## GREENE COUNTY GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

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 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 15-1317 Worksheet S Parts I-III Peri od. From 01/01/2017 AND SETTLEMENT SUMMARY То 12/31/2017 Date/Time Prepared: 5/30/2018 10: 38 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 5/30/2018 Time: 10:38 am use only 2. [ Manually submitted cost report ]If this is an amended report enter the number of times the provider resubmitted this cost report ]Medicare Utilization. Enter "F" for full or "L" for low. 3 0 Ē 4 [ 

 [1] Cost Report Status
 6. Date Received:

 [1] As Submitted
 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

 (12. Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 11. Contractor's Code:

 (13. Settled with Audit
 9.

 [N] Final Report for this Provider CCN
 11.

 [N] Contractor 5. use only number of times reopened = 0-9. (3) Settled with Audit (4) Reopened (5) Amended PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST REPORT MAY BE PUNISHABLE BY CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMORE, IF SERVICES IDENTIFIED IN THIS REPORT WERE PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT. CERTIFICATION BY CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OF PROVIDER(S) I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENE COUNTY GENERAL HOSPITAL (15-1317) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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. ]I have read and agree with the above certification statement. I certify that I intend my electronic Γ signature on this certification statement to be the legally binding equivalent of my original signature. (Si gned) Officer or Administrator of Provider(s) Title Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-37, 338	-682, 396	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-34, 423	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-71, 761	-682, 396	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 valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

Heal th	Financial Systems	GREENE COU	INTY GENER	RAL HOSE	PI TAL			n Lieu	ı of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	ATA	Provi c	er CCN:	15-1317	Period: From 01/01	/2017	Workshe Part I	eet S-2	
							To 12/31	/2017	Date/Ti 5/30/20		
	1.00 Hospital and Hospital Health Care Co		00		3.00			4.00			
1.00	Street: R. R 1	P0 Box: 1	000								1.00
2.00	City: LINTON	State: I					ty: GREENE	Dayma	nt Suct	om (D	2.00
		Component Na		CCN Number	CBSA Numbe		r Date Certified		ent Syst , O, or  XVIII	N)	
		1.00		2.00	3.00	4.00	5.00	6.00	-	8.00	
3.00	Hospital and Hospital-Based Componer Hospital	nt Identification: GREENE COUNTY GEN		151317	99915	5 1	02/01/2003	3 N	0	0	3.00
4 00		HOSPI TAL									4.00
4.00 5.00	Subprovi der – IPF Subprovi der – IRF										4.00 5.00
6.00	Subprovider - (Other)			157017	99915	-	02 /01 /2007			N	6.00
7.00	Swing Beds - SNF	GREENE COUNTY GEN HOSPITAL	NERAL	15Z317	99915		02/01/2003	3 N	0	N	7.00
8.00	Swing Beds - NF										8.00
9. 00 10. 00	Hospital-Based SNF Hospital-Based NF										9.00 10.00
11.00	Hospital-Based OLTC										11.00
12.00 13.00	Hospital-Based HHA Separately Certified ASC										12.00 13.00
14.00	Hospital-Based Hospice										14.00
15.00 16.00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15.00 16.00
17.00	Hospital-Based (CMHC) I										17.00
18.00 19.00	Renal Dialysis Other										18.00 19.00
		1	I			I	From		То		
20.00	Cost Reporting Period (mm/dd/yyyy)						1.00		2. ( 12/31/		20.00
21.00	Type of Control (see instructions) Inpatient PPS Information						9			-	21.00
22.00	Does this facility qualify and is it										22.00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
00.01	amendment hospital?) In column 2, en	iter "Y" for yes o	or "N" fo	r no.							00.01
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y						) N		N		22.01
	reporting period occurring prior to										
	for no for the portion of the cost r (see instructions)	eporting period c	Securring	on or	arter u	ictober I.					
22.02	Is this a newly merged hospital that determined at cost report settlement								N		22.02
	or "N" for no, for the portion of th										
	in column 2, "Y" for yes or "N" for or after October 1.	no, for the porti	on of th	e cost	reporti	ng period	on				
22.03	Did this hospital receive a geograph								N		22.03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for						er				
	prior to October 1. Enter in column	2, "Y" for yes or	r "N" for	no for	the po	rtion of t	he				
	cost reporting period occurring on c hospital contain at least 100 but no						th				
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N	N″ for no								
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i						ท	0			23.00
	method of identifying the days in th	is cost reporting	g period (	di ffere	nt from	the metho					
	used in the prior cost reporting per	TOUR IN COLUMN 2	In-State			Out-of		Medi ca	id 0	ther	
			Medicaid			State		HMO da	<i>y</i>	di cai d	
			paid days	unp		Medicaid aid days	Medicaid eligible			lays	
		-	1 00	da 2.	-	3.00	unpai d 4. 00	5.00	1	00	
24.00	If this provider is an IPPS hospital	, enter the	1.00	0	0	3.00	4.00	3.00	0	<u>5.00</u> 0	24.00
	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col										
	out-of-state Medicaid paid days in c	olumn 3,									
	out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in	column 6.									
25.00	If this provider is an IRF, enter th Medicaid paid days in column 1, the			0	0	0	0		0		25.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid days in column Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid days										

	Financial Systems GREENE COU AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC	CN: 15-1317	Period: From 01/01/20	017	of Form Workshee Part I	et S-2	
					To 12/31/20	017	Date/Tir 5/30/201	ne Pre 18 10:	pared: 38 am
				L	Urban/Rural	S	Date of	Geogr	
26.00	Enter your standard geographic classification (not wa	iae) st	atus at the be	ainnina of th	1.00 e	1	2.00	)	26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	řrural ige) st	atus at the en	d of the cost		1			27.00
5.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35.00
					Begi nni ng 1. 00	:	Endi n 2. 00		
	Enter applicable beginning and ending dates of SCH st		Subscript line	36 for numbe			2.00	5	36.00
	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of perio	ds MDH status		0			37.00
	ls this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo								37. Oʻ
	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.						38.00		
					Y/N 1.00		Y/N 2.00		
	Does this facility qualify for the inpatient hospital				2. UC N	<u>J</u>	39.00		
	hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	eage r	equirements in	accordance	e				
0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1.	Enter "Y" for				Ν		40.00
		(000				V 1.00	XVIII 2.00	XI X 3. 00	
	Prospective Payment System (PPS)–Capital Does this facility qualify and receive Capital paymen	t for	di sproporti ona	te share in a	ccordance	N	N	N	45.00
6. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	ption	for extraordin	ary circumsta	inces	N	N	N	46.00
7.00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS c Is the facility electing full federal capital payment					N N	N N	N N	47.00 48.00
6.00	Teaching Hospitals Is this a hospital involved in training residents in	approv	ed GME program	s? Enter "Y"	for yes	N			56.00
7.00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes o h of t ", com	r "N" for no i his cost repor plete Workshee	n column 1. l ting period?	f column 1 Enter "Y"				57.0
	If line 56 is yes, did this facility elect cost reimb	urseme	nt for physici	ans' services	as	Ν			58.0
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes			, Pt. I.		Ν			59.0
				NAHE 413.85 Y/N	Worksheet Line #		Pass-Thi Qualific Criter Code	ation ion	
				1.00	2.00		3.00		
	Are you claiming nursing and allied health education any programs that meet the criteria under §413.85? (	see in	structions)	N					60.0
		Y/N	IME	Direct GME	IME		Di rect	GME	
1 00	Did your beenital receive FTE clots under ACA	1.00 N	2.00	3.00	4.00	). 00	5.00		61.0
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				. 00		0.00	
	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)								61.0
1. 02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of								61.02
	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for								61.03

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider C	CN: 15-1317	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/30/2018 10:	pared:
	Y/N	I ME	Direct GME	I ME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
<ul> <li>51.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).</li> <li>51.05 Enter the difference between the baseline primary</li> </ul>						61.04
and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61.06
care or general surgery. (see instructions)						
	Pro	ogram Name	Program Cod	e Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program special ty, 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.				0.00	0.00	61. 10
51.20 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, the direct GME FTE unweighted count.				0.00	0. 00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Ser				and for which	0.00	(2.00
52.00 Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	ctions)					62.00
52.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	gram. (s	<u>see instructio</u>		to your hospital	0.00	62.01
53.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					Ν	63.00
			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
			Nonprovider Site	- Hospital	col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor			-This base ye	ar is your cost	reporting	
54.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted nor resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	ty train -priman all non d non-pu	ned residents ry care nprovider rimary care	0.	00 0.00	0. 000000	64.00
resident FTEs that trained in your hospital. Enter ir of (column 1 divided by (column 1 + column 2)). (see						
Program Name		ogram Code	Unweighted FTEs Nonprovider	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
			Site			
1.00		2.00	3.00	4.00	5.00	

SPITAL AND HOSPITAL HEA	ALIN CARE COMPLE	A IDENTIFICATION D	ATA Provider (	Fr	riod: om 01/01/2017	Worksheet S-2 Part I	
				То	12/31/2017	Date/Time Pre 5/30/2018 10:	pareo 38 ai
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
.00 Enter in column 1, is yes, or your far trained residents year period, the p associated with pr FTEs for each prim program in which your residents. Enter in the program code. I column 3, the numbour unweighted primary residents attribut. rotations occurring non-provider settific column 4, the numbour unweighted primary resident FTEs that your hospital. Enter 5, the ratio of (column 1, the setting)	acility in the base program name timary care anary care you trained n column 2, Enter in over of care FTE table to ng in all ngs. Enter in per of care t trained in ter in column			0.00	0.00	0. 000000	, 05.
divided by (column 4)). (see instruct	n 3 + column			Unwei ghted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 +	
				Nonprovider Site	Hospi tal	col . 2))	
Section 5504 of th	e ACA Current V	par FTF Residents i	n Nonprovider Settir	1.00	2.00	3.00	
beginning on or af			in nonprovinder bettin			ring perirous	
			rv care resident	0.00	0.00	0, 00000	66.
00 Enter in column 1 FTEs attributable Enter in column 2 FTEs that trained	the number of un to rotations occ the number of un in your hospital	nweighted non-prima curring in all nonp nweighted non-prima . Enter in column column 2)). (see in	rovider settings. ry care resident 3 the ratio of structions)	0.00	0.00		66.
00 Enter in column 1 FTEs attributable Enter in column 2 FTEs that trained	the number of un to rotations occ the number of un in your hospital	nweighted non-prima curring in all nonp nweighted non-prima . Enter in column	rovider settings. ry care resident 3 the ratio of	0.00 Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	0.000000 Ratio (col. 3/ (col. 3 + col. 4))	66.
<ul> <li>00 Enter in column 1 FTEs attributable Enter in column 2 FTEs that trained (column 1 divided)</li> <li>00 Enter in column 1,</li> </ul>	the number of un to rotations occ the number of un in your hospital by (column 1 + column the program	nweighted non-prima curring in all nonp nweighted non-prima . Enter in column column 2)). (see in	rovider settings. ry care resident 3 the ratio of structions)	Unweighted FTEs Nonprovider	Unweighted FTEs in	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	-
00 Enter in column 1 FTEs attributable Enter in column 2 FTEs that trained (column 1 divided	the number of un to rotations occ the number of un in your hospital by (column 1 + of the program th each of programs in residents. the program umn 3, the red primary s attributable rring in all ngs. Enter in per of r care trained in rer in column solumn 3 n 3 + column	nweighted non-prima curring in all nonp nweighted non-prima . Enter in column column 2)). (see in Program Name	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00	-
<ul> <li>00 Enter in column 1 FTEs attributable Enter in column 2 FTEs that trained (column 1 divided 1</li> <li>00 Enter in column 1, name associated wi your primary care which you trained Enter in column 2, code. Enter in column 2, code. Enter in column 2, code. Enter in column 2, code. Enter in column 2, code Enter in column 4, to rotations occur non-provider setti column 4, the numb unweighted primary resident FTEs that your hospital. Enter 5, the ratio of (column 4)). (see instruct</li> </ul>	the number of un to rotations occ the number of un in your hospital by (column 1 + column the program th each of programs in residents. the program umn 3, the red primary s attributable rring in all ngs. Enter in per of care trained in rer in column column 3 n 3 + column tions)	nweighted non-prima curring in all nonp nweighted non-prima . Enter in column column 2)). (see in Program Name 1.00	rovider settings. ry care resident 3 the ratio of structions) Program Code	Unweighted FTEs Nonprovider Site 3.00	Unweighted FTEs in Hospital 4.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	-
<ul> <li>O0 Enter in column 1         FTEs attributable Enter in column 2         FTEs that trained             (column 1 divided 1             (column 2, code. Enter in column 2, code. Enter in column 2, code. Enter in column 4, the numburnomber of unweighted primary resident FTEs that your hospital. Enter 5, the ratio of (column 4, the numburnospital. Ente 5, the ratio of (colum 4)). (see instruct             (see instruct             (see instruct                   (column 4, the numburnospital. Enter             ) (see instruct             (column 4, the numburnospital. Enter             (column 4, the numburnospital. Enter             (column 4)). (see instruct             (see instruct</li></ul>	the number of un to rotations occ the number of un in your hospital by (column 1 + of the program th each of programs in residents. the program umn 3, the red primary s attributable rring in all ngs. Enter in ver of care trained in rer in column column 3 n 3 + column cions)	hweighted non-prima curring in all nonp weighted non-prima . Enter in column column 2)). (see in Program Name 1.00	IPF), or does it con	Unweighted FTEs Nonprovider Site 3.00 0.00	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000	- 67.
<ul> <li>Enter in column 1         FTEs attributable Enter in column 2         FTEs that trained             (column 1 divided      </li> <li>OD Enter in column 1,         name associated wi             your primary care             which you trained             Enter in column 2,             code. Enter in column 4,             care FTE residents             to rotations occur             non-provider settii             column 4, the numb             unweighted primary             resident FTEs that             your hospital. Ente             5, the ratio of (ci             divided by (column             4)). (see instruct          </li> <li>Inpatient Psychiat         </li> <li>Inpatient Psychiat         </li> <li>Enter "Y" for yes             recent cost report             42 CFR 412.424(d) (             program in accorda         </li> </ul>	the number of un to rotations occ the number of un in your hospital by (column 1 + col the program th each of programs in residents. the program umn 3, the red primary s attributable rring in all ngs. Enter in eer of care trained in rer in column column 3 n 3 + column tions) rric Facility PP filed on or bei filed on	hweighted non-prima curring in all nonp weighted non-prima . Enter in column column 2)). (see in Program Name 1.00 1.00 1.00 5 chiatric Facility have a Fore November 15, 2 Jmn 2: Did this fac 412.424 (d)(1)(iii ate which program y	rovi der settings. ry care resident 3 the ratio of structions) Program Code 2.00	Unweighted FTEs Nonprovider Site 3.00 0.00 tain an IPF subp ing program in f yes or "N" for r s in a new teach yes or "N" for r	Unwei ghted FTEs in Hospi tal 4.00 0.00 0.00 1.00 provi der? N the most no. (see i ng no.	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000	67.

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider (	CCN: 15-1317	Period: From 01/01/2017 To 12/31/2017		epared
		1.0	0 2.00 3.00	-
.00 If line 75 is yes: Column 1: Did the facility have an approved GME teach recent cost reporting period ending on or before November 15, 2004? Ente no. Column 2: Did this facility train residents in a new teaching progra CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: I indicate which program year began during this cost reporting period. (se	er "Y" for yes m in accordan f column 2 is	n the most or "N" for ce with 42 Y,	0	76.C
Long Term Care Hospital PPS			1.00	
.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for .00 Is this a LTCH co-located within another hospital for part or all of the "Y" for yes and "N" for no. TEFRA Providers		ng period? Enter	- N N	80. C 81. C
.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Ent .00 Did this facility establish a new Other subprovider (excluded unit) unde	2		N	85. C 86. C
<ul> <li>§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.</li> <li>.00 Is this hospital an extended neoplastic disease care hospital classified 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.</li> </ul>	l under sectio	'n	Ν	87.0
		V 1.00	XI X 2.00	
Title V and XIX Services .00 Does this facility have title V and/or XIX inpatient hospital services?	Enter "Y" for	N	Y	90.0
yes or "N" for no in the applicable column. .00 Is this hospital reimbursed for title V and/or XIX through the cost repo full or in part? Enter "Y" for yes or "N" for no in the applicable colum		N	Y	91. (
.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certifica instructions) Enter "Y" for yes or "N" for no in the applicable column.	ition)? (see		N	92. (
.00 Does this facility operate an ICF/IID facility for purposes of title V a "Y" for yes or "N" for no in the applicable column.			N	93.0
.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for applicable column. .00 If line 94 is "Y", enter the reduction percentage in the applicable colu		0. 00	0. 00	94.0
.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for applicable column.		N	N	96.0
<ul> <li>.00   f line 96 is "Y", enter the reduction percentage in the applicable colu</li> <li>.00 Does title V or XIX follow Medicare (title XVIII) for the interns and re stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N column 1 for title V, and in column 2 for title XIX.</li> </ul>	sidents post	0. 00 N	0. 00 Y	97. 98.
.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of c C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and i title XIX.			Y	98.
.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no for title V, and in column 2 for title XIX.		Ν	Y	98.
.03 Does title V or XIX follow Medicare (title XVIII) for a critical access reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for for title V, and in column 2 for title XIX.			N	98.
.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 1 outpatient services cost? Enter "Y" for yes or "N" for no in column 1 fo in column 2 for title XIX.		N	N	98.
05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE d Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for			Y	98.
<ul> <li>column 2 for title XIX.</li> <li>06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed f Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title column 2 for title XIX.</li> </ul>		N	Y	98.
Rural Providers 5.00Does this hospital qualify as a CAH?		Y		105.0
5.00 If this facility qualifies as a CAH, has it elected the all-inclusive me for outpatient services? (see instructions)	1 3	nt N		106.
7.00 If this facility qualifies as a CAH, is it eligible for cost reimburseme training programs? Enter "Y" for yes or "N" for no in column 1. (see ins yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the reimbursed. If yes complete Wkst. D-2, Pt. II.	structions) If			107.
reimbursed. If yes complete wkst. D-2, Pt. II. 8.00 Is this a rural hospital qualifying for an exception to the CRNA fee sch	edule? See 4	2 Y		108.

Health Financial Systems GREENE COUNTY GEN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CN: 15-1317 Pe	eri od:		of Form C Worksheet	
		To	rom 01/01/2 p 12/31/2		Part I Date/Time 5/30/2018	
	Physi cal 1.00	Occupational 2.00	Speech 3.00		Respirato 4.00	
09.00  f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N		N	109.0
					1.00	
10.00 Did this hospital participate in the Rural Community Hospita Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes o	"N" for no. I	f yes,		N	110.0
			1.00		2.00	
11.00 If this facility qualifies as a CAH, did it participate in THE Health Integration Project (FCHIP) demonstration for this can "Y" for yes or "N" for no in column 1. If the response to can integration prong of the FCHIP demo in which this CAH is participate all that apply: "A" for Ambulance services; "B" for an for tele-health services.	ost reporting olumn 1 is Y, rticipating in	period? Enter enter the column 2.	N			111.0
			-	1.00	2.00 3.	00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	. If column 2 nt for long te	is "E", enter erm care (inclu	in column des	N		0 115.0
16.00 Is this facility classified as a referral center? Enter "Y" 17.00 Is this facility legally-required to carry malpractice insun no.			"N" for	N Y		116. ( 117. (
18.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the policy	is	1		118.0
		Premi ums	Losses		Insuranc	e
		1.00	2.00		3.00	
18.01 List amounts of malpractice premiums and paid losses:		115, 746		0		0118.0
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein.			1.00 N		2.00	118.0
9.00D0 NOT USE THIS LINE (0.00] s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no.	n column 1, "\ ualifies for t	(" for yes or the Outpatient	Ν		Ν	119. 120.
21.00Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	antable device	es charged to	N			121.
22.00 Does the cost report contain healthcare related taxes as de Act?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information			N			122.
5.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N'	for no. If	N			125.
6.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 1		fication date				126.
7.00  f this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 1	ter the certi	fication date				127.
	ter the certi	fication date				128.
8.00 If this is a Medicare certified liver transplant center, en		cation date in				129.
8.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2 9.00 If this is a Medicare certified lung transplant center, enter						1
<ul> <li>8.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2.</li> <li>9.00 If this is a Medicare certified lung transplant center, enticolumn 1 and termination date, if applicable, in column 2.</li> <li>0.00 If this is a Medicare certified pancreas transplant center,</li> </ul>	er the certifi enter the cen					130.
<ul> <li>8.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2</li> <li>9.00 If this is a Medicare certified lung transplant center, enticolumn 1 and termination date, if applicable, in column 2.</li> <li>0.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2.</li> <li>0.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1.00 If this is a Medicare certified intestinal transplant center</li> </ul>	er the certifi enter the cen lumn 2. r, enter the c	ti fi cati on				
<ul> <li>18.00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2.</li> <li>19.00 If this is a Medicare certified lung transplant center, enticolumn 1 and termination date, if applicable, in column 2.</li> <li>10.00 If this is a Medicare certified pancreas transplant center, enticolumn 1 and termination date, if applicable, in column 2.</li> <li>10.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1.</li> <li>10.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2.</li> <li>10.00 If this is a Medicare certified intestinal transplant center (ate in column 1 and termination date, if applicable, in column 2.</li> <li>10.00 If this is a Medicare certified islet transplant center, entities a medicare certified islet transplant center and termination and termination and t</li></ul>	er the certifi enter the cer lumn 2. r, enter the c lumn 2. ter the certif	rti fi cati on certi fi cati on				130. 131. 132.
<ul> <li>28.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 2</li> <li>29.00 If this is a Medicare certified lung transplant center, enticolumn 1 and termination date, if applicable, in column 2</li> <li>30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2</li> <li>30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 31.00 If this is a Medicare certified intestinal transplant center</li> </ul>	er the certifi enter the cer lumn 2. r, enter the c lumn 2. ter the certif 2. ter the certif 2.	rtification certification fication date fication date				131.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		GENERAL HOSPITAL	N· 15-1317	Perioc		u of Form CMS-2 Worksheet S-2	
				From C	)1/01/2017 12/31/2017	Part I Date/Time Pre 5/30/2018 10:	pared:
					1.00		
140.00 Are there any related organization chapter 10? Enter "Y" for yes or	"N" for no in column 1.	If yes, and home	office cos		1.00 N	2.00	140.00
are claimed, enter in column 2 th			i ons)		2.00		
1.00 If this facility is part of a cha		2.00 on lines 141 throu	uah 143 the	e name a	3.00 nd address	of the home	
office and enter the home office	contractor name and con	tractor number.	<u> </u>				
141.00Name: 142.00Street:	Contractor's Name: PO Box:		Contrac	ctor's N	umber:		141.00 142.00
143. 00 Ci ty:	State:		Zip Coo	de:			142.00
	I						
144.00 Are provider based physicians' co	sts included in Worksho	at 12				1.00 Y	144.00
144. 00 AT e provider based physicians co		et A?				T	144.00
					1.00	2.00	
145.00 If costs for renal services are c inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	" for yes or "N" for no clude Medicare utilizati for no in column 2.	in column 1. If c on for this cost	column 1 is reporting	5			145.00
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Put			lf	N		146.00
						1.00	
147.00 Was there a change in the statist						N	147.00
148.00 Was there a change in the order of 149.00 Was there a change to the simplif				or no		N	148.00 149.00
	i cu cost i i i i i i i i i i i i i i i i i i i	Part A	Part B		Title V	Title XIX	117.00
		1.00	2.00		3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
155. 00 Hospi tal		N N	N		N N	N	155.00
156.00 Subprovi der – IPF		N	Ν		Ν	Ν	156.00
157. 00 Subprovi der – IRF 158. 00 SUBPROVI DER		N	N		N	Ν	157.00 158.00
159. 00 SNF		N	Ν		N	Ν	159.00
160.00 HOME HEALTH AGENCY		N	Ν		N	Ν	160.00
161.00 CMHC			N		N	N	161.00
						1.00	
Multicampus							
165.00 Is this hospital part of a Multic. Enter "Y" for yes or "N" for no.	ampus hospital that has	one or more campu	uses in dif	ferent (	CBSAs?	Ν	165.00
	Name	County	State 2	Zip Code	CBSA	FTE/Campus	
	0	1.00	2.00	3.00	4.00	5.00	
166.00 If line 165 is yes, for each campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
						1.00	
Health Information Technology (HI	T) incentive in the Ame	rican Recoverv and	d Reinvestr	ment Act		1.00	
167.00 Is this provider a meaningful use 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the	r under §1886(n)? Enter D5 is "Y") and is a mear	r "Y" for yes or " ningful user (line	'N" for no.			Y 1, 062, 388	167. 00 168. 00
168.01 If this provider is a CAH and is exception under §413.70(a)(6)(ii) 169.00 If this provider is a meaningful	? Enter "Y" for yes or ' user (line 167 is "Y") a	'N" for no. (see i	nstruction	ıs)		0. 00	168. 01 169. 00
transition factor. (see instruction	ons)				alphier	End!	
				BE	egi nni ng 1. 00	Endi ng 2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)	peginning date and endir	ng date for the re	eporti ng	01	/01/2017		170.00

Health Financial Systems						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 15-1317	Period: From 01/01/2017	Worksheet S	-2	
			To 12/31/2017			
			1.00	2.00		
171.00 If line 167 is "Y", does this provide			N		0171.00	
section 1876 Medicare cost plans repo						
"Y" for yes and "N" for no in column	on					
1876 Medicare days in column 2. (see	instructions)					

Health Financial Systems

## GREENE COUNTY GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems GREENE COUNTY G	ENERAL HOSPI TAL	_	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-1317 P	Period: From 01/01/2017 To 12/31/2017	Worksheet S- Part II	2
		1	0 12/31/2017	5/30/2018 10	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO r	esponses. Ente	r all dates in	the	
Provider Organization and Operation					1
.00 Has the provider changed ownership immediately prior to th	he beainnina of	the cost	N		1.00
reporting period? If yes, enter the date of the change in	column 2. (see	instructions)			
		Y/N	Date	V/I	
		1.00	2.00	3.00	
.00 Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu- voluntary or "I" for involuntary.	Program? If umn 3, "V" for	N			2.00
.00 Is the provider involved in business transactions, includi contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provi officers, medical staff, management personnel, or members of directors through ownership, control, or family and oth relationships? (see instructions)	offices, drug ider or its of the board	Y			3.00
		Y/N	Туре	Date	
		1.00	2.00	3.00	
Financial Data and Reports					
1.00 Column 1: Were the financial statements prepared by a Cel Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date av column 3. (see instructions) If no, see instructions.	for Compiled,	N			4.00
5.00 Are the cost report total expenses and total revenues diff		Ν			5.00
those on the filed financial statements? If yes, submit re	econciliation.				
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities			1		
.00 Column 1: Are costs claimed for nursing school? Column 2:	: lfyes,ist	he provider is	N		6.00
the legal operator of the program? .00 Are costs claimed for Allied Health Programs? If "Y" see i		1 1 1 11	N		7.00
<ul> <li>Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.</li> <li>Are costs claimed for Interns and Residents in an approved</li> </ul>		0	N		8.00 9.00
program in the current cost report? If yes, see instruction 0.00 Was an approved Intern and Resident GME program initiated	ons.		N		10.00
cost reporting period? If yes, see instructions.					10.00
<ol> <li>Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.</li> </ol>		proved	N		11.00
				Y/N 1.00	
Bad Debts				1.00	
2.00 Is the provider seeking reimbursement for bad debts? If ye	es see instruc	tions		Y	12.00
3.00 If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			st reporting	N	13.00
4.00 If line 12 is yes, were patient deductibles and/or co-payr Bed Complement	ments waived? I	fyes, see ins	tructions.	N	14.00
5.00 Did total beds available change from the prior cost repor-	ting period? If	yes, see inst	ructions.	N	15.00
	Par	rt A	Par	тВ	
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
6.00 Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see	Y	04/10/2018	Y	04/10/2018	16.00
instructions) 7.00 Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17.00
either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 8.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	N		N		18.00
but are not included on the PS&R Report used to file this cost report? If yes, see instructions. 9.00 If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
Report data for corrections of other PS&R Report information? If yes, see instructions.					

Health Financial Systems

GREENE	COUNTY	GENERAL	HOSPI TAL

In Lieu of Form CMS-2552-10

	Filialicial Systems GREENE COUNT G					
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2017 Fo 12/31/2017	Worksheet S Part II Date/Time P 5/30/2018 10	repared:
		Descri	ption	Y/N	Y/N	
		(	)	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	HOSPI TALS)			
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	ee instructions			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	e due to apprais	sals made duri	ng the cost	Ν	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	red into during	this cost rep	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during instructions.	g the cost repo	rting period?	lfyes, see	Ν	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during 1 instructions.	the cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during the copy.	yes, submit	Ν	27.00		
	Interest Expense				<u>.</u>	
28.00	Were new loans, mortgage agreements or letters of credit e period? If yes, see instructions.	Ν	28.00			
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	serve Fund)	Y	29.00		
30.00	Has existing debt been replaced prior to its scheduled mat	see	Ν	30.00		
31.00	instructions. Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes,	see	Ν	31.00
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care se	orvicos furnish	od through con	tractual	N	32.00
	arrangements with suppliers of services? If yes, see instr	ructions.	0			
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.	ppiled pertainin	ng to competit	ive bidding? Ii	Γ Ν	33.00
	Provi der-Based Physi ci ans					
	Are services furnished at the provider facility under an a If yes, see instructions.	0			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended exphysicians during the cost reporting period? If yes, see i		nts with the p	rovi der-based	Ν	35.00
				Y/N 1.00	Date 2.00	
	Home Office Costs				2.00	
36.00	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	prepared by the	home office?	N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year er	ffice different	from that of	Ν		38.00
39.00	If line 36 is yes, did the provider render services to oth			Ν		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	lf yes, see	Ν		40.00
	instructions.					
		1.	00	2.	00	
	Cost Report Preparer Contact Information					41.00
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	by the cost report preparer in columns 1, 2, and 3,				
40	respectively.	BKD, LLP				
42.00	Enter the employer/company name of the cost report preparer.		42.00			
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-383-3787		BBRANDENBURG@B	KD. COM	43.00

Heal th	Financial Systems GREENE COUN	TY GE	ENERAL HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	E	Provi der CCN: 15-1317	Period: From 01/01/2017	Worksheet S-2 Part II	
				To 12/31/2017		pared: <u>38 am</u>
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	۱	PARTNER			41.00
	held by the cost report preparer in columns 1, 2, and	3,				
	respectively.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the co	ost				43.00
	report preparer in columns 1 and 2, respectively.					

