RHC I		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	2, 493, 343 0. 001090			2, 493, 343 0. 000000	
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	2, 718	11, 50	7 0	0	3.0
4. 00	Injections/infusions and related medical supplies costs (from your records)	106, 536	98, 11	5 0	0	4.0
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	109, 254 3, 256, 926	109, 62 3, 256, 92		0 3, 256, 926	5. 0 6. 0
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	2, 763, 872 0. 033545			2, 763, 872 0. 000000	
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	92, 714 201, 968			0	
11. 00 12. 00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	494 408. 84	2, 09 96. 8	7 0.00	0. 00	11. 0 12. 0 13. 0
13. 00 13. 01	Number of injection/infusion administered to Program beneficiaries Number of COVID-19 vaccine injections/infusions	12	88	9 0	0	
14. 00	administered to MA enrollees Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	4, 906	86, 11	7 0	0	
					COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1. 00	2. 00	
	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.	M-3, line 2)			404, 616	
16. 00	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				91, 023	16.0

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od: From 01/01/2023	Worksheet M-4	
		Component		To 12/31/2023		
			XVIII	RHC II		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL 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)	942, 223	942, 22	23 942, 223	942, 223	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 003741	0. 01861	0. 000000	0.000000	2.0
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	3, 525	17, 54	13 0	0	3.0
4. 00	Injections/infusions and related medical supplies costs (from your records)	82, 575	93, 04	13 0	0	4.0
5. 00	Direct cost of injections/infusions (line 3 plus line 4)	86, 100	110, 58	36 0	0	5.0
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	1, 243, 216				6.0
7. 00	Total overhead (from Wkst. M-2, line 19)	714, 128				7.0
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 069256	0. 08895	0. 000000	0.000000	8. 0
9. 00	Overhead cost - injection/infusion (line 7 x line 8)	49, 458			0	
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	135, 558	·	0	0	
11. 00	Total number of injections/infusions (from your records)	392				11.0
12. 00	Cost per injection/infusion (line 10/line 11)	345. 81				12.0
13. 00	Number of injection/infusion administered to Program beneficiaries	25	77	71 0	0	
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	8, 645	68, 80	0	0	14.0
	Tanu 13.01, as appricable)				COST OF	
					INJECTIONS /	
					INFUSIONS AND	
					ADMI NI STRATI O	
					N	
				1. 00	2. 00	
15. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		309, 667	15.0
16. 00	Total Program cost of injections/infusions and their admin		s (sum of		77, 449	16.0
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou	nt to Wkst. M-3	3, line 21)			

OMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der CO		Peri od:	Worksheet M-4	
		Component (From 01/01/2023 To 12/31/2023	Date/Time Pre 5/28/2024 4:3	
		Title	XVIII	RHC III		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	694, 191	694, 19	1 694, 191	694, 191	1.00
. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001409	0. 00606	0. 000000	0.000000	2.00
. 00	Injection/infusion health care staff cost (line 1 x line 2)	978	4, 21	2 0	0	3.0
. 00	Injections/infusions and related medical supplies costs (from your records)	28, 630	30, 27		0	4.0
. 00 . 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from	29, 608 968, 194	34, 48 968, 19		968, 194	5. 00 6. 00
	Worksheet M-1, col. 7, line 22)					
. 00 . 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct	676, 297 0. 030581	676, 29 0. 03562		676, 297 0. 000000	7. 0 8. 0
	cost (line 5 divided by line 6)				_	
. 00 0. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration	20, 682 50, 290	24, 09 58, 58		0	
1. 00	costs (sum of lines 5 and 9) Total number of injections/infusions (from your records)	140	60	0	0	11. C
2. 00	Cost per injection/infusion (line 10/line 11)	359. 21	97. 1	5 0.00	0.00	12.0
3. 00	Number of injection/infusion administered to Program beneficiaries	17	23	5 0	0	13. C
3. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. C
4. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	6, 107	22, 83	0	0	14. C
	and to one de approach of				COST OF	
					I NJECTI ONS /	
					INFUSIONS AND ADMINISTRATIO	
					N N	
				1.00	2. 00	
5. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		columns 1,		108, 870	15. (
6. 00	Total Program cost of injections/infusions and their admin		s (sum of		28, 937	16. (
	columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou				25, 767	

