near th i manci	ai systems	GREENE COUNTY GENER	AL HUSTITAL		111 L		NI3-2332-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Fai	Ture to report	can resul	lt in all inte	rim FORM APPRO	OVED
payments made	since the beginning of the cost	reporting period being	deemed overpa	yments (42	2 USC 1395g).	OMB NO. OS EXPIRES OS	
HOSPITAL AND H	HOSPITAL HEALTH CARE COMPLEX COST SUMMARY	T REPORT CERTIFICATION	Provider CCN:	15-1317	Period: From 01/01/20 To 12/31/20	Worksheet Parts I-II Date/Time 5/29/2019	li Prepared:
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically filed co				Date: 5/29/	/2019 Ti me	e: 12:35 pm
use only	2. [] Manually submitted cost 3. [0] If this is an amended ro 4. [F] Medicare Utilization. En	eport enter the number		rovi der ir	esubmitted thi	s cost report	
Contractor use only	(1) As Submitted 7. (2) Settled without Audit 8.	Date Received: Contractor No. [N] Initial Report fo [N] Final Report for	or this Provide this Provider (11. C r CCN 12. [endor Code: column 1 is times reopene	

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 01/01/2018 and ending 12/31/2018 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 signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned)
Officer or Administrator of Provider(s)
Title

Date

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	-185, 740	-446, 354	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	-31, 545	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
10.00 LINTON CLINIC I	0		0		0	10.00
10.01 BLOOMFIELD CLINIC II	0		0		0	10.01
10.02 WESTGATE CLINIC III	0		0		0	10.02
200. 00 Total	0	-217, 285	-446, 354	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.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1317 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 12:35 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: P0 Box: 1000 1.00 Street: R. R 1 1.00 Zip Code: 47441-9457 County: GREENE 2.00 City: LINTON State: IN 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal GREENE COUNTY GENERAL 151317 99915 02/01/2003 Ν 0 0 3.00 HOSPI TAI Subprovi der - IPF 4.00 4.00 5.00 Subprovi der - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF GREENE COUNTY GENERAL 157317 99915 lo2/01/2003| N N 0 7.00 7 00 HOSPI TAI 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14 00 Hospi tal -Based Hospi ce 14 00 MY LINTON CLINIC 15.00 Hospital-Based Health Clinic - RHC 158535 99915 12/18/2018 Ν Ν 15.00 Ν Hospital-Based Health Clinic - RHC MY BLOOMFIELD CLINIC 158533 99915 12/18/2018 15.01 Ν Ν Ν 15.01 Hospital -Based Health Clinic - RHC MY WESTGATE CLINIC 158534 99915 Ν 15.02 15 02 12/18/2018 N N $\Pi\Pi$ Hospital -Based Health Clinic - FQHC 16.00 Hospital -Based (CMHC) I 17.00 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: 1. 00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) Q 21.00 1. 00 2. 00 3. 00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this 22.01 Ν Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22.03 Ν rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for ves or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 0 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

		In-State Medicaid paid days	In-State Medicaid eligible	Out-of State Medicaid	Out-of State Medicaid	Medicai HMO day	ys Me	Other di cai d days	
			unpai d days	pai d days	el i gi bl e unpai d				
		1. 00	2. 00	3.00	4. 00	5. 00		6. 00	
24. 00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and these Medicaid days in column 6.		C	0	0		0	0	24.00
25. 00	column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	С	0			0		25. 00
					Urban/F	Rural S 00		f Geogr 00	_
26. 00	Enter your standard geographic classification (not w		at the be	ginning of		2			26. 00
	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif	age) status r "2" for r ication in	ural. If a column 2.	ppl i cabl e,		2			27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods S	CH status i	n	0			35.00
	, and the second				Begi n			i ng: 00	
36. 00	Enter applicable beginning and ending dates of SCH s		script line	36 for num		00	۷.	00	36.00
37. 00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente		er of perio	ds MDH stat	us	0			37. 00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for t accordance with FY 2016 OPPS final rule? Enter "Y" f								37. 01
38. 00	<pre>instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number o enter subsequent dates.</pre>								38.00
					Y/ 1.			/N 00	
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i or "N" for no. (see instructions)), (ii), or the mileage	(iii)? En e requireme	ter in colu nts in	ume N ımn			N	39. 00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octono in column 2, for discharges on or after October 1	ber 1. Ente	er "Y" for			I		N	40.00
		(<u> </u>	V	XVIII		
	Prospective Payment System (PPS)-Capital					1.00	2.00	3. 00	
45. 00	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt for disp	proporti ona	te share in	accordance	e N	N	N	45. 00
46. 00	Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.					N	N	N	46.00
	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital paymen					N N	N N	N N	47. 00 48. 00
	Teaching Hospitals Is this a hospital involved in training residents in					N			56.00
	or "N" for no. If line 56 is yes, is this the first cost reporting	period duri	ng which r	esidents in	approved				57.00
	GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	th of this Y", complet	cost repor e Workshee	ting period	l? Enter "\				
58. 00	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	bursement f	or physici	ans' servic	es as	N			58. 00
59. 00	Are costs claimed on line 100 of Worksheet A? If yes			, Pt. I.		N			59. 00

	costs for structions) IME 2.00	NAHE 413. 85 Y/N 1.00 N Direct GME 3.00	Worksheet A Li ne # 2.00 IME 4.00	Pass-Through Qualification Criterion Code 3.00	60.00
(see in Y/N 1.00 N	structions) IME	N Direct GME	I ME		60.00
(see in Y/N 1.00 N	structions) IME	Direct GME		Direct GME	60.00
1.00 N				Direct GME	
N	2. 00	3.00	4. 00		
				5. 00	61. 00
			0.00	0.00	61. 0
re					61. 02
					61. 03
					61. 04
e					61. 0
					61. 0
Pro			IME FTE Count	Direct GME FTE Count	
	1.00	2.00			61. 10
			0.00	0.00	61. 20
				1. 00	
			iod for which	0.00	62.00
a Teachi ogram. (s	see instructio		your hospital	0.00	62. 0°
setti ngs	during this d	67. (see instr Unweighted	uctions) Unweighted	Ratio (col.	63. 0
		Nonprovi der Si te	Hospi tal	col. 2))	
<u>ore June</u> ity traii	ned residents	-This base year	is your cost	reporti ng	64. 00
	Nonprovi fore June ity trai non-prima non lin colum	Program Name 1.00	Program Name Program Code 1.00 2.00 1.00 2.00 1.100	Program Name Program Code IME FTE Count 1.00 2.00 3.00 1.00 0.00	Program Name Program Code Unweighted IME FTE Count 1.00 2.00 3.00 4.00 0.00 0.00 0.00 0.00 0.00 0

HOSPITAL AND HOSPITAL HEALTH CARE COMPL			Fr		5/29/2019 12:	pared:
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
5.00 Enter in column 1, if line 63	1. 00	2. 00	3.00	4. 00	5. 00	/ F 0/
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column				J. 33	5. 555555	
4)). (see instructions)			Unwei ahted	Unwei ghted	Patio (col	
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col. 1 + col. 2))	
Section 5504 of the ACA Current	Year FTE Residents i	n Nonprovider Settir	1.00 nasEffective f	2.00 or cost report		
beginning on or after July 1, 20	10	·				
6.00 Enter in column 1 the number of of FTEs attributable to rotations of Enter in column 2 the number of of FTEs that trained in your hospital (column 1 divided by (column 1 +	ccurring in all nonpo unweighted non-prima al. Enter in column :	rovider settings. ry care resident 3 the ratio of	0.00	0. 00	0. 000000	66.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1. 00	2.00	3.00	4. 00	5. 00	
7.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00		. 67. 0
, , , , (22221 doi: 66)				1.00	2 00 2 00	
Inpatient Psychiatric Facility Pl	PS			1.00	2.00 3.00	
0.00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no.		IPF), or does it con	itain an IPF subp	orovi der? N	Ratio (col. 3/ (col. 3 + col. 4)) 5.00 0.000000 Ratio (col. 1 + col. 2)) 3.00 ting periods 0.000000 Ratio (col. 3 + col. 4) 5.00 0.000000 0.0000000 0.0000000 0.000000	70.00
1.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, india (see instructions)	the facility have an efore November 15, 20 umn 2: Did this faci R 412.424 (d)(1)(iii) cate which program yo	004? Enter "Y" for ility train resident)(D)? Enter "Y" for	yes or "N" for i s in a new teacl yes or "N" for i	no. (see ni ng no.	0	71.00
75.00 Inpatient Rehabilitation Facility Is this facility an Inpatient Relsubprovider? Enter "Y" for yes a	nabilitation Facilit	y (IRF), or does it	contain an IRF	N		75.00