	Financial Systems GR AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	EENE COUNTY GE	Provider C		Period:	u of Form CMS-2 Worksheet S-3	
HUSPII	AL AND HUSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C		From 01/01/2017	Part I	
					To 12/31/2017	Date/Time Pre	
						5/30/2018 10:	<u>38 am</u>
						I/P Days /	
						0/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	component	Line Number	NO. OI DEUS	Avai I abl e	CAIT HOULS	nue v	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		20			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, 30	50, 496. 00	0	7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31.00	5	1, 82	5 5, 424. 00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00				0	12.00
13.00 14.00	NURSERY	43.00	25	9, 12	5 55, 920. 00	0	13.00 14.00
14.00	Total (see instructions) CAH visits		25	9,12	5 55, 920. 00	0	14.00
16.00	SUBPROVIDER - IPF					0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
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	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		C		32.00
32.01	Total ancillary labor & delivery room						32.01
<u> </u>	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges				1		33.01

HOSPI 1	Financial Systems GR AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	<u>EENE COUNTY GEN</u> AL DATA	Provider CC		Period: From 01/01/2017	u of Form CMS-2 Worksheet S-3 Part I	
					To 12/31/2017	Date/Time Pre 5/30/2018 10:	
		I/P Days	/ O/P Visits	/ Trips	Full Time I	qui val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 191	55	2, 10	4		1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2.00	for the portion of LDP room available beds) HMO and other (see instructions)	20	0				2.00
2.00	HMO IPF Subprovider	28 0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF	433	0	43	3		5.00
6.00	Hospital Adults & Peds. Swing Bed SM	400	0		0		6.00
7.00	Total Adults and Peds. (exclude observation	1, 624	55	2, 53	7		7.00
	beds) (see instructions)	1,021		2,00			
8.00	INTENSIVE CARE UNIT	195	0	22	6		8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		155	17	6		13.00
14.00	Total (see instructions)	1, 819	210	2, 93	9 0.00	246.64	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER – I PF						16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSI NG FACI LI TY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	0	0		0		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	0	0		0.00	0.00	26.00
26.25 27.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	0	0		0 0.00 0.00	246.64	
28.00	Observation Bed Days		205	1, 12		240.04	27.00
28.00	Ambulance Trips	0	205	1, 12			28.00
30.00	Employee discount days (see instruction)	U			0		30.00
31.00	Employee discount days (see first detroit)				0		31.00
32.00	Labor & delivery days (see instructions)	0	51	5	-		32.00
32.00	Total ancillary labor & delivery room	۲ ۱	51		0		32.00
52.01	outpatient days (see instructions)						02.01
33.00	LTCH non-covered days	О					33.00
	LTCH site neutral days and discharges	o					33.01

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-1317	Period: From 01/01/2017 To 12/31/2017	Worksheet S-3 Part I Date/Time Pre 5/30/2018 10:	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 24.\ 10\\ 22.\ 00\\ 23.\ 00\\ 24.\ 10\\ 25.\ 00\\ 24.\ 10\\ 25.\ 00\\ 26.\ 02\\ 26.\ 00\\ 28.\ 00\\ 29.\ 00\\ 30.\ 00\\ \end{array}$	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IPF Subprovider Hospital Adults & Peds. Swing Bed NF Total Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSI VE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction)	0.00	0	4:	31     84       9     0       00     0       31     84	819	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.10 25.00 26.00 26.05 27.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 26.00 27.00 20.0
31.00 32.00 32.01 33.00 33.01	Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		31.00 32.00 32.01 33.00 33.01

Health Financial Systems GREENE COUNTY GENERAL HO	ISPITAL		In Lie	u of Form CMS-2	2552-10				
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Prov	ider CCN: 15-1		eri od:	Worksheet S-1	0				
		To	rom 01/01/2017 0 12/31/2017	Date/Time Pre 5/30/2018 10:					
				1.00					
Uncompensated and indigent care cost computation				1.00					
1.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 divider	d by line 202	col umn	8)	0. 297169	1.00				
Medicaid (see instructions for each line)	<b>_</b>								
2.00 Net revenue from Medicaid				2, 269, 741	2.00				
3.00 Did you receive DSH or supplemental payments from Medicaid?		Y	3.00						
4.00 If line 3 is yes, does line 2 include all DSH and/or supplemental	d?	N 1, 251, 510	4.00 5.00						
5.00 [If line 4 is no, then enter DSH and/or supplemental payments from 1 6.00 [Medicaid charges	5.00 If line 4 is no, then enter DSH and/or supplemental payments from Medicaid								
5	5								
8.00 Difference between net revenue and costs for Medicaid program (line	e 7 minus sum	ofline	s 2 and 5 if	4, 405, 161 883, 910	7.00 8.00				
< zero then enter zero)		or rrne			0.00				
Children's Health Insurance Program (CHIP) (see instructions for ea	ach line)								
9.00 Net revenue from stand-alone CHIP				0	9.00				
10.00 Stand-alone CHIP charges				0	10.00				
11.00 Stand-alone CHIP cost (line 1 times line 10)	- 11	0 : 6		0	11.00				
12.00 Difference between net revenue and costs for stand-alone CHIP (line enter zero)	e ii minus ii	ne 9; IT	< zero then	0	12.00				
Other state or local government indigent care program (see instruc	tions for eac	h line)		I					
13.00 Net revenue from state or local indigent care program (Not include				0	13.00				
14.00 Charges for patients covered under state or local indigent care pro	ogram (Not in	cl uded i	n lines 6 or	0	14.00				
15.00 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 indiger	nt care progr	am (line	15 minus line	0	16.00				
13; if < zero then enter zero)									
Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	nd state/local	l indige	nt care progra	ams (see					
instructions for each line) 17.00 Private grants, donations, or endowment income restricted to fundi	ng charity ca	re		0	17.00				
18.00 Government grants, appropriations or transfers for support of hosp				0	18.00				
19.00 Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)	digent care p	rograms	(sum of lines	883, 910	19.00				
		sured	Insured	Total (col. 1					
		ents	patients	+ col . 2)					
Uncompensated Care (see instructions for each line)	I.	00	2.00	3.00					
20.00 Charity care charges and uninsured discounts for the entire facili	tv	255, 166	0	255, 166	20.00				
(see instructions)	- ,		-						
21.00 Cost of patients approved for charity care and uninsured discounts instructions)	(see	75, 827	0	75, 827	21.00				
22.00 Payments received from patients for amounts previously written off charity care	as	0	0	0	22.00				
		75, 827	0	75, 827	23.00				
23.00 Cost of charity care (line 21 minus line 22)			-						
23.00 Cost of charity care (line 21 minus line 22)				1.00					
	avs beyond a	length o	f stav limit	1.00					
24.00 Does the amount on line 20 column 2, include charges for patient da		length o	f stay limit	1.00					
<ul> <li>24.00 Does the amount on line 20 column 2, include charges for patient data imposed on patients covered by Medicaid or other indigent care propared.</li> <li>25.00 If line 24 is yes, enter the charges for patient days beyond the indicated of the second second</li></ul>	gram?	•	-	1.00	24.00				
24.00 Does the amount on line 20 column 2, include charges for patient due imposed on patients covered by Medicaid or other indigent care prov	gram? ndigent care	•	-		24.00 25.00				
24.00 Does the amount on line 20 column 2, include charges for patient daimposed on patients covered by Medicaid or other indigent care pro- 25.00 If line 24 is yes, enter the charges for patient days beyond the instay limit	gram? ndigent care ctions)	program'	-	0	24.00 25.00 26.00				
<ul> <li>24.00 Does the amount on line 20 column 2, include charges for patient d. imposed on patients covered by Medicaid or other indigent care provided to the stay limit.</li> <li>26.00 Total bad debt expense for the entire hospital complex (see instruction).</li> <li>27.00 Medicare reimbursable bad debts for the entire hospital complex (see instruction).</li> </ul>	gram? ndigent care ctions) ee instructio	program'	-	0 4, 296, 991 689, 911 1, 061, 402	24.00 25.00 26.00 27.00 27.01				
<ul> <li>24.00 Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care provided of the stay limit.</li> <li>26.00 Total bad debt expense for the entire hospital complex (see instruction) Medicare reimbursable bad debts for the entire hospital complex (see 28.00 Non-Medicare bad debt expense (see instructions)</li> </ul>	gram? ndigent care ctions) ee instruction instructions)	program' ns)	-	0 4, 296, 991 689, 911 1, 061, 402 3, 235, 589	24.00 25.00 26.00 27.00 27.01 28.00				
<ul> <li>24.00 Does the amount on line 20 column 2, include charges for patient day imposed on patients covered by Medicaid or other indigent care provements of the stay limit.</li> <li>25.00 If line 24 is yes, enter the charges for patient days beyond the instay limit.</li> <li>26.00 Total bad debt expense for the entire hospital complex (see instruction).</li> <li>27.00 Medicare reimbursable bad debts for the entire hospital complex (see 128.00 Non-Medicare bad debt expense (see instructions).</li> <li>29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense.</li> </ul>	gram? ndigent care ctions) ee instruction instructions)	program' ns)	-	0 4, 296, 991 689, 911 1, 061, 402 3, 235, 589 1, 333, 008	24.00 25.00 26.00 27.00 27.01 28.00 29.00				
<ul> <li>24.00 Does the amount on line 20 column 2, include charges for patient days imposed on patients covered by Medicaid or other indigent care provided of the stay limit</li> <li>25.00 If line 24 is yes, enter the charges for patient days beyond the instay limit</li> <li>26.00 Total bad debt expense for the entire hospital complex (see instruction)</li> <li>27.00 Medicare reimbursable bad debts for the entire hospital complex (see 128.00 Non-Medicare bad debt expense (see instructions)</li> </ul>	gram? ndigent care ctions) ee instruction instructions) e (see instru	program' ns)	-	0 4, 296, 991 689, 911 1, 061, 402 3, 235, 589	24.00 25.00 26.00 27.00 27.01 28.00 29.00 30.00				

Heal th	Financial Systems GR	EENE COUNTY GENE	RAL HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider C		Peri od:	Worksheet A	
					From 01/01/2017 To 12/31/2017	Data /Tima Dra	norod.
					10 12/31/2017	Date/Time Pre 5/30/2018 10:	
	Cost Center Description	Sal ari es	Other	Total (col.	I Reclassi fi cat		
	···· · · · · · · · · · · · · · · · · ·			+ col. 2)	ions (See	Trial Balance	
				,	A-6)	(col. 3 +-	
						col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS				-		
1.00	00100 CAP REL COSTS-BLDG & FIXT		990, 399				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		431, 897				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 058, 899				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 604, 575	3, 149, 090				5.00
7.00	00700 OPERATION OF PLANT	502, 486	1, 353, 027				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	0	307, 024				8.00
9.00	00900 HOUSEKEEPI NG	389, 228	96, 301				9.00
10.00	01000 DI ETARY	522, 820	539, 466				
11.00		0	150 120		0 942, 566		
13.00	01300 NURSI NG ADMI NI STRATI ON	768, 176	150, 139				•
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	20, 973			,	
	01600 MEDICAL RECORDS & LIBRARY	508, 459	17, 547	526,00		,	•
16.00 17.00	01700 SOCIAL SERVICE	240, 225 263, 362	25, 439 41				
17.00	01900 NONPHYSICIAN ANESTHETISTS	203, 302	41	263, 40	0 461, 396		
19.00	INPATIENT ROUTINE SERVICE COST CENTERS	U	0		401, 390	461, 396	19.00
30, 00	03000 ADULTS & PEDIATRICS	2, 202, 487	155, 620	2, 358, 10	7 369, 546	2, 727, 653	30,00
30.00	03100 I NTENSI VE CARE UNI T	491, 970	34, 328				•
43.00	04300 NURSERY	315	0, 520				43.00
45.00	ANCI LLARY SERVI CE COST CENTERS	515	0	1 31	5 02, 517	02,032	45.00
50.00	05000 OPERATING ROOM	376, 280	148, 547	524, 82	7 0	524, 827	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	57, 923				52.00
53.00	05300 ANESTHESI OLOGY	0	485, 458				•
54.00	05400 RADI OLOGY-DI AGNOSTI C	934, 643	770, 752				
60.00	06000 LABORATORY	865, 883	1, 429, 246				
65.00	06500 RESPI RATORY THERAPY	568, 064	38, 194	606, 25	8 0	606, 258	65.00
66.00	06600 PHYSI CAL THERAPY	330, 176	30, 237	360, 41	3 0	360, 413	66.00
67.00	06700 OCCUPATI ONAL THERAPY	157, 441	1, 877	159, 31	8 0	159, 318	67.00
68.00	06800 SPEECH PATHOLOGY	16, 759	37	16, 79	6 0	16, 796	68.00
69.00	06900 ELECTROCARDI OLOGY	0	11, 529	11, 52	9 0	11, 529	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	788, 740	788, 74	0 0	788, 740	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	229, 171	1, 249, 068	1, 478, 23	9 0	1, 478, 239	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	1, 127, 540	649, 192	1, 776, 73	2 0	1, 776, 732	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	1		1	Т	I	
118.00		12, 100, 060	15, 990, 990	28, 091, 05	0 171, 392	28, 262, 442	118.00
	NONREI MBURSABLE COST CENTERS			1	-1		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	753, 817	422				
	07950 FOUNDATION / MOBS	10 050 077	0		0 256, 889		•
200.00	TOTAL (SUM OF LINES 118 through 199)	12, 853, 877	15, 991, 412	28, 845, 28	9 0	28, 845, 289	200.00

ealth Financial Systems GF RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (		NERAL HOSPITAL Provider CCN: 15-13	In Lieu of Form ( 317 Period: Worksheet	
			From 01/01/2017	
			To 12/31/2017 Date/Time 5/30/2018	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
	6.00	7.00		
GENERAL SERVICE COST CENTERS	I			
I. 00 00100 CAP REL COSTS-BLDG & FIXT	-154, 576			1.0
2.00 00200 CAP REL COSTS-MVBLE EQUIP	-118, 046			2.0
1. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	256, 889			4. (
5. 00 00500 ADMINI STRATI VE & GENERAL	-1, 338, 241	3, 288, 299		5.0
7.00 00700 OPERATION OF PLANT	-173, 072	1, 682, 441		7.0
3. 00 00800 LAUNDRY & LINEN SERVICE	0	307,024		8.0
2.00 00900 HOUSEKEEPI NG	0			9. (
0. 00 01000 DI ETARY	0	119, 720		10.0
1.00 01100 CAFETERI A	-360, 784	581, 782		11. (
3. 00 01300 NURSING ADMINISTRATION	0	918, 315		13.0
4. 00 01400 CENTRAL SERVICES & SUPPLY	0	20, 973		14.0
5.00 01500 PHARMACY	0	526, 006		15.
6.00 01600 MEDICAL RECORDS & LIBRARY	-6, 166			16.0
7.00 01700 SOCIAL SERVICE	0	263, 403		17.0
9.00 01900 NONPHYSI CI AN ANESTHETI STS	-218, 520	242, 876		19.0
INPATIENT ROUTINE SERVICE COST CENTERS	110.151			
30. 00 03000 ADULTS & PEDIATRICS	-443, 651	2, 284, 002		30.0
31.00 03100 INTENSIVE CARE UNIT	0			31.0
13.00 04300 NURSERY	0	62, 832		43.0
ANCI LLARY SERVI CE COST CENTERS		504.007		
50. 00 05000 OPERATING ROOM	0			50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0			52.
3.00 05300 ANESTHESI OLOGY	0	24,062		53.
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 705, 395		54.
00.00 06000 LABORATORY	-163, 650			60.0
55.00 06500 RESPI RATORY THERAPY	0	606, 258		65.
6. 00 06600 PHYSI CAL THERAPY	-136			66.0
07.00 06700 OCCUPATIONAL THERAPY	0	159, 318		67.
08.00 06800 SPEECH PATHOLOGY	0	16, 796		68.
99.00 06900 ELECTROCARDI OLOGY	0			69.0
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0			71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.0
73.00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0	1, 478, 239		73.0
	0	1 774 722		01
21.00 09100 EMERGENCY 22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 776, 732		91.0
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS	l			92.0
	-2, 719, 953	25 542 480		118.0
	-2, /19, 953	25, 542, 489		118.0
NONREI MBURSABLE COST CENTERS	2			100
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190.
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.
194.00 07950 FOUNDATION / MOBS	0	256, 889		194.
00.00   TOTAL (SUM OF LINES 118 through 199)	-2, 719, 953	26, 125, 336		200.

Heal th	Financial Systems	GR	EENE COUNTY GEN	ERAL HOSPITAL		In Lieu	u of Form CMS-	2552-10
RECLAS	SSI FI CATI ONS			Provider C	CN: 15-1317	Peri od:	Worksheet A-	5
						From 01/01/2017		
						To 12/31/2017	Date/Time Pre 5/30/2018 10:	epared:
		Increases					0/ 30/ 2010 10.	<u>50 uiii</u>
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
	A - CRNA RECLASS							
1.00	NONPHYSI CI AN ANESTHETI STS	19.00	0	461, 396				1.00
	0			461, 396				
	B - LABOR & DELIVERY							
1.00	DELIVERY ROOM & LABOR ROOM	52.00	36, 468	0				1.00
	0		36, 468	0				
	C - DIETARY RECLASS							
1.00	CAFETERI A	11.00	463, 898	478, 668				1.00
	0		463, 898	478, 668				
	E - INSURANCE RECLASS	· ·	<u>.</u>					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	46, 587				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 394				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	78, 144				3.00
	0		0	127, 125				1
	F - OB RECLASS							]
1.00	ADULTS & PEDIATRICS	30.00	0	40, 250				1.00
	0		0	40, 250				
	H - RELATED PARTIES RECLASS							]
1.00	FOUNDATION / MOBS	194.00	0	256, 889				1.00
	0		0	256, 889				
	I - HOSPITALIST RECLASS							
1.00	ADULTS & PEDIATRICS	30.00	428, 281	0				1.00
	TOTALS		428, 281	0				
	J - NURSERY RECLASS							
1.00	NURSERY	43.00	62, 517	0				1.00
	TOTALS		62, 517	0				
500.00	) Grand Total: Increases		991, 164	1, 364, 328				500.00
		•	•					

Heal th	Financial Systems	GR	EENE COUNTY GEN	ERAL HOSPITA	L	In Lieu	u of Form CMS-2552-1
RECLASS	SI FI CATI ONS			Provi der (	CCN: 15-1317	Peri od:	Worksheet A-6
						From 01/01/2017 To 12/31/2017	Date/Time Prepared 5/30/2018 10:38 am
		Decreases					
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Rei	<u>.</u>	
	6.00	7.00	8.00	9.00	10.00		
	A – CRNA RECLASS						
1.00	ANESTHESIOLOGY	53.00	0	46 <u>1, 3</u> 96		Q	1.0
	0		0	461, 396	)		
	B - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30. 00	36, 468	0	)	0	1.0
	0		36, 468	0			
	C – DIETARY RECLASS						
1.00	DI ETARY	<u> </u>	<u>463, 8</u> 98	47 <u>8, 6</u> 68		0	1.0
	0		463, 898	478, 668			
	E - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	127, 125	-	12	1.0
2.00		0.00	0	C	-	12	2.0
3.00		0.00	0	C		0	3.0
	0		0	127, 125		7	
	F - OB RECLASS					·	
1.00	DELIVERY ROOM & LABOR ROOM	52.00	0	40, 250		0	1.0
	0			40, 250		7	
	H - RELATED PARTIES RECLASS	· · · · · ·					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	256, 889		0	1.0
	0		0	256, 889		7	
	I - HOSPITALIST RECLASS						
1.00	PHYSICIANS' PRIVATE OFFICES	192.00	428, 281	C	)	0	1.0
	TOTALS		428, 281	o		7	
	J - NURSERY RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	62, 517	C		0	1.0
	TOTALS		62, 517	o		1	
500 00	Grand Total: Decreases		991, 164	1, 364, 328			500.0

Health Financial Systems         GREENE COUNTY GENERAL HOSPITAL         In Lieu of For           RECONCILIATION OF CAPITAL COSTS CENTERS         Provider CCN: 15-1317         Period:         Workshe		
From 01/01/2017 Part I To 12/31/2017 Date/Ti	me Pre	pared:
5/30/20	18 10: .	<u>38 am</u>
Beginning Purchases Donation Total Disposal	s and	
Balances Retirer		
1.00 2.00 3.00 4.00 5.0	)	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		
1.00 Land 651,198 0 0 0	0	1.00
2.00 Land Improvements 335, 729 0 0 0	0	2.00
3.00 Buildings and Fixtures 7, 117, 370 460, 425 0 460, 425	0	3.00
4.00 Building Improvements 0 0 0 0	0	4.00
5.00 Fixed Equipment 3,697,952 0 0 0	5,641	5.00
6.00 Movable Equipment 2, 334, 434 87, 100 0 87, 100	0	6.00
7.00 HIT designated Assets 1,062,388 0 0 0	0	7.00
8.00 Subtotal (sum of Lines 1-7) 15, 199, 071 547, 525 0 547, 525	5,641	8.00
9.00 Reconciling Items 0 0 0 0	0	9.00
10.00 Total (line 8 minus line 9) 15, 199, 071 547, 525 0 547, 525	5,641	10.00
Ending Fully		
Bal ance Depreciated		
Assets		
6.00 7.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES		
1.00 Land 651,198 0		1.00
2.00 Land Improvements 335,729 0		2.00
3.00 Buildings and Fixtures 7, 577, 795 0		3.00
4.00 Building Improvements 0 0		4.00
5.00 Fixed Equipment 3,692,311 0		5.00
6.00 Movable Equipment 2, 421, 534 0		6.00
7.00 HIT designated Assets 1,062,388 0		7.00
8.00 Subtotal (sum of lines 1-7) 15,740,955 0		8.00
9.00 Reconciling Items 0 0		9.00
10.00   Total (line 8 minus line 9) 15,740,955 0		10.00

Heal th	Financial Systems G	REENE COUNTY GE	NERAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		eriod:	Worksheet A-7	
					rom 01/01/2017 o 12/31/2017	Part II Date/Time Pre	narod
				1	0 12/31/2017	5/30/2018 10:	
			SL	JMMARY OF CAPIT	AL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					(see	instructions)	
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR				-	-	
1.00	CAP REL COSTS-BLDG & FIXT	644, 032		346, 367	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	431, 897		0	0	0	2.00
3.00	Total (sum of lines 1-2)	1,075,929		346, 367	0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at					
		ed Costs (see	9 through 14)				
		instructions)	-				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLU	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	990, 399	•			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	431, 897				2.00
3.00	Total (sum of lines 1-2)	0	1, 422, 296				3.00

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2017 To 12/31/2017		pared:
	COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio	instructions)		
			(col. 1 -			
	1.00	2.00	<u>col.2)</u> 3.00	4,00	5,00	
PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	5.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FLXT	13, 319, 421	0	13, 319, 421	0. 846163	0	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	2, 421, 534		2, 421, 534			2.00
3.00 Total (sum of lines 1-2)	15, 740, 955		15, 740, 955		0	3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPI TAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel at	cols. 5			
		ed Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C			1 -	100.151		
1.00 CAP REL COSTS-BLDG & FIXT	0	, o		489, 456		1.00
2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		) 313, 851 803, 307	0	2.00 3.00
3.00   TOTAL (SUM OF TIMES T-2)	0		JMMARY OF CAPI		0	3.00
		50				
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	10.00	10.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
1.00 CAP REL COSTS-BLDG & FIXT	346, 367	46, 587			882, 410	1.00
2.00 CAP REL COSTS-BEDG & TTXT	0			-	316, 245	2.00
3.00 Total (sum of lines 1-2)	346, 367			-	1, 198, 655	3.00
	,,	,			.,,	