COMPUT	ATION OF HOSPITAL-BASED RHC/FQHC VACCINE COST	Provi der Co		Peri od: From 01/01/2023	Worksheet M-4	
		Component (To 12/31/2023	Date/Time Prep 5/28/2024 4:30	
			XVIII	RHC IV		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2.00	2. 01	2. 02	
1. 00 2. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10) Ratio of injection/infusion staff time to total health care staff time	641, 957 0. 000268	641, 95 0. 01140		641, 957 0. 000000	1. 00 2. 00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	172	7, 32	1 0	0	3.0
4. 00	Injections/infusions and related medical supplies costs (from your records)	4, 753	52, 80	3 0	0	4.0
5. 00 6. 00	Direct cost of injections/infusions (line 3 plus line 4) Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	4, 925 887, 158	60, 12 887, 15		0 887, 158	5. 00 6. 00
7. 00 8. 00	Total overhead (from Wkst. M-2, line 19) Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	714, 414 0. 005551	714, 41 0. 06777		714, 414 0. 000000	7. 0 8. 0
9. 00 10. 00	Overhead cost - injection/infusion (line 7 x line 8) Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	3, 966 8, 891	48, 41 108, 54		0	9. 0 10. 0
11.00	Total number of injections/infusions (from your records) Cost per injection/infusion (line 10/line 11)	25 355. 64	102. 2	0. 00	0. 00	11. 0 12. 0
13. 00 13. 01	Number of injection/infusion administered to Program beneficiaries Number of COVID-19 vaccine injections/infusions	/	46	9 0	0	13.0
14. 00	administered to MA enrollees Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13	2, 489	47, 93	2 0	0	
	and 13.01, as applicable)				COST OF INJECTIONS / INFUSIONS AND ADMINISTRATIO N	
				1. 00	2. 00	
5. 00	Total cost of injections/infusions and their administratio 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst.		f columns 1,		117, 432	15. 0
6.00	Total Program cost of injections/infusions and their admin columns 1, 2, 2.01, and 2.02, line 14) (transfer this amou		•		50, 421	16.0

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-1317 Component CCN: 15-8535	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 4:36 pm

		·		5/28/2024 4: 36	6 pr
			RHC I		
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
	otal interim payments paid to hospital-based RHC/FQHC			607, 473	1
	nterim payments payable on individual bills, either submitte			0	2
	the contractor for services rendered in the cost reporting pe	eriod. If none, write			
	NONE" or enter a zero				
	ist separately each retroactive lump sum adjustment amount l				3
	revision of the interim rate for the cost reporting period. A	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
Pr	rogram to Provider				
)1				0	3
)2				0	3
)3				0	3
)4				0	3
)5				0	3
Pr	rovider to Program			•	
50				0	3
51				0	3
52				0	3
3				0	3
54				O	3
99 S	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98	8)		0	3
о Т	otal interim payments (sum of lines 1, 2, and 3.99) (transfe	er to Worksheet M-3, line		607, 473	
2	77)				
TO	O BE COMPLETED BY CONTRACTOR				
	ist separately each tentative settlement payment after desk	review. Also show date of	F		Ę
	each payment. If none, write "NONE" or enter a zero. (1)				
Pr	rogram to Provider				
)1				0	5
)2				0	Ę
)3				0	5
Pr	rovider to Program				
0				0	5
51				0	5
52				0	5
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	Ę
	Determined net settlement amount (balance due) based on the cost report. (1)				6
)1 S	SETTLEMENT TO PROVI DER			0	6
)2 S	SETTLEMENT TO PROGRAM			10, 422	6
00 Т	otal Medicare program liability (see instructions)			597, 051	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-1317 Component CCN: 15-8533	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 4:36 pm