	F	eriod: rom 01/01/ o 12/31/	2018 2018	of Form Workshe Part I Date/Ti 5/29/20	et S-2 me Pre	pared:
		-	1 00	2.00	3 00	
	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes on column 2: Did this facility train residents in a new teaching program in accordance CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y indicate which program year began during this cost reporting period. (see instructions)	r "N" for with 42	1.00	2.00	0	76.00
			F	1.0	00	
	Long Term Care Hospital PPS					
	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. TEFRA Providers	period? E	inter	N N		80. 00 81. 00
	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Sectic §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		no.	N		85. 00 86. 00
87. 00	Is this hospital an extended neoplastic disease care hospital classified under section [1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N		87. 00
		V		XI)		
	Title V and VIV Complete	1.00		2. 0	00	
90. 00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Υ		90.00
91. 00	yes of N for high the appricable column. Is this hospital reimbursed for title V and/or XIX through the cost report either in [full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		Υ		91.00
92. 00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93. 00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94. 00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00		0.0	00	95.00
	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96. 00
	If line 96 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	0. 00 N		0. 0 Y		97. 00 98. 00
98. 01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Y		98. 01
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Υ		98. 02
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98. 03
98. 04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		N		98. 04
98. 05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Υ		98. 05
98. 06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N		Υ		98. 06

column 2 for title XIX.

Rural Providers

105.00 Does this hospital qualify as a CAH?

106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)

107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R

N

107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.

108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42

CFR Section §412.113(c). Enter "Y" for yes or "N" for no.

Health Financial Systems GREENE COUNTY GEN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der C	CN: 15-1317 F	Period: From 01/01/		of Form C Worksheet Part I	
			o 12/31/		Date/Time 5/29/2019	
	Physi cal	Occupati onal	Speech	า	Respirato	
	1.00	2. 00	3.00		4.00	
109.00 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		N	109. 00
				-	1. 00	
110.00 Did this hospital participate in the Rural Community Hospita					N	110.0
Demonstration) for the current cost reporting period? Enter 'complete Worksheet E, Part A, lines 200 through 218, and Worapplicable.				,		
			1. 00		2. 00	_
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared by the FCHIP demonstration for the FCHIP demonstration prongular that apply: "A" for Ambulance services; "B" for action for tele-health services.	ost reporting olumn 1 is Y, rticipating i	period? Enter enter the n column 2.	N			111.0
				1. 00	2.00 3.	00
Miscellaneous Cost Reporting Information 115.00 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" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"	. If column 2 nt for long to rs) based on	is "E", enter erm care (incl the definition	in column udes	N N		115. 0
117.00 s this facility legally-required to carry malpractice insur	,		"N" for	Y		117.0
118.00 s 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
oranii maac. Enter 2 11 the porrey 13 decarrence.		Premi ums	Losses	6	Insuranc	е
		1.00	2. 00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:		267, 03)	0		0118.0
			1.00		2. 00	
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheo			N			118. 0
and amounts contained therein.	aure risting (1100
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen	d Harmless pro n column 1, "' ualifies for	ovision in ACA Y" for yes or the Outpatient	N		N	
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla	d Harmless pro n column 1, "' ualifies for nts? (see ins	ovision in ACA Y" for yes or the Outpatient tructions)	N N		N	120. 0
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included.	d Harmless pront of the column 1, "'ualifies for onts? (see instantable device fined in §190	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the			N	120. 0
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA \$3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information	d Harmless pront of the column 1, "" ualifies for some of the column 1, "" and the column 1, "" and the column 1, "", ento the column 1,	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2	N N		N	120. 0 121. 0 122. 0
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 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain healthcare related taxes as defact? Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, enter in column 1 and termination date, if applicable, in column 2 	d Harmless pron column 1, "" ualifies for standard device fined in §190: 1 is "Y", ento or yes and "No the cert 2.	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If	N N		N	120. 0 121. 0 122. 0 125. 0 126. 0
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119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that question Hold Harmless provision in ACA §3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain heal thcare related taxes as defact?Enter "Y" for yes or "N" for no in column 1. If column the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, entering in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, entering in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, entering in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, entering in column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column 1. 132.00 If this is a Medicare certified intestinal transplant center, entering in column 1 and termination date, if applicable, in column 1.	d Harmless pron column 1, " ualifies for onts? (see insome see ins	ovision in ACA Y" for yes or the Outpatient tructions) es charged to 3(w)(3) of the er in column 2 " for no. If ification date fication date ication date if rtification certification fication date	N N		N	120. 0 121. 0 122. 0 125. 0 126. 0 127. 0 128. 0 129. 0 130. 0 131. 0
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IOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CCI	N: 15-1317		1/01/2018 2/31/2018	Worksheet S- Part I Date/Time Pr 5/29/2019 12	epared:
					1. 00	2. 00	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 the	'N" for no in column 1. I	f yes, and home	office co	ı	N		140.00
1.00	2.	00			3. 00		
If this facility is part of a cha			ugh 143 th	ie name ar	nd address	of the home	
office and enter the home office 41.00 Name:	<u>contractor name and contr</u> Contractor's Name:	actor number.	Contro	ctor's Nu	mhor		141.00
42. 00 Street:	PO Box:		Contra	CLOI S NU	ilibei .		142.00
43. 00 Ci ty:	State:		Zi p Co	de:			143.00
44.00	at a first to the West about	40				1.00	111 00
44.00 Are provider based physicians' co	sts included in Worksheet	A'?				Υ	144.00
					1. 00	2. 00	\dashv
45.00 f costs for renal services are clinpatient services only? Enter "Y' no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodologenter "Y" for yes or "N" for no in yes, enter the approval date (mm/d)	'for yes or "N" for no iclude Medicare utilization for no in column 2. gy changed from the previncolumn 1. (See CMS Pub.	n column 1. If on for this cost ously filed cost	column 1 i reporting t report?		N		145. 00
							_
47.00 Was there a change in the statisti	cal basis? Enter "V" for	was as "N" for	no			1. 00 N	147. 0
48.00 Was there a change in the order of						N	148. 0
49.00 Was there a change to the simplifi				for no.		N	149.0
		Part A	Part B	B T	itle V	Title XIX	
D 6		1.00	2. 00		3. 00	4. 00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
55. 00 Hospi tal	N TOT HO TOT EACH COMPO	N N	N	b. (3ee 4	N 941	N	155.0
56. 00 Subprovi der - IPF		N	N		N	N	156. 0
57. 00 Subprovi der - I RF		N	N		N	N	157. 0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N N	N		N	N	159.0
60. OO HOME HEALTH AGENCY 61. OO CMHC		N	N N		N N	N N	160. 0 161. 0
81. ООДСИИНС			IN		IV	IV	101.0
						1.00	_
Multicampus							
65.00 Is this hospital part of a Multica	ampus hospital that has o	ne or more campu	uses in di	fferent C	BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2.00	3. 00	4. 00	5. 00	\dashv
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. (00 166. 00
Hoal th Information Tachnal and (III)	T) inconting in the Ameri	can Poccycey and	d Poi pyost	mont Act		1. 00	
Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10.00 If this provider is a CAH (under §1886(n)? Enter	"Y" for yes or "	'N" for no		r the	Υ	167. 00 0168. 00
reasonable cost incurred for the I	HIT assets (see instructi	ons)					
68.01 If this provider is a CAH and is a					dshi p		168. 0°
exception under §413.70(a)(6)(ii)	? Enter "Y" for yes or "N user (line 167 is "Y") an				enter the	0. 0	00169.00
	ons)						
transition factor. (see instruction	ons)			Be	gi nni ng	Endi ng	
	,				gi nni ng 1. 00 '01/2018	Endi ng 2.00 12/31/2018	170.0

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE CO	OMPLEX IDENTIFICATION DATA		Peri od: From 01/01/2018	Worksheet S-2	
				Date/Time Pre 5/29/2019 12:	
					, i
			1. 00	2. 00	
171.00 If line 167 is "Y", does this	provider have any days for indi	viduals enrolled in	N	C	171.00
section 1876 Medicare cost pla	ans reported on Wkst. S-3, Pt. I	, line 2, col. 6? Enter			
"Y" for yes and "N" for no in	column 1. If column 1 is yes, e	nter the number of section	on		
1876 Medicare days in column 2	2. (see instructions)				