supplies to other than patients00.0017.00Sale of drugs to other than patients00.0018.00Sale of medical records and abstractsB-6, 166 MEDICAL RECORDS & LIBRARY16.0018.00Sale of medical records and abstractsB-6, 166 MEDICAL RECORDS & LIBRARY16.00019.00Nursing and allied health education (tuition, fees, books, etc.)00.000020.00Vending machinesB-2, 106 CAFETERIA11.000021.00Income from imposition of interest, finance or penalty charges (chapter 21)000.00020.01Interest expression Medicare overpayments and borrowings to repay Medicare overpayments therapy costs in excess of limitation (chapter 14)00023.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-300024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-300+** Cost Center Deleted ***114.0025.00Uperciation - CAP REL COSTS-BLDG & FIXT to operciation - CAP REL COSTS-MUBLE EQUIP000026.00Physicians' compensation (chapter 21)0000026.00Operciation - CAP REL COSTS-MUBLE EQUIP0000029.00Physicians' assistant o therapy costs in excess of limitation (chapter 14)00000 <td< th=""><th>Heal th</th><th>Financial Systems</th><th>GR</th><th>REENE COUNTY GE</th><th>ENERAL HOSPITAL</th><th>In Lie</th><th>u of Form CMS-2</th><th>2552-10</th></td<>	Heal th	Financial Systems	GR	REENE COUNTY GE	ENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
Total          Total <th< th=""><th>ADJUST</th><th>MENTS TO EXPENSES</th><th></th><th></th><th>Provider CCN: 15-1317</th><th></th><th>Worksheet A-8</th><th></th></th<>	ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1317		Worksheet A-8	
Cost Center Description         Basis/Oute (2)         Amount         Cost Center         Line #         Mksit. A-7           1.00         Trevesiment income - CAP REL (2)         2.00         -0.00         4.00         4.00         5.00           2.00         Immediate Low PC (Apple P)         0.00         0.00         4.00         0.00						From 01/01/2017 To 12/31/2017		
(2)         3.00         4.00         5.00           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0.04 APREL COSTS-BLDG & FIXT         1.00         0.00           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0.00         0.00         0           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0.00         0.00         0           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0.00         0.00         0           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0         0.00         0           1.00         Investment income - GAP REL 00         0.00         0.00         0           1.00         Refunds and rebates of sequences (chapter 8)         0         0.00         0.00         0           1.00         Fations and under) (chapter 21)         0         0.00         0.00         0           1.00         Fations and under) chapter 21)         0         0.00         0.00         0           1.00         Fations and under and 1.00         Fations and under and 1.00         0.00         0.00         0         0.00         0           1.00         Gaternet 3)         0         0         0.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
(2)         3.00         4.00         5.00           1.00         Investment i noove - CAP REL 1.00         0.00 (AP REL COSTS-BLDG & FIXT         1.00         0.00           2.00         COSTS-MULE EQUIP         0.00 (AP REL COSTS-MULE EQUIP         2.00         0           3.00         CostS-MULE EQUIP         0.00 (AP REL COSTS-MULE EQUIP         2.00         0           3.00         CostS-MULE EQUIP         0.00 (AP REL COSTS-MULE EQUIP         2.00         0           4.00         Todds quartity, and time         0         0.00 (AP REL COSTS-MULE EQUIP         2.00           5.00         Refunds and reabres of expenses (Chapter 1)         0         0.00 (AP REL COSTS-MULE EQUIP         0.00 (AP REL COSTS-MULE EQUIP           6.00         Bental of provider space by staptiers (Chapter 2)         0         0.00 (AP REL COSTS-MULE EQUIP         0.00 (AP REL COSTS-MULE EQUIP           7.00         Stations and radio service         0         0.00 (AP REL COSTS-MULE EQUIP         0.00 (AP REL COSTS-MULE EQUIP           8.00         Television and radio service         0         0.00 (AP REL COSTS-MULE EQUIP         0.00 (AP REL COSTS-MULE EQUIP           9.00         Fishight (AP REL COSTS-MULE EQUIP         0.00 (AP REL COSTS-MULE EQUIP         0.00 (AP REL COSTS-MULE EQUIP           10.00         CostSectore (AP REL COSTS-MULE								
(2)         3.00         4.00         5.00           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0.04 APREL COSTS-BLDG & FIXT         1.00         0.00           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0.00         0.00         0           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0.00         0.00         0           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0.00         0.00         0           1.00         Investment income - GAP REL 00575-WELE EQUP (chapter 2)         0         0.00         0           1.00         Investment income - GAP REL 00         0.00         0.00         0           1.00         Refunds and rebates of sequences (chapter 8)         0         0.00         0.00         0           1.00         Fations and under) (chapter 21)         0         0.00         0.00         0           1.00         Fations and under) chapter 21)         0         0.00         0.00         0           1.00         Fations and under and 1.00         Fations and under and 1.00         0.00         0.00         0         0.00         0           1.00         Gaternet 3)         0         0         0.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
1.00         Investment income - CAP BFL         0 CAP RFL COSTS-BLRG & FLXT         1.00         0           2.00         Investment income - CAP BFL         0 CAP RFL COSTS-BLRG & FLXT         1.00         0           2.01         Investment income - CAP BFL         0 CAP RFL COSTS-AURE FOULP         2.00         0           2.02         Investment income - CAP BFL         0 CAP RFL COSTS-AURE FOULP         2.00         0           2.03         Investment income - CAP BFL         0 CAP RFL COSTS-AURE FOULP         2.00         0           2.04         Trade, quantity, and time         0         0.00         0         0           3.00         Refunds and relates of         0         0.00         0		Cost Center Description	(2)				Ref.	
20STS-BLIDS & FLYT (chapter 2)         0CAP REL COSTS-MVBLE EDUIP         2.00         0           3.00         COSTS-MVBLE EDUIP (chapter 2)         0         0.00         0           3.00         Investment 1 nome - other         0         0.00         0           4.00         Transfer 7)         0         0.00         0           5.00         Refunds and rebates of expenses (chapter 1)         0         0.00         0           6.00         Rental of provider space by 0         0         0         0         0           7.00         Stations oxclude() (chapter 2)         A         -1.827 ADMINISTRATIVE & GENERAL 5.00         0           8.00         Tolevision and radio service (chapter 21)         0         0.00         0         0           9.00         Parking 1ot (chapter 21)         A-8-2         -431.407         0         0         0           10.00         Sate of scrap, waste, etc. (chapter 2)         0         0         0         0         0         0         0         0           10.00         Sate of scrap, waste, etc. (chapter 10)         0         0         0         0         0         0         0         0         0         0         0         0         0         <	1 00	Investment income CAD DEL	1.00					1.00
00STS_MMELE EQUP (chapter 2)         0         0.00         0.00           01         Trade, quantity, and the         0         0.00         0.00           0.00         Refuncts and relative of exponency expo		COSTS-BLDG & FIXT (chapter 2)						
Chapter 2)         Chapter 2)         0         0         0         0           1 acounts (chapter 8)         0         0         0         0         0           5.00         Refinitions and relates of         0         0         0         0         0           6.00         supports (chapter 8)         0         0         0         0         0           7.00         Telephone services (pay stations excluded) (chapter 2)         0 <t< td=""><td>2.00</td><td>COSTS-MVBLE EQUIP (chapter 2)</td><td></td><td>0</td><td>CAP REL COSTS-MVBLE EQUIP</td><td>2.00</td><td>0</td><td>2.00</td></t<>	2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
4.00       Trade, quantity, and time       0       0.00       0         6.00       Refunds and rebates of       0       0.00       0         6.00       Refunds and rebates of       0       0.00       0         7.00       Topping (Chapter 9)       A       -1,827 ADM NI STRATIVE & GENERAL       5.00       0         7.00       Television and radio service (chapter 21)       0       0.00       0       0         8.00       Derking 1ot (chapter 21)       0       0.00       0       0         9.00       Parking 1ot (chapter 21)       0       0.00       0       0         10.01       Portion set of scrap, waste, etc.       0       0.00       0       0         11.00       Sel ated organization       A=8-1       0       0.00       0         12.00       Rental of guarters to engloyee       0       0.00       0       0         13.00       Laundry and I inen service       0       0.00       0       0         14.00       Cafeteria-engloyees and guasts       8       -558,678CAFETERIA       11.00       0         15.00       Rental of aureters to engloyee       0       0.00       0       0         15.00       Sa	3.00			0		0.00	0	3.00
5.00       Refunds and robates of supplices (chapter 8)       0       0       0       0         6.00       Rental of provider space by supplices (chapter 8)       0       0       0       0         7.00       Talephone services (pay st) instructule 0 (chapter 21)       0       0       0       0         8.00       Dervision and radio service (chapter 21)       0       0       0       0         9.00       Parking 1ct (chapter 21)       0       0       0       0         10.00       Provider-based physician       A-8-2       -431.497       0       0         11.00       Sale of scrap, waste, etc.       0       0       0       0       0         12.00       Rentation of scrap, waste, etc.       0       0       0       0       0         13.00       Laundry and linen service       0       0       0       0       0       0         14.00       Cafeter hann patients       0       0       0       0       0       0         17.00       Sale of medical records and supplication (thition, fees.       0       0       0       0       0         10.00       Variang and lined health end call records and supplicatin (thition, fees.       0       0 <td>4.00</td> <td>Trade, quantity, and time</td> <td></td> <td>0</td> <td></td> <td>0.00</td> <td>0</td> <td>4.00</td>	4.00	Trade, quantity, and time		0		0.00	0	4.00
6.00         Supplies (chapter 8)         0         0.00         0           7.00         Telephone services (pay stations excluded) (chapter 21)         0         0.00         0           8.00         Television and radio service         0         0.00         0           9.00         Provider base duided) (chapter 21)         0         0.00         0           9.00         Provider base duided         0         0.00         0           10.00         Parking lots (chapter 21)         0         0.00         0           11.00         Sale of screp, waste, etc.         0         0         0         0           10.00         Laudry and Line service         0         0         0         0         0           11.00         Cafteria =employees and guests         B         -358, 678(CAFETERIA         11.00         0           12.00         Narsing and allied health         0         0         0         0         0         0         0	5.00	Refunds and rebates of		0		0.00	0	5.00
7.00       Tai ophone services (pay 21)       A       -1.827ADMINISTRATIVE & GENERAL       5.00       0         8.07       Television and radio service       0       0.00       0         9.00       Parking 1ct (chapter 21)       0       0.00       0         9.00       Provider-based physician       A-8-2       -431,497       0       0.00       0         9.00       Provider-based physician       A-8-1       0       0.00       0         10.00       Schapter 23)       waste, etc.       0       0.00       0         10.00       Cardet organization       A-8-1       0       0.00       0         13.00       Landray and Linen service       0       0       0.00       0         14.00       Cafterria-employees and guests       8       -358, 678 CAFETERIA       11.00       0         15.00       Rental of quarters to employee       0       0.00       0       0       0         17.00       Sale of medical and surgical       0       0.00       0       0       0         17.00       Sale of medical and surgical       0       0       0.00       0       0       0       0       0       0       0       0       0<	6.00	Rental of provider space by		0		0.00	0	6.00
8.00       Television and radio service (chapter 21)       0       0.00       0         9.00       Parking 1 of (chapter 21)       0       0       0       0         10.00       Provider-based physician adjustment       A-8-2       -431,497       0       0         10.00       Sale of scrap, waste, etc.       0       0       0       0       0         10.00       Related organization transactions (chapter 10)       A-8-1       0       0.00       0         13.00       Landry and 11 nen service       0       0       0.00       0         14.00       Caffetria-engloyees and guests       B       -558, 678/CAFETERIA       11.00       0         14.00       Caffetria-engloyees and guests       B       -6, 166 MEDICAL RECORDS & LIBRARY       16.00       0         15.00       Sale of medical and surgical       0       0       0       0       0         17.00       Sale of medical records and adstracts       B       -6, 166 MEDICAL RECORDS & LIBRARY       16.00       0         18.00       Sale of medical and surgical       0       0       0       0         20.00       Income from imposition of interest, finance or penality interest, finance or penality interapy costs in excess of imprapy costs in excess of imati	7.00	Telephone services (pay stations excluded) (chapter	А	-1, 827	ADMI NI STRATI VE & GENERAL	5.00	0	7.00
9.00       Parking Lot (chapter 21)       0       0.00       0.00         10.00       Provider-based physician       A-8-2       -431,497       0       0       0         adjustment       0       0       0       0       0       0       0         10.00       Safe of scrap, waste, etc.       0       0       0       0       0         10.00       Canderdy and Line service       0       0       0       0       0         13.00       Landry and Line service       0       0       0       0       0         14.00       Cafeteria-employees and guests       8       -358,678/CAFETERIA       11.00       0       0         15.00       Bantal of quarters to employee       0	8.00	Television and radio service		0		0.00	0	8.00
adjustment       adjustment       adjustment         1.00       Side of Scrap, waste, etc. (chapter 23)       b       adjustment       0         12.00       Related organization       A-8-1       0       0         13.00       Laundry and I line service       0       0.00       0         14.00       Cafeteria-employees and guests       B       -358, 678CAFETERIA       11.00       0         16.00       Sale of medical and surgical and others       0       0.00       0       0         17.00       Sale of fredical records and abstracts       B       -6.166MEDICAL RECORDS & LIBRARY       16.00       0         18.00       Sale of medical records and abstracts       B       -2.106CAFETERIA       11.00       0         19.00       Wending machines       B       -2.106CAFETERIA       11.00       0         21.00       Incerestry finance or penal ty charges (chapter 21)       0       0.00       0         22.00       Vending machines       B       -2.106CAFETERIA       11.00       0         23.00       Adjustment for orespiratory therapy costs in excess of Limitation (chapter 14)       A-8-3       0       0.00       0         24.00       Adjustment for orespinatory physici ans' compensation (Chapter 21)		Parking lot (chapter 21)		0		0.00	-	
(Chapter 23)       (Chapter 12)       (Chapter 12)       (Chapter 10)         12:00       Related organization       A-8-1       0       0         13:00       Laundry and I inen service       0       0.00       0         14:00       Cafeteria-employees and guests       B       -358, 678 CAFETERIA       11.00       0         15:00       Rental of quarters to employee       0       0.00       0       0         16:00       Sale of medical and surgical ents       0       0       0.00       0         17:00       Sale of fugis to other than patients       0       0.00       0       0         17:00       Sale of medical records and education (tuition, fees, book, etc.)       0       0.00       0       0         18:00       Sale of medical records and point in the education of tuition, fees, book, etc.)       0       0.00       0       0         10:00       Nursing and allied health       0       0       0.00       0       0         10:00       Nursing and allied health       0       0       0.00       0       0         20:00       Wending machines       B       -2.106 CAFETERIA       11.00       0       0       0         21:00       Interest e	10.00		A-8-2	-431, 497			0	10.00
12.00Related organization transactions (chapter 10)A-8-10013.00Laundry and Linen service of Low Section 2 (chapter 1)000.00014.00Cafeteria-employees and guests and othersB-358.678CAFETERIA11.00015.00Rental of quarters to employee and others00.000016.00Sale of medical and surgical supplies to other than patients00.000017.00Sale of medical records and abstractsB-6.166MEDICAL RECORDS & LIBRARY 016.00018.00Sale of medical records and abstractsB-6.166MEDICAL RECORDS & LIBRARY 016.00019.00Nursing and allied heal th education (tuition, fees, books, etc.)B-2.106CAFETERIA11.00020.00Income from imposition of interest, finance or penalty charges (chapter 21)000023.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-300024.00Adjustment for respiratory charges (chapter 21)A-8-3000025.00byperciation - CAP REL costs in excess of limitation (chapter 14)000025.00byperciation - CAP REL costs-aluon +	11.00			0		0.00	0	11.00
13. 00Laundry and Linen service00.00014. 00Cafeteriaemployees and guestsB-358, 678 CAFETERIA11.00015. 00Rental of quarters to employee00.000and others00.00016. 00Sale of medical and surgical00.000patients00.00017. 00Sale of drugs to other than00.000patients00.000018. 00Sale of medical records andB-6, 166 MEDICAL RECORDS & LIBRARY16.00019. 00Nursing and allied heal th00.0000eduction (tuition, fees, books, etc.)00.000020. 00Incerest, finance or penalty00.000charges (chapter 21)000.00023. 00Adjustment for respiratoryA-8-3000charges (chapter 14)000024. 00Adjustment for respiratoryA-8-300011. 10000000011. 11. 10100000025. 00Ndustment for respiratoryA-8-300011. 11. 11. 11. 11. 11. 11. 11. 11. 11.	12.00	Related organization	A-8-1	0			0	12.00
15.00Rental of quarters to employee00.000and others00.00016.00Sale of medical and surgical00.000supplies to other than00.000patients00.00017.00Sale of frugs to other than00.000abstracts00.00018.00Sale of medical records andB-6,166MEDICAL RECORDS & LIBRARY16.0019.00Nursing and allied health00.000education (tuition, fees, books, etc.)00.00020.00Vending machinesB-2,106CAFETERIA11.00021.00Income from imposition of overpayments and borrowings to therapy costs in excess of timitation (chapter 21)00.00022.00Valuement for physical therapy costs in excess of therapy costs in excess of timitation (chapter 14)0*** Cost Center Deleted ***114.0024.00Adjustment for physical til cast compensation (chapter 21)000025.00Verificas' assistant 0000026.00Depreciation - CAP REL costS-BUDG & FIXT00027.00Depreciation - CAP REL costS-MUBLE EQUIP00028.00NonPhysicians' assistant 0000029.00Physicia		Laundry and linen service		0			-	
16.00       Sale of medical and surgical patients to other than patients       0       0.00       0         17.00       Sale of fungs to other than patients       0       0.00       0         18.00       Sale of medical records and B       -6,166 MEDI CAL RECORDS & LI BRARY       16.00       0         19.00       Nursing and allied heal th old theal th       0       0.00       0         20.00       Vending machines       B       -2,10c CAFETERIA       11.00       0         21.00       Income from imposition of reces, books, etc.)       0       0.00       0       0         22.00       Interest, Finance or penal ty interest, Finance or penal ty compayments and borrowings to repay Medicare overpayments       0       0.00       0         22.00       Interest conserverpayments       A-8-3       0       0       0       0         23.00       Adjustment for physical       A-8-3       0       PHYSI CAL THERAPY       66.00       0         111 tation (chapter 14)       0       *** Cost Center Deleted ***       114.00       0         25.00       Utilization review - physical an Cost Second First       0       0       0         26.00       Depreciation - CAP REL COSTS-MUBLE EQUIP       2.00       0       0		Rental of quarters to employee		-358, 678 0	CAFETERIA		-	
17.00Sale of drugs to other than patients00.00018.00Sale of medical records and abstractsB-6,166 MEDI CAL RECORDS & LIBRARY16.00018.00Sale of medical records and abstractsB-6,166 MEDI CAL RECORDS & LIBRARY16.00019.00Nursing and allied health education (tuition, fees, books, etc.)000020.00Vending machinesB-2,106 CAFETERIA11.00020.00Increase represe on Medicare overpayments and borrowings to repay Medicare overpayments00023.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-300024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)0*** Cost Center Deleted ***114.0025.00Depreciation - CAP REL COSTS-BLDG & FIXT000026.00Depreciation - CAP REL COSTS-MUBLE EQUIP000026.00Physiciana' assistant o ONONPHYSICIAN ANESTHETISTS19.000029.00Physiciana' assistant imitation (chapter 14)000029.00Physiciana' assistant o o000030.00Physiciana' assistant imitation (chapter 14)000030.00Adjustment for occupational therapy costs in excess of limitation (chapter 14)00030.00Physiciana' assistan	16.00	Sale of medical and surgical supplies to other than		C		0.00	0	16.00
18.00Sale of medical records and abstracts books, etc.)B-6,166 MEDICAL RECORDS & LIBRARY16.00019.00Nursing and allied health education (tuition, fees, books, etc.)000.00020.00Vending machinesB-2,106 CAFETERIA11.00021.00Income from imposition of interest, finance or penal ty charges (chapter 21) therapy costs in excess of limitation (chapter 14)B-2,106 CAFETERIA11.00022.00Otherest expense on Medicare overpayments and borrowings to repay Medicare overpayments therapy costs in excess of limitation (chapter 14)A-8-30RESPI RATORY THERAPY65.0024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-30PHYSI CAL THERAPY66.0025.00Utilization review - physicians' compensation (CASTS-BLDG & FIXT0*** Cost Center Deleted ****114.0026.00Depreciation - CAP REL COSTS-MUBLE EQUIP0CAP REL COSTS-BLDG & FIXT1.00027.00Depreciation - CAP REL COSTS-MUBLE EQUIP0CAP REL COSTS-MVBLE EQUIP2.00029.00Physicians' assistant o ustant to no chapter 14)000029.00Physicians' assistant o therapy costs in excess of limitation (chapter 14)000029.00Physicians' assistant o therapy costs in excess of limitation (chapter 14)000029.00Physicians' assistant o limi	17.00	Sale of drugs to other than		0		0.00	0	17.00
19.00Nursing and allied health education (tuition, fees, books, etc.)00.00020.00Vending machinesB-2,106 (CAFETERIA11.00021.00Increest, finance or penality charges (chapter 21)000023.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-300024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-300025.00Utilization review - physicians' compensation (chapter 21)0*** Cost Center Deleted ***114.0026.00Depreciation - CAP REL COSTS-BLDG & FIXT0CAP REL COSTS-BLDG & FIXT1.00026.00Depreciation - CAP REL COSTS-MUBLE EQUIP0CAP REL COSTS-BLDG & FIXT1.00027.00Depreciation - CAP REL COSTS-MUBLE EQUIP0CAP REL COSTS-MUBLE EQUIP2.00028.00Non-physician Anesthetist O COSTS-WUBLE EQUIP000029.00Physicians' assistant o therapy costs in excess of limitation (chapter 14)000030.09Hospice (non-distinct) (see0ADULTS & PEDIATRICS30.000	18.00	Sale of medical records and	В	-6, 166	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
books, etc.)B-2, 106CAFETERIA11.00020.00Vending machinesB-2, 106CAFETERIA11.000021.00Income from imposition of interest, finance or penality charges (chapter 21)0000022.00Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments therapy costs in excess of limitation (chapter 14)0000024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-3 therapy costs in excess of limitation review - physicians' compensation (chapter 21)A-8-3 therapy costs in excess of limitation chapter 14)0*** Cost Center Deleted ***114.0026.00Depreciation - CAP REL COSTS-BLOG & FIXT0CAP REL COSTS-BLDG & FIXT to 00027.00Depreciation - CAP REL COSTS-MUBLE EQUIP0CAP REL COSTS-MUBLE EQUIP to 02.00028.00Non-physician Anesthetist to 0000029.00Physicians' assistant therapy costs in excess of limitation (chapter 14)00030.09Hospice (non-distinct) (see0000	19.00			0		0.00	0	19.00
20.00Vending machinesB-2,106CAFETERIA11.00021.00Incerefrom imposition of interest, finance or penality charges (chapter 21)000022.00Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments000023.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-3000024.00Adjustment for physical (charger 21)A-8-30000025.00Utilization review - physicians' compensation (chapter 21)0*** Cost Center Deleted ***114.00025.00Depreciation - CAP REL COSTS-BLDG & FIXT00**** Cost Center Deleted ***114.00027.00Depreciation - CAP REL COSTS-MUBLE EQUI P0CAP REL COSTS-MUBLE EQUI P00028.00Non-physician Anesthetist Usicians' assistant O0000030.09Hospice (non-distinct) (see00000030.99Hospice (non-distinct) (see0000000								
interest, finance or penal ty charges (chapter 21)0022.00Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments00.00023.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-30RESPIRATORY THERAPY65.0024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-30PHYSICAL THERAPY66.0025.00Utilization review - physicians' compensation (chapter 21)0*** Cost Center Deleted ***114.0026.00Depreciation - CAP REL COSTS-BLDG & FIXT0CAP REL COSTS-BLDG & FIXT1.00027.00Depreciation - CAP REL COSTS-MVBLE EQUIP0CAP REL COSTS-MVBLE EQUIP2.00028.00Non-physician Anesthetist UP nysicians' assistant do and sthetist0000030.00Adjustment for occupational therapy costs in excess of limitation (chapter 14)A-8-3000030.09Hospice (non-distinct) (see0ADULTS & PEDIATRICS30.0000		Vending machines	В	-2, 106	CAFETERI A		-	
22.00Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments00023.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-30RESPIRATORY THERAPY65.0024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-30PHYSICAL THERAPY66.0025.00Utilization review - physicians' compensation (chapter 21)0*** Cost Center Deleted ***114.0026.00Depreciation - CAP REL COSTS-BLDG & FIXT0CAP REL COSTS-BLDG & FIXT1.00027.00Depreciation - CAP REL COSTS-MUBLE EQUIP0CAP REL COSTS-BLDG & FIXT1.00028.00Non-physician Anesthetist 00000029.00Physicians' assistant therapy costs in excess of I imitation (chapter 14)A-8-3000030.00Adjustment for occupational therapy costs in excess of I imitation (chapter 14)A-8-3000030.99Hospice (non-distinct) (see000000		interest, finance or penalty					-	
23.00Adjustment for respiratory therapy costs in excess of limitation (chapter 14)A-8-3ORESPIRATORY THERAPY65.0024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-3OPHYSICAL THERAPY66.0025.00Utilization review - physicians' compensation (chapter 21)O*** Cost Center Deleted ***114.0026.00Depreciation - CAP REL COSTS-BLDG & FIXTOCAP REL COSTS-BLDG & FIXT1.00026.00Depreciation - CAP REL COSTS-BLDG & FIXTO CAP REL COSTS-BLDG & FIXT1.00027.00Depreciation - CAP REL COSTS-MVBLE EQUI POCAP REL COSTS-MVBLE EQUI P2.00028.00Non-physician Anesthetist therapy costs in excess of limitation (chapter 14)A-8-3OCCUPATI ONAL THERAPY67.0028.00Non-physician Anesthetist therapy costs in excess of limitation (chapter 14)A-8-3OCCUPATI ONAL THERAPY67.0030.09Hospice (non-distinct) (seeOADULTS & PEDI ATRICS30.000	22.00	Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
1 imitation (chapter 14)A-8-3O PHYSI CAL THERAPY66.0024.00Adjustment for physical therapy costs in excess of limitation (chapter 14)A-8-3O *** Cost Center Deleted ***114.0025.00Utilization review - physicians' compensation (chapter 21)O *** Cost Center Deleted ***114.0026.00Depreciation - CAP REL COSTS-BLDG & FIXTO CAP REL COSTS-BLDG & FIXT1.00O27.00Depreciation - CAP REL COSTS-MVBLE EQUIPO CAP REL COSTS-MVBLE EQUIP2.00O28.00Non-physician Anesthetist Ust cians' assistantO NONPHYSICIAN ANESTHETISTS19.00O29.00Physicians' assistant therapy costs in excess of limitation (chapter 14)A-8-3O OCCUPATIONAL THERAPY67.0030.99Hospice (non-distinct) (seeO ADULTS & PEDIATRICS30.00O	23.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
1 imitation (chapter 14)025.00Utilization review - physicians' compensation (chapter 21)26.00Depreciation - CAP REL COSTS-BLDG & FIXT26.00Depreciation - CAP REL COSTS-BLDG & FIXT27.00Depreciation - CAP REL COSTS-WVBLE EQUIP28.00Non-physician Anesthetist 029.00Physicians' assistant 030.00Adjustment for occupational therapy costs in excess of 1 imitation (chapter 14)30.99Hospice (non-distinct) (see	24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
physicians' compensation (chapter 21)physicians' compensation (chapter 21)26.00Depreciation - CAP REL COSTS-BLDG & FIXT0 CAP REL COSTS-BLDG & FIXT1.00027.00Depreciation - CAP REL 	25 00	limitation (chapter 14)			*** Cost Contor Dolotod ***	114.00		25.00
26.00Depreciation - CAP REL COSTS-BLDG & FIXT0027.00Depreciation - CAP REL COSTS-MVBLE EQUIP0CAP REL COSTS-BLDG & FIXT1.00027.00Depreciation - CAP REL COSTS-MVBLE EQUIP0CAP REL COSTS-MVBLE EQUIP2.00028.00Non-physician Anesthetist0NONPHYSICIAN ANESTHETISTS19.00029.00Physicians' assistant000030.00Adjustment for occupational Limitation (chapter 14)A-8-300030.99Hospice (non-distinct) (see0ADULTS & PEDIATRICS30.000	23.00	physicians' compensation				114.00		23.00
27.00Depreciation - CAP REL COSTS-MVBLE EQUIP2.00028.00Non-physician Anesthetist0NONPHYSICIAN ANESTHETISTS19.0029.00Physicians' assistant00030.00Adjustment for occupational therapy costs in excess of limitation (chapter 14)A-8-30030.99Hospice (non-distinct) (see0ADULTS & PEDIATRICS30.00	26.00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
28.00Non-physician Anesthetist0NONPHYSICIAN ANESTHETISTS19.0029.00Physicians' assistant00030.00Adjustment for occupational therapy costs in excess of limitation (chapter 14)A-8-30OCCUPATIONAL THERAPY67.0030.99Hospice (non-distinct) (see0ADULTS & PEDIATRICS30.00	27.00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
30. 00 therapy costs in excess of limitation (chapter 14)A-8-30 OCCUPATIONAL THERAPY67. 0030. 99Hospice (non-distinct) (see0 ADULTS & PEDIATRICS30. 00		Non-physician Anesthetist						28.00
I imitation (chapter 14)30. 99Hospice (non-distinct) (see0 ADULTS & PEDIATRICS30. 00		Adjustment for occupational	A-8-3	-			0	29.00 30.00
	30, 99	limitation (chapter 14)		0	ADULTS & PEDLATRICS	30.00		30.99
		i nstructi ons)						

	FINANCIAI SYSTEMS	Gr	COUNTY GE	INERAL HUSPITAL	III LIE	U UI FUIII CN3-2	2002-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	narod
					10 12/31/2017	5/30/2018 10:	
				Expense Classification o	n Worksheet A	0/00/2010 10.	
				To/From Which the Amount is			
					· · · · · · · · · · · · · · · · · · ·		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Line #	Wkst. A-7	
		(2)				Ref.	
		1.00	2.00	3.00	4.00	5.00	
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for	A	-118, 046	CAP REL COSTS-MVBLE EQUIP	2.00	9	32.00
	Depreciation and Interest						
33.00	CPR TRAINING	В		ADMINISTRATIVE & GENERAL	5.00	0	00.00
33.01	MISC REVENUE - ADMIN	В		ADMINISTRATIVE & GENERAL	5.00		00.01
33.02	AHA DUES	A	-2, 187	ADMINISTRATIVE & GENERAL	5.00		
33.03	I HA DUES	A		ADMINISTRATIVE & GENERAL	5.00	0	00.00
33.04	MARKETING & ADVERTISING	A	-76, 135	ADMINISTRATIVE & GENERAL	5.00		
33.05	RENTAL OF PROVIDER SPACE -	В	-43, 264	CAP REL COSTS-BLDG & FIXT	1.00	9	33.05
	BENEFITS						
33.06	GIFT CARD USAGE	В		ADMINISTRATIVE & GENERAL	5.00	0	
33.07	THERAPY REVENUE	В		PHYSI CAL THERAPY	66.00		00.07
33.08	CRNA TO MARKET ADJUSTMENT	A		NONPHYSICIAN ANESTHETISTS	19.00		33.08
33.09	BOND INTEREST	A		CAP REL COSTS-BLDG & FIXT	1.00		00.07
33.10	DR RIDGE OFFSET	A		ADULTS & PEDIATRICS	30.00		
33. 11	LLC AND HHC BENEFITS	A		EMPLOYEE BENEFITS DEPARTMEN			33.11
33. 12	HOSPITAL ASSESSMENT FEE	A		ADMI NI STRATI VE & GENERAL	5.00		
33.13	BOND AMORTIZATION EXPENSE	A	22, 264	CAP REL COSTS-BLDG & FIXT	1.00	9	33.13
	ADJUSTMENT						
33.14	MISC REVENUE - INSURANCE	В	-16, 225	ADMI NI STRATI VE & GENERAL	5.00	0	33.14
	PROCEEDS						
33.15	MISC EXPENSE - ADMIN	A		ADMI NI STRATI VE & GENERAL	5.00		00110
33.16	INSURANCE PROCEEDS - R&M	В		OPERATION OF PLANT	7.00		
33.17	INSURANCE PROCEEDS - LAB	В		LABORATORY	60.00		
33.18	INUSRANCE PROCEEDS - ADMIN	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.18
50.00	TOTAL (sum of lines 1 thru 49)		-2, 719, 953				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
<							

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

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

Heal th	Fi nanci a	I Systems	
DDOLU D		DUN (OL OL AN)	AD HUGTH

## GREENE COUNTY GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

Hearth	Financial Syste	ellis	GREENE COUNTY G	ENERAL HUSPITA	L		SU OF FORM CMS-	2002-10
PROVI DE	ER BASED PHYSIC	CLAN ADJUSTMENT		Provider (	1	Period: From 01/01/2017 Fo 12/31/2017		
						10 12/31/2017	5/30/2018 10:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
					·		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	28, 655	28, 655	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	428, 281	374, 746	53, 535	0	0	2.00
3.00	60.00	LABORATORY	28, 096	28, 096	0	0	0	3.00
4.00	91.00	EMERGENCY	594, 297	0	594, 297	0	0	4.00
5.00	0.00		0	0	0	0	o	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			1,079,329	431, 497	647,832		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Limit		Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Education	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	60.00	LABORATORY	0	0	0	0	0	3.00
4.00	91.00	EMERGENCY	0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	30.00	ADULTS & PEDIATRICS	0	0	0	28, 655		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	374, 746		2.00
3.00	60.00	LABORATORY	0	0	0	28, 096		3.00
4.00	91.00	EMERGENCY	0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	431, 497		200.00
	•						, I	