				5/28/2024 4: 30	6 pm
			RHC II		
				t B	
			mm/dd/yyyy	Amount	
			1. 00	2. 00	
1.00	Total interim payments paid to hospital-based RHC/FQHC			212, 752	1.00
2.00	Interim payments payable on individual bills, either submitte			0	2.00
	the contractor for services rendered in the cost reporting p	eriod. If none, write			
	"NONE" or enter a zero				
3.00	List separately each retroactive lump sum adjustment amount				3.00
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
3. 01				0	3. 01
3. 02				0	3. 02
3.03				0	3.03
3. 04				0	3. 04
3. 05				0	3.05
	Provider to Program				
3.50				0	3.50
3. 51				0	3. 51
3. 52				0	3. 52
3. 53				0	3. 53
3.54				0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.96			0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer	er to Worksheet M-3, line		212, 752	4.00
	27)				
	TO BE COMPLETED BY CONTRACTOR				
5.00	List separately each tentative settlement payment after desk	review. Also show date o	f		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
	Provider to Program				
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 5.50-5.98)			0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)				6.00
6. 01	SETTLEMENT TO PROVIDER			68, 861	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	6. 02
7. 00	Total Medicare program liability (see instructions)			281, 613	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 GENER	RAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED SERVICES RENDERED TO PROGRAM BENEFICIAR		Provider CCN: 15-1317 Component CCN: 15-8534	Peri od: From 01/01/2023 To 12/31/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 4:36 pm

	•		5/28/2024 4: 36	6 pı
		Par		
		mm/dd/yyyy	Amount	
		1. 00	2. 00	
Total interim payments paid to hospital-based RHC/FQHC			423, 998	1
			0	2
the contractor for services rendered in the cost reporting per	riod. If none, write			
"NONE" or enter a zero				
List separately each retroactive lump sum adjustment amount ba	ased on subsequent			3
	Iso show date of each			
payment. If none, write "NONE" or enter a zero. (1)				
Program to Provider				
			0	3
			o	3
			l ol	3
			l ol	3
			l ol	3
Provider to Program		•		
			0	: ا
			l ol	: ا
			ا ا	3
			1	
Subtotal (sum of lines 3 01-3 49 minus sum of lines 3 50-3 98))		1	3
			-	1
	to worksheet in o, Time		120, 770	
	review. Also show date of			5
			0	ļ 5
			l ol	
			l ol	
Provider to Program				
			0	5
			o	
			o	
Subtotal (sum of lines 5 01-5 49 minus sum of lines 5 50-5 98)			l ol	į
Determined net settlement amount (balance due) based on the cost report. (1)				}
SETTLEMENT TO PROVIDER			0	
			1	1
Total modification program fruitifity (500 fristructions)		Contractor		<u> </u>
		Number	(Mo/Day/Yr)	
			2.00	
	0	1. 00		
	Interim payments payable on individual bills, either submitte the contractor for services rendered in the cost reporting pe "NONE" or enter a zero List separately each retroactive lump sum adjustment amount be revision of the interim rate for the cost reporting period. A payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfe 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98 Determined net settlement amount (balance due) based on the contractions.	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Provider to Program Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM	Total interim payments paid to hospital-based RHC/FOHC Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Worksheet M-3, line 27) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1) SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions) Contractor	Ref III Part B mm/dd/yyyy Amount 1.00 2.00

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED F SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1317 Component CCN: 15-8538	From 01/01/2023	Worksheet M-5 Date/Time Prepared: 5/28/2024 4:36 pm

		·		5/28/2024 4: 36	6 pr
			RHC I V		
				rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00 .	Total interim payments paid to hospital-based RHC/FQHC			402, 055	1
	Interim payments payable on individual bills, either submitte			0	2
	the contractor for services rendered in the cost reporting pe	riod. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount b	ased on subsequent			3
	revision of the interim rate for the cost reporting period. A	Iso show date of each			
Ŀ	payment. If none, write "NONE" or enter a zero. (1)				
F	Program to Provider				
)1 [0	3
)2				0	3
)3				l ol	3
)4				l ol	3
)5					3
	Provider to Program			_	
io [0	3
1				0	3
2				l ol	3
3				0	3
54					3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0	3
	Total interim payments (sum of lines 1, 2, and 3.99) (transfe			402, 055	4
	27)	to not restrict in o, 11110		102, 000	
	TO BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after desk	review. Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider			•	
)1				0	
)2				l ol	Ę
)3				0	5
	Provider to Program				
50 F				0	5
51				0	5
2				l ol	E
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			l ol	E
	Determined net settlement amount (balance due) based on the cost report. (1)				é
	SETTLEMENT TO PROVIDER			0	6
	SETTLEMENT TO PROGRAM			606	6
	Total Medicare program liability (see instructions)			401, 449	7
55	Total modificate program frability (See Histiactions)		Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	
		0	1.00	2.00	
00	Name of Contractor				