Heal th	Financial Systems GREENE COUNTY GE	NERAL HOSPITAL	_	In Lie	eu of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Peri od: From 01/01/2018	Worksheet S-2	epared:
				Y/N	Date	
	Constant Instantian Fator V for all VEC managers Fator	N 6II NO	F	1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N TOP ALL NO FE	esponses. Ent	er all dates in	tne 	
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.00
	reporting period? If yes, enter the date of the change in	corumn 2. (see	Y/N	Date	V/I	
			1.00	2.00	3. 00	
2. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in coluvoluntary or "I" for involuntary.		N			2.00
3. 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 der or its of the board	Y			3.00
			Y/N	Туре	Date	
	[F]		1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cer	tified Dublic	Υ	A	I	4.00
5. 00	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. Are the cost report total expenses and total revenues diff	for Compiled, ailable in	N N	A		5.00
5.00	those on the filed financial statements? If yes, submit re		l IN			3.00
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities	1.0				
6. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is the	he provider i	s N		6.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see i	nstructions		N		7.00
8. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	N		8.00
9. 00	Are costs claimed for Interns and Residents in an approved		cal educatior	n N		9. 00
10. 00	program in the current cost report? If yes, see instructio Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than Teaching Program on Worksheet A? If yes, see instructions.	I & R in an App	proved	N		11.00
				_	Y/N	
					1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bad debts? If ye	s soo instruc	tions		Y	12.00
	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			cost reporting	N N	13.00
	If line 12 is yes, were patient deductibles and/or co-paym Bed Complement				N	14.00
15. 00	Did total beds available change from the prior cost report		_yes, see ins t A		<u>N</u> -t B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
16. 00	PS&R Data 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	04/02/2019	Y	04/02/2019	16. 00
17. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	N		N		17. 00
18. 00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	N		N		18. 00
19. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

	Financial Systems GREENE COUNTY G				u of Form CM	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-1317	Peri od: From 01/01/2018 To 12/31/2018		Prepared:
		Descr	iption	Y/N	Y/N	
	To a contract of the contract		0	1.00	3. 00	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS	HOSPI TALS)		1.00	
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, se	ee instructions	3		N	22. 00
23.00	Have changes occurred in the Medicare depreciation expense	e due to apprai	sals made du	ring the cost	N	23. 00
	reporting period? If yes, see instructions.					
24.00	Were new leases and/or amendments to existing leases enter	red into durino	g this cost r	eporting period?	N	24.00
	If yes, see instructions					
25. 00	Have there been new capitalized leases entered into during	g the cost repo	orting period	? If yes, see	N	25. 00
	i nstructi ons.					
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during t	the cost report	ing period?	lf yes, see	N	26. 00
27.00	instructions.			e	N.	27.00
27. 00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? i	r yes, submit	N	27. 00
	copy. Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit e	entered into du	iring the cos	t reporting	N	28.00
20.00	period? If yes, see instructions.	sintered Tinto de	irring the cos	t reporting	14	20.00
29. 00	Did the provider have a funded depreciation account and/or	bond funds ([eht Service	Reserve Fund)	Υ	29. 00
27.00	treated as a funded depreciation account? If yes, see inst		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	noodi vo i ana)	,	27.00
30.00	Has existing debt been replaced prior to its scheduled mat		w debt? If ve	s. see	N	30.00
	instructions.		,			
31.00	Has debt been recalled before scheduled maturity without i	ssuance of nev	w debt? If ye	s, see	N	31.00
	i nstructi ons.					
	Purchased Services					
32. 00	Have changes or new agreements occurred in patient care se		ned through c	ontractual	N	32. 00
	arrangements with suppliers of services? If yes, see instr				Į	
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap	oplied pertaini	ng to compet	itive bidding? If	N	33.00
	no, see instructions.					
24.00	Provi der-Based Physi ci ans	nnongoment wit	the providence b	acad abusi al ana?	Y	34.00
34. 00	Are services furnished at the provider facility under an a lf yes, see instructions.	arrangement wi	.n provider-b	ased physicians?	Y	34.00
35 00	If line 34 is yes, were there new agreements or amended ex	vistina aarooma	ants with the	nrovi der-hased	N	35.00
33.00	physicians during the cost reporting period? If yes, see i		ants with the	provider-based	14	33.00
	perjorane during the boot reporting perrour in job, boot			Y/N	Date	
				1. 00	2. 00	
	Home Office Costs					
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	prepared by the	e home office	? N		37.00
	If yes, see instructions.	-				
38.00	If line 36 is yes, was the fiscal year end of the home of			f N		38. 00
	the provider? If yes, enter in column 2 the fiscal year er					
39. 00	J	ner chain compo	onents? If ye	s, N		39. 00
40.00	see instructions.	. homo cee: - 0	1£ vo= -::	N.I		10.00
40. 00	If line 36 is yes, did the provider render services to the instructions.	e nome office?	ir yes, see	N		40.00
	Thisti deti ons.					
		1	. 00	2	00	
	Cost Report Preparer Contact Information			Σ.		
41.00	Enter the first name, last name and the title/position	NI CK		EICHELMAN		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	BKD, LLP				42.00
	preparer.					
43.00	Enter the telephone number and email address of the cost	317-383-3781		NEI CHELMAN@BKD	. COM	43.00
	report preparer in columns 1 and 2, respectively.					

pared: 35 pm
41.00
42.00
43.00
ŗ

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provi der CCN: 15-1317

						To 12/31/2018	Date/Time Pre 5/29/2019 12:	
							1/P Days /	JJ PIII
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	. of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
	,	1. 00		2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		20	7, 30	0 46, 152. 00	0	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)							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		ŀ				0	6. 00
7. 00	Total Adults and Peds. (exclude observation		•	20	7, 30	46, 152. 00		7. 00
	beds) (see instructions)				.,,,,	,	_	
8.00	INTENSIVE CARE UNIT	31.00		5	1, 82	5, 064. 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)							12.00
13. 00	NURSERY	43. 00					0	13.00
14. 00	Total (see instructions)			25	9, 12	51, 216. 00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVIDER - I PF							16.00
17. 00 18. 00	SUBPROVIDER - IRF							17. 00 18. 00
19. 00	SUBPROVIDER SKILLED NURSING FACILITY		ŀ					19.00
20.00	NURSING FACILITY							20.00
21. 00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY							22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE							24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25.00	CMHC - CMHC							25. 00
26.00	LINTON CLINIC	88. 00					0	26.00
26. 01	BLOOMFIELD CLINIC	88. 01					0	26. 01
26. 02	WESTGATE CLINIC	88. 02					0	26. 02
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			25			_	27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30. 00 31. 00
31. 00 32. 00	Employee discount days - IRF Labor & delivery days (see instructions)			0		o		31.00
32. 00	Total ancillary labor & delivery room			U	'			32.00
JZ. UI	outpatient days (see instructions)							JZ. U1
33. 00	LTCH non-covered days							33. 00
	LTCH site neutral days and discharges							33. 01

Period: Worksheet S-3 From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

						5/29/2019 12:	35 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	Equi val ents	
		,		•		•	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 288	29	1, 923	3		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)	30	0				2.00
3.00	HMO IPF Subprovi der	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	433	0	440)		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	C			6. 00
7. 00	Total Adults and Peds. (exclude observation	1, 721	29	2, 363	3		7. 00
	beds) (see instructions)						
8. 00	I NTENSI VE CARE UNIT	168	4	211			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)		400				12.00
13.00	NURSERY	4 000	109			070 57	13.00
14.00	Total (see instructions)	1, 889	142	2, 765	0.00	278. 57	
15.00	CAH visits	O O	0	()		15.00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - I RF						17.00
18. 00 19. 00	SUBPROVIDER SKILLED NURSING FACILITY						18. 00 19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24. 00	HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)			(24. 00
25. 00	CMHC - CMHC				,		25.00
26. 00	LINTON CLINIC	o	0	(0.00	0. 00	
26. 01	BLOOMFIELD CLINIC		0			0.00	
26. 02	WESTGATE CLINIC		0			0.00	1
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	o o	0			0.00	
27. 00	Total (sum of lines 14-26)		Ŭ		0.00	278. 57	27. 00
28. 00	Observation Bed Days		134	1, 069		270.07	28.00
29. 00	Ambulance Trips	o	101	1,007			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)	o	58	58			32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)]			
33.00	LTCH non-covered days	o					33.00
33. 01	LTCH site neutral days and discharges	o					33. 01
		. '		•		•	•