Heal th Financial	Systems			
COST ALLOCATION	- GENERAL	SERVI CE	COSTS	

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		Peri od:	Worksheet B	
					From 01/01/2017	Part I	
					To 12/31/2017	Date/Time Pre 5/30/2018 10:	pared:
				ATED COSTS		573072018 10.	
				LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	DEDG & TIXI		BENEFITS	50510101	
		Allocation			DEPARTMENT		
		(from Wkst A			DELARTMENT		
		col. 7)					
		0	1.00	2.00	4.00	4A	
	GENERAL SERVICE COST CENTERS		1.00	2.00	1.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT	882, 410	882, 410				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	316, 245	,	316, 24	5		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 137, 043	0		3, 137, 043		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 288, 299	64, 297		, ,	3, 767, 242	5.00
7.00	00700 OPERATION OF PLANT	1, 682, 441	119, 229			1, 967, 034	7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE	307, 024	6, 161	2,20		315, 393	8.00
9.00	00900 HOUSEKEEPI NG	485, 529	6, 817			589, 782	9.00
10.00	01000 DI ETARY	119, 720	32, 180			177, 813	10.00
11.00	01100 CAFETERI A	581, 782	35, 347			743, 013	
13.00	01300 NURSI NG ADMI NI STRATI ON	918, 315	4, 429			1, 111, 807	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	20, 973	39, 739			74, 954	14.00
15.00	01500 PHARMACY	526,006	19, 795			676, 986	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	259, 498	13, 189			336, 042	16.00
17.00	01700 SOCI AL SERVI CE	263, 403	3, 538			332, 484	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	242, 876	0,000		0 04,2,5	242, 876	19.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	242,070	0		0	242,070	17.00
30, 00	03000 ADULTS & PEDIATRICS	2, 284, 002	151, 486	54, 29	2 617, 896	3, 107, 676	30.00
31.00	03100 I NTENSI VE CARE UNI T	526, 298	33, 157			691, 405	31.00
43.00		62, 832	6, 310			86, 737	43.00
45.00	ANCI LLARY SERVICE COST CENTERS	02,032	0, 510	2,20	1 13, 334	00,737	43.00
50.00	05000 OPERATING ROOM	524, 827	96, 576	34, 61	2 91, 833	747, 848	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	54, 141	41, 372			119, 240	52.00
53.00	05300 ANESTHESI OLOGY	24, 062	41, 372		0 0	24, 062	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 705, 395	56, 342		-	2, 010, 032	54.00
60.00	06000 LABORATORY	2, 131, 479	23, 074			2, 374, 144	
65.00	06500 RESPIRATORY THERAPY	606, 258	6, 334			753, 500	65.00
66.00	06600 PHYSI CAL THERAPY	360, 277	11, 778			456, 857	66.00
67.00	06700 OCCUPATI ONAL THERAPY	159, 318	11, 778			213, 741	67.00
68.00	06800 SPEECH PATHOLOGY	16, 796	3, 526			25,676	68.00
69.00	06900 ELECTROCARDI OLOGY	11, 529	1, 967			14, 201	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	788, 740	1, 907		0 0	788, 740	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	, 00, , 40	0		0 0	0 100, 740	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 478, 239	9, 947	3, 56		1, 547, 681	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	1,470,237	7, 747	5, 50	5 55, 750	1, 547, 001	73.00
91.00	09100 EMERGENCY	1, 776, 732	70, 248	25, 17	6 275, 181	2, 147, 337	91.00
		1, 770, 732	70, 240	23, 17	275,101	2, 147, 337	92.00
92.00	SPECIAL PURPOSE COST CENTERS					0	92.00
118.00		25, 542, 489	868, 616	311, 30	1 3, 057, 595	25, 444, 303	110 00
110.00	NONREI MBURSABLE COST CENTERS	25, 542, 407	000,010	511, 30	1 3,037,375	25, 444, 505	110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	o	3, 439	1, 23	3 0	1 672	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	325, 958	10, 355			419, 472	
	07950 FOUNDATION / MOBS	256, 889	10, 355		0 79,448	256, 889	
200.00		200, 889	0				200.00
200.00	5		^				200.00
201.00	5	26, 125, 336	0 882, 410	316, 24	0 0 5 3, 137, 043		
202.00	I TOTAL (Sum TITIES FIG through 201)	20, 120, 330	002,410	1 510, 24	5, 157, 045	20, 120, 330	202.00

		REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod:	Worksheet B	
					rom 01/01/2017 o 12/31/2017	Part I Date/Time Pre	narod
				1	0 12/31/2017	5/30/2018 10:	38 am
	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 & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 767, 242					5.00
7.00	00700 OPERATION OF PLANT	331, 437	2, 298, 471				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	53, 142					8.00
9.00	00900 HOUSEKEEPI NG	99, 376	22, 420		711, 578		9.00
10.00	01000 DI ETARY	29, 961	105, 832			313, 606	
11.00	01100 CAFETERI A	125, 195	116, 248			0	
13.00	01300 NURSING ADMINISTRATION	187, 335	14, 567	0	9, 555	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 629	130, 693	482	7, 273	0	14.00
15.00	01500 PHARMACY	114, 069	65, 102	0	10, 767	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	56, 622	43, 374	0	0	0	
17.00	01700 SOCIAL SERVICE	56, 022	11, 637	0	0	0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	40, 924	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	523, 624	498, 192	104, 639	289, 082	283, 188	30.00
31.00	03100 I NTENSI VE CARE UNI T	116, 499	109, 046	30, 531	57, 545	30, 418	31.00
43.00	04300 NURSERY	14, 615	20, 751	0	2, 995	0	43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	126, 009	317, 617		68, 598	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	20, 091	136, 063				
53.00	05300 ANESTHESI OLOGY	4,054	0	-	-	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	338, 682	185, 297			0	
60.00	06000 LABORATORY	400, 034				0	
65.00	06500 RESPI RATORY THERAPY	126, 962	20, 833			0	
66.00	06600 PHYSI CAL THERAPY	76, 979				0	
67.00	06700 OCCUPATI ONAL THERAPY	36, 015	38, 736			0	
68.00	06800 SPEECH PATHOLOGY	4, 326	11, 596		-	0	
69.00	06900 ELECTROCARDI OLOGY	2, 393	6, 470		-	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	132, 900	0		-	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	260, 778	32, 714	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS	0(1.010	004.004	00.011	450.050		
91.00	09100 EMERGENCY	361, 818	231, 031	83, 911	153, 953	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
118.00	SPECIAL PURPOSE COST CENTERS	3, 652, 491	2 252 102	380, 571	693, 894	212 (0(	110.00
118.00	SUBTOTALS         (SUM OF LINES 1 through 117)           NONREIMBURSABLE         COST         CENTERS	3, 052, 491	2, 253, 103	380, 571	093, 894	313, 606	1118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	787	11, 311	0	285	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	70, 679					192.00
	07950 FOUNDATION / MOBS	43, 285	0,007		17, 377		194.00
200.00		10, 200	Ŭ	l		0	200.00
200.00	5	0	n	0	0	n	201.00
202.00	5	3, 767, 242	2, 298, 471	388, 798	711, 578		
						2.2, 500	

13:00       NURSING ADMINISTRATION       59, 521       1, 382, 785       226, 031         14:00       01400 CENTRAL SERVICES & SUPPLY       0       0       226, 031         16:00       01500 PHARMACY       39, 059       0       772       906, 755         16:00       01000 SOCIAL SERVICE       19, 138       0       4       0       0         17:00       01700 SOCIAL SERVICE       19, 138       0       0       0       0       0         19:00       03000 ADULTS & PEDIATRICS       256, 320       770, 143       6, 892       0       90, 343         31:00       03000 ADULTS & PEDIATRICS       256, 320       770, 143       6, 892       0       90, 343         31:00       03000 NURSERY       5, 958       0       0       0       1, 960         ANCILLARY SERVICE COST CENTERS       5       0       0       14, 90       0       0         50:00       05200 PEATING ROOM       39, 179       117, 718       2, 656       0       24, 505         50:00       05200 PEATING ROOMSTIC       102, 130       1, 410       0       980         60:00       06000 RESPI RATORY THERAPY       37, 674       0       0       3, 267	Heal th F	inancial Systems GR	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Center Description         CAFETERIA ADMINISTRATIO         NURSING ADMINISTRATIO         CENTRAL SERVICES & SUPPLY         PHARMACY MEDICAL RECORDS & LIBRARY           10.00         00100 CAP REL COST-CENTERS         11.00         13.00         14.00         16.00           1.00         00100 CAP REL COST-SHAUEL EQUIP         11.00         13.00         14.00         16.00           1.00         00200 CAP REL COSTS-MULE EQUIP         14.00         16.00         16.00           1.00         00200 CAP REL COSTS-MULE EQUIP         14.00         16.00         16.00           1.00         00200 CAP REL COSTS-MULE EQUIP         17.00         17.00         16.00           1.00         00200 CAP REL COSTS-MULE EQUIP         17.00         17.00         16.00           1.00         00200 CAP REL COSTS-MULE EQUIP         17.00         17.00         17.00           1.00         000000 ULMISH KA ADININISTRATION         95.521         1.382.785         226.031           1.10         01100 AFETRIA         995.921         1.382.785         0         479.323           1.00         01000 ADMERISK ADMINISTRATION         95.521         1.382.785         0         0         0           1.10         01000 ADMERISK ADMINISTRATION         95.521         1.382.785	COST ALL	OCATION - GENERAL SERVICE COSTS		Provider CO				
Cost Center Description         CAFETERIA         NURSING ADMINISTRATIO         CENTRAL SUPPLY         HARMACY         MURSING MECORDS & LIBRARY           10.00         COST CENTERS         11.00         13.00         14.00         15.00         16.00           10.00         COST CENTERS         11.00         13.00         14.00         15.00         16.00           10.00         COST CENTERS         10.00         15.00         16.00         16.00           10.00         COST CENTERS         10.00         15.00         16.00         16.00           10.00         COST CENTERS         10.00         15.00         16.00         16.00           10.00         COST CENTERS         COST         CENTRAL SERVICE         16.00         16.00           10.00         COST CENTERS         COST         CENTRAL SERVICE         17.00         17.00         17.00         17.00         17.00         17.00         14.00         17.2         90.675         17.00         17.2         90.675         17.00         17.2         90.675         17.00         17.00         17.00         17.00         17.00         17.00         17.00         17.00         17.00         17.00         17.00         17.00         17.00         17.00<						From 01/01/2017		parad
Cost Center Description         CAFETERIA ADMINISTRATU ADMINISTRATU SERVICES & ULBRARY         PHARMACY ADMINISTRATU SERVICES & ULBRARY         MEDICAL RECORDS & LIBRARY           00         COTOQ CAP REL COSTS - BLDG & FIXT         0         13.00         14.00         16.00           2.00         COTOQ CAP REL COSTS - MUBE E QUIP         0						10 12/31/2017		
ADMINISTRATIO         SERVICES & SUPPLY         LIBRARY LIBRARY           10 00         CADMINISTRATIO         SEVENUCES & SUPPLY         LIBRARY           10 00         CADMINISTRATIO         SEVENUCES & SUPPLY         LIBRARY           10 00         CADMINISTRATIO         SEVENUCES & SUPPLY         16.00           10 00         CAP REL COSTS-BUDG & FIXT         16.00           10 00         COORD CAPR EL COSTS-BUDG & FIXT         16.00           10 00         COORD CAPREL COSTS DEPARTMENT         50.0           50 00         OSCOLAMINISTRATION OF PLANT         59.51           10 00         OTOD OPERATION OF PLANT         50.0           11 00         OTOD OPERATION OF PLANT         59.521           13 00         D1300 CAPETERIA         995, 312           11 00         OTOD OPERATION OF PLANT         59.521           13 00         D1300 CANURSING AMMINISTRATION         59.521           13 00         D1300 CALL RECORDS & LIBRARY         42.910         0           10 01300 PLANTANY SICHAN ANDERTHITISTS         0         0         0           10 03000 ADULTS & PEDIATINICS         266.320         770.143         6.892         0           10 03000 ADULTS & PEDIATINICS         265.320         770.143         6.892 </td <td></td> <td>Cost Center Description</td> <td>CAFETERIA</td> <td>NURSI NG</td> <td>CENTRAL</td> <td>PHARMACY</td> <td></td> <td></td>		Cost Center Description	CAFETERIA	NURSI NG	CENTRAL	PHARMACY		
N         SUPPLY         LIBRARY           10.0         00100 CAP REL COST CENTERS         11.00         13.00         14.00         16.00           2.00         00200 CAP REL COST S-MUBE EQUIP         1.00         13.00         14.00         16.00           4.00         00400 PMLOYEE DEVENT SD EPARTMENT         5.00         5.00         16.00         16.00           5.00         00500 ADM IN STRATI VE & GENERAL         5.00         7.00         5.00         7.00         5.00         7.00         5.00         7.00         5.00         7.00         5.00         7.00         5.00         7.00         5.00         7.00         5.00         7.00         5.00         7.00         5.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00							RECORDS &	
GENERAL SERVICE COST CENTERS         Control           1.00         OTOO CAP FEL COSTS-HUDG & FLYT         Control           2.00         D0200 CAP FEL COSTS-HUDG & FLYT         Control           5.00         D0200 CAP FEL COSTS-MUDG & FLYT         Control           5.00         D0200 OPERATION OF PLANT         Control           7.00         D0700 OPERATION OF PLANT         Control           8.00         D0800 OPERATION OF PLANT         Control           10.00         D1000 OPERATION OF PLANT         Control           11.00         D1100 CAFFEER NA         September           10.00         D1000 OPERATION OF PLANT         Control           11.00         D1100 CAFFEER NA         September           11.00         D1100 CAFFEER NA         September           10.00         D1000 OPERATION NESERVICE         D           11.00         D1100 CAFFEER NA         September           11.00         D1100 CAFFEER NA         September           11.00         D1100 CAFFEER NA         September           12.00         D1000 OPERATION NESERVICE         D           13.00         D100 OPERATION NESERVICE         D           13.00         D100 OPERATION NESERVICE COST CENTERS         D           13				Ν	SUPPLY		LI BRARY	
1.00         00100 CAP REL COSTS-MUBLE FOULP            2.00         00200 CAP REL COSTS-MUBLE FOULP            0.00         00400 EMPLOYEE BENEFITS DEPARTMENT            0.00         00000 DADMI MI STRATI VE & GENERAL            0.00         00000 DADMI MI STRATI VE & GENERAL            0.00         00000 DADMI MI STRATI VE & GENERAL            10.00         01000 DETARY          900.0000 PENDISKEEPI NG           10.00         01000 CENTRAL SERVICES & SUPPLY         0         0         226.031           11.00         01100 CAPETERIA         985.312         1.382.785         1.382.785           11.00         01100 CAPETERIA MINI STRATI ON         59.521         1.382.785         0         479.323           11.00         01100 CAPETERIA MACY         39.059         772         906.755         0           11.00         01100 SOLAL SERVICE S & SUPPLY         0         0         0         0         0           12.00         01300 ONEDISAL RECORDS & LIBRARY         42.910         375         0         479.323           13.00         01300 ONEDISAL SERVICE COST CENTERS         0         0         0         0         0           14.00			11.00	13.00	14.00	15.00	16.00	
2.00         00200         CAP_REL_COSTS-MUBLE_EQUIP           4.00         00400         CMPUOYEE_DENETTS DEPRATIKENT         Image: Control of PLAINT           5.00         00500         ADMINISTRATIVE_& GENERAL         Image: Control of PLAINT           8.00         00500         DEPRATION OF PLAINT         Image: Control of PLAINT           8.00         00500         DEVENTES         Service         Image: Control of PLAINT           9.00         00500         DEVENTES         Service         Image: Control of PLAINT           9.00         00500         NURSI NG ADMINISTRATION         S59, 521         1, 382, 785           11.00         OTIDOD OLELAL RECORDS & LIBRARY         42, 910         0         375         0         479, 323           11.00         OTODO NON-PHYSICIAN ANESTHETISTS         0<	GE	ENERAL SERVICE COST CENTERS	•					
4. 00         00400         EMPLOYEE BENEFITS DEPARTMENT	1.00 00	0100 CAP REL COSTS-BLDG & FIXT						1.00
5. 00         00500 ADMI NI STRATI VE & GENERAL	2.00 00	0200 CAP REL COSTS-MVBLE EQUIP						2.00
7. 00         00700 (PERATION OF PLANT	4.00 00	0400 EMPLOYEE BENEFITS DEPARTMENT						4.00
8. 00         00800 LAUNDRY & LINEN SERVICE	5.00 00	0500 ADMINISTRATIVE & GENERAL						5.00
9. 00         00900 HOUSEKEEPI NG         985, 312           11. 00         01100 CAFETERIA         985, 312           13. 00         01300 NURSING ADMINI STRATION         59, 521         1, 382, 785           14. 00         01400 CENTRAL SERVICES & SUPPLY         0         0         226, 031           15. 00         01500 PHARMACY         39, 059         0         772         906, 755           16. 00         01600 MEDICAL RECORDS & LIBRARY         42, 910         0         375         0         479, 323           17. 00         01700 SOCIAL SERVICE ANDERNICTIS S         0         0         0         0         0         0           19. 00         19700 SOCIAL SERVICE ANDERNICTIS S         256, 320         770, 143         6, 892         0         90, 343           31. 00         03000 NURSERY         5, 958         0         0         0         1, 960           AKCILLARY SERVICE COST CENTERS         5, 958         0         0         0         1, 960           ACILLARY SERVICE COST CENTERS         5, 958         0         0         0         1, 960           ACILLARY SERVICE COST CENTERS         0         0         149         0         0           52.00         52000 DELVICENTO	7.00 00	0700 OPERATION OF PLANT						7.00
10:00         010000         DIETARY         965, 512         1           11:00         01100         CAFETERIA         965, 512         1, 382, 785         226, 031           14:00         01400         CENTRAL SERVICES & SUPPLY         0         0         226, 031           15:00         015000 MURSING ADMINISTRATION         59, 521         1, 382, 785         2           16:00         016000 MEDICAL RECORDS & LIBRARY         42, 910         0         375         0         479, 323           17:00         07000 SOCIAL SERVICE         19, 138         0         4         0	8.00 00	0800 LAUNDRY & LINEN SERVICE						8.00
11.00       CHEFTERIA       985, 312         13.00       01300       NURSI NG ADMINI STATI ON       59, 521       1, 382, 785         14.00       01400       CENTRAL SERVI CES & SUPPLY       0       0       226, 031         15.00       01500       PHARMACY       39, 059       0       772       906, 755         16.00       01600       MEDICAL RECORDS & LIBRARY       42, 910       0       375       0       479, 323         17.00       01700       SOCIAL SERVICE       19, 138       0       4       0       0         19.00       01900 NONPHSICIAL AN ESTHETISTS       0       0       0       0       0         30.00       03000 INTENSIVE CARE UNIT       47, 123       141, 588       699       7, 188         43.00       04300 NURSERY       5, 958       0       0       1, 960         60.00       DS000 PERATI NG ROOM       3, 491       0       6       0       0         50.00       DS000 PERATI NG ROOM       3, 491       0       1, 410       980       0       2, 743         50.00       DS200 PELVERY ROOM & LABOR ROOM       3, 917,9       117, 718       2, 656       0       24, 505       5       0       0	9.00 00	0900 HOUSEKEEPI NG						9.00
13.00       01300       RURSING ADMINISTRATION       59, 521       1, 382, 785       226, 031         14.00       01400 CENTRAL SERVICES & SUPPLY       0       0       226, 031         15.00       01500 PHARMACY       39, 059       772       906, 755         16.00       01600 SOCIAL SERVICE       19, 138       0       4       0       0         17.00       01700 SOCIAL SERVICE       19, 138       0       4       0       0       0         18.00       000 SOCIAL SERVICE COST CENTERS       0       0       0       0       0       0       0       0         18.00       0300 INUESING ADULTS & DEDIATRICS       256, 320       770, 143       6, 892       0       90, 343         31.00       0300 INUESING ROM       39, 179       117, 718       2, 656       0       24, 505         50.00       05000 DERATI NG ROM       39, 179       117, 718       2, 656       0       0       0         51.00       05000 DERATI NG ROM       39, 179       117, 718       2, 656       0       24, 505       0       0       0       0       0       0       0       0       1, 460       0       0       0       0       0       0 </td <td>10.00 01</td> <td>1000 DI ETARY</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>10.00</td>	10.00 01	1000 DI ETARY						10.00
14.00       CONTRAL SERVICES & SUPPLY       0       226,031         15.00       01500       PHARMACY       39,059       0       772       906,755         16.00       01000       MEDI CAL RECORDS & LI BRARY       42,910       0       375       0       479,323         17.00       01000       NOPHYSICIAN       ANESTHETI STS       0			985, 312					11.00
15.00       01500       PHARMACY       39,059       0       772       906,755         16.00       01600       MEDICAL RECORDS & LIBRARY       42,910       0       375       0       0       0         17.00       01700       SOCIAL SERVICE       19,138       0       4       0       <			59, 521	1, 382, 785				13.00
16.00       01600       MEDI CAL RECORDS & LIBRARY       42,910       0       375       0       479,323         17.00       01700       SOCI AL SERVICE       19,138       0       4       0       0         19.00       1900       01900       00       0 <td></td> <td></td> <td>Ŭ</td> <td>-</td> <td>226, 03</td> <td>1</td> <td></td> <td>14.00</td>			Ŭ	-	226, 03	1		14.00
17.00       01700       SOCI AL SERVI CE       19,138       0       4       0       0         19.00       01900       NONPHYSI CI AN ANESTHETI STS       0			39, 059	0				15.00
19.00       01900   NONPHYSI CI AN ANESTHETI STS       0       0       0       0       0         INPATI ENT ROUTI NE SERVI CE COST CENTERS	16.00 01	1600 MEDICAL RECORDS & LIBRARY	42, 910	0	37	5 0	479, 323	16.00
INPATIENT ROUTINE SERVICE COST CENTERS         1			19, 138					
30.00       03000       ADULTS & PEDIATRICS       256, 320       770, 143       6, 892       0       90, 343         31.00       03100       INTENSIVE CARE UNIT       47, 123       141, 588       699       0       7, 188         43.00       04300       NURSERY       5, 958       0       0       0       1, 960         ANCILLARY SERVICE COST CENTERS			0	0		0 0	0	19.00
31.00       03100       INTENSI VE CARE UNI T       47, 123       141, 588       699       0       7, 188         43.00       04300       NURSERY       5, 958       0       0       0       1, 960         ANCILLARY SERVICE COST CENTERS								
43.00       04300       NURSERY       5,958       0       0       1,960         ANCI LLARY SERVICE COST CENTERS         50.00       05000       DFERATI NG ROOM       39,179       117,718       2,656       0       24,505         52.00       05200       DELI VERY ROOM & LABOR ROOM       3,491       0       6       0       0         53.00       05300       ANESTHESI OLOGY       0       0       1449       0       0         54.00       05400       RADI OLOGY-DI AGNOSTI C       102,130       0       1,410       0       980         60.00       06600       RESPI RATORY THERAPY       116,273       0       122,783       0       12,743         65.00       06600       RESPI RATORY THERAPY       37,674       0       807       0       3,267         67.00       06700       0CUPATI ONAL THERAPY       11,254       0       0       3,267         68.00       06800       SPEECH PATHOLOGY       1,143       0       3       0       980         69.00       07000       CEURTCCARDI OLOGY       4,995       0       282       0       817         71.00       OT3000       DRUSC CHARGED TO PATI ENTS <td></td> <td></td> <td>256, 320</td> <td></td> <td></td> <td></td> <td>90, 343</td> <td>30.00</td>			256, 320				90, 343	30.00
ANCILLARY SERVICE COST CENTERS         Image: Content of the service of the ser								
50.00         05000         OPERATING ROOM         39, 179         117, 718         2, 656         0         24, 505           52.00         05200         DELIVERY ROOM & LABOR ROOM         3, 491         0         6         0         0           53.00         OS300         ANESTHESI OLOGY         0         0         149         0         0           64.00         05400         RADIOLOGY-DI AGNOSTI C         102, 130         0         1, 410         980           60.00         06600         LABORATORY         THERAPY         116, 273         0         122, 783         0         12, 743           65.00         06500         RESPI RATORY THERAPY         37, 674         0         807         0         3, 921           66.00         06600         PHYSI CAL THERAPY         11, 254         0         0         0         3, 921           68.00         066000         SPECH PATHOLOGY         1, 143         0         3         0         980           69.00         0         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         82, 432         0         817           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         16, 249			5, 958	0		0 0	1, 960	43.00
52.00         05200         DELIVERY ROOM & LABOR ROOM         3, 491         0         6         0         0           53.00         05300         ANESTHESI 0LOGY         0         0         149         0         0           54.00         05400         RADI 0LOGY-DI AGNOSTI C         102, 130         0         1, 410         0         980           60.00         06600         LABORATORY         116, 273         0         122, 783         0         12, 743           65.00         06500         RESPI RATORY THERAPY         49, 470         0         2, 096         0         15, 357           66.00         06600         PHYSI CAL THERAPY         37, 674         0         807         0         3, 267           67.00         0CCUPATI ONAL THERAPY         11, 254         0         0         3, 921         1         133         0         380         980           69.00         06800         SPEECH PATHOLOGY         1, 143         0         3         0         980         980         920         0         817         71.00         7100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         0         0         0         0         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
53.00         05300         ANESTHESI OLOGY         0         149         0         0           54.00         RADI OLOGY-DI AGNOSTI C         102, 130         0         1, 410         0         980           60.00         LABORATORY         116, 273         0         12, 743         0         12, 743           65.00         O6500         RESPI RATORY THERAPY         49, 470         0         2, 096         0         3, 267           66.00         06600         PHYSI CAL THERAPY         37, 674         0         807         0         3, 267           67.00         06700         CCUPATI ONAL THERAPY         11, 254         0         0         3, 267           68.00         SPEECH PATHOLOGY         1, 143         0         3         0         980           69.00         OF100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0         0         822         0         817           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <t< td=""><td></td><td></td><td></td><td></td><td>2, 65</td><td></td><td></td><td></td></t<>					2, 65			
54.00       05400       RADI OLOGY-DI AGNOSTI C       102, 130       0       1, 410       0       980         60.00       06000       LABORATORY       116, 273       0       122, 783       0       12, 743         65.00       06500       RESPI RATORY THERAPY       49, 470       0       2, 096       0       15, 357         66.00       06600       PHYSI CAL THERAPY       37, 674       0       807       0       3, 267         67.00       0CCUPATI ONAL THERAPY       11, 254       0       0       0       3, 921         68.00       06800       SPEECH PATHOLOGY       1, 143       0       3       0       980         69.00       06900       ELECTROCARDI OLOGY       4, 995       0       282       0       817         71.00       OT100       MEDI EAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0								
60.00       06000       LABORATORY       116, 273       0       122, 783       0       12, 743         65.00       06500       RESPI RATORY THERAPY       49, 470       0       2, 096       0       15, 357         66.00       06600       PHYSI CAL THERAPY       37, 674       0       807       0       3, 267         67.00       06700       0CCUPATI ONAL THERAPY       11, 254       0       0       0       3, 921         68.00       06800       SPEECH PATHOLOGY       1, 143       0       3       0       980         69.00       06900       ELECTROCARDI OLOGY       4, 995       0       282       0       817         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       0       0         72.00       07200       IMPL.       DEV.       CHARGED TO PATI ENTS       0       0       0       0       0         71.00       07100       ENT SERVICE COST CENTERS       117, 597       353, 336       3, 005       0       314, 648         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       117, 597       353, 336       3, 005       0       314, 648         92				-				
65.00       06500       RESPI RATORY THERAPY       49,470       0       2,096       0       15,357         66.00       06600       PHYSI CAL THERAPY       37,674       0       807       0       3,267         67.00       0CCUPATI ONAL THERAPY       11,254       0       0       0       3,921         68.00       06800       SPEECH PATHOLOGY       1,143       0       3       0       980         69.00       06900       ELECTROCARDI OLOGY       4,995       0       282       0       817         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       282       0       817         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       0         09100       ENERGENCY       017,597       353,336       3,005       0       314,648         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       117,597       353,336       3,005       0       314,648         SPECIAL PURPOSE COST CENTERS         18.00       SUBTOTALS (SUM OF LINES 1 through 117)       969,484       1,382,785       226,031       906,755       479,323       1 <td< td=""><td></td><td></td><td></td><td></td><td></td><td>-</td><td></td><td></td></td<>						-		
66.00       06600       PHYSI CAL THERAPY       37, 674       0       807       0       3, 267         67.00       06700       OCCUPATI ONAL THERAPY       11, 254       0       0       0       3, 921         68.00       06800       SPEECH PATHOLOGY       1, 143       0       3       0       980         69.00       06900       ELECTROCARDI OLOGY       4, 995       0       282       0       817         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       82, 432       0       817         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       16, 249       0       1, 660       906, 755       1, 797         00       09100       EMERGENCY       117, 597       353, 336       3, 005       0       314, 648         92.00       09200       DBSERVATI ON BEDS (NON-DI STI NCT PART)       117, 597       353, 336       3, 005       0       314, 648         92.00       0BSERVATI ON BEDS (NON-DI STI NCT PART)       906, 755       479, 323       1          DBSERVATI ON BEDS (NON-DI STI NCT P								
67.00       06700       0CCUPATI ONAL THERAPY       11, 254       0       0       3, 921         68.00       06800       SPEECH PATHOLOGY       1, 143       0       3       0       980         69.00       06900       ELECTROCARDI OLOGY       4, 995       0       282       0       817         71.00       OT100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       82, 432       0       817         72.00       O7200       IMPL.       DEV. CHARGED TO PATI ENTS       0       0       0       0       0         73.00       O7300       DRUGS CHARGED TO PATI ENTS       16, 249       0       1, 660       906, 755       1, 797         0UTPATI ENT SERVICE COST CENTERS       117, 597       353, 336       3, 005       0       314, 648         92.00       O9200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       117, 597       353, 336       3, 005       0       314, 648         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       117, 597       353, 336       3, 005       0       314, 648         92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       117, 597       353, 336       3, 005       0       314, 648         90.00 <t< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></t<>				-				
68.00       06800       SPEECH PATHOLOGY       1, 143       0       3       0       980         69.00       06900       ELECTROCARDI OLOGY       4, 995       0       282       0       817         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       82, 432       0       817         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
69.00       06900       ELECTROCARDI OLOGY       4,995       0       282       0       817         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       82,432       0       817         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       0       0         000TPATI ENT SERVICE COST CENTERS       16,249       0       1,660       906,755       1,797         010DE EMERGENCY       09100       EMERGENCY       117,597       353,336       3,005       0       314,648         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       117,597       353,336       3,005       0       314,648         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       117,597       353,336       3,005       0       314,648         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       117,597       353,336       3,005       0       314,648         92.00       9URDALS (SUM OF LINES 1 through 117)       969,484       1,382,785       226,031       906,755       479,323 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td> <td></td>				-				
71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         0         0         82,432         0         817           72.00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         <				0		0		
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0					-	-		
73.00         07300         DRUGS CHARGED TO PATIENTS         16,249         0         1,660         906,755         1,797           OUTPATIENT SERVICE COST CENTERS         0         09100         EMERGENCY         117,597         353,336         3,005         0         314,648           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         117,597         353,336         3,005         0         314,648           92.00         0BSERVATION BEDS (NON-DISTINCT PART)         117,597         353,336         226,031         906,755         479,3231           SPECIAL PURPOSE COST CENTERS           118.00           NONREI MBURSABLE COST CENTERS           190.00         19000         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         0         1           190.00         19200         PHYSICIANS' PRIVATE OFFICES         15,828         0			-					
OUTPATI ENT SERVICE COST CENTERS           91.00         09100         EMERGENCY         117, 597         353, 336         3, 005         0         314, 648           92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         117, 597         353, 336         3, 005         0         314, 648           92.00         0BSERVATI ON BEDS (NON-DI STI NCT PART)         117, 597         353, 336         3, 005         0         314, 648           92.00         0BSERVATI ON BEDS (NON-DI STI NCT PART)         117, 597         353, 336         3, 005         0         314, 648           92.00         0BSERVATI ON BEDS (SUM OF LINES 1 through 117)         969, 484         1, 382, 785         226, 031         906, 755         479, 323 1           NONREI MBURSABLE COST CENTERS         190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         0         117           192.00         19200         GIFT, FLOWER, COFFICES         15, 828         0			-	-				
91.00         09100         EMERGENCY         117, 597         353, 336         3, 005         0         314, 648           92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART)         117, 597         353, 336         3, 005         0         314, 648           92.00         OBSERVATI ON BEDS (NON-DI STI NCT PART)         117, 597         353, 336         3, 005         0         314, 648           SPECI AL PURPOSE COST CENTERS           I18.00         SUBTOTALS (SUM OF LI NES 1 through 117)         969, 484         1, 382, 785         226, 031         906, 755         479, 323         1           NONREI IMBURSABLE COST CENTERS           190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         0           192.00         19200         PHYSI CI ANS' PRI VATE OFFI CES         15, 828         0			16, 249	0	1,66	0 906, 755	1, 797	73.00
92.00         09200         0BSERVATION         BEDS         (NON-DISTINCT PART)         Image: Constraint of the constraint			117 507	252.22(	2.00		214 (40	01 00
SPECI AL PURPOSE COST CENTERS           118. 00         SUBTOTALS (SUM OF LINES 1 through 117)         969, 484         1, 382, 785         226, 031         906, 755         479, 323         1           NONREI MBURSABLE COST CENTERS         Image: Cost center			117, 597	353, 330	3,00	5 0	314, 648	
118.00         SUBTOTALS (SUM OF LINES 1 through 117)         969, 484         1, 382, 785         226, 031         906, 755         479, 323         1           NONREI MBURSABLE COST CENTERS								92.00
NONRE I MBURSABLE COST CENTERS           190. 00         0			060 404	1 202 705	226.02	1 004 755	470 202	110 00
190.00         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN         0			909, 484	1, 382, 785	220, 03	1 906, 755	479, 323	118.00
192.00         PHYSI CLANS'         PRI VATE         OFFICES         15,828         0							0	190.00
194.00 07950 FOUNDATION / MOBS 0 0 0 0 0			-					
								192.00 194.00
			0	0		0	0	200.00
			_				~	
201.00         Negative Cost Centers         0 </td <td></td> <td></td> <td>005 212</td> <td>1 202 705</td> <td>226 02</td> <td></td> <td></td> <td>201.00</td>			005 212	1 202 705	226 02			201.00
	202.00	TOTAL (Sum TINES TTO LITUUGIT 201)	700, 312	1, 302, 703	220, 03	1 700,755	417, 323	202.00