				To	12/31/2018	Date/Time Pre 5/29/2019 12:	
		Full Time		Di sch	arges	37 2 77 20 1 7 12.	JJ PIII
		Equi val ents		5. 56.	a. 900		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	'	Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	455	52	864	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)			8	0		2.00
3. 00	HMO IPF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				0		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	455	52	864	14. 00
15. 00	CAH visits						15.00
16.00	SUBPROVIDER - IPF						16.00
17.00	SUBPROVI DER - I RF						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	HOSPI CE						24.00
24. 10 25. 00	HOSPICE (non-distinct part)						24. 10 25. 00
26. 00	CMHC - CMHC LINTON CLINIC	0. 00					26.00
26. 00	BLOOMFIELD CLINIC	0.00					26. 00
26. 02	WESTGATE CLINIC	0.00					26. 01
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	,	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30.00	Employee discount days (see instruction)				ļ		30.00
31.00	Employee discount days - IRF						31.00
32.00	. ,						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00				0			33.00
33. 01	LTCH site neutral days and discharges			0	l		33. 01

		REENE COUNTY GE	ENERAL HOSPITAI		In Lie	u of Form CMS-	
JSPI TAL-BASE	ED RHC/FQHC STATISTICAL DATA		Provi der C	CCN: 15-1317	Period: From 01/01/2018	Worksheet S-8	3
			Component	CCN: 15-8535	To 12/31/2018	Date/Time Pre	epared
						5/29/2019 12:	35 pn
					RHC I		
					1	00	-
Clinic	Address and Identification				I.	00	
00 Street					1210 N. 1000 W	1	1.
00 311661	<u> </u>		C	ty	State	ZIP Code	1.
				00	2. 00	3. 00	1
00 City,	State, ZIP Code, County		LINTON	. 00		47441	2.
35 3. t y	State, 211 couch country		2.11.011			.,	
						1.00	
00 HOSPIT	TAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for	urban		0	3.
				Gran	nt Award	Date	
					1.00	2. 00	
	of Federal Funds						
	nity Health Center (Section 330(d), PHS						4.
	nt Health Center (Section 329(d), PHS A						5.
1	n Services for the Homeless (Section 34)	O(d), PHS Act)					6.
	achian Regional Commission						7.
00 Look-A							8.
00 OTHER	(SPECI FY)						9.
					1.00	0.00	-
00 D +		: 4-1 1	DUC FOUCO F		1.00	2. 00	10.
yes or 2. (Ent	this facility operate as other than a hore "N" for no in column 1. If yes, indicater in subscripts of line 11 the type o	ate number of	other operation	ns in column			10.
hours.		Cum	-do.	1	landay	Tuesday	
		from	nday to	from	londay to	from	+
		1. 00	2.00	3. 00	4. 00	5. 00	1
Facili	ty hours of operations (1)	1.00	2.00	0.00	1. 00	0.00	
. 00 CLINIC							11.
					1. 00	2. 00	
.00 Have y	you received an approval for an exception	on to the prod	luctivity stand	lard?	N		12.
30.8? number	s a consolidated cost report as defined Enter "Y" for yes or "N" for no in column of providers included in this report. This below.	umn 1. If yes,	enter in colu	ımn 2 the	N	0	13.
Trumber	5 DOLOW.			Provi	der name	CCN number	
					1. 00	2.00	
. 00 RHC/FQ	OHC name, CCN number						14.
	,	Y/N	V	XVIII	XIX	Total Visits	
		1. 00	2.00	3. 00	4.00	5. 00	
	ou provided all or substantially all ost? Enter "Y" for yes or "N" for no in						15.
GME co column 4 the Intern XIX, a number	n 1. If yes, enter in columns 2, 3 and number of program visits performed by a & Residents for titles V, XVIII, and as applicable. Enter in column 5 the of total visits for this provider.						
GME co column 4 the Intern XIX, a number	number of program visits performed by a & Residents for titles V, XVIII, and as applicable. Enter in column 5 the						
GME co column 4 the Intern XIX, a number	number of program visits performed by a & Residents for titles V, XVIII, and as applicable. Enter in column 5 the of total visits for this provider.			unty			
GME co column 4 the Intern XIX, a number (see i	number of program visits performed by a & Residents for titles V, XVIII, and as applicable. Enter in column 5 the of total visits for this provider. nstructions)		4.	unty 00			
GME co column 4 the Intern XIX, a number (see i	number of program visits performed by a & Residents for titles V, XVIII, and as applicable. Enter in column 5 the of total visits for this provider.	Tuesday	GREENE 4	00			2.
GME co column 4 the Intern XIX, a number (see i	number of program visits performed by a & Residents for titles V, XVIII, and as applicable. Enter in column 5 the of total visits for this provider. nstructions)	Tuesday	GREENE Wedn	00 esday		sday	2.
GME co column 4 the Intern XIX, a number (see i	number of program visits performed by a & Residents for titles V, XVIII, and as applicable. Enter in column 5 the of total visits for this provider. nstructions)	to	GREENE Wedn	esday to	from	to	2.
GME co column 4 the Intern XIX, a number (see i	number of program visits performed by a & Residents for titles V, XVIII, and as applicable. Enter in column 5 the of total visits for this provider. nstructions)		GREENE Wedn	00 esday			2.

Health Financial Systems GF	REENE COUNTY GEN	IERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co		Peri od:	Worksheet S-8	
				From 01/01/2018		
		Component	CCN: 15-8535	To 12/31/2018		
					5/29/2019 12:	35 pm
				RHC I		
	Frid	lay	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC						11.00

OSPI TAL-BASEI	RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1317	Peri od:	Worksheet S-	8
	Component CCN: 15			CCN: 15-8533	From 01/01/2018 To 12/31/2018	Date/Time Pr 5/29/2019 12	
					RHC II	3/2//2017 12	00 pii
			-				
					1.	00	
	Address and Identification				EE N. IUDOE CT		۱,
00 Street			Ci	ty	55 N. JUDGE ST State	ZIP Code	1.
				00	2.00	3. 00	
00 City, S	tate, ZIP Code, County		BLOOMFI ELD			47424	2.
OO LIOCDI TA	L DACED FOLICE ONLY Designation Field	!!D!!	! "!!"			1. 00	2
00 HOSPI TA	L-BASED FQHCs ONLY: Designation - Ente	er "R" for rur	al or "U" for		nt Award	Date	0 3.
					1. 00	2. 00	
Source	of Federal Funds			1		2.00	
	ty Health Center (Section 330(d), PHS						4.
	Health Center (Section 329(d), PHS Ac					I	5.
1	Services for the Homeless (Section 340)(d), PHS Act)				I	6.
00 Appal ac 00 Look-Al	hian Regional Commission ikes			1		1	7. 8.
	SPECI FY)					I	9.
10111-11							
					1. 00	2. 00	
yes or	is facility operate as other than a ho "N" for no in column 1. If yes, indica r in subscripts of line 11 the type of	ite number of	other operation	ns in column		(0 10.
[110 u 1 3.]		Sur	nday	N	londay	Tuesday	
		from	to	from	to	from	
		1. 00	2. 00	3. 00	4. 00	5. 00	
Facility.	y hours of operations (1)						11.
. 00 CLINIC							+ 11.
					1.00	2. 00	
. 00 Have yo	u received an approval for an exception	on to the prod	luctivity stand	ard?	N		12.
30. 8? E	a consolidated cost report as defined nter "Y" for yes or "N" for no in colu of providers included in this report.	umn 1. If yes,	enter in colu	mn 2 the	N	(0 13.
1				Prov	ider name	CCN number	
					1. 00	2. 00	
. 00 RHC/FQH	C name, CCN number	\/ / 21	.,	Va	V1.V	T. I. I. M. I.	14.
		Y/N 1.00	V 2.00	XVIII	XIX	Total Visits	+
. 00 Have yo	u provided all or substantially all	1. 00	2. 00	3. 00	4. 00	5. 00	15.
GME cos column 4 the n	t? Enter "Y" for yes or "N" for no in 1. If yes, enter in columns 2, 3 and umber of program visits performed by & Residents for titles V, XVIII, and						10.
XIX, as number	applicable. Enter in column 5 the of total visits for this provider. structions)						
				inty 00			
00 City, S	tate, ZIP Code, County		GREENE 4.	00			2.
oo joily, 3	reate, ZII code, codifty	Tuesday		esday	Thur	sdav	+
		to	from	to	from	to	
		6. 00	7.00	8.00	9. 00	10. 00	