	Financial         Systems         GR           LLOCATION - GENERAL         SERVICE         COSTS		NERAL HOSPITAL Provider CC	N: 15-1317	Peri od:	u of Form CMS- Worksheet B	
					From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/30/2018 10:	
	Cost Center Description	SOCI AL	NONPHYSI CI AN	Subtotal	Intern &	Total	
		SERVI CE	ANESTHETI STS		Residents		
					Cost & Post		
					Stepdown		
					Adjustments		
		17.00	19.00	24.00	25.00	26.00	
1 00	GENERAL SERVICE COST CENTERS		1				1 1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERIA						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDI CAL RECORDS & LI BRARY	44.0.005					16.00
	01700 SOCI AL SERVI CE	419, 285	000.000				17.00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0	283, 800				19.00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	200 2/5		( 210 4		( 210 4(4	20.00
	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T	280, 365	0	6, 210, 4		6, 210, 464	
		70, 723	0	1, 302, 7		1, 302, 765	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	0	133, 0	10 0	133, 016	43.00
50.00	05000 OPERATING ROOM	0	0	1, 462, 6	41 0	1, 462, 641	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0		297, 4		297, 431	
	05300 ANESTHESI OLOGY	0		312, 0		312, 065	
	05400 RADI OLOGY-DI AGNOSTI C	0	203,000	2, 713, 2		2, 713, 221	
	06000 LABORATORY	0	0	3, 120, 0		3, 120, 045	
	06500 RESPI RATORY THERAPY	0		979, 0		979, 057	
	06600 PHYSI CAL THERAPY	0	0	679, 2		679, 204	
	06700 OCCUPATI ONAL THERAPY	0	0	352, 2		352, 298	
	06800 SPEECH PATHOLOGY	0	0	43, 7		43, 724	
	06900 ELECTROCARDI OLOGY	0	0	29, 1		29, 158	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1,004,8		1,004,889	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	C	
	07300 DRUGS CHARGED TO PATIENTS	0	0	2, 767, 6	34 0	2, 767, 634	
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	68, 197	0	3, 834, 8	33 0	3, 834, 833	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	419, 285	283, 800	25, 242, 4	45 0	25, 242, 445	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	17, 0	55 0	17, 055	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	565, 6	62 0	565, 662	2 192.00
194 00	07950 FOUNDATION / MOBS	0	0	300, 1	74 0	300, 174	194.00
171.00							
200.00	Cross Foot Adjustments		0		0 0	Ĺ	200.00
		0	0		0 0		200.00

ALLOCAT	ION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1317	Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/30/2018 10:	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	ENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.0
	00200 CAP REL COSTS-MVBLE EQUIP						2.0
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	4.0
	00500 ADMINI STRATI VE & GENERAL	0	64, 297	23, 04		0	5.0
	00700 OPERATION OF PLANT	0	119, 229	42, 73		0	7.0
	00800 LAUNDRY & LINEN SERVICE	0	6, 161	2, 20		0	
	00900 HOUSEKEEPI NG	0	6, 817	2, 44		0	9. (
	01000 DI ETARY	0	32, 180	11, 53		0	10. (
	01100 CAFETERI A	0	35, 347	12, 66		0	11. (
	01300 NURSING ADMINISTRATION	0	4, 429			0	13.
	01400 CENTRAL SERVICES & SUPPLY	0	39, 739	14, 24		0	14.
	1500 PHARMACY	0	19, 795	7,09		0	15.
	01600 MEDI CAL RECORDS & LI BRARY	0	13, 189			0	16.
	01700 SOCIAL SERVICE	0	3, 538	1, 26		0	17.
	1900 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	19.
	NPATIENT ROUTINE SERVICE COST CENTERS	0	151 407	E4.00	205 770	0	1 20 /
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT		151, 486	54, 29			30.0
	04300 NURSERY	0	33, 157 6, 310	11, 88		0	
	NCILLARY SERVICE COST CENTERS	0	0, 310	2,20	0, 571	0	43.
	D5000 OPERATING ROOM	0	96, 576	34, 61	12 131, 188	0	50.
	05200 DELIVERY ROOM & LABOR ROOM	0	41, 372	14, 82		0	52.
	05300 ANESTHESI OLOGY	0	0	11, 02	0 0	0	53.
	05400 RADI OLOGY-DI AGNOSTI C	0	56, 342	20, 19	76, 534	0	54.
	06000 LABORATORY	0	23, 074	8, 26		0	60.
	06500 RESPIRATORY THERAPY	0	6, 334	2, 27		0	65.
	06600 PHYSI CAL THERAPY	0	11, 778	4, 22		0	66.
	06700 OCCUPATI ONAL THERAPY	0	11, 778	4, 22		0	67.
	06800 SPEECH PATHOLOGY	0	3, 526	1, 26		0	68.
	06900 ELECTROCARDI OLOGY	0	1, 967	70		0	69.
1.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.
2.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.
3.00 0	7300 DRUGS CHARGED TO PATIENTS	0	9, 947	3, 56	5 13, 512	0	73.
0	UTPATIENT SERVICE COST CENTERS						
	09100 EMERGENCY	0	70, 248	25, 17	76 95, 424	0	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.0
	SPECIAL PURPOSE COST CENTERS						
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	868, 616	311, 30	01 1, 179, 917	0	118.
	IONREI MBURSABLE COST CENTERS	1		r			
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 439	1, 23			190.
	9200 PHYSI CLANS' PRI VATE OFFI CES	0	10, 355	3, 71	14, 066		192.
	7950 FOUNDATION / MOBS	0	0		0 0	0	194.
00.00	Cross Foot Adjustments				0		200.
01.00	Negative Cost Centers		0		0 0		201.
02.00	TOTAL (sum lines 118 through 201)	0	882, 410	316, 24	1, 198, 655	0	202.

		REENE COUNTY GE				u of Form CMS-2	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider C		eriod: rom 01/01/2017	Worksheet B Part	
					o 12/31/2017	Date/Time Pre	nared
					0 12/31/2017	5/30/2018 10:	38 am
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	•	E & GENERAL	PLANT	LINEN SERVICE			
	1	5.00	7.00	8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	87, 340					5.00
7.00	00700 OPERATION OF PLANT	7,683	169, 642				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 232	1, 496	11, 097			8.00
9.00	00900 HOUSEKEEPI NG	2, 304	1, 655	0	13, 219		9.00
10.00	01000 DI ETARY	695	7, 811	0	0	52, 219	10.00
11.00	01100 CAFETERI A	2,902	8, 580	0	16	0	11.00
13.00	01300 NURSING ADMINISTRATION	4, 343	1, 075	l o	178	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	293	9, 646	14	-	0	14.00
15.00	01500 PHARMACY	2,644	4, 805	0		0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	1, 313	3, 201	0		0	16.00
17.00	01700 SOCIAL SERVICE	1, 299	859	-	-	0	17.00
17.00	01900 NONPHYSI CLAN ANESTHETI STS	949	0			0	19.00
19.00	INPATIENT ROUTINE SERVICE COST CENTERS	949	0	0	0	0	19.00
20.00		12 140	26 760	2 007	E 271	47 154	20.00
30.00	03000 ADULTS & PEDIATRICS	12, 149	36, 769		5, 371	47, 154	30.00
31.00	03100 I NTENSI VE CARE UNI T	2, 701	8,048		1,069	5,065	31.00
43.00	04300 NURSERY	339	1, 532	0	56	0	43.00
F0 00	ANCI LLARY SERVICE COST CENTERS	2,021	22,442	E 20	1 074	0	
50.00	05000 OPERATING ROOM	2, 921	23, 442	528		0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	466	10, 042			0	52.00
53.00	05300 ANESTHESI OLOGY	94	0	, s	-	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 851	13, 676	1, 517		0	54.00
60.00	06000 LABORATORY	9, 273	5, 601	0		0	60.00
65.00	06500 RESPI RATORY THERAPY	2, 943	1, 538	0	201	0	65.00
66.00	06600 PHYSI CAL THERAPY	1, 784	2, 859	1, 294	363	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	835	2, 859	1, 256	86	0	67.00
68.00	06800 SPEECH PATHOLOGY	100	856	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	55	477	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 081	0	l o	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 045	2, 414	0	-	0	
	OUTPATIENT SERVICE COST CENTERS	-,	_,	-			
91.00	09100 EMERGENCY	8, 387	17,052	2, 395	2, 860	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,001	.,,002	2,070	2,000	0	92.00
72.00	SPECIAL PURPOSE COST CENTERS			L			12.00
118.00		84, 681	166, 293	10, 862	12, 891	52, 219	118 00
110.00	NONREI MBURSABLE COST CENTERS	04,001	100, 273	10,002	12,071	52,217	110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	18	835	0	5	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	1, 638	2, 514	235			192.00
	07950 FOUNDATION / MOBS	1,038	2, 514	233			192.00
		1,003	0		0	0	
	) Croce Foot Adjustmonte						
200.00			0	0	_	0	200.00
	Negative Cost Centers	0 87, 340	0 169, 642	0 11, 097	0 13, 219	0 52, 219	201.00

Heal th	Financial Systems GR	EENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet B Part II Date/Time Pre 5/30/2018 10:	epared: 38 am
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI O N	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT						7.00
	00800 LAUNDRY & LINEN SERVICE						8.00
	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A	59, 513					11.00
	01300 NURSI NG ADMI NI STRATI ON	3, 595					13.00
	01400 CENTRAL SERVICES & SUPPLY	3, 373	15, 207		0		14.00
	01400 CENTRAL SERVICES & SUPPLY	2, 359	-				14.00
						25 120	1
	01600 MEDI CAL RECORDS & LI BRARY	2, 592				25, 128	1
	01700 SOCIAL SERVICE	1, 156			1 0	0	
	01900 NONPHYSI CI AN ANESTHETI STS	0	0		0 0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
	03000 ADULTS & PEDIATRICS	15, 481				4, 736	
	03100 I NTENSI VE CARE UNI T	2, 846		19		377	31.00
-	04300 NURSERY	360	0		0 0	103	43.00
	ANCI LLARY SERVI CE COST CENTERS				-		
	05000 OPERATING ROOM	2, 366		75		1, 285	
	05200 DELIVERY ROOM & LABOR ROOM	211	0		2 0	0	
	05300 ANESTHESI OLOGY	0	-		2 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	6, 169	0	40		51	54.00
	06000 LABORATORY	7,023	0	34,80	2 0	668	60.00
65.00	06500 RESPI RATORY THERAPY	2, 988	0	59	4 0	805	65.00
66.00	06600 PHYSI CAL THERAPY	2, 276	0	22	9 0	171	66.00
67.00	06700 OCCUPATI ONAL THERAPY	680	0		0 0	206	67.00
68.00	06800 SPEECH PATHOLOGY	69	0		1 0	51	68.00
69.00	06900 ELECTROCARDI OLOGY	302	0	8	0 0	43	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	23, 36	6 0	43	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	981	0	47	0 37, 116	94	73.00
	OUTPATIENT SERVICE COST CENTERS						
91.00	09100 EMERGENCY	7, 103	3, 886	85	2 0	16, 495	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS			•			
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	58, 557	15, 207	64, 06	9 37, 116	25, 128	118.00
	NONREI MBURSABLE COST CENTERS						1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	956			0 0		192.00
	07950 FOUNDATION / MOBS	0			0 0		194.00
200.00	Cross Foot Adjustments	-	-				200.00
201.00	Negati ve Cost Centers	n	0		0 0	n	201.00
202.00	TOTAL (sum lines 118 through 201)	59, 513	15, 207	64,06	9 37, 116		202.00

		EENE COUNTY GE	NERAL HOSPITAL			u of Form CMS-	2552-10
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1317	Period: From 01/01/2017 To 12/31/2017		
	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	
	RAL SERVICE COST CENTERS						
2.00 00200 4.00 00400 5.00 00500 7.00 00700 8.00 00800 9.00 00900 10.00 01000	D CAP REL COSTS-BLDG & FIXT D CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL OPERATION OF PLANT LAUNDRY & LINEN SERVICE D HOUSEKEEPING D DI ETARY						1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00
13.000130014.000140015.000150016.0001600	NURSI NG ADMI NI STRATI ON CENTRAL SERVI CES & SUPPLY PHARMACY MEDI CAL RECORDS & LI BRARY						13.00 14.00 15.00 16.00
	D SOCIAL SERVICE	8, 121					17.00
	NONPHYSICIAN ANESTHETISTS	0	949				19.00
	FLENT ROUTINE SERVICE COST CENTERS	5, 430		346, 27	78 0	346, 278	30.00
	DINTENSIVE CARE UNIT	1, 370		69, 14			
	D NURSERY	0		10, 96			
	LARY SERVICE COST CENTERS						
	OPERATING ROOM	0		165, 05			
	DELIVERY ROOM & LABOR ROOM	0		67, 26			
	ANESTHESI OLOGY	0		13			
	D RADI OLOGY-DI AGNOSTI C D LABORATORY	0		106, 59 89, 04	-		
	RESPIRATORY THERAPY	0		17, 67			
	PHYSI CAL THERAPY	0		24, 97			
67.00 06700	OCCUPATIONAL THERAPY	0		21, 92			
68.00 06800	SPEECH PATHOLOGY	0		5,86	57 0		
	D ELECTROCARDI OLOGY	0		3, 62			
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0		26, 49			
	DIMPL. DEV. CHARGED TO PATIENTS	0		10.11	0 0 32 0		
	D DRUGS CHARGED TO PATIENTS	0		60, 63	0	60, 632	73.00
	EMERGENCY	1, 321		155, 77	75 0	155, 775	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)	1, 521		100, 77	0		92.00
	AL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 121	0	1, 171, 44	1 0	1, 171, 441	118.00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		5, 53	30 0	5 530	190.00
	PHYSICIANS' PRIVATE OFFICES	0		19, 73			192.00
	FOUNDATION / MOBS	0		1, 00			194.00
200.00	Cross Foot Adjustments	0	949	94			200.00
	Negative Cost Centers	0	0		0 0		201.00
201.00	negative cost conters	0	0		0	0	201.00

Heal t	h	Fi nanci a	al	S	ystems	
COST	Α	LLOCATIO	N ·	_	STATI STI CAL	BA

## GREENE COUNTY GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

Heal th F	inancial Systems GF	REENE COUNTY GE	NERAL HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider C		eri od:	Worksheet B-1	
					rom 01/01/2017		
					o 12/31/2017		
			ATED COSTS			5/30/2018 10:	
		CAPITAL REL	LATED CUSTS				
	Cost Contor Description	BLDG & FIXT	MVBLE EQUIP		Decenciliatio	ADMI NI STRATI V	
	Cost Center Description			EMPLOYEE			
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
GE	ENERAL SERVICE COST CENTERS						
1.00 00	D100 CAP REL COSTS-BLDG & FIXT	71, 323					1.00
2.00 00	0200 CAP REL COSTS-MVBLE EQUIP		71, 323				2.00
4.00 00	0400 EMPLOYEE BENEFITS DEPARTMENT	0	0	12, 853, 877	r		4.00
	0500 ADMI NI STRATI VE & GENERAL	5, 197	5, 197			22, 358, 094	
	0700 OPERATION OF PLANT	9,637					
	0800 LAUNDRY & LINEN SERVICE	498					
	0900 HOUSEKEEPI NG	551				589, 782	
	1000 DI ETARY	2, 601				177, 813	
	1100 CAFETERI A	2, 857					
13.00 0	1300 NURSI NG ADMI NI STRATI ON	358	358	768, 176	0	1, 111, 807	13.00
14.00 0	1400 CENTRAL SERVICES & SUPPLY	3, 212	3, 212	0	0 0	74, 954	14.00
15.00 0	1500 PHARMACY	1, 600	1,600	508, 459	0	676, 986	15.00
	1600 MEDICAL RECORDS & LIBRARY	1,066					
	1700 SOCIAL SERVICE	286					
	1900 NONPHYSI CI AN ANESTHETI STS	0					
		0	0		<u> </u>	242,070	19.00
	NPATIENT ROUTINE SERVICE COST CENTERS	10.011	10.011	0 501 700		0.407.474	
	3000 ADULTS & PEDIATRICS	12, 244					
	3100 INTENSIVE CARE UNIT	2, 680					
	4300 NURSERY	510	510	62, 832	0	86, 737	43.00
A	NCILLARY SERVICE COST CENTERS						
50.00 0	5000 OPERATING ROOM	7,806	7,806	376, 280	0 0	747, 848	50.00
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	3, 344	3, 344	36, 468	0	119, 240	52.00
	5300 ANESTHESI OLOGY	0					
	5400 RADI OLOGY-DI AGNOSTI C	4, 554	-	-	-	,	
	6000 LABORATORY	1,865					
	6500 RESPIRATORY THERAPY	512					
						753, 500	
	6600 PHYSI CAL THERAPY	952					
	6700 OCCUPATI ONAL THERAPY	952				213, 741	
	6800 SPEECH PATHOLOGY	285		16, 759	0	25, 676	68.00
	6900 ELECTROCARDI OLOGY	159	159	0	0 0	14, 201	69.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0 0	788, 740	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0 0	0	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	804	804	229, 171	0	1, 547, 681	73.00
	JTPATIENT SERVICE COST CENTERS						
	9100 EMERGENCY	5, 678	5, 678	1, 127, 540	) 0	2, 147, 337	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0,010	0,0,0	1,127,010		2, , 00 .	92.00
	PECIAL PURPOSE COST CENTERS						72.00
		70 209	70 209	10 500 241	2 747 242	21, 677, 061	1110 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	70, 208	70, 208	12, 528, 341	-3, 767, 242	21,077,001	118.00
	ONREI MBURSABLE COST CENTERS	070	070			4 (70	1.00.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	278					190.00
	9200 PHYSI CLANS' PRI VATE OFFI CES	837	837	325, 536	0		
194.000	7950 FOUNDATION / MOBS	0	0	0	0 0	256, 889	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,	882, 410	316, 245	3, 137, 043		3, 767, 242	202.00
00	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	12. 372026	4. 433983	0. 244054		0. 168496	203 00
		12. 372020	4. 433703	0.244034			
204.00	Cost to be allocated (per Wkst. B,					87,340	204.00
005 00	Part II)						0.05 0.0
205.00	Unit cost multiplier (Wkst. B, Part			0.000000		0.003906	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

SI ALLOCAII	ON - STATI STICAL BASIS		Provider C	CN: 15-1317	Period: From 01/01/2017 To 12/31/2017	Worksheet B-1 Date/Time Pre 5/30/2018 10:	epar
(	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (PI ECES OF LAUNDRY)	HOUSEKEEPI N (HOURS OF SERVI CE)	G DI ETARY (MEALS SERVED)	CAFETERI A (HOURS)	
		7.00	8.00	9.00	10.00	11.00	
GENERA	L SERVICE COST CENTERS	_					
	CAP REL COSTS-BLDG & FIXT						1
00 00200 0	CAP REL COSTS-MVBLE EQUIP						2
00400 E	EMPLOYEE BENEFITS DEPARTMENT						4
00500 A	ADMINISTRATIVE & GENERAL						5
00700	OPERATION OF PLANT	56, 489					7
1 00800 OC	LAUNDRY & LINEN SERVICE	498	12, 098				8
00900 H	HOUSEKEEPI NG	551	0	249, 4	75		9
00 01000 0	DI ETARY	2, 601	0		0 6, 990		10
00 01100 0	CAFETERIA	2, 857	0	30	00 00	16, 372	11
1 1	NURSING ADMINISTRATION	358		3, 3		989	
00 01400 0	CENTRAL SERVICES & SUPPLY	3, 212	15			0	14
	PHARMACY	1,600				649	
	MEDICAL RECORDS & LIBRARY	1, 066		0,,	0 0	713	
	SOCIAL SERVICE	286			0 0	318	
	VONPHYSI CI AN ANESTHETI STS	0			0 0	010	
	ENT ROUTINE SERVICE COST CENTERS		, <u> </u>	1	0 0	0	1 .
	ADULTS & PEDIATRICS	12, 244	3, 256	101, 3	50 6, 312	4, 259	30
	INTENSIVE CARE UNIT	2, 680				783	
00 04300		510				99	
	ARY SERVICE COST CENTERS	510	<u> </u>	1, 0;	<u> </u>	99	43
	DPERATING ROOM	7 904	576	24, 0	50 0	651	50
		7,806					
	DELIVERY ROOM & LABOR ROOM	3, 344		6, 50		58	
	ANESTHESI OLOGY	C	-		0 0	0	
	RADI OLOGY-DI AGNOSTI C	4, 554				1, 697	
		1,865				1, 932	
	RESPI RATORY THERAPY	512		-1		822	
	PHYSI CAL THERAPY	952				626	
	DCCUPATIONAL THERAPY	952				187	
	SPEECH PATHOLOGY	285			0 0	19	
	ELECTROCARDI OLOGY	159			0 0	83	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	C	-		0 0	0	
	MPL. DEV. CHARGED TO PATIENTS	C	-		0 0	0	
	DRUGS CHARGED TO PATIENTS	804	0		0 0	270	73
	I ENT SERVICE COST CENTERS		1				
	EMERGENCY	5, 678	2, 611	53, 9	75 0	1, 954	
	DBSERVATION BEDS (NON-DISTINCT PART)						92
	L PURPOSE COST CENTERS	r	-	1			
	SUBTOTALS (SUM OF LINES 1 through 117)	55, 374	11, 842	243, 2	75 6, 990	16, 109	118
	MBURSABLE COST CENTERS	r	-	1			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	278			00 00		190
2.00 19200 F	PHYSICIANS' PRIVATE OFFICES	837	256	6, 10	00 00	263	192
4. 00 07950 F	FOUNDATION / MOBS	C	0		0 0	0	194
0.00	Cross Foot Adjustments						200
1.00	Negative Cost Centers						201
2.00	Cost to be allocated (per Wkst. B,	2, 298, 471	388, 798	711, 5	78 313, 606	985, 312	202
F	Part I)						1
3. OO U	Jnit cost multiplier (Wkst. B, Part I)	40. 688824	32. 137378	2.85230	02 44. 864950	60. 182751	203
	Cost to be allocated (per Wkst. B,	169, 642				59, 513	
	Part II)						1
	Jnit cost multiplier (Wkst. B, Part	3. 003098	0. 917259	0. 0529	87 7. 470529	3. 635048	205
		5.000070				2.000010	
	VAHE adjustment amount to be allocated	1					206
	(per Wkst. B-2)						[
	VAHE unit cost multiplier (Wkst. D,	1					207
	Parts III and IV)	1	1	1			1-0

OST ALLOC	ancial Systems GF ATION - STATISTICAL BASIS	REENE COUNTY GEN	Provider CO		In Lie Period:	Worksheet B-1	1
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/30/2018 10:	epare
	Cost Center Description	NURSI NG ADMI NI STRATI O N (DI RECT NURS. HRS.)	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.)	PHARMACY (COSTED REQUI S. )	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCIAL SERVICE (TIME SPENT)	38 8
		13.00	14.00	15.00	16.00	17.00	
GENE	RAL SERVICE COST CENTERS						
.00         0010           .00         0020           .00         0040           .00         0050           .00         0050           .00         0070           .00         0080           .00         0090	00 CAP REL COSTS-BLDG & FIXT 100 CAP REL COSTS-MVBLE EQUIP 100 EMPLOYEE BENEFITS DEPARTMENT 100 ADMINISTRATIVE & GENERAL 100 OPERATION OF PLANT 100 LAUNDRY & LINEN SERVICE 100 HOUSEKEEPING						1. 2. 4. 5. 7. 8. 9.
1.00         0110           3.00         0130           4.00         0140           5.00         0150	00 DI ETARY 100 CAFETERI A 100 NURSI NG ADMI NI STRATI ON 100 CENTRAL SERVI CES & SUPPLY 100 PHARMACY 100 MEDI CAL RECORDS & LI BRARY	7, 647 0 0	2, 125, 646 7, 263 3, 524	10	0 0 73, 350		10. 11. 13. 14. 15. 16.
	0 SOCI AL SERVI CE	0	41		0 0	16, 600	
	00 NONPHYSI CLAN ANESTHETI STS	0	0		0 0	0	
	TIENT ROUTINE SERVICE COST CENTERS						
0.00 0300	0 ADULTS & PEDIATRICS	4, 259	64, 817		0 13, 825	11, 100	30
	O INTENSIVE CARE UNIT	783	6, 578		0 1, 100	2, 800	
	0 NURSERY	0	0		0 300	0	43
	LLARY SERVICE COST CENTERS					-	
	O OPERATING ROOM	651	24, 982		0 3, 750	0	
	0 DELIVERY ROOM & LABOR ROOM	0	60		0 0 0 0	0	
	00 ANESTHESI OLOGY	0	1,403			0	
	00 RADI OLOGY-DI AGNOSTI C 00 LABORATORY	0	13, 257				
	0 RESPIRATORY THERAPY	0	1, 154, 660 19, 713		0 1, 950 0 2, 350	0	
	0 PHYSI CAL THERAPY	0	7, 593		0 2,350	0	
-	0 OCCUPATIONAL THERAPY	0	7, 343		0 600	0	
	O SPEECH PATHOLOGY	0	26		0 150	0	
	0 ELECTROCARDI OLOGY	0	2,649		0 125	0	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	775, 211		0 125	C C	
	O IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
	DO DRUGS CHARGED TO PATIENTS	0	15, 609	10		0	
	ATIENT SERVICE COST CENTERS		10,007		2,0		
	O EMERGENCY	1, 954	28, 260		0 48, 150	2, 700	91
2.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART)						92
SPEC	I AL PURPOSE COST CENTERS						
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	7,647	2, 125, 646	10	0 73, 350	16, 600	118
	EI MBURSABLE COST CENTERS						
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190
	0 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192
	FOUNDATION / MOBS	0	0		0 0	0	194
00.00	Cross Foot Adjustments						200
01.00	Negative Cost Centers	1 202 705	224 021	00/ 75	- 470 000	410 005	201
02.00	Cost to be allocated (per Wkst. B,	1, 382, 785	226, 031	906, 75	5 479, 323	419, 285	202
03. 00	Part I) Unit cost multiplier (Wkst. B, Part I)	180. 827122	0. 106335	9, 067. 55000	0 6. 534738	25. 258133	202
00 04.00	Cost to be allocated (per Wkst. B,	15, 207	64,069	37, 11		8, 121	
	Part II)	15, 207	04,009	37,11	20, 120	0, 121	204
05.00	Unit cost multiplier (Wkst. B, Part	1. 988623	0. 030141	371. 16000	0 0. 342577	0. 489217	205
06.00	II) NAHE adjustment amount to be allocated		0.000141	0.1.10000	5.012077	0. 10/21/	205
	(per Wkst. B-2)						
07.00	NAHE unit cost multiplier (Wkst. D,						207
	Parts III and IV)						