Health Financial Systems GF	REENE COUNTY GEN	IERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co		Peri od:	Worksheet S-8	
				From 01/01/2018		
		Component	CCN: 15-8533	To 12/31/2018		
					5/29/2019 12:	35 pm
				RHC II		
	Frid	lay	Sa ⁻	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC						11.00

	nancial Systems GR -BASED RHC/FQHC STATISTICAL DATA	EENE COUNTY GE	ENERAL HOSPITAL		Period:	u of Form CMS-	
JSPI IAL-	-BASED RHC/FUHC STATESTICAL DATA		Provider C	CN: 15-1317	From 01/01/2018	Worksheet S-8	3
			Component	CCN: 15-8534	To 12/31/2018	Date/Time Pre	epared
						5/29/2019 12:	35 pn
					RHC III		1
					1	00	-
CLi	inic Address and Identification				1.	00	
	reet				1985 E. FREEDOI	M DD	1.
00 311	1 661		Ci	ty	State	ZIP Code	1.
				00	2. 00	3. 00	
00 Ci 1	ty, State, ZIP Code, County		NEWBERRY	00		47449	2.
00 0.	ty, state, zir seae, seamty		premoent.			.,,	
						1. 00	
00 H09	OSPITAL-BASED FQHCs ONLY: Designation - Ento	er "R" for rur	al or "U" for	urban		0	3.
				Grai	nt Award	Date	
					1. 00	2. 00	
	urce of Federal Funds						
	ommunity Health Center (Section 330(d), PHS						4.
	grant Health Center (Section 329(d), PHS A						5.
4	ealth Services for the Homeless (Section 340	J(d), PHS Act)					6.
	opalachian Regional Commission						7.
	ook-Alikes						8.
00 OTI	THER (SPECIFY)						9.
					1.00	0.00	-
00 D=	this facility, annuals as ather than a b		DUC FOUCO F	"V"	1.00	2. 00	10.
yes 2.	pes this facility operate as other than a hopes or "N" for no in column 1. If yes, indication (Enter in subscripts of line 11 the type or	ate number of	other operation	ns in column		O	10.
hou	ours.)	Cur	ada.	T	landau	Tuesday	
	•	from	nday to	from	londay to	from	+
		1. 00	2.00	3.00	4.00	5. 00	1
Fac	cility hours of operations (1)	1.00	2.00	0.00	1.00	0.00	
. 00 CLI							11.
				•			
					1.00	2. 00	
. 00 Hav	ave you received an approval for an exception	on to the prod	luctivity stand	lard?	N		12.
30. nur	s this a consolidated cost report as defined).8? Enter "Y" for yes or "N" for no in columber of providers included in this report. Imbers below.	umn 1. If yes,	enter in colu	mn 2 the	N	0	13.
ITIUI	AIIIDOI 3 DOI OW.			Provi	ider name	CCN number	
					1. 00	2. 00	
. 00 RH	HC/FQHC name, CCN number						14.
		Y/N	V	XVIII	XIX	Total Visits	
		1. 00	2.00	3.00	4. 00	5. 00	
. 00 Hav	ave you provided all or substantially all ME cost? Enter "Y" for yes or "N" for no in Dlumn 1. If yes, enter in columns 2, 3 and						15.
GME col 4 i I ni XI X	the number of program visits performed by ntern & Residents for titles V, XVIII, and X, as applicable. Enter in column 5 the umber of total visits for this provider.						
GME col 4 i I ni XI X	ntern & Residents for titles V, XVIII, and X, as applicable. Enter in column 5 the			<u> </u>			
GME col 4 i I ni XI X	ntern & Residents for titles V, XVIII, and X, as applicable. Enter in column 5 the umber of total visits for this provider.			unty			
GME col 4 i 1 ni XI) nur (se	ntern & Residents for titles V, XVIII, and X, as applicable. Enter in column 5 the umber of total visits for this provider. see instructions)		4.	unty 00			
GME col 4 i 1 ni X1) nur (se	ntern & Residents for titles V, XVIII, and X, as applicable. Enter in column 5 the umber of total visits for this provider.	Tupeday	4. GREENE	00	7	and a v	2.
GME col 4 i 1 ni X1) nur (se	ntern & Residents for titles V, XVIII, and X, as applicable. Enter in column 5 the umber of total visits for this provider. see instructions)	Tuesday	GREENE Wedn	00 esday		sday	2.
GME col 4 i 1 ni XI) nur (se	ntern & Residents for titles V, XVIII, and X, as applicable. Enter in column 5 the umber of total visits for this provider. see instructions)	to	4. GREENE Wedn	esday to	from	to	2.
GME col 4 in XI) nur (se	ntern & Residents for titles V, XVIII, and X, as applicable. Enter in column 5 the umber of total visits for this provider. see instructions)		GREENE Wedn	00 esday			2.

Health Financial Systems GR	GREENE COUNTY GENERAL HOSPITAL In L				u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der CO		Peri od:	Worksheet S-8	
				From 01/01/2018		
		Component	CCN: 15-8534	To 12/31/2018		
					5/29/2019 12:	35 pm
				RHC III		
	Fric	lay	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11.00

Heal th	Financial Systems GRE	EENE COUNTY GENERAL HOS	PI TAL	In Lie	u of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA		der CCN: 15-1317	Peri od:	Worksheet S-1			
				From 01/01/2018		norod.		
				To 12/31/2018	Date/Time Pre 5/29/2019 12:			
					1. 00			
	Uncompensated and indigent care cost computat	i on			1.00			
1.00	Cost to charge ratio (Worksheet C, Part I lir		by line 202 colu	mn 8)	0. 268056	1. 00		
0.00	Medicaid (see instructions for each line)				0.040.005	0.00		
2. 00 3. 00	Net revenue from Medicaid Did you receive DSH or supplemental payments	from Modicaid2			2, 960, 925 Y	2. 00 3. 00		
4. 00	If line 3 is yes, does line 2 include all DSF		ovments from Medi	cai d?	N N	4. 00		
5. 00	If line 4 is no, then enter DSH and/or supple			cara.	1, 198, 096	5. 00		
6.00	Medi cai d charges	. 3			19, 284, 891	6.00		
7.00	Medicaid cost (line 1 times line 6)				5, 169, 431	7.00		
8. 00	Difference between net revenue and costs for	Medicaid program (line	7 minus sum of I	ines 2 and 5; if	1, 010, 410	8. 00		
	<pre>< zero then enter zero) Children's Health Insurance Program (CHIP) (s</pre>	on instructions for one	th Lino)					
9. 00	Net revenue from stand-alone CHIP	see Tristi ucti ons Tor eac	n ine)		0	9. 00		
10.00	Stand-alone CHIP charges				Ö	10.00		
11. 00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00		
12. 00	Difference between net revenue and costs for	stand-alone CHIP (line	11 minus line 9;	if < zero then	0	12.00		
	enter zero)			. \				
13. 00	Other state or local government indigent care program (see instructions for each line) Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9) 0 13							
14. 00								
00	10)	ocaa. ge ca. c p. c.	,. a (110 t 1110) aao	4	0	14. 00		
15.00	State or local indigent care program cost (li	0	15.00					
16.00	O Difference between net revenue and costs for state or local indigent care program (line 15 minus line							
	13; if < zero then enter zero) Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see							
	instructions for each line)	. For Medicard, Chip and	i State/Tocal Thu	rgent care progra	illis (see			
17. 00	Private grants, donations, or endowment incom				0	17. 00		
18. 00	Government grants, appropriations or transfer				0	18. 00		
19. 00	Total unreimbursed cost for Medicaid, CHIP a 8, 12 and 16)	and state and Local Indi	gent care progra	ms (sum of lines	1, 010, 410	19.00		
	1-7		Uni nsured		Total (col. 1			
			pati ents	pati ents	+ col . 2) 3.00			
	Uncompensated Care (see instructions for each	ıline)	1.00	2. 00	3.00			
20. 00	Charity care charges and uninsured discounts		354,9	959 0	354, 959	20. 00		
	(see instructions)	-						
21. 00	Cost of patients approved for charity care ar instructions)	nd uninsured discounts	(see 95, 1	149 0	95, 149	21. 00		
22. 00	Payments received from patients for amounts p	previously written off a	is .	0 0	0	22. 00		
	charity care	•			05.440			
23. 00	Cost of charity care (line 21 minus line 22)		95, 1	149 0	95, 149	23.00		
					1. 00			
24. 00	Does the amount on line 20 column 2, include			h of stay limit	N	24. 00		
25 00	imposed on patients covered by Medicaid or ot If line 24 is yes, enter the charges for pati			am's Length of	0	25. 00		
25.00	stay limit	ent days beyond the rin	ingent care progr	am 3 rength of		23.00		
26. 00	Total bad debt expense for the entire hospita				6, 590, 295			
27. 00	Medicare reimbursable bad debts for the entire		,		770, 568			
27. 01 28. 00	Medicare allowable bad debts for the entire h Non-Medicare bad debt expense (see instruction		isti ucti ons)		1, 185, 489 5, 404, 806			
29.00	Cost of non-Medicare and non-reimbursable Medicare	•	(see instruction	s)	1, 863, 712			
	Cost of uncompensated care (line 23 column 3			•	1, 958, 861			
	Total unreimbursed and uncompensated care cos))		2, 969, 271	31.00		