Heal th	Fi nanci al	Systems	
COST A			1

Health Financial Systems	GREENE COUNTY GENE	ERAL HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-1317	Peri od:	Worksheet B-1
			From 01/01/2017 To 12/31/2017	Date/Time Prepared:
Cost Center Description	NONPHYSI CI AN			5/30/2018 10:38 am
	ANESTHETI STS			
	(ASSI GNED			
	TIME) 19.00			
GENERAL SERVICE COST CENTERS	17.00			
1.00 00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00 00500 ADMINI STRATI VE & GENERAL				5.00
7.00 00700 OPERATION OF PLANT				7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG				8.00 9.00
10. 00 01000 DI ETARY				10.00
11. 00 01100 CAFETERI A				11.00
13.00 01300 NURSING ADMINISTRATION				13.00
14.00 01400 CENTRAL SERVICES & SUPPLY				14.00
15.00 01500 PHARMACY				15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY				16.00
17.00 01700 SOCIAL SERVICE	100			17.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100			19.00
30. 00 03000 ADULTS & PEDIATRICS	0			30.00
31. 00 03100 I NTENSI VE CARE UNI T	0			31.00
43.00 04300 NURSERY	0			43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			52.00
53. 00 05300 ANESTHESI OLOGY	100			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	0			54.00 60.00
65. 00 06500 RESPIRATORY THERAPY	0			65.00
66. 00 06600 PHYSI CAL THERAPY	0			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0			67.00
68.00 06800 SPEECH PATHOLOGY	0			68.00
69. 00 06900 ELECTROCARDI OLOGY	0			69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS				73.00
91. 00 09100 EMERGENCY	0			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	)			92.00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 1	17) 100			118.00
NONREI MBURSABLE COST CENTERS				100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			190.00 192.00
194. 00 07950 FOUNDATION / MOBS	0			192.00
200.00 Cross Foot Adjustments				200.00
201.00 Negative Cost Centers				201.00
202.00 Cost to be allocated (per Wkst. B,	283, 800			202.00
Part I)				
203.00 Unit cost multiplier (Wkst. B, Part				203.00
204.00 Cost to be allocated (per Wkst. B,	949			204.00
205.00 Part II) Unit cost multiplier (Wkst. B, Part	9. 490000			205.00
	7.470000			205.00
206.00 NAHE adjustment amount to be alloca	ted			206.00
(per Wkst. B-2)				
207.00 NAHE unit cost multiplier (Wkst. D,				207.00
Parts III and IV)				

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 10:	parec 38 ar
		Title	XVIII	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1			-11		
0. 00 03000 ADULTS & PEDIATRICS	6, 210, 464		6, 210, 46		0	
1.00 03100 INTENSIVE CARE UNIT	1, 302, 765		1, 302, 76		0	
3. 00 04300 NURSERY	133, 016		133, 01	6 0	0	43.
ANCILLARY SERVICE COST CENTERS		1				4
0.00 05000 OPERATING ROOM	1, 462, 641		1, 462, 64		0	
2.00 05200 DELIVERY ROOM & LABOR ROOM	297, 431		297, 43		0	
3. 00 05300 ANESTHESI OLOGY	312, 065		312, 06		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 713, 221		2, 713, 22		0	
0. 00 06000 LABORATORY	3, 120, 045		3, 120, 04		0	
5. 00 06500 RESPI RATORY THERAPY	979, 057		979, 05		0	
6. 00 06600 PHYSI CAL THERAPY	679, 204		679, 20		0	
7.00 06700 OCCUPATI ONAL THERAPY	352, 298		352, 29		0	
8.00 06800 SPEECH PATHOLOGY	43, 724		43, 72		0	
9. 00 06900 ELECTROCARDI OLOGY	29, 158		29, 15		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1,004,889		1, 004, 88	9 0	0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	
3.00 07300 DRUGS CHARGED TO PATIENTS	2, 767, 634		2, 767, 63	4 0	0	73.
OUTPATIENT SERVICE COST CENTERS	-	1				4
1.00 09100 EMERGENCY	3, 834, 833		3, 834, 83		0	1
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 911, 430		1, 911, 43		0	1
00.00 Subtotal (see instructions)	27, 153, 875		27, 153, 87			200.
01.00 Less Observation Beds	1, 911, 430		1, 911, 43			201.
02.00 Total (see instructions)	25, 242, 445	0	25, 242, 44	5 0	0	202.

Health Financial Systems G	REENE COUNTY GEI	NERAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 10:	pared: 38 am
		Title	XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 899, 711		2, 899, 71	1		30.00
31.00 03100 INTENSIVE CARE UNIT	581, 900		581, 90	0		31.00
43.00 04300 NURSERY	238, 114		238, 11	4		43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	604, 849	3, 003, 038	3, 607, 88	0. 405401	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	179, 017	21, 605	200, 62	1. 482544	0.00000	52.00
53.00 05300 ANESTHESI OLOGY	118, 799	401, 144	519, 94	3 0. 600191	0.00000	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	639, 699	18, 361, 610	19,001,30	0. 142791	0.00000	54.00
60. 00 06000 LABORATORY	1, 197, 236	16, 557, 851	17, 755, 08	0. 175727	0.00000	60.00
65. 00 06500 RESPI RATORY THERAPY	1, 194, 716	1, 290, 061	2, 484, 77	0. 394022	0.00000	65.00
66. 00 06600 PHYSI CAL THERAPY	169, 818	2, 376, 797	2, 546, 61	5 0. 266709	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	86, 508	774, 265	860, 77	3 0. 409281	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	13, 710	111, 270	124, 98	0. 349848	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	268, 820	1, 935, 960	2, 204, 78	0. 013225	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 154, 182	1, 496, 576	2, 650, 75	0. 379095	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0.000000	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 046, 242	8, 040, 923	10, 087, 16	0. 274372	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	651, 183	16, 739, 828	17, 391, 01	1 0. 220507	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	185, 160	1, 602, 564	1, 787, 72	4 1.069197	0.000000	92.00
200.00 Subtotal (see instructions)	12, 229, 664	72, 713, 492	84, 943, 15	6		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	12, 229, 664	72, 713, 492	84, 943, 15	6		202.00

5/30/2018 10:38 am C: \MCRIF32\Greene County 2017 5.29 with insurance.mcrx

lealth Financial Systems	GREENE COUNTY GEN		In Lieu of Form CMS-2552-1		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1317	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Prepar 5/30/2018 10:38	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30	
31. 00 03100 INTENSIVE CARE UNIT				31	
43. 00 04300 NURSERY				43	
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000			50	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52	
53. 00 05300 ANESTHESI OLOGY	0. 000000			53	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54	
50. 00 06000 LABORATORY	0. 000000			60	
55. 00 06500 RESPIRATORY THERAPY	0. 000000			65	
56. 00 06600 PHYSI CAL THERAPY	0. 000000			66	
57. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67	
58. 00 06800 SPEECH PATHOLOGY	0. 000000			68	
59. 00 06900 ELECTROCARDI OLOGY	0. 000000			69	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				71	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000 0. 000000			72	
OUTPATIENT SERVICE COST CENTERS	0.00000			73	
P1. 00 09100 EMERGENCY	0. 000000			91	
22. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92	
200.00 Subtotal (see instructions)	, 0.000000			200	
201.00 Less Observation Beds				201	
202.00 Total (see instructions)				202	

Heal th	Fi nan	ci al	Syst	ems			
COMPUT	ATION	OF F	RATIO	0F	COSTS	T0	CHARG

## GREENE COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1317	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/30/2018 10:	
		Ti tl	e XIX	Hospi tal	Cost	
				Costs		
Cost Center Description	Total Cost (from Wkst.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	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	6, 210, 464		6, 210, 46	04 0	6, 210, 464	30.00
31.00 03100 INTENSIVE CARE UNIT	1, 302, 765		1, 302, 76	5 0	1, 302, 765	31.00
43.00 04300 NURSERY	133, 016		133, 01	6 0	133, 016	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 O5000 OPERATING ROOM	1, 462, 641		1, 462, 64		1, 462, 641	
52.00 05200 DELIVERY ROOM & LABOR ROOM	297, 431		297, 43	31 0	297, 431	52.00
53. 00 05300 ANESTHESI OLOGY	312, 065		312, 06		312, 065	
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 713, 221		2, 713, 22		2, 713, 221	
60. 00 06000 LABORATORY	3, 120, 045		3, 120, 04		3, 120, 045	
65. 00 06500 RESPI RATORY THERAPY	979, 057	0	979, 05		979, 057	
66. 00 06600 PHYSI CAL THERAPY	679, 204	0	679, 20		679, 204	
67.00 06700 OCCUPATI ONAL THERAPY	352, 298	0	352, 29		352, 298	
68.00 06800 SPEECH PATHOLOGY	43, 724	0	43, 72		43, 724	68.00
69. 00 06900 ELECTROCARDI OLOGY	29, 158		29, 15		29, 158	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 004, 889		1, 004, 88	39 0	1, 004, 889	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 767, 634		2, 767, 63	34 0	2, 767, 634	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	3, 834, 833		3, 834, 83		-/ //	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 911, 430		1, 911, 43		1, 911, 430	
200.00 Subtotal (see instructions)	27, 153, 875	0	,,		211 1001010	
201.00 Less Observation Beds	1, 911, 430		1, 911, 43		1, 911, 430	
202.00  Total (see instructions)	25, 242, 445	0	25, 242, 44	15 0	25, 242, 445	202.00

Health Financial Systems G	REENE COUNTY GEI	NERAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2017	Worksheet C Part I	
				To 12/31/2017	Date/Time Pre	pared:
					5/30/2018 10:	<u>38 am</u>
			e XIX	Hospi tal	Cost	
Cost Center Description	Inpatient	Charges Outpatient	Total (col	6 Cost or Other	TEFRA	
cost center bescription	Inpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
			+ cor. 7)	Ratio	Ratio	
	6,00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	0.00		0100	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100	
30. 00 03000 ADULTS & PEDI ATRI CS	2, 899, 711		2, 899, 71	1		30.00
31.00 03100 INTENSIVE CARE UNIT	581, 900		581, 90			31.00
43.00 04300 NURSERY	238, 114		238, 11	4		43.00
ANCILLARY SERVICE COST CENTERS						1
50.00 05000 OPERATING ROOM	604, 849	3, 003, 038	3, 607, 88	0. 405401	0.00000	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	179, 017	21, 605	200, 62	1. 482544	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	118, 799	401, 144	519, 94	3 0. 600191	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	639, 699	18, 361, 610			0.00000	
60. 00 06000 LABORATORY	1, 197, 236	16, 557, 851	17, 755, 08	0. 175727	0.00000	
65. 00 06500 RESPI RATORY THERAPY	1, 194, 716	1, 290, 061	2, 484, 77		0.000000	
66. 00 06600 PHYSI CAL THERAPY	169, 818	2, 376, 797	2, 546, 61		0.000000	
67.00 06700 OCCUPATI ONAL THERAPY	86, 508	774, 265			0.000000	
68.00 06800 SPEECH PATHOLOGY	13, 710	111, 270				
69. 00 06900 ELECTROCARDI OLOGY	268, 820	1, 935, 960			0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 154, 182	1, 496, 576	2, 650, 75		0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0. 000000		
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 046, 242	8, 040, 923	10, 087, 16	0. 274372	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	651, 183	16, 739, 828			0.000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	185, 160	1, 602, 564			0.000000	1
200.00 Subtotal (see instructions)	12, 229, 664	72, 713, 492	84, 943, 15	6		200.00
201.00 Less Observation Beds	10 000 ///	70 710 400	04 040 45			201.00
202.00  Total (see instructions)	12, 229, 664	72, 713, 492	84, 943, 15	0		202.00

5/30/2018 10:38 am C: \MCRIF32\Greene County 2017 5.29 with insurance.mcrx

	GREENE COUNTY GENI			u of Form CMS-2552
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1317	Period: From 01/01/2017	Worksheet C Part I
			To 12/31/2017	
				5/30/2018 10:38
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30
31.00 03100 INTENSIVE CARE UNIT				31
43. 00 04300 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
0.00 05000 OPERATING ROOM	0. 000000			50
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52
53. 00 05300 ANESTHESI OLOGY	0. 000000			53
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54
50. 00 06000 LABORATORY	0. 000000			60
55. 00 06500 RESPI RATORY THERAPY	0. 000000			65
56. 00 06600 PHYSI CAL THERAPY	0. 000000			66
57.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67
58.00 06800 SPEECH PATHOLOGY	0. 000000			68
59. 00 06900 ELECTROCARDI OLOGY	0. 000000			69
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73
OUTPATIENT SERVICE COST CENTERS				
P1. 00 09100 EMERGENCY	0. 000000			91
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92
200.00 Subtotal (see instructions)				200
201.00 Less Observation Beds				201
202.00 Total (see instructions)				202

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2017 To 12/31/2017		nared
				10 12/31/2017	5/30/2018 10:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	I		T			
50.00 05000 OPERATING ROOM	165, 052					
52.00 05200 DELIVERY ROOM & LABOR ROOM	67, 264				0	52.00
53.00 05300 ANESTHESI OLOGY	136				19	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	106, 598					54.00
60. 00 06000 LABORATORY	89, 048					
65. 00 06500 RESPI RATORY THERAPY	17,673	2, 484, 777	0. 00711	3 701, 205	4, 988	65.00
66. 00 06600 PHYSI CAL THERAPY	24, 975		0. 00980	72, 522	711	66.00
67.00 06700 OCCUPATI ONAL THERAPY	21, 921	860, 773	0. 02546	22, 867	582	67.00
68.00 06800 SPEECH PATHOLOGY	5, 867	124, 980	0. 04694	4 9, 758	458	68.00
69. 00 06900 ELECTROCARDI OLOGY	3, 629	2, 204, 780	0. 00164	6 207, 947	342	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 490	2, 650, 758	0.00999	77, 037	770	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	60, 632	10, 087, 165	0. 00601	1 1, 816, 526	10, 919	73.00
OUTPATIENT SERVICE COST CENTERS	_					
91.00 09100 EMERGENCY	155, 775	17, 391, 011	0. 00895	39, 295	352	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	106, 576	1, 787, 724	0. 05961	5 0	0	92.00
200.00 Total (lines 50 through 199)	851, 636	81, 223, 431		4, 478, 726	34, 094	200.00

Heal th	Health Financial Systems GREENE COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552-10						2552-10
APPORT	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C	CN: 15-1317	Peri od:	Worksheet D	
THROUG	H COSTS				From 01/01/2017		norod.
					To 12/31/2017	Date/Time Pre 5/30/2018 10:	38 am
			Title	XVIII	Hospi tal	Cost	00 411
	Cost Center Description	Non Physician		Nursi ng		Allied Health	
	'	Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0 0	0	50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
	05300 ANESTHESI OLOGY	283, 800	0		0 0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60.00	06000 LABORATORY	0	0		0 0	0	60.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
	06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0 0	73.00
	OUTPATIENT SERVICE COST CENTERS	1				-	
	09100 EMERGENCY	0	0		0 0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	
200.00	Total (lines 50 through 199)	283, 800	0		0  C	0 0	200.00

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE	RVICE OTHER PAS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017 To 12/31/2017		narod
				10 12/31/2017	5/30/2018 10:	38 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of col 1	Outpatient	(from Wkst.	to Charges	
	Educati on	through col.	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col. 2, 3 an	d col. 8)	col. 7)	
			4)			
	4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0	0		0 3, 607, 887		1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 200, 622		1
53. 00 05300 ANESTHESI OLOGY	0	283, 800		0 519, 943	0. 545829	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 19, 001, 309	0.000000	54.00
60. 00 06000 LABORATORY	0	0		0 17, 755, 087	0.000000	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 484, 777	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 2, 546, 615	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 860, 773	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 124, 980	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 2, 204, 780	0.000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 2, 650, 758	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 10, 087, 165	0.000000	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0		0 17, 391, 011	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 787, 724	0.000000	92.00
200.00 Total (lines 50 through 199)	0	283, 800		0 81, 223, 431		200.00

Health Financial Systems GF	REENE COUNTY GEN	ERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2017 To 12/31/2017		nared
				10 12/31/2017	5/30/2018 10:	38 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷		Costs (col. 8	3	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVICE COST CENTERS			1			
50.00 05000 OPERATING ROOM	0. 000000	180, 924		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	73, 261		8 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	452, 870		0 0	0	54.00
60. 00 06000 LABORATORY	0. 000000	824, 514		0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	701, 205		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	72, 522		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	22, 867		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	9, 758		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	207, 947		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	77, 037		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 816, 526		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0. 000000	39, 295		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00   Total (lines 50 through 199)		4, 478, 726	39, 98	8 0	0	200.00

Health Financial Systems GR	EENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	-	Period: From 01/01/2017 Fo 12/31/2017		
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 405401	0	890, 74	5 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 482544	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 600191	0	252, 093	3 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 142791	0	6, 772, 492	2 0	0	54.00
60. 00 06000 LABORATORY	0. 175727	0	6, 721, 60	3 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 394022	0	505, 550	6 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 266709	0	993, 65	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 409281	0	268, 46	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 349848	0	9, 57	2 0	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 013225	0	978, 22	4 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.379095	0	522, 103	3 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 274372	0	3, 453, 842	2 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		•	•			1
91.00 09100 EMERGENCY	0. 220507	0	5, 608, 38	1 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 069197	0	625, 40	3 0	0	92.00
200.00 Subtotal (see instructions)		0	27, 602, 13	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	27, 602, 13	0	0	202.00

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lieu	ı of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CO	CN: 15-1317	Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/30/2018 10:	
		Title	XVIII	Hospi tal	Cost	
	Cos					
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS	2(1.100	0				50.00
50.00 05000 OPERATING ROOM	361, 109	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	151, 304	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	967, 051	0				54.00
60. 00 06000 LABORATORY	1, 181, 167	0				60.00
65. 00 06500 RESPI RATORY THERAPY	199, 200	0				65.00
66. 00 06600 PHYSI CAL THERAPY	265, 016	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	109, 876	0				67.00
68.00 06800 SPEECH PATHOLOGY	3, 349	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	12, 937	0				69.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	197, 927	0				71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 O7300 DRUGS CHARGED TO PATIENTS	947, 638	0				73.00
OUTPATIENT SERVICE COST CENTERS	1 00/ /07	0				01.00
91.00 09100 EMERGENCY	1, 236, 687	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	668, 684	0				92.00
200.00 Subtotal (see instructions)	6, 301, 945	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	4 201 045	0				202 00
202.00 Net Charges (line 200 - line 201)	6, 301, 945	0				202.00

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1317	Period:	Worksheet D	
		Composit		From 01/01/2017	Part V	and the second se
		Component	CCN: 15-Z317	Го 12/31/2017	Date/Time Pre 5/30/2018 10:	
		Title	XVIII S	wing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1			1		
50.00 05000 OPERATING ROOM	0. 405401			0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 482544	0	(	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 600191	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 142791	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 175727	0	(	0 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 394022	0	(	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 266709	0	(	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 409281	0	(	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 349848	0	(	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 013225	0	(	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 379095	0	(	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	(	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 274372	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS		•	•	· · · · · · · · · · · · · · · · · · ·		
91.00 09100 EMERGENCY	0. 220507	0	(	0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 069197	0		0 0	0	92.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	(	0 0	0	202.00

Health Financial Systems GR	ealth Financial Systems GREENE COUNTY GENERAL HOSPITAL			In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1317	Peri od:	Worksheet D	
		Component	CON. 15 7017	From 01/01/2017	Part V	norod.
		component (	CCN: 15-Z317	To 12/31/2017	Date/Time Pre 5/30/2018 10:	
		Title	XVIII	Swing Beds - SNF		00 0
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7.00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
60. 00 06000 LABORATORY	0	0				60.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
OUTPATIENT SERVICE COST CENTERS						
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems GR	EENE COUNTY GE	NERAL HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2017 To 12/31/2017		pared: 38 am
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	Charge Ratio	Reimbursed	Reimbursed	Reimbursed	(see inst.)	
	From	Services (see	Servi ces	Services Not		
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.		Ded. & Coins.	Ded. & Coins.		
	9		(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 405401	0	57, 91	4 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 482544	0	41	7 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 600191	0	19, 04	5 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 142791	0	354, 10	4 0	0	54.00
60. 00 06000 LABORATORY	0. 175727	0	319, 31	8 0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 394022	0	24, 87	9 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 266709	0	45, 83	7 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 409281	0	14, 93	2 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 349848	0	2, 14	6 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 013225	0	37, 33	5 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 379095	0	28, 61	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 274372	0	156, 23	0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS			•	·		1
91.00 09100 EMERGENCY	0. 220507	0	322, 82	8 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 069197	0	30, 90	5 0	0	92.00
200.00 Subtotal (see instructions)		0	1, 414, 50	0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0	1, 414, 50	0 0	0	202.00

Health Financial Systems GF	th Financial Systems GREENE COUNTY GENERAL HOSPITAL				In Lieu of Form CMS-2552-10			
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet D Part V Date/Time Pre 5/30/2018 10:			
		Ti tl	e XIX	Hospi tal	Cost			
	Cos							
Cost Center Description	Cost	Cost						
	Reimbursed	Reimbursed						
	Servi ces	Services Not						
	Subject To	Subject To						
		Ded. & Coins.						
	(see inst.)	(see inst.)						
	6.00	7.00				_		
ANCI LLARY SERVICE COST CENTERS	00.470	0				50.00		
50.00 05000 OPERATING ROOM	23, 478	0				50.00		
52. 00 05200 DELIVERY ROOM & LABOR ROOM	618	0				52.00		
53. 00 05300 ANESTHESI OLOGY	11, 431	0				53.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	50, 563	0				54.00		
60. 00 06000 LABORATORY	56, 113	0				60.00		
65. 00 06500 RESPI RATORY THERAPY	9, 803	0				65.00		
66. 00 06600 PHYSI CAL THERAPY	12, 225	0				66.00		
67. 00 06700 OCCUPATI ONAL THERAPY	6, 111	0				67.00		
68.00 06800 SPEECH PATHOLOGY	751	0				68.00		
69. 00 06900 ELECTROCARDI OLOGY	494	0				69.00		
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	10, 846	0				71.00		
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.00		
73.00 O7300 DRUGS CHARGED TO PATIENTS	42, 865	0				73.00		
OUTPATIENT SERVICE COST CENTERS	74.404							
91.00 09100 EMERGENCY	71, 186	0				91.00		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	33, 044	0				92.00		
200.00 Subtotal (see instructions)	329, 528	0				200.00		
201.00 Less PBP Clinic Lab. Services-Program	0					201.00		
Only Charges	220 520	0				202.00		
202.00 Net Charges (line 200 - line 201)	329, 528	0				202.00		

## CREENE COUNTY CENERAL HOSDITAL

	inancial Systems GREENE COUNTY GENER	RAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTAT	FION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Period: From 01/01/2017	Worksheet D-1	
			To 12/31/2017	Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/30/2018 10: Cost	<u>38 am</u>
	Cost Center Description				
D/	ART I - ALL PROVIDER COMPONENTS			1.00	
	NPATIENT DAYS				
	npatient days (including private room days and swing-bed day			3, 665	1.00
	npatient days (including private room days, excluding swing-		riveta reem deve	3, 232	2.00
	rivate room days (excluding swing-bed and observation bed da lo not complete this line.	iys). Ti you nave only p	rivate room days,	0	3.00
	emi-private room days (excluding swing-bed and observation b	ed days)		2, 104	4.00
	otal swing-bed SNF type inpatient days (including private ro	om days) through Decemb	er 31 of the cost	433	5.00
	eporting period otal swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	0	6.00
	eporting period (if calendar year, enter 0 on this line)			0	0.00
	otal swing-bed NF type inpatient days (including private roo	m days) through Decembe	r 31 of the cost	0	7.00
	eporting period otal swing-bed NF type inpatient days (including private roo	m days) after December	31 of the cost	0	8.00
0.00 n	eporting period (if calendar year, enter 0 on this line)	an days) arter becember	ST OF the cost	0	0.00
9.00 T	otal inpatient days including private room days applicable t	o the Program (excludin	g swing-bed and	1, 191	9.00
	wwborn days) wing-bed SNF type inpatient days applicable to title XVIII o	nly (including private	room days)	433	10.00
	hrough December 31 of the cost reporting period (see instruc		room days)	+55	10.00
	wing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
	ecember 31 of the cost reporting period (if calendar year, e wing-bed NF type inpatient days applicable to titles V or XI		te room davs)	0	12.00
	hrough December 31 of the cost reporting period	x only (the during priva	te room days)	0	12.00
	wing-bed NF type inpatient days applicable to titles V or XI			0	13.00
	fter December 31 of the cost reporting period (if calendar y ledically necessary private room days applicable to the Progr			0	14.00
	otal nursery days (title V or XIX only)	alli (excluding swing-bed	uays)	0	
16.00 N	lursery days (title V or XIX only)			0	
	WING BED ADJUSTMENT	an thursuch Describer 21	-6 +b+		17.00
	ledicare rate for swing-bed SNF services applicable to servic reporting period	es through becember st	of the cost		17.00
18.00 M	edicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.00
19.00 M	eporting period ledicaid rate for swing-bed NF services applicable to service	s through December 31 o	f the cost	138.07	19.00
	eporting period ledicaid rate for swing-bed NF services applicable to service	s after December 31 of	the cost	0.00	20.00
	reporting period			0100	20100
	otal general inpatient routine service cost (see instruction			6, 210, 464	
	wing-bed cost applicable to SNF type services through Decemb x line 17)	er 31 of the cost repor	ting period (line	0	22.00
23.00 Si	wing-bed cost applicable to SNF type services after December line 18)	31 of the cost reporti	ng period (line é	0	23.00
24.00 SI	wing-bed cost applicable to NF type services through Decembe	er 31 of the cost report	ing period (line	0	24.00
	x line 19) wing-bed cost applicable to NF type services after December	31 of the cost reportin	g period (line 8	0	25.00
	line 20)			700 701	0/ 2-
	otal swing-bed cost (see instructions) meneral inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		733, 731 5, 476, 733	
	RI VATE ROOM DI FFERENTI AL ADJUSTMENT			3, 470, 733	27.00
	eneral inpatient routine service charges (excluding swing-be	d and observation bed c	harges)	0	
	rivate room charges (excluding swing-bed charges) emi-private room charges (excluding swing-bed charges)			0	
	eneral inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	verage private room per diem charge (line 29 ÷ line 3)			0.00	32.00
	verage semi-private room per diem charge (line 30 ÷ line 4) verage per diem private room charge differential (line 32 mi	nus line 33)(see instru	ctions)	0.00 0.00	
	verage per diem private room cost differential (line 34 x li			0.00	
36. 00 P	rivate room cost differential adjustment (line 3 x line 35)			0	36.00
	eneral inpatient routine service cost net of swing-bed cost 7 minus line 36)	and private room cost d	ifferential (line	5, 476, 733	37.00
	ART II - HOSPITAL AND SUBPROVIDERS ONLY				1
PF	ROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				1
38.00 A	djusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 694. 53 2, 018, 185	
20 00 0					1 37.00
	ledically necessary private room cost applicable to the Progr			2,010,100	

	inancial Systems IION OF INPATIENT OPERATING COST	GREENE COUNTY GEN			Peri od:	u of Form CMS- Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre	eparo
				e XVIII	Hospi tal	5/30/2018 10: Cost	38 8
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpatient	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col. 2)		col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	URSERY (title V & XIX only)	0	C	0.0	0 0	0	) 42
	ntensive Care Type Inpatient Hospital Unit			1			
	NTENSI VE CARE UNI T	1, 302, 765	226	5, 764. 4	5 195	1, 124, 068	
	ORONARY CARE UNIT						44
	URN INTENSIVE CARE UNIT						45
	URGICAL INTENSIVE CARE UNIT						46
00 0	THER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	-
00 P	rogram inpatient ancillary service cost (	Wkst D_3 col 3	Line 200)			1, 174, 301	48
	otal Program inpatient costs (sum of line			ons)		4, 316, 554	
	ASS THROUGH COST ADJUSTMENTS			01107		1,010,001	
	ass through costs applicable to Program in	npatient routine	services (fro	m Wkst. D, sur	n of Parts I and	0	50
1	11)						
	ass through costs applicable to Program in	npatient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	) 51
	nd IV)					-	_
	otal Program excludable cost (sum of line		1			0	
	otal Program inpatient operating cost excl		ατea, non-ph	ysician anesti	ielist, and	0	) 53
	edical education costs (line 49 minus line ARGET AMOUNT AND LIMIT COMPUTATION	e 52)				I	-
	rogram discharges					0	54
	arget amount per discharge					0.00	
	arget amount (line 54 x line 55)					0.00	
	ifference between adjusted inpatient operation	ating cost and ta	rget amount (	line 56 minus	line 53)	0	
	onus payment (see instructions)	-				0	
00 L	esser of lines 53/54 or 55 from the cost	reporting period	endi ng 1996,	updated and co	ompounded by the	0.00	59
	arket basket						
	esser of lines 53/54 or 55 from prior year					0.00	
	fline 53/54 is less than the lower of line					0	6
	hich operating costs (line 53) are less tl mount (line 56), otherwise enter zero (se		s (Times 54 x	60), or 1% of	the target		
	elief payment (see instructions)	e mstructrons)				0	62
	llowable Inpatient cost plus incentive pa	vment (see instru	ctions)			0	
	ROGRAM INPATIENT ROUTINE SWING BED COST						
	ledicare swing-bed SNF inpatient routine co	osts through Dece	mber 31 of th	e cost reporti	ng period (See	733, 731	64
i	nstructions)(title XVIII only)	-					
	ledicare swing-bed SNF inpatient routine c	osts after Decemb	er 31 of the	cost reportinț	g period (See	0	65
	nstructions)(title XVIII only)						
	otal Medicare swing-bed SNF inpatient rou	tine costs (line	64 plus line	65)(title XVII	l only). For	733, 731	66
	AH (see instructions)	ina aaata thraugh	December 21	of the east m	porting ported		67
	itle V or XIX swing-bed NF inpatient rout line 12 x line 19)	The costs through	December 31	of the cost re	eporting period	0	<i>י</i> ן מ
1 1	itle V or XIX swing-bed NF inpatient rout	ine costs after D	ecember 31 of	the cost rep	orting period	0	68
	line 13 x line 20)				si ting period		
	otal title V or XIX swing-bed NF inpatien	t routine costs (	line 67 + lin	e 68)		0	69
P	ART III - SKILLED NURSING FACILITY, OTHER	NURSING FACILITY	, AND ICF/IID	ONLY			
. 00 S	killed nursing facility/other nursing fac	ility/ICF/IID rou	tine service	cost (line 37)	)		70
	djusted general inpatient routine service		ine 70 ÷ line	2)			7
	rogram routine service cost (line 9 x line			05)			72
	ledically necessary private room cost appli	0	•				73
	otal Program general inpatient routine se apital-related cost allocated to inpatien				Part II column		74
	6, line 45)	LI OULTHE SELVICE		NOI KOILEEL D, I	art II, CUIUNN		
	er diem capital-related costs (line 75 ÷ 1	line 2)					76
	Program capital-related costs (line 9 x lin						7
	npatient routine service cost (line 74 min						7
00 A	ggregate charges to beneficiaries for exc	ess costs (from p	rovi der recor	ds)			79
	otal Program routine service costs for co	•	ost limitatio	n (line 78 mir	nus line 79)		80
	npatient routine service cost per diem lin						8
	npatient routine service cost limitation	•					82
	easonable inpatient routine service costs	•	s)				8
	rogram inpatient ancillary services (see i		nc)				84
	tilization review - physician compensation otal Program inpatient operating costs (su						88
	ART IV - COMPUTATION OF OBSERVATION BED PA					I	
	otal observation bed days (see instruction					1, 128	8 87
	djusted general inpatient routine cost pe		line 2)			1, 694. 53	
. 00 A							