Heal th	Financial Systems GR	REENE COUNTY GENE	RAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	OF EXPENSES	Provi der Co		Peri od:	Worksheet A	
					From 01/01/2018	D-+- /T: D	
					To 12/31/2018	Date/Time Pre 5/29/2019 12:	
	Cost Center Description	Sal ari es	Other	Total (col.	Reclassi fi cat	Reclassi fied	JJ PIII
				+ col . 2)	i ons (See	Trial Balance	
				,	A-6)	(col. 3 +-	
					ŕ	col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 036, 723	1, 036, 72		1, 079, 967	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		400, 619		·	402, 927	2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	3, 322, 173			3, 185, 827	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 667, 913	3, 525, 610	5, 193, 52		5, 057, 810	5. 00
7. 00	00700 OPERATION OF PLANT	563, 544	1, 213, 380			1, 776, 924	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	287, 716			287, 716	8. 00
9. 00	00900 HOUSEKEEPI NG	288, 509	126, 379	414, 88		414, 888	9. 00
10.00	01000 DI ETARY	562, 194	554, 788		·	123, 426	10.00
11.00	01100 CAFETERI A	0	0	l	993, 556	993, 556	11.00
13.00	01300 NURSING ADMINISTRATION	781, 250	158, 334	939, 58		939, 584	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	46, 321	46, 32		46, 321	14.00
15.00	01500 PHARMACY	517, 060	81, 234	598, 29		598, 294	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	255, 822	29, 611	285, 43		285, 433	16.00
17.00	01700 SOCIAL SERVICE	236, 963	11, 815			248, 778	17.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0 466, 226	466, 226	19. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 994, 957	174, 807	2, 169, 76	4 582, 088	2, 751, 852	30.00
31. 00	03100 I NTENSI VE CARE UNI T	519, 769	33, 496			553, 265	31.00
43. 00	04300 NURSERY	89	33, 470	8		67, 609	43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	07			7 07, 320	07,009	43.00
50. 00	05000 OPERATING ROOM	500, 887	188, 692	689, 57	9 -1, 125	688, 454	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	213, 588	55, 224	268, 81	·	92, 894	52.00
53. 00	05300 ANESTHESI OLOGY	0	477, 383	477, 38	·	14, 107	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	937, 993	749, 276	1, 687, 26		1, 687, 269	54.00
60.00	06000 LABORATORY	857, 975	1, 747, 363	2, 605, 33		2, 605, 338	60.00
65.00	06500 RESPIRATORY THERAPY	621, 328	73, 900			684, 496	65.00
66.00	06600 PHYSI CAL THERAPY	355, 213	35, 574			390, 787	66.00
67.00	06700 OCCUPATI ONAL THERAPY	169, 036	. 0	169, 03	6 0	169, 036	67.00
68.00	06800 SPEECH PATHOLOGY	16, 010	166	16, 17		16, 176	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0		o o	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	788, 539	788, 53	9 0	788, 539	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	231, 818	1, 248, 855	1, 480, 67	3 0	1, 480, 673	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 LINTON CLINIC	0	0		0 106, 658	106, 658	88. 00
88. 01	08801 BLOOMFIELD CLINIC	0	0		0 34, 288	34, 288	88. 01
88. 02	08802 WESTGATE CLINIC	0	0		0 17, 230	17, 230	88. 02
91. 00	09100 EMERGENCY	2, 518, 123	479, 221	2, 997, 34	4 10, 732	3, 008, 076	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
440 -	SPECIAL PURPOSE COST CENTERS	40.040.0::	4.047 :	00 (55 5)			
118. 00	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	13, 810, 041	16, 847, 199	30, 657, 24	0 407, 184	31, 064, 424	118.00
100.00	NONREI MBURSABLE COST CENTERS					_	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	020.047		0 0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 FOUNDATION / MOBS	2, 856, 377	830, 916	3, 687, 29		3, 055, 427	
200. 00		16 644 410	17, 678, 115	34, 344, 53	0 224, 682 3 0	224, 682	
200.00	TOTAL (SUM OF LINES 118 through 199)	16, 666, 418	17,078,115	34, 344, 53	이	34, 344, 533	1200.00

 Health Financial
 Systems
 GREENE COUNTY

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provi der CCN: 15-1317

				10	12/31/2018	Date/IIme Pre 5/29/2019 12:	
	Cost Center Description	Adjustments	Net Expenses			3/2//2017 12.	Jo piii
	, , , , , , , , , , , , , , , , , , ,	(See A-8)	For				
		, ,	Allocation				
		6. 00	7. 00				
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT	-48, 285					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	-40, 794	362, 133				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	224, 682	3, 410, 509				4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 217, 068					5.00
7.00	00700 OPERATION OF PLANT	-12, 652					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	287, 716				8. 00
9. 00	00900 HOUSEKEEPI NG	0	414, 888				9. 00
10.00	01000 DI ETARY	0	123, 426				10.00
11. 00	01100 CAFETERI A	-376, 752	616, 804				11. 00
13.00	01300 NURSING ADMINISTRATION	0	939, 584				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	46, 321				14.00
15. 00	01500 PHARMACY	0	598, 294				15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	-5, 959					16. 00
17. 00	01700 SOCI AL SERVI CE	0	248, 778				17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	-223, 260	242, 966				19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	-445, 564	2, 306, 288				30.00
31. 00	03100 I NTENSI VE CARE UNI T	0	,				31.00
43.00		0	67, 609				43.00
	ANCILLARY SERVICE COST CENTERS						4
50.00	05000 OPERATING ROOM	0	688, 454				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	-37, 250		•			52.00
53.00	05300 ANESTHESI OLOGY	0	14, 107	•			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 687, 269	•			54.00
60.00	06000 LABORATORY	-59, 658					60.00
65.00	06500 RESPI RATORY THERAPY	-19, 040	665, 456				65.00
66.00	06600 PHYSI CAL THERAPY	-51	390, 736				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	169, 036	•			67.00
68.00	06800 SPEECH PATHOLOGY	0	16, 176				68.00
69.00	06900 ELECTROCARDI OLOGY	10.045	777 504				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-10, 945	777, 594	1			71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	1 400 473	l .			72.00
73.00	OUTPATIENT SERVICE COST CENTERS	0	1, 480, 673				73.00
88. 00	08800 LINTON CLINIC		106, 658				88. 00
88. 01	08801 BLOOMFIELD CLINIC	0	34, 288				88. 01
88. 02	08802 WESTGATE CLINIC	0	17, 230				88. 02
91.00	09100 EMERGENCY	-1, 044, 381	1, 963, 695				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-1,044,301	1, 703, 073				92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		-3, 316, 977	27, 747, 447				118.00
110.00	NONREI MBURSABLE COST CENTERS	-3, 310, 9//	21,141,441				1110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
	19000 BIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190.00
	07950 FOUNDATION / MOBS		224, 682	•			194.00
200.00	1 1	-3, 316, 977					200.00
200.00	I TOTAL (SOM OF LINES TTO CHIOUGH 199)	3,310,977	51,021,330	I			1200.00