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017		pared: 38 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	346, 278	6, 210, 464	0.05575	57 1, 911, 430	106, 576	90.00
91.00 Nursing School cost	0	6, 210, 464	0.00000	0 1, 911, 430	0	91.00
92.00 Allied health cost	0	6, 210, 464	0.00000	0 1, 911, 430	0	92.00
93.00 All other Medical Education	0	6, 210, 464	0.0000	1, 911, 430	0	93.00

## GREENE COUNTY GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

	Financial Systems GREENE COUNTY GENE ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Davatarat		
			Peri od:	Worksheet D-1	
			From 01/01/2017 To 12/31/2017		
		<b>T</b>		5/30/2018 10:	
	Cost Center Description	Title XIX	Hospi tal	Cost	
				1.00	
F	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed day			3, 665	•
	Inpatient days (including private room days, excluding swing Private room days (excluding swing-bed and observation bed d		rivata room dave	3, 232 0	•
	do not complete this line.	ays). If you have only p	nivate room uays,	0	3.00
	Semi-private room days (excluding swing-bed and observation	bed days)		2, 104	4.00
	Total swing-bed SNF type inpatient days (including private r		per 31 of the cost	433	5.00
	reporting period				
	Total swing-bed SNF type inpatient days (including private re	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	7.00
	reporting period	on days) through becenbe	i of the cost	0	7.00
	Total swing-bed NF type inpatient days (including private ro	om days) after December	31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)				
	Total inpatient days including private room days applicable	to the Program (excludir	ng swing-bed and	55	9.00
	newborn days) 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 instru		room days)	0	10.00
	Swing-bed SNF type inpatient days applicable to title XVIII		room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year,		-		
	Swing-bed NF type inpatient days applicable to titles V or X	IX only (including priva	ate room days)	0	12.00
	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or X	IX only (including prive	ata room davc)	0	13.00
	after December 31 of the cost reporting period (if calendar			0	13.00
	Medically necessary private room days applicable to the Prog			0	14.00
	Total nursery days (title V or XIX only)	· 5 5	5 /	176	15.00
	Nursery days (title V or XIX only)			155	16.00
	SWING BED ADJUSTMENT		- C		1 17 00
	Medicare rate for swing-bed SNF services applicable to servi- reporting period	ces through December 31	or the cost		17.00
	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	° the cost		18.00
	reporting period				
	Medicaid rate for swing-bed NF services applicable to servic	es through December 31 c	of the cost	0.00	19.00
	reporting period			0.00	
	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of	the cost	0.00	20.00
	Total general inpatient routine service cost (see instruction	ns)		6, 210, 464	21.00
	Swing-bed cost applicable to SNF type services through Decem		ting period (line		
	5 x line 17)	·			
	Swing-bed cost applicable to SNF type services after Decembe	r 31 of the cost reporti	ng period (line 6	0	23.00
	x line 18) Swing-bed cost applicable to NF type services through Decemb	or 21 of the cost report	ting pariod (line	0	24.00
	7 x line 19)	el 31 01 the cost report	ing period (ine	0	24.00
1	Swing-bed cost applicable to NF type services after December	31 of the cost reportin	ng period (line 8	0	25.00
1	x line 20)				
1	Total swing-bed cost (see instructions)			733, 731	•
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 476, 733	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ed and observation bed o	harges)	0	28.00
	Private room charges (excluding swing-bed charges)		indi ges)	0	1
	Semi-private room charges (excluding swing-bed charges)			0	30.00
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		uctions)	0.00	
	Average per diem private room charge differential (line 32 m Average per diem private room cost differential (line 34 x l			0. 00 0. 00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36.00
	General inpatient routine service cost net of swing-bed cost		lifferential (line		
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ULCTNENTS			-
F					1
F	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.			1 604 50	30 00
8.00 F	Adjusted general inpatient routine service cost per diem (se	e instructions)		1, 694. 53 93, 199	
F 38. 00 39. 00		e instructions) e 38)		1, 694. 53 93, 199 0	39.00

OMPUT	Financial Systems G ATION OF INPATIENT OPERATING COST	REENE COUNTY GEN	Provi der C		Peri od:	u of Form CMS- Worksheet D-1	
					From 01/01/2017		
					To 12/31/2017	Date/Time Pre 5/30/2018 10:	
			Ti tl	e XIX	Hospi tal	Cost	50 8
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient	Inpati ent	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)	1.00	<u>col. 4)</u>	
00	NUDSERV (title V & VIX enly)	1.00	2.00	3.00 755.7	4.00	5. 00 117, 144	42
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit:		170	/ 105. /	1 155	117, 144	42
. 00	INTENSIVE CARE UNIT	1, 302, 765	226	5, 764. 4	5 0	C	43
. 00	CORONARY CARE UNIT	.,,			-	-	44
. 00	BURN INTENSIVE CARE UNIT						45
. 00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
.00	Program inpatient ancillary service cost (W	kst D-3 col 3	Line 200)			74, 108	3 48
	Total Program inpatient costs (sum of lines			ons)		284, 451	
	PASS THROUGH COST ADJUSTMENTS						
. 00	Pass through costs applicable to Program in	patient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50
	111)						
. 00	Pass through costs applicable to Program in	patient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	) 51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				0	52
3. 00	Total Program inpatient operating cost excl		lated non-nh	vsician anest	hetist and		
. 00	medical education costs (line 49 minus line		natea, non pr	ysi ci all'allest			/ 33
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient opera	ting cost and ta	irget amount (	ine 56 minus	line 53)	0	
. 00 . 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost r	operting period	onding 1004	indated and a	ompounded by the	0. 00	
. 00	market basket	eporting period	enurny 1990,	upuateu anu c	unpounded by the	: 0.00	09
. 00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by the	market basket		0.00	60
. 00	If line 53/54 is less than the lower of lin					C	61
	which operating costs (line 53) are less th	an expected cost	s (lines 54 x	60), or 1% o	f the target		
	amount (line 56), otherwise enter zero (see	instructions)					
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see Instru	ictions)			0	) 63
. 00	Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of th	e cost report	ing period (See	C	64
. 00	instructions)(title XVIII only)	sts through bood					
. 00	Medicare swing-bed SNF inpatient routine co	sts after Decemb	er 31 of the	cost reportin	g period (See	0	65
	instructions)(title XVIII only)						
. 00	Total Medicare swing-bed SNF inpatient rout	ine costs (line	64 plus line	65)(title XVI	ll only). For	0	66
	CAH (see instructions)		D 1 01	C III			
7.00	Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	December 31	of the cost r	eporting period	0	67
3. 00	Title V or XIX swing-bed NF inpatient routi	ne costs after D	ecember 31 of	the cost ren	orting period	c c	68
5. 00	(line 13 x line 20)			the cost rep	or tring period		/ 00
9.00	Total title V or XIX swing-bed NF inpatient	routine costs (	line 67 + lin	e 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER I	NURSING FACILITY	, AND ICF/IID	ONLY			
0. 00	Skilled nursing facility/other nursing faci				)		70
. 00	Adjusted general inpatient routine service		ine 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line		(lipo 14 y l	no 35)			72
. 00	Medically necessary private room cost appli Total Program general inpatient routine ser	U U	•	,			74
. 00	Capital -related cost allocated to inpatient				Part II. column		75
	26, line 45)						
. 00	Per diem capital-related costs (line 75 ÷ l						76
	Program capital-related costs (line 9 x lin	,					7
. 00	Inpatient routine service cost (line 74 min						78
00	Aggregate charges to beneficiaries for exce	• •			nus lino 70)		79
00	Total Program routine service costs for com Inpatient routine service cost per diem lim	•	ost i i mitati O	I (IIIE /8 MI	nus IIIe 19)		80
. 00	Inpatient routine service cost per drem from		)				82
. 00	Reasonable inpatient routine service costs						83
. 00	Program inpatient ancillary services (see i	•					84
. 00	Utilization review - physician compensation		ons)				85
. 00	Total Program inpatient operating costs (su		rough 85)				86
	PART IV - COMPUTATION OF OBSERVATION BED PA						
. 00	Total observation bed days (see instruction		line 2)			1, 128	
3.00	Adjusted general inpatient routine cost per					1, 694. 53 1, 911, 430	
$\cap \cap$	Observation bed cost (line 87 x line 88) (s						

Health Financial Systems GF	REENE COUNTY GE	ENERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017		pared: 38 am
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	346, 278	6, 210, 464	0. 05575	7 1, 911, 430	106, 576	90.00
91.00 Nursing School cost	C	6, 210, 464	0.00000	0 1, 911, 430	0	91.00
92.00 Allied health cost	C	6, 210, 464	0.00000	0 1, 911, 430	0	92.00
93.00 All other Medical Education	C	6, 210, 464	0.00000	1, 911, 430	0	93.00

Health Financial Systems GREENE COUNTY GENE	RAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN: 15-1317	Peri od:	Worksheet D-3	3
		From 01/01/2017 To 12/31/2017		narod.
		10 12/31/2017	5/30/2018 10:	
	Title XVIII	Hospi tal	Cost	
Cost Center Description	Ratio of Co	ost Inpatient	I npati ent	
	To Charge	s Program	Program Costs	
		Charges	(col. 1 x	
			col. 2)	
	1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS		1, 648, 014		30.00
31.00 03100 INTENSIVE CARE UNIT		450, 450		31.00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 405		73, 347	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1. 482		-	
53. 00 05300 ANESTHESI OLOGY	0.600			
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 142			
60. 00 06000 LABORATORY	0. 175			
65. 00 06500 RESPI RATORY THERAPY	0. 394			
66. 00 06600 PHYSI CAL THERAPY	0. 266			
67. 00 06700 OCCUPATI ONAL THERAPY	0. 409			
68.00 06800 SPEECH PATHOLOGY	0. 349			
69. 00 06900 ELECTROCARDI OLOGY	0.013			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 379	095 77,037	29, 204	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 274	372 1, 816, 526	498, 404	73.00
OUTPATIENT SERVICE COST CENTERS				
91.00 09100 EMERGENCY	0. 220			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1.069		0	
200.00 Total (sum of lines 50 through 94 and 96 through 98)		4, 478, 726	1, 174, 301	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)	0		201.00
202.00 Net charges (line 200 minus line 201)		4, 478, 726		202.00

Health Financial Systems GREENE COUNTY GENEI	RAL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1317	Peri od:	Worksheet D-3	
	Component	CCN: 15-Z317	From 01/01/2017 To 12/31/2017		nared
	oomponente	0011. 10 2017	10 12/01/2017	5/30/2018 10:	
	Title		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
		1.00		col . 2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31.00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 OS000 OPERATING ROOM		0. 40540	1	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 48254			
53. 00 105200 DEELVERT ROOM & EABOR ROOM		0. 60019		0	
54. 00  05500  ANESTHESTOLOGY 54. 00  05400  RADI OLOGY-DI AGNOSTI C		0. 14279		-	
60. 00 06000 LABORATORY		0. 17572			
65. 00 06500 RESPI RATORY THERAPY		0. 39402			•
66. 00 06600 PHYSI CAL THERAPY		0. 26670			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 40928			
68. 00 06800 SPEECH PATHOLOGY		0. 34984			
69. 00 06900 ELECTROCARDI OLOGY		0.01322			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.37909		52, 585	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.00000	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27437	2 174, 594	47, 904	73.00
OUTPATI ENT SERVI CE COST CENTERS					1
91. 00 09100 EMERGENCY		0. 22050	07 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.06919	07 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			695, 505	220, 886	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			695, 505		202.00

Health Financial Systems GREENE COUNTY GENER/	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	N: 15-1317	Peri od:	Worksheet D-3	
			From 01/01/2017 To 12/31/2017		narod
			10 12/31/2017	5/30/2018 10:	
	Title	e XIX	Hospi tal	Cost	
Cost Center Description	1	Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			84, 416		30.00
31. 00 03100 I NTENSI VE CARE UNI T			16, 005		31.00
43. 00 04300 NURSERY			6, 549		43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0.40540			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		1. 48254			
53. 00 05300 ANESTHESI OLOGY		0.60019	8, 920	5, 354	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.14279		2, 512	54.00
60. 00 06000 LABORATORY		0. 17572	32, 930	5, 787	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 39402	22 32, 861	12, 948	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 26670	)9 4, 671	1, 246	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 40928	2, 379	974	67.00
68.00 06800 SPEECH PATHOLOGY		0. 34984	8 377	132	68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 01322	25 7, 394	98	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.37909	95 31, 494	11, 939	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.0000	0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS		0.27437	2 55, 122	15, 124	73.00
OUTPATIENT SERVICE COST CENTERS					
91.00 09100 EMERGENCY		0. 22050	)7 17, 911	3, 950	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1.06919	97 0	0	92.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			233, 214	74, 108	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			233, 214		202.00
	1		200,211		1202.00

Image: Interpretation         Image: Interpretation         Image:	Heal th	Financial Systems GREENE COUNTY GENERA	AL HOSPI TAL		u of Form CMS-2	2552-10
Image: The second sec	CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1317	Period: From 01/01/2017		
Title XHII         Hogslief         Cost           Net 6         Medical and other services relevance (see instructions)         4, 001,045         2.00           1.00         Medical and other services relevance (see instructions)         4, 001,045         2.00           2.00         Medical and other services relevance (see instructions)         6         4.00           2.00         Medical and other services relevance         6         6.00         6.00           2.00         Medical and other services relevance         6         6.00					Date/Time Pre	
MAT B - VEDICAL AND OTHER HEALTH SERVICES           10         Medical and other services (see instructions)         6, 201,945         1.0           2.00         Medical and other services (see instructions)         0         2.00           0.00         Utilier reconciliation acount (see instructions)         0         2.00           0.01         Line 2 Lines Line 5         0.00         0.00           0.01         Organ acquisitions         6.01         0.00         0.00           0.01         Organ acquisitions         6.01         0.00 <td></td> <td></td> <td>Title XVIII</td> <td>Hospi tal</td> <td></td> <td>38 811</td>			Title XVIII	Hospi tal		38 811
MAT B - VEDICAL AND OTHER HEALTH SERVICES           10         Medical and other services (see instructions)         6, 201,945         1.0           2.00         Medical and other services (see instructions)         0         2.00           0.00         Utilier reconciliation acount (see instructions)         0         2.00           0.01         Line 2 Lines Line 5         0.00         0.00           0.01         Organ acquisitions         6.01         0.00         0.00           0.01         Organ acquisitions         6.01         0.00 <td></td> <td></td> <td></td> <td></td> <td>1 00</td> <td></td>					1 00	
2.00         Medi cal and other services reinflueursed under OPPS (see instructions)         0         0.00           0.00         OPPS payments         0.00		PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
3 00       OPES payment S:       0       0.00       0.00		Medical and other services (see instructions)				1.00
4.00     Dutlier payment (see instructions)     0     0.40       6.00     Dutlier payment (see instructions)     0.00     5.00       6.00     Sime or reconcilisition amount (see instructions)     0.00     5.00       6.00     Sime or rises 3.e., amount (see instructions)     0.00     5.00       6.00     Transitional corrisor payment (see instructions)     0.00     5.00       6.00     Total could (sum of lines 1 and 10) (see instructions)     0.00     0.00       7.00     Total could (sum of lines 1 and 10) (see instructions)     0.00     0.00       7.00     Total could (sum of lines 1 and 10) (see instructions)     0.12.00       7.00     Total could (sum of lines 1 and 10) (see instructions)     0.12.00       7.00     Total could (sum of lines 1 and 10) (see instructions)     0.12.00       7.00     Total could (sum of lines 1 and 10) (see instructions)     0.12.00       7.00     Total counds (sum of lines 1 and 10)     (see instructions)     0.12.00       7.00     Total counds (sum of lines 1 and 10)     (see instructions)     0.12.00       7.00     Total counds (sum of lines 1 and 10)     (see instructions)     0.12.00       7.00     Total counds (sum of lines 1 and 10)     (see instructions)     0.12.00       7.00     Total counds (sum of lines 1 and 10)     (see instructions)     0			tions)			2.00
4.01         Outlier resentitiation amount (see instructions)         0         0         4.01           0.02         Destructions         0.02         0.05		1.5				
6.00         Line 2 times line 5         0         6.00         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>4.01</td>						4.01
2.00         Sum of lines 3, 4, and 4, 01, divide by line 6         0.00         0			ctions)			
8.00       Transitional corridor payment (see instructions)       0						
10.00         Organ acquisitions         0         10.00           00         Constructions)         0,301.495           01.00         Constructions)         0,300.495           01.00         Constructions)         0,300.090           01.00         Constructions)         0,300.090           01.00         Constructions)         0,344.494           01.00         Constructions)         0,344.494           01.00         Constructions)         0,344.494           01.00         Constructions)         0,344.494           01.00         Constructions)         0,320.00						8.00
11.00       Total cost: (sum of lines 1 and 10) (see instructions)       6.301,491       11.00         Communication of the second comparison of the s			V, col. 13, line 200			9.00
COMPUTATION OF LESSER OF COST OR CHARGES           Reasonable charges         0           12.00 Ancillary service charges         0           13.00 Gran acquisition charges (from West. D-4, Pt. 111, col. 4, line 69)         0           14.00 Total reasonable charges (sum of lines 12 and 13)         0           15.00 Kargen acquisition charges (from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 5413.13(c)         0           16.00 Total customary charges (see instructions)         0         0           17.00 Ratio of line 15 to line 16 (not to exceed 1.000000)         0         0         0           19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see linstructions)         0         0           20.00 Excess of residents (see instructions)         0         0         0         0           21.00 Lesser of cost or charges (see instructions)         0         20.00 Cost of physiclans' services in a teaching hospital (see instructions)         0         20.00 Cost of physiclans' services in a teaching hospital (see instructions)         0         21.00 Cost of graduate mediate ducation costs (from West. E-4, line 30)         0         21.00 Cost of graduate mediate ducation costs (from West. E-4, line 30)         0         21.00 Cost of graduate mediate ducation costs (from West. E-4, line 30)         0         21.00 Distret graduate mediate ducation costs (from West. E-4, line		5 I				10.00
Reasonable charges         Construction         Construction           13.00         Organ acquisition charges (xmm Wkst. D-4, Pt. 111, col. 4, line 69)         0         12.00           13.00         Organ acquisition charges (xmm Wkst. D-4, Pt. 111, col. 4, line 69)         0         14.00           14.00         Total reasonable charges (xmm Wkst. D-4, Pt. 111, col. 4, line 69)         0         14.00           15.00         Aggregate amount actually collected from patients liable for payment for services on a chargebasis         0         15.00           16.00         Fordia customery charges (xmm of the xecced 1.000000)         11.00         0.000000         10.00           17.00         Ratio or file 15 to line 16 (not to excced 1.000000)         0.000000         10.00         0.000000         11.00           18.00         Extension         Fordia customery charges (xee instructions)         0.000000         10.00         0.000000         10.00         0.000000         10.00         0.000000         10.00         0.000000         11.00         0.000000         10.00         0.000000         10.00         0.000000         10.00         0.000000         10.000000         10.000000         10.000000         10.000000         10.000000         10.000000         10.000000         10.0000000         10.000000000000000000000         10.0000000000000000	11.00				0, 301, 945	11.00
13.00       Organ acquisition charges (from West, D.4, Pt, III, col. 4, line 69)       0       13.00         14.00       Total reasonable charges (sum of lines 12 and 13)       0       14.00         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       0       15.00         16.00       Amounts that would have been realized from patients liable for payment for services on a charge basis       0       15.00         17.00       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.000000       17.00         18.00       Destormary charges over reasonable cost (complete only if line 18 exceeds line 11) (see       0       0.000000         19.00       Excess of customary charges (see instructions)       6.34,494       20.00         20.00       Interns and residents (see instructions)       0.30,000       23.00         21.00       Lesser of cost or charges (see instructions)       0.30,000       24.00         20.00       Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)       63,008       25.00         22.00       Direct graduate medical education payments (from West, E.4, line 50)       0       21.11,209       27.00         23.00       Cost tibes and coinsurance relating to amount on line 24 (for CAH, see instructions)       2,112,209       27.00       28.00						
14.00       Total reasonable charges (sum of lines 12 and 13)       0       14.00         15.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       0       16.00         16.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       0       16.00         16.00       Aggregate amount actually collected from patients liable for payment for services on a charge basis       0       16.00         17.00       Ratio or line 15 to line 16 (not to exceed in 0.000000)       0       0.000000       17.00         18.00       Total customary charges (see instructions)       0       0       0       0         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see linstructions)       0       22.00         21.00       Lesser of cost or charges (see instructions)       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       22.00       0       22.01       0       22.01       0       22.01       0       22.01       0       22.01       0       22.01       0       22.01       22.01       2		5	(0)			
Customery charges         Isol           15:00         Amounts that would have been realized from patients liable for payment for services on a charge basis         0           16:00         Amounts that would have been realized from patients liable for payment for services on a charge basis         0           17:00         Ratio of line 15 to line 16 (not to exceed 1.000000)         0         0           18:00         Total customary charges (see instructions)         0         0         0           19:00         Excess of customary charges (see instructions)         6         3.64, 964         20.00           20:00         Excess of reasonable cost over customary charges (see instructions)         6         3.64, 964         20.00           21:00         Instructions)         6         3.64, 964         20.00         23.00           22:00         Interns and residents (see instructions)         6         3.64, 964         2.00           23:00         Cost of physicians' services in a teaching hospital (see instructions)         6.3, 649         2.00           24:00         Deductibles and coinsurance (for CAF, see instructions)         6.3, 64, 26.00         2.102, 300           25:00         Deductibles and coinsurance (for CAF, see instructions)         6.3, 608         2.00           26:00         Deductibles and coinsurance (for CA			ne 69)			
16.00       Amounts that would have been realized from patients liable for payment for services on a chargebasis have been made in accordance with 42 CFR \$413.13(e)       0       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)       0.000000       17.00         19.00       Excess of customary charges (see instructions)       0.000000       17.00         20.00       Excess of cost or charges (see instructions)       6.364.964       21.00         21.00       Lesser of cost or charges (see instructions)       6.364.964       21.00         22.00       Interms and residents (see instructions)       6.364.964       21.00         23.00       Cost of physicians' services in a teaching hospital (see instructions)       6.30.008       22.00         25.00       Deductibles and coinsurance (rot CAH, see instructions)       4.189.47       26.00         26.00       Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)       4.189.47       26.00         20.01       Statis (see instructions)       2.111.490       2.112.499       30.00         20.00       Statis (statis	14.00				0	14.00
had such payment been made in accordance with 42 CFR §413.13(e)       0         100       Ratio of line 15 to line 16 (not to exceed 1.000000)       0.0000001         18.00       Total customery charges (see instructions)       0.0000001         19.00       Excess of reasonable cost over customary charges (complete only if line 18 exceeds line 18) (see instructions)       0.000         100       tesses of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0.2000         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0.2000         21.00       Lesses of reasonable cost over customary charges (see instructions)       0.2100       0.22.00         22.00       Interns and residents (see instructions)       0.23.00       0.22.00         23.00       Cost of physic lane Structers in a tacching hospital (see instructions)       0.23.00       0.23.00         24.00       Total prospective payment (sum of lines 23, 4, 401, 8 and 9)       0.24.00       0.24.00         25.00       Deductibles and coinsurance (realing to abount on line 24 (for CAH, see instructions)       4.89,647 26.00       2.112.309       2.112.309       2.112.309       2.00         26.00       Divotal (cline 30 minus line 31)       2.112.309       2.112.309       30.00       2.112.309       30.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
17. 00       Ratio of Line 15 to Line 16 (not to exceed 1.00000)       0.000000       0.000000         18.00       Total customary charges (see instructions)       0.000000       0.000000         19. 00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       0.000000       0.000000         20. 00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0.20. 00         21. 00       Lesser of cost or charges (see instructions)       0.24. 00       0.23. 00         23. 00       Cost of physiclans' services in a teaching hospital (see instructions)       0.24. 00       0.24. 00         25. 00       Deductibles and coin surance (ror CAH, see instructions)       6.30.08 25. 00       2.00         26. 00       Deductibles and coin surance (ror CAH, see instructions)       0.23. 00       2.112. 00       2.00         26. 00       Deductible sand coin surance (ror CAH, see instructions)       0.21. 00       2.00       2.112. 00       2.00         20. 01       Subtrating (maint ins the sum of lines 22 intructions)       0.23. 00       2.112. 00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00       2.00	16.00			on a chargebasis	0	16.00
18.00       Total customary charges (see instructions)       0       18.00         19.00       Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)       0       18.00         10.00       Excess of customary charges over reasonable cost (complete only if line 11 exceeds line 18) (see instructions)       0       0         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)       0<	17.00		=)		0.000000	17.00
Instructions)       0.0         20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)       0.0         21.00       Lesses of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see Instructions)       0.0         22.00       Interns and residents (see instructions)       6.364,964       21.00         23.00       Cost of physiclans' services in a teaching hospital (see instructions)       0.23.00         23.00       Cost of physiclans' services in a teaching hospital (see instructions)       0.23.00         25.00       Deductibles and coinsurance (for CAH, see instructions)       6.36.002       25.00         26.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       0.21.12.309       2.112.309         27.00       Subtal (sum of lines 27 through 29)       2.111.409       0.21.12.309       0.21.12.309         20.00       Direct graduate medical education costs (from Wkst. E-4, line 50)       0.23.00       0.24.00         20.00       Direct graduate medical education surance relating to amount on surance relating to amou		Total customary charges (see instructions)				18.00
20.00       Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see       0       0         21.00       Lesser of cost or charges (see instructions)       6.364,964       21.00         22.00       Interns and residents (see instructions)       0       22.00         23.00       Cost of physicians' services in a teaching hospital (see instructions)       0       23.00         23.00       Cost of physicians' services in a teaching hospital (see instructions)       0       24.00         25.00       Deductibles and coinsurance (for CAH, see instructions)       4.189,647       26.00         26.00       Deductibles and coinsurance (for Wst. E-4, line 30)       2.112,309       27.00         27.00       Subtral (see instructions)       4.189,647       26.00         28.00       Direct graduate medical education payments (from Wst. E-4, line 30)       2.112,309       2.00         29.00       Distructions)       2.112,309       2.00       2.112,309       2.00         30.00       Subtral (see instructions)       2.112,309       2.00       2.112,309       2.00         31.00       Primary payer payments       (from Wst. E-4, line 30)       2.112,309       2.00       2.112,309       2.00         32.00       Dintary payer payments       2.703,971	19.00		y if line 18 exceeds l	ine 11) (see	0	19.00
Instructions)6,364,96421.0021.00Lesser of cost or charges (see instructions)6,364,96421.0022.00Interns and residents (see instructions)023.0023.00Cost of physicians' services in a teaching hospital (see instructions)023.0024.00Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)024.0025.00Deductibles and coinsurance (for CAH, see instructions)6,30.0825.0026.00Deductibles and coinsurance relating to amount on line 24 (for CAH, see instructions)4,189,64726.0027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)21.01,20927.0028.00Direct graduate medical education payments (from Wkst. E-4, line 50)028.0029.00ESRD direct medical education costs (from Wsst. E-4, line 36)21.01,20921.01,20920.00Subtotal (sum of lines 27 through 29)2,111,40920.0121.00Subtotal (sum of lines 27 through 29)2,111,40930.0131.00Composite rate ESRO (from Wsst. I-5, line 11)003.0033.00Composite rate ESRO (from Wsst. I-5, line 11)033.0034.00Altowable bad debts (see instructions)755, 7016.0035.00Altowable bad debts (see instructions)755, 7016.0036.00Misted reinburshiet Sisten tamount from PS&R039.9037.00Subtotal (see instructions)039.9038.00Misten ration amount	20 00		vifline 11 exceeds l	ine 18) (see	0	20 00
22.00         Interns and residents (see instructions)         0         22.00           23.00         Cost of physicians' services in a teaching hospital (see instructions)         0         23.00           24.00         Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)         0         24.00           25.00         Deductibles and Coinsurance (for CAH, see instructions)         63.008         25.00           26.00         Deductibles and Coinsurance (for CAH, see instructions)         4.189.647         26.00           27.01         Osubotal ((lines 2) and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23) (see instructions)         2.112.309         27.01           28.00         Direct graduate medical education payments (from Wkst. E-4, line 36)         0         2.9.00         2.9.00           29.00         ESRD direct medical education costs (from Wkst. E-4, line 36)         0         2.9.00         2.9.00           30.00         Primary payer payments         900         31.00         2.9.112,309         30.00           31.00         Composite rate ESR0 (from Wkst. I-5, line 11)         0         0         2.9.01           32.00         Allowable bad debts (see instructions)         1,003,942         34.00         33.00           33.00         Composite rate ESR0 (from Wkst. I-5, line 11)         10.03	20.00		y in this in exceeds i		Ū	20.00
23.00       Cost of physicians' services in a teaching hospital (see instructions)       0       23.00         24.00       Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)       0       24.00         25.00       Deductibles and coinsurance (for CAH, see instructions)       4, 189, 647       26.00         27.00       Subtotal ((lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)       2, 112, 309       27.00         28.00       Direct graduate medical education payments (from Wkst. E-4, line 50)       0       28.00       2, 112, 309       30.00         29.00       Subtotal (sum of lines 27 through 29)       2, 112, 309       30.00       20.00       30.00       2, 111, 409       32.00         30.00       Composite rate ESR0 (from Wkst. I-5, line 11)       0       33.00       33.00       33.00         31.00       Composite rate ESR0 (from Wkst. I-5, line 11)       0       33.00       652, 562       35.00         32.00       Subtotal (see instructions)       1,003, 942       4.00       38.00       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57       39.57 </td <td></td> <td>0 1</td> <td></td> <td></td> <td></td> <td></td>		0 1				
24.00         Total prospective payment (sum of lines 3, 4, 401, 8 and 9)         0         24.00           COMPUTATION OF RELIMBURSEMENT SETTLEMENT         63.008         25.00           Deductibles and coinsurance (for CAH, see instructions)         63.008         25.00           25.00         Deductibles and coinsurance (for CAH, see instructions)         63.008         25.00           26.00         Deductibles and coinsurance (for CAH, see instructions)         63.008         25.00           27.00         Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)         2.112.309         27.00           28.00         Direct graduate medical education payments (from Wkst. E-4, line 50)         0         28.00         2.900         2.112.309         20.00         2.900         2.900         2.900         2.9100         2.900         2.9000         2.9000         2.9000         2.9000         2.9000         2.9000         2.9000         2.9000         2.9000         2.9000         2.9000         2.9000         2.9100         2.9000         2.9000         2.9000         2.90000         2.9000         2.90000         2.90000         2.90000         2.90000         2.90000         2.90000         2.90000         2.90000         2.90000         2.900000         2.900000         2.9		· · · ·	ructions)			
COMPUTATION OF RELIMENESEMENT SETTLEMENT         63,008         25.00         Deductibles and coinsurance (for CAH, see instructions)         63,008         25.00         25.0			uctions)			23.00
26.00Deductibles and Coinsurance relating to amount on line 24 (for CM+, see instructions)4,189,64726.0027.00Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)2,112,30927.0028.00Direct graduate medical education payments (from Wkst. E-4, line 36)028.0000.00Subtotal (sum of lines 27 through 29)2,112,30921.0031.00Subtotal (line 30 minus line 31)2,111,40932.00ALLOWABLE EAD DEBTS FOR PROFESSIONAL SERVICES)1,003,94233.0033.00Composite rate ESRD (from Wkst. I-5, line 11)033.0040.01Allowable bad debts (see instructions)1,003,94234.0041.03 usted reimbursable bad debts (see instructions)652,56235.0036.00Milowable bad debts (see instructions)755,70136.0037.00MER ADJUSTMENTS (SEE INSTRUCTIONS)2,763,97137.0038.00MSP-LCC reconciliation amount from PS&R039.9039.00THER ADJUSTMENTS (SEE INSTRUCTIONS)039.9039.90Pioneer AC0 demonstration payment adjustment (see instructions)039.9039.90Recoverky of ACCELERATED DEPRECIATION039.9039.90Recoverky of ACCELERATED DEPRECIATION039.9030.00Compositer at escile instructions)039.9039.90Recoverky of ACCELERATED DEPRECIATION039.9030.00Composite rate escile instructions)0039.90Recover		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
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Instructions)028.00Direct graduate medical education payments (from Wkst. E-4, line 50)028.0028.00Direct graduate medical education costs (from Wkst. E-4, line 36)00030.00Subtotal (sum of lines 27 through 29)2,112,30930.0030.00Subtotal (line 30 minus line 31)2,111,40932.0031.00Composite rate ESRD (from Wkst. I-5, line 11)033.0033.00Composite rate ESRD (from Wkst. I-5, line 11)033.0033.00Allowable bad debts (see instructions)1,03,94234.0034.00Allowable bad debts for dual eligible beneficiaries (see instructions)755,70136.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)755,70136.0037.00Subtotal (see instructions)0,89.0039.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI FY)039.0039.97Demonstration payment adjustment (see instructions)39.9739.98Partial or full credits received from manufacturers for replaced devices (see instructions)39.9739.99RecoVERV OF ACCELERATED DEPRECIATION039.9740.00Subtotal (see instructions)039.9740.01Isternation payment adjustment amount after sequestration039.9740.02Demonstration payment adjustment amount after sequestration039.9740.03Subtotal (see instructions)039.9740.04Subtotal (see instructions)039.97<						
29.00         ESR0 direct medical education costs (from Wkst. E-4, line 36)         0         29.00           30.00         Subtotal (sum of lines 27 through 29)         2, 112, 309         30.00           31.00         Primary payer payments         2, 111, 409         2, 111, 409         32.00           32.00         Composite rate ESR0 (from Wkst. 1-5, line 11)         0         33.00         2, 111, 409         32.00           33.00         Composite rate ESR0 (from Wkst. 1-5, line 11)         0         33.00         1, 003, 942         34.00           36.00         Allowable bad debts (see instructions)         652, 562         35.00         37.00         Subtotal (see instructions)         755, 701         36.00           37.00         Subtotal (see instructions)         0         38.00         38.00         38.00         38.00         38.00         38.00         38.00         39.90         38.00         39.90         38.00         39.90         38.00         39.90	27.00				2/ 112/00/	271.00
30.00       Subtotal (sum of lines 27 through 29)       2, 112, 309       30.00         31.00       Primary payer payments       900       31.00         900       Subtotal (line 30 minus line 31)       2, 111, 409       32.00         ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)       0       33.00         33.00       Composite rate ESRD (from Wkst. 1-5, line 11)       0       33.00         34.00       Allowable bad debts (see instructions)       1, 003, 942       34.00         35.00       Adjusted reimbursable bad debts (see instructions)       652, 562       35.00         36.00       Allowable bad debts (see instructions)       652, 562       35.00         37.00       Subtotal (see instructions)       755, 701       36.00         38.00       MSP-LCC reconciliation amount from PS&R       0       39.90         39.01       Demonstration payment adjustment (see instructions)       0       39.95         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.90         30.01       Sequestration adjustment amount after sequestration       0       39.97         30.99       RECOVERY OF ACCELERATED DEPRECIATION       52.774       40.00         40.01       Sequestration adjustment amount after sequestration       0			ne 50)			28.00
31.00       Primary payer payments       900       31.00         32.00       Subtotal (line 30 minus line 31)       2,111,409       32.00         ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)       0       33.00         33.00       Composite rate ESRD (from Wkst. 1-5, line 11)       0       33.00         34.00       Allowable bad debts (see instructions)       1,003,942       34.00         35.00       Adjusted reimbursable bad debts (see instructions)       755,701       36.00         37.00       Subtotal (see instructions)       755,701       36.00         38.00       MSP-LCC reconciliation amount from PS&R       0       38.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.97       Demonstration payment adjustment (see instructions)       39.97       39.97         39.99       RECOVERY OF ACCELERATED DEPRECIATION       0       39.97         40.00       Subtotal (see instructions)       0       39.97         40.01       Interim payment adjustment amount after sequestration       0       39.97         40.02       Demonstration payment adjustment amount after sequestration       0       39.97         40.01       Stequestration adjustment (see instructions)       0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td></t<>						
32.00Subtotal (ine 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)2, 111, 40932.0033.00Composite rate ESRD (from Wkst. 1-5, line 11)00034.00Allowable bad debts (see instructions)1,003, 94234.0035.00Adjusted reimbursable bad debts (see instructions)1,003, 94234.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)652, 56235.0036.00Allowable bad debts for dual eligible beneficiaries (see instructions)755, 70136.0037.00Subtotal (see instructions)2, 763, 97137.0038.00MSP-LCC reconciliation amount from PS&R039.0039.00OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)039.0039.97Demonstration payment adjustment sequestration039.9239.98Partial or full credits received from manufacturers for replaced devices (see instructions)039.9239.99RECOVERY OF ACCELERATED DEPRECIATION039.9240.01Sequestration adjustment (see instructions)039.9240.02Demonstration payment adjustment after sequestration040.0241.00Iterim apayments (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.241.0042.00Tentative settlement (for contractors use only)-682, 36443.0043.00Balance due provi der/program (see instructions)090.0040.00Original outlier amount (see instructions)0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
33.00       Composite rate ESRD (from Wkst. I-5, line 11)       0       33.00       33.00       1,003,942       34.00         34.00       Allowable bad debts (see instructions)       1,003,942       34.00         35.00       Adjusted reimbursable bad debts (see instructions)       755,701       36.00         36.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       755,701       36.00         37.00       Subtotal (see instructions)       755,701       36.00         38.00       MSP-LCC reconciliation amount from PS&R       0       39.00         39.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       39.00         39.97       Demonstration payment adjustment (see instructions)       0       39.97         39.98       Partial or full credits received from manufacturers for replaced devices (see instructions)       0       39.99         39.99       RECOVERY OF ACCELERATED DEPRECIATION       2,763,971       40.00         40.01       Sequestration adjustment amount after sequestration       0       39.97         40.02       Demonstration payment adjustment amount after sequestration       0       40.02         41.00       Interim payments       3, 391, 088       41.00       -682, 396         42.00       Tentative settlem	32.00				2, 111, 409	32.00
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40.02       Demonstration payment adjustment amount after sequestration       0       40.02         41.00       Interim payments       3,391,088       41.00         42.00       Tentative settlement (for contractors use only)       0       42.00         43.00       Balance due provider/program (see instructions)       -682,396       43.00         44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,       0       44.00         5115.2       TO BE COMPLETED BY CONTRACTOR       0       90.00       90.00         90.00       Original outlier amount (see instructions)       0       91.00       91.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       91.00       91.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00       93.00       93.00						
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43.00       Balance due provider/program (see instructions)       -682,396       43.00         44.00       Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0       44.00         90.00       Original outlier amount (see instructions)       0       90.00         91.00       Outlier reconciliation adjustment amount (see instructions)       0       90.00         92.00       The rate used to calculate the Time Value of Money       0.00       92.00         93.00       Time Value of Money (see instructions)       0       93.00						
44.00       Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, <u>\$115.2</u> <u>TO BE COMPLETED BY CONTRACTOR</u> <u>0</u> 44.00         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       Time Value of Money (see instructions)       0       93.00						42.00
§115.2TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)00.010.010.020.030.040.040.050.050.060.070.070.080.00			CO with CMS Dub 15 2	chanter 1		
TO BE COMPLETED BY CONTRACTOR90.00Original outlier amount (see instructions)090.0091.00Outlier reconciliation adjustment amount (see instructions)091.0092.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00	44. UU		ICE WILLII UNO PUD. 10-2,	chapter I,	0	44.00
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92.00The rate used to calculate the Time Value of Money0.0092.0093.00Time Value of Money (see instructions)093.00						
93.00 Time Value of Money (see instructions) 0 93.00		•				

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC		Period: From 01/01/2017 To 12/31/2017		pare
		Title	XVIII	Hospi tal	Cost	_
		Inpatien		Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		3, 852, 7	45	3, 391, 088	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	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					
01	ADJUSTMENTS TO PROVIDER	08/02/2017	102, 2	00	0	3.
02	ABSOSTMENTS TO TROVIDER	00/02/2017	102, 2	0	0	3.
03				0	0	3
04				0	0	3
05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53				0	0	3
54				0	0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		102, 2	00	0	3
00	3.50-3.98)			45	2 201 000	4
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		3, 954, 9	45	3, 391, 088	4
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	5
03	Provider to Program			0	0	5
50	TENTATI VE TO PROGRAM			0	0	5
50 51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
	5. 50-5. 98)			-	_	-
00	Determined net settlement amount (balance due) based on					6
	the cost report. (1)					
01	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM		37, 3		682, 396	
00	Total Medicare program liability (see instructions)		3, 917, 6		2, 708, 692	7
				Contractor	NPR Date	
			<b>`</b>	<u>Number</u> 1.00	(Mo/Day/Yr)	
		C	)	1.00	2.00	8

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	F	Period: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
			20111	La Dala CNI	5/30/2018 10:	38 am
		Inpati en		wing Beds - SNF	Cost T B	
		Inpatren	I PAIL A	Pai	ГР	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		928, 217	,	0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		C	5	0	2.00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider	00 (00 (0017	17.700			
3. 01 3. 02 3. 03 3. 04	ADJUSTMENTS TO PROVIDER	08/29/2017	47, 700 C C C		0 0 0	3. 01 3. 02 3. 03 3. 04
3.05			C		0	3.05
0.00	Provider to Program					0.00
3.50	ADJUSTMENTS TO PROGRAM		С	)	0	3.50
3. 51			C		0	
3.52			C		0	3.52
3.53			C		0	3.53
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C 47, 700		0	3.54 3.99
3.99	3. 50-3. 98)		47,700		0	3.95
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		975, 917	,	0	4.00
	TO BE COMPLETED BY CONTRACTOR					1
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider		-	1	-	
5.01	TENTATI VE TO PROVIDER		C		0	5.01 5.02
5.02 5.03			C		0	5.02 5.03
0.00	Provider to Program	1	- C	·I	0	5.00
5.50	TENTATI VE TO PROGRAM		C	)	0	5.50
5.51			C		0	5.51
5.52			C		0	5.52
5.99 6.00	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Determined net settlement amount (balance due) based on		C	)	0	5.9
6. 00	the cost report. (1) SETTLEMENT TO PROVIDER		C		0	6.00
6.02	SETTLEMENT TO PROGRAM		34, 423		0	
7.00	Total Medicare program liability (see instructions)		941, 494		0	
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C	)	1.00	2.00	

Heal th	Financial Systems GREENE COUNTY GENE	RAL HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1317	Period: From 01/01/2017 To 12/31/2017		repared:
		Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00	
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	N			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instructio	ns)		32.00

LCULA	TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS Prov	vider CCN: 15-1317	Period: From 01/01/2017	Worksheet E-2	
	Com	ponent CCN: 15-Z317	To 12/31/2017	Date/Time Pre 5/30/2018 10:	
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	OMPUTATION OF NET COST OF COVERED SERVICES		741.040	0	1 1
	npatient routine services - swing bed-SNF (see instructions) npatient routine services - swing bed-NF (see instructions)		741, 068	0	1. 2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A,	and sum of Wkst D	223, 095	0	
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instru		223,075	0	J .
	Per diem cost for interns and residents not in approved teaching			0.00	4.
i	nstructions)				
	Program days		433	0	
	nterns and residents not in approved teaching program (see instru			0	
	Itilization review - physician compensation - SNF optional method	onl y	0		7.
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		964, 163	0	
	Primary payer payments (see instructions)		0(4,1(2)	0	
	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applicable	a ta phycician	964, 163	0	
	professional services)	e to physician	0	0	' ' '
	Subtotal (line 10 minus line 11)		964, 163	0	12.
	Coinsurance billed to program patients (from provider records) (e:	kcl ude coi nsurance	3, 455	0	
	for physician professional services)				
. 00 8	30% of Part B costs (line 12 x 80%)			0	14
. 00   S	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		960, 708	0	15
. 00   0	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16
	Pioneer ACO demonstration payment adjustment (see instructions)				16
	Rural community hospital demonstration project (§410A Demonstration	on) payment	0		16
	adjustment (see instructions)			0	
	Demonstration payment adjustment amount before sequestration		0	0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	
-	Allowable bad debts for dual eligible beneficiaries (see instruct	ons)	0	0	
	fotal (see instructions)		960, 708	0	
	Sequestration adjustment (see instructions)		19, 214	0	
	Demonstration payment adjustment amount after sequestration)		0	0	19
. 00   I	nterim payments		975, 917	0	20
	<pre>Fentative settlement (for contractor use only)</pre>		0	0	
	Balance due provider/program (line 19 minus lines 19.01, 20, and 2		-34, 423	0	
	Protested amounts (nonallowable cost report items) in accordance w	with CMS Pub. 15-2,	0	0	23
	chapter 1, §115.2				
	ural Community Hospital Demonstration Project (§410A Demonstration s this the first year of the current 5-year demonstration period				200
	Century Cures Act? Enter "Y" for yes or "N" for no.				200
	ost Reimbursement				1
	Medicare swing-bed SNF inpatient routine service costs (from Wkst	D-1, Pt. II, line			201
	66 (title XVIII hospital))				
	Medicare swing-bed SNF inpatient ancillary service costs (from Wk	st. D-3, col. 3, li	ne		202
	200 (title XVIII swing-bed SNF))				
	fotal (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)	t waar of the own	ant E year demons		204
	omputation of Demonstration Target Amount Limitation (N/A in firs eriod)	st year of the curre	ent o-year demons		
	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 times	line 204)			206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursemen				1
	Program reimbursement under the §410A Demonstration (see instruct				207
3. OO N	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, co	ol. 1, sum of lines	1		208
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruction	ns)			209
	Reserved for future use				210
	omparision of PPS versus Cost Reimbursement				045
o. UU∣I	fotal adjustment to Medicare swing-bed SNF PPS payment (line 209   nstructions)	bius line 210) (see			215

	n Financial Systems GREENE COUNTY GE LATION OF REIMBURSEMENT SETTLEMENT	NERAL HOSPITAL Provider CCN: 15-1317	Peri od:	u of Form CMS-2 Worksheet E-3	
CALCU	LATION OF REIMBURSEMENT SETTLEMENT	Provider CCN. 15-1317	From 01/01/2017	Part V	
			To 12/31/2017		pared:
				5/30/2018 10:	38 am
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICA	ARE PART A SERVICES - COS	T REIMBURSEMENT		
1.00	Inpatient services			4, 316, 554	1.00
2.00	Nursing and Allied Health Managed Care payment (see instru-	ctions)		0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			4, 316, 554	4.00
5.00	Primary payer payments			10, 975	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)	)		4, 348, 745	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				1
7.00	Routine service charges			0	
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
10.00				0	10.00
11.00	Customary charges Aggregate amount actually collected from patients liable for	or payment for sorvices or	a chargo basis	0	1 11.00
12.00					
12.00	had such payment been made in accordance with 42 CFR 413.13		on a charge basis	0	12.00
13.00		3(e)		0.000000	13.00
14.00				0.000000	
15.00		only if line 14 exceeds l	ine 6) (see	0	
	instructions)			-	
16.00		only if line 6 exceeds li	ne 14) (see	0	16.00
	instructions)				
17.00		nstructions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18.00	5	E-4, line 49)		0	
19.00				4, 348, 745	
20.00				388, 536	
21.00				0	
22.00 23.00				3, 960, 209	
23.00				0 3, 960, 209	
24.00		ruleas) (cas instructions)			
25.00				57, 460 37, 349	
26.00		netructione)		37, 349	
27.00	5			39, 160	
28.00				3, 447, 558	
29.00		ions)		0	•
29.99		2		0	
30.00				3, 997, 558	
30.01				79, 951	
	Demonstration payment adjustment amount after sequestration	n		0	1
31.00				3, 954, 945	
32.00				0, 701, 710	
33.00		0.02, 31, and 32)		-37, 338	
34.00			chapter 1,	0	
	§115. 2		•		

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1317	Peri od:	Worksheet E-3	3
			From 01/01/2017 To 12/31/2017	Part VII Date/Time Pre	epar
		Title XIX	Hospi tal	5/30/2018 10: Cost	38
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH	I SERVICES FOR TITLES V OR X	(IX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		284, 451		1
00	Medical and other services			329, 528	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		284, 451	329, 528	
00	Inpatient primary payer payments		0	0	5
00	Outpatient primary payer payments		204 451	220 520	1 1
00	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		284, 451	329, 528	7
	Reasonable Charges				-
00	Routine service charges		0		18
00	Ancillary service charges		233, 214	1, 414, 500	
D. 00	Organ acquisition charges, net of revenue		200, 214	.,,	10
1.00	Incentive from target amount computation		0		11
2.00	Total reasonable charges (sum of lines 8 through 11)		233, 214	1, 414, 500	
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment	t for services on a charge	0	0	13
	basi s				
1.00	Amounts that would have been realized from patients liable		on O	0	14
	a charge basis had such payment been made in accordance wi	th 42 CFR §413.13(e)			
5.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
5.00	Total customary charges (see instructions)		233, 214	1, 414, 500	
7.00	Excess of customary charges over reasonable cost (complete	e only if line 16 exceeds	0	1, 084, 972	17
3. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete	only if line 1 exceeds lin	ne 51, 237	0	18
5.00	16) (see instructions)	e only if the 4 exceeds iff	51,257	0	
9.00	Interns and Residents (see instructions)		0	0	19
0.00	Cost of physicians' services in a teaching hospital (see i	nstructions)	0	0	
1.00	Cost of covered services (enter the lesser of line 4 or li	-	284, 451	329, 528	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only				
2.00	Other than outlier payments	· · ·	0	0	22
3.00	Outlier payments		0	0	23
4.00	Program capital payments		0		24
5.00	Capital exception payments (see instructions)		0		25
5.00	Routine and Ancillary service other pass through costs		0	0	
7.00	Subtotal (sum of lines 22 through 26)		0	0	
3.00	Customary charges (title V or XIX PPS covered services onl	у)	0	0	
9.00	Titles V or XIX (sum of lines 21 and 27)		284, 451	329, 528	29
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		51, 237	0	30
1.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 ar	ad 6)	284, 451	329, 528	
2.00	Deductibles		204, 431	0	
3.00	Coi nsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review		0	Ŭ	35
o. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32	2 and 33)	284, 451	329, 528	
. 00	TO ZERO OUT MEDICALD SETTLEMENT	-	-284, 451	-329, 528	
3. 00	Subtotal (line 36 ± line 37)		0	0	
9.00	Direct graduate medical education payments (from Wkst. E-4	4)	0		39
0. 00	Total amount payable to the provider (sum of lines 38 and	39)	0	0	
I. 00	Interim payments		0	0	
2.00	Balance due provider/program (line 40 minus line 41)		0	0	
3.00	Protested amounts (nonallowable cost report items) in acco			0	43

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C		Period: From 01/01/2017 To 12/31/2017		
		General Fund	Specific Purpose Fund		5/30/2018 10: Plant Fund	38 ai
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
	Cash on hand in banks	992, 451		0 0	0	1 1.
	Temporary investments	2,001,195		0 0	0	
	Notes receivable	0		0 0	0	3.
	Accounts receivable	6, 103, 251		0 0	0	4.
00	Other receivable	-908, 928		0 0	0	5.
00	Allowances for uncollectible notes and accounts receivable	0		0 0	0	6.
00	Inventory	293, 635		0 0	0	7.
00	Prepaid expenses	1, 477, 116		0 0	0	8
00	Other current assets	0		0 0	0	9
	Due from other funds	0		0 0	0	10
	Total current assets (sum of lines 1-10)	9, 958, 720		0 0	0	11
-	FIXED ASSETS			1	1	
	Land	651, 198		0 0	0	
	Land improvements	335, 729		0 0	0	
	Accumulated depreciation	-124, 549		0 0	0	14
	Buildings	7, 577, 795		0 0	0	15
	Accumulated depreciation	-2, 988, 288	1	0 0	0	16
	Leasehold improvements Accumulated depreciation	0		0 0	0	17   18
	Fixed equipment	3, 692, 311			0	10
	Accumulated depreciation	-1, 226, 330		0 0	0	20
	Automobiles and trucks	-1, 220, 330		0 0	0	
	Accumulated depreciation	0		0 0	0	22
	Major movable equipment	2, 421, 534		0 0	0	23
	Accumulated depreciation	-1, 193, 128	1	0 0	0	24
	Minor equipment depreciable	0	1	0 0	0	25
	Accumulated depreciation	0		0 0	0	26
	HIT designated Assets	0		0 0	0	27
	Accumulated depreciation	0		0 0	0	28
	Minor equipment-nondepreciable	0		0 0	0	29
	Total fixed assets (sum of lines 12-29)	9, 146, 272		0 0	0	30
	OTHER ASSETS					
. 00	Investments	928, 611		0 0	0	31
	Deposits on Leases	0		0 0	0	32
	Due from owners/officers	0		0 0	0	33
	Other assets	21, 995	1	0 0	0	34
	Total other assets (sum of lines 31-34)	950, 606		0 0	0	35
	Total assets (sum of lines 11, 30, and 35)	20, 055, 598		0 0	0	36
	CURRENT_LIABILITIES	1 ( ( 0 000				1
	Accounts payable	1, 663, 288		0 0	0	37
	Salaries, wages, and fees payable	1, 770, 940		0 0 0 0		
	Payroll taxes payable Notes and Loans payable (short term)	136, 777 521, 024		0 0	0	
	Deferred income	521, 024		0 0	0	
	Accelerated payments	0		0	0	42
	Due to other funds	0		0 0	0	
	Other current liabilities	0		0 0		
	Total current liabilities (sum of lines 37 thru 44)	4, 092, 029		0 0		
	LONG TERM LI ABI LI TI ES		1			
. 00	Mortgage payable	0		0 0	0	1 46
. 00	Notes payable	9, 900, 641		0 0	0	47
00	Unsecured Loans	0		0 0	0	48
00	Other long term liabilities	0		0 0	0	49
00	Total long term liabilities (sum of lines 46 thru 49)	9, 900, 641		0 0	0	
	Total liabilities (sum of lines 45 and 50)	13, 992, 670		0 0	0	51
	CAPI TAL ACCOUNTS		1		1	4
	General fund balance	6, 062, 928				52
	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	6,062,928		0 0	0	59
	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	20, 055, 598	1	0 0 0 0	-	
	TOTAL TRANSPORTED AND THE ADDRESS AND ADDRE	∠ບ, ບວວ, ວ98	9	U U	. 0	1 00

	2	REENE COUNTY GENI			_	In Lie	u of Form CMS	
STATEMENT OF CHANGES IN FUND BALANCES			Provider CC	CN: 15-1317	Period: From 01/0 To 12/3	)1/2017 31/2017	Worksheet G- Date/Time Pr 5/30/2018 10	epared:
		General	Fund	Speci al	Purpose Fu	und	Endowment Fund	
		1.00	2.00	3.00	4. (	00	5.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance		2, 463, 879 -1, 400, 951 6, 062, 928 0 6, 062, 928 0 6, 062, 928	5.00	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00         19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0			10.00         11.00         12.00         13.00         14.00         15.00         16.00         17.00         18.00         19.00

	Health Financial Systems GREENE COUNTY GENERAL HOSPITA				ieu of Form CMS-	
STATEN	ENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider C	CN: 15-1317	Period: From 01/01/20 To 12/31/20		epared:
	Cost Center Description		I npati ent	Outpati ent		
	· · · · · · · · · · · · · · · · · · ·		1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		2, 672, 4	54	2, 672, 454	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER – IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	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)		2, 672, 4	54	2, 672, 454	10.00
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		581, 9	00	581, 900	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	581, 9	00	581, 900	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16)		3, 254, 3		3, 254, 354	
18.00	Ancillary services		9, 389, 5			
19.00	Outpatient services			0	0 0	
20.00	RURAL HEALTH CLINIC			0	0 0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0 0	
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P. )					25.00
26.00	HOSPICE			0		26.00
27.00	OTHER (SPECIFY)	to Wkot	12 (42 0		0 0	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 G-3, line 1)	to wkst.	12, 643, 8	56 73, 797, 3	46 86, 441, 202	28.00
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			28, 845, 2	89	29.00
30.00	BAD DEBT NOT ON WORKSHEET A		7, 436, 6		0,	30.00
31.00			., 100, 0	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)			7, 436, 6	73	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	)(transfer		36, 281, 9	62	43.00
	to Wkst. G-3, line 4)					1

Heal th	Financial Systems GREENE COUNTY	GENERAL HOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-1317	Period: From 01/01/2017 To 12/31/2017	Worksheet G-3 Date/Time Pre	pared:
				5/30/2018 10:	38 am
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3	line 28)		86, 441, 202	1.00
2.00	ess contractual allowances and discounts on patients' accounts				2.00
3.00	Net patient revenues (line 1 minus line 2)			53, 446, 384 32, 994, 818	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			36, 281, 962	4.00
5.00	Net income from service to patients (line 3 minus line 4			-3, 287, 144	5.00
	OTHER INCOME				
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 communic	ation services		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to ot	her than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00				0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	GRANTS, PURCHASE DI SCOUNTS, RENT I NC			1, 886, 193	
25.00	Total other income (sum of lines 6-24)			1, 886, 193	
26.00	Total (line 5 plus line 25)			-1, 400, 951	26.00
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 line	28)		-1, 400, 951	29.00