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

					From 01/01/2018 To 12/31/2018	Date/Time Pi 5/29/2019 12	repared: 2:35 pm
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
	A - CRNA RECLASS						
1.00	NONPHYSICIAN ANESTHETISTS	19. 00	0	466, 226			1.00
2.00		0.00	0	0			2. 00
3.00		0.00	0	0			3. 00
				466, 226			
	B - LABOR & DELIVERY						
1.00	ADULTS & PEDIATRICS	30. 00	175, 918	0			1.00
			175, 918	0			
	C - DIETARY RECLASS						
1.00	CAFETERI A	11. 00	500, 072	493, 484			1.00
		$ \top$	500, 072	493, 484			
	D - RHC ALLOCATION						
1.00	LINTON CLINIC	88. 00	74, 915	31, 743			1.00
2.00	BLOOMFIELD CLINIC	88. 01	24, 551	9, 737			2.00
3.00	WESTGATE CLINIC	88. 02	9, 308	7, 922			3.00
	TOTALS		108, 774	49, 402			
	E - INSURANCE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	43, 244			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	O	2, 308			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	O	88, 336			3.00
				133, 888			1
	H - RELATED PARTIES RECLASS						
1.00	FOUNDATION / MOBS	194. 00	0	224, 682			1.00
				224, 682			İ
	I - HOSPITALIST RECLASS	<u> </u>					
1.00	ADULTS & PEDIATRICS	30. 00	473, 690	0			1. 00
			473, 690				
	J - NURSERY RECLASS						
1.00	NURSERY	43. 00	67, 520	0			1. 00
			67, 520				İ
	K - EKG RECLASSIFICATION	<u> </u>					
1.00	EMERGENCY	91.00	0	10, 732			1.00
	TOTALS	†		10, 732			
500.00	Grand Total: Increases		1, 325, 974	1, 378, 414			500.00

From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm Decreases Cost Center 0ther Wkst. A-7 Ref. Li ne # Sal ary 10.00 6.00 7.00 8.00 9.00 A - CRNA RECLASS 1.00 ADMINISTRATIVE & GENERAL 5.00 0 1,825 0 1.00 OPERATING ROOM 50.00 0 1, 125 0 2.00 2.00 3.00 ANESTHESI OLOGY 53.00 463, 276 3.00 0 466, 226 B - LABOR & DELIVERY 52. 00 175, 918 1.00 DELIVERY ROOM & LABOR ROOM 0 1.00 0 175, 918 Ō - DI ETARY RECLASS DI ETARY 10. 00 500, 072 493, 484 1.00 0 1.00 500, 072 493, 484 D - RHC ALLOCATION 1.00 PHYSICIANS' PRIVATE OFFICES 192. 00 108, 774 49, 402 0 1.00 2.00 0.00 0 0 2.00 0 3.00 3.00 0. 00 0 0 TOTALS 108, 774 49, 402 E - INSURANCE RECLASS ADMINISTRATIVE & GENERAL 133, 888 1.00 5.00 0 12 1.00 0 2.00 0.00 12 2.00 0 3.00 0.00 0 0 0 3.00 133, 888 H - RELATED PARTIES RECLASS 1.00 EMPLOYEE BENEFITS DEPARTMENT 4.00 224, 682 0 1.00 224, 682 I - HOSPITALIST RECLASS PHYSICIANS' PRIVATE OFFICES 1.00 192.00 473, 690 0 0 1.00 473, 690 - NURSERY RECLASS ADULTS & PEDIATRICS 6<u>7, 5</u>20 1.00 30. 00 1.00 0 67, 520 EKG RECLASSIFICATION RESPIRATORY THERAPY 65. 00 1.00 10, 732 1.00

1, 325, 974

10, 732

1, 378, 414

500.00

TOTALS

500.00 Grand Total: Decreases

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1317 Peri od: Worksheet A-7 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 12:35 pm Acqui si ti ons Begi nni ng Purchases Disposals and Donati on Total Bal ances Retirements 2.00 3.00 4.00 5.00 1.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 651, 198 1.00 Land 0 335, 729 2.00 Land Improvements 6, 135 6, 135 28, 396 2.00 3.00 7, 577, 795 584, 704 Buildings and Fixtures 91, 440 3.00 584, 704 0 4.00 Building Improvements 0 4.00 Fi xed Equi pment 3, 692, 311 179, 783 0 179, 783 5.00 32, 105 5.00 0 6.00 6.00 Movable Equipment 2, 421, 534 757, 336 719, 667 719, 667 0 7.00 HIT designated Assets 1,062,388 947, 352 7.00 8.00 Subtotal (sum of lines 1-7) 15, 740, 955 1, 490, 289 0 1, 490, 289 1, 856, 629 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 15, 740, 955 1, 490, 289 1, 8<u>56, 629</u> 1, 490, 289 10.00 10.00 O Endi ng Ful I y 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 0 2.00 Land Improvements 313, 468 3.00 Buildings and Fixtures 8, 071, 059 0 3.00 4.00 Building Improvements 0 4.00 5.00 Fixed Equipment 3, 839, 989 0 5.00 0 6.00 Movable Equipment 2, 383, 865 6.00 0 HIT designated Assets 7.00 115, 036 7.00

15, 374, 615

15, 374, 615

0

0

0

8.00

9.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-1317		Period: From 01/01/2018 To 12/31/2018		pared:	
		SUMMARY OF CAPITAL						
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9. 00	10. 00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2				
1.00	CAP REL COSTS-BLDG & FIXT	674, 403	0	362, 32	0 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	400, 619	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	1, 075, 022	0	362, 32	0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1)					
		Capi tal -Rel at	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14 00	15 00					

					(300	Tristi de trons)	
					instructions)		
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	674, 403	0	362, 320	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	400, 619	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1, 075, 022	0	362, 320	0	0	3.00
		SUMMARY 0	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, COLUI	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 036, 723				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	400, 619				2.00
3.00	Total (sum of lines 1-2)	0	1, 437, 342				3.00

Heal th	n Financial Systems GR	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS				Period: Worksheet A-7 From 01/01/2018 Part III		
		Т			To 12/31/2018 Date/Time Prepa 5/29/2019 12:35		
		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 -			
				col . 2)			
	DART III DECONOLILIATION OF CARLTAL COCTO O	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CL CAP REL COSTS-BLDG & FIXT			12 000 750	0.044040		1.00
2.00	CAP REL COSTS-BLDG & FTXT	12, 990, 750 2, 383, 865	l .	12, 990, 750 2, 383, 865			2.00
3.00	Total (sum of lines 1-2)	15, 374, 615	l .	15, 374, 615			3.00
3.00	Total (Suil of Titles 1-2)		TION OF OTHER (F CAPITAL	3.00
		ALLOOM	TION OF OTHER C	JAI I IAL	SOMMATCE	OALLIAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Rel at	col s. 5	·		
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1. 00	CAP REL COSTS-BLDG & FIXT	0	0		626, 118	l e e e e e e e e e e e e e e e e e e e	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(359, 825		2.00
3. 00	Total (sum of lines 1-2)	0	0	IMMADY OF CARL	985, 943	0	3. 00
			SL	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DADT III DECONCILIATION OF CADITAL COCTO C	11. 00	12. 00	13. 00	14. 00	15. 00	

362, 320

362, 320

43, 244 2, 308 45, 552 0 0 0 1, 031, 682 1. 00 362, 133 2. 00 1, 393, 815 3. 00

0 0 0

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT
CAP REL COSTS-MVBLE EQUIP

1. 00 2. 00

3.00 Total (sum of lines 1-2)

	MENTS TO EXPENSES	GR	CEENE COUNTY GE	Provi der CCN: 15-1317 P	eri od:	Worksheet A-8	
ADJUS1	MENTS TO EXPENSES			F	rom 01/01/2018	Date/Time Pre 5/29/2019 12:	pared:
				Expense Classification on To/From Which the Amount is		372772017 12.	33 piii
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4.00	Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone services (pay stations excluded) (chapter 21)	Α	-1, 896	OPERATION OF PLANT	7. 00	0	7. 00
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -1, 508, 985		0.00	O O	
11. 00	1 3		0		0. 00	0	11.00
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	0 -375, 040	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	9		0		0. 00	0	17. 00
18. 00	patients Sale of medical records and abstracts	В	-5, 959	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.) Vending machines Income from imposition of	В	-1, 712 0	CAFETERI A	11. 00 0. 00	0	
21.00	interest, finance or penalty charges (chapter 21)		0		0.00	O	21.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FLXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		О	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
55.00	therapy costs in excess of limitation (chapter 14)	5 5		THE WALL	07.00		33.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99

Health Financial Systems	GF	REENE COUNTY GE	NERAL HOSPITAL	In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES				Peri od:	Worksheet A-8		
				From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 12:		
			Expense Classification or				
			To/From Which the Amount is	to be Adjusted			
Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7		
oost center bescription	(2)	7 tillodi i e	Jose Jones	Line "	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	-40, 794	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32.00	
Depreciation and Interest							
33. 00 CPR TRAINING	В	· ·	ADMINISTRATIVE & GENERAL	5. 00	0	33.00	
33. 01 MISC REVENUE - ADMIN	В		ADMINISTRATIVE & GENERAL	5. 00	0	00.0.	
33. 02 AHA DUES	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 02	
33. 03 I HA DUES	A		ADMINISTRATIVE & GENERAL	5. 00	0		
33.04 MARKETING & ADVERTISING	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 04	
33.05 RENTAL OF PROVIDER SPACE - BENEFITS	В	-38, 468	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 05	
33.06 GIFT CARD USAGE	В	-4, 755	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06	
33. 07 THERAPY REVENUE	В	-51	PHYSI CAL THERAPY	66. 00	0	33. 07	

-223, 260 NONPHYSI CI AN ANESTHETI STS

-1, 084, 745 ADMINISTRATIVE & GENERAL

-10, 756 OPERATION OF PLANT

PATI ENTS

-59, 658 LABORATORY

-3, 316, 977

-37, 250 DELIVERY ROOM & LABOR ROOM

21, 364 CAP REL COSTS-BLDG & FIXT

-31, 181 CAP REL COSTS-BLDG & FIXT

-10, 945 MEDICAL SUPPLIES CHARGED TO

-233 ADMINISTRATIVE & GENERAL

224, 682 EMPLOYEE BENEFITS DEPARTMENT

19.00

52.00

4.00

5.00

1.00

5.00

7.00

60.00

1.00

71.00

33.08

33.09

33.10

33.11

33.12

33.13

33.14

33. 15

33.16

33.17

50.00

O

0

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

Α

Α

Α

Α

Α

Α

В

В

В

В

(2) Basis for adjustment (see instructions).

I NUSRANCE PROCEEDS - CAPITAL

TOTAL (sum of lines 1 thru 49)

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

CRNA TO MARKET ADJUSTMENT

OB ON CALL TIME

33. 11 HOSPITAL ASSESSMENT FEE

33. 12 BOND AMORTIZATION EXPENSE

MISC EXPENSE - ADMIN

33. 14 I NSURANCE PROCEEDS - R&M

33. 15 I NSURANCE PROCEEDS - LAB

33. 10 LLC AND HHC BENEFITS

ADJUSTMENT

33. 08

33.09

33. 13

33. 16

50.00

33. 17 REBATES

B. Amount Received - if cost cannot be determined.

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

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

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

| Period: | Worksheet A-8-2 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1317

					-	Γο 12/31/2018	Date/Time Pre 5/29/2019 12:	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	JJ PIII
		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	496, 009	445, 564	50, 445	0	0	1.00
2.00		DELIVERY ROOM & LABOR ROOM	24, 500			0	0	2.00
3.00		RESPIRATORY THERAPY	19, 040			0	0	3.00
4.00	•	EMERGENCY	1, 533, 054	1, 044, 381	488, 673	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		0 070 (00	1 500 005	5/0/10	O	0	10.00
200.00	WI+ A I : //	C+ C+ (Db	2, 072, 603				0	200.00
	Wkst. A Line #	1	Unadjusted RCE		Cost of		Physician Cost	
		l denti fi er	Limit	Unadjusted RCE Limit	•	Component	of Malpractice Insurance	
				LIIIII	Continuing Education	Share of col.	Trisui ance	
	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1. 00		ADULTS & PEDIATRICS	0.00	7.00		0	0	1. 00
2. 00		DELIVERY ROOM & LABOR ROOM	0	Ö	_	-	0	2. 00
3. 00		RESPIRATORY THERAPY	l o	Ō		o	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	200.00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDIATRICS	15.00	10.00		445, 564		1. 00
2. 00		DELIVERY ROOM & LABOR ROOM		Ö	_			2. 00
3.00		RESPIRATORY THERAPY	١	0		19, 040		3.00
4. 00	1	EMERGENCY	1 0	0	_	1, 044, 381		4. 00
5. 00	0.00	1	0	0	_	0		5. 00
6. 00	0.00	1	0	0	_	0		6. 00
7. 00	0.00		0	Ö	0	o o		7. 00
8. 00	0.00		0	0	0	0		8. 00
9. 00	0.00		1 0	Ō	0	o		9. 00
10.00	0.00		0	0	0	O		10.00
200.00			0	0	0	1, 508, 985		200.00
	•	•	•	•	•		'	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS GREENE COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: 5/29/2019 12:35 pm Provider CCN: 15-1317

						5/29/2019 12:	35 pm_
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		for Cost			BENEFITS		
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)					
	OFNEDAL CEDIUSE OCCT OFNEDO	0	1.00	2. 00	4. 00	4A	
1 00	GENERAL SERVICE COST CENTERS	1 021 402	1 021 (02				1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	1, 031, 682					1.00 2.00
		362, 133	ł	362, 133	2 410 500		
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 410, 509	0	-	3, 410, 509	4 227 075	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	3, 840, 742			371, 988		1
7.00	00700 OPERATION OF PLANT	1, 764, 272	121, 759		125, 685		
8.00	00800 LAUNDRY & LI NEN SERVI CE	287, 716			(4.245	296, 334	
9.00	00900 HOUSEKEEPI NG	414, 888			64, 345		
10.00	01000 DI ETARY	123, 426			13, 855	182, 386	1
11.00	01100 CAFETERI A	616, 804			111, 529		
13.00	01300 NURSI NG ADMI NI STRATI ON	939, 584	4, 595		174, 239	1, 120, 031	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	46, 321	43, 770		0	105, 455	
15.00	01500 PHARMACY	598, 294	20, 537		115, 318		
16.00	01600 MEDICAL RECORDS & LIBRARY	279, 474			57, 055		
17. 00	01700 SOCI AL SERVI CE	248, 778			52, 849		
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	242, 966	0	0	0	242, 966	19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	2, 306, 288			574, 747	3, 153, 739	
31.00	03100 INTENSIVE CARE UNIT	553, 265			115, 922	715, 662	
43.00	04300 NURSERY	67, 609	4, 865	1, 708	15, 079	89, 261	43.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	688, 454	59, 956		111, 711	881, 166	
52.00	05200 DELIVERY ROOM & LABOR ROOM	55, 644			8, 401	82, 166	1
53.00	05300 ANESTHESI OLOGY	14, 107	0		0	14, 107	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 687, 269	58, 454		209, 197	1, 975, 438	1
60.00	06000 LABORATORY	2, 545, 680			191, 351	2, 777, 176	
65.00	06500 RESPI RATORY THERAPY	665, 456			138, 572	815, 578	
66.00	06600 PHYSI CAL THERAPY	390, 736			79, 222	486, 467	
67.00	06700 OCCUPATI ONAL THERAPY	169, 036	12, 220	4, 289	37, 699	223, 244	67.00
68. 00	06800 SPEECH PATHOLOGY	16, 176	3, 658	1, 284	3, 571	24, 689	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	777, 594	0	0	0	777, 594	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 480, 673	10, 615	3, 726	51, 701	1, 546, 715	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 LINTON CLINIC	106, 658	3, 093	1, 086	16, 708	127, 545	88. 00
88. 01	08801 BLOOMFIELD CLINIC	34, 288	1, 771	622	5, 476	42, 157	88. 01
88. 02	08802 WESTGATE CLINIC	17, 230	1, 489	523	2, 076	21, 318	88. 02
91.00	09100 EMERGENCY	1, 963, 695	72, 881	25, 582	255, 071	2, 317, 229	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	27, 747, 447	905, 905	317, 983	2, 903, 367	27, 070, 378	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 568	1, 253	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	3, 055, 427	122, 209	42, 897	507, 142	3, 727, 675	192.00
	07950 FOUNDATION / MOBS	224, 682	0	0	0	224, 682	
200.00		1					200.00
201.00			0	0	ol	0	201.00
202.00	1 1 3	31, 027, 556	1, 031, 682	362, 133	3, 410, 509		

				''	0 12/31/2016	5/29/2019 12:	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	ос р
		E & GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS			•			
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 327, 875					5.00
7.00	00700 OPERATION OF PLANT	333, 017	2, 387, 472				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	48, 034	18, 468	362, 836			8.00
9.00	00900 HOUSEKEEPI NG	79, 230	20, 475	0	588, 493		9.00
10.00	01000 DI ETARY	29, 564	96, 651	0	0	308, 601	10.00
11.00	01100 CAFETERI A	126, 090	106, 164	0	o	0	11.00
13.00	01300 NURSING ADMINISTRATION	181, 551	13, 303	0	o	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	17, 094	126, 713	1, 277	6, 951	0	14.00
15.00	01500 PHARMACY	120, 170	59, 455	0	6, 703	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	57, 546	39, 612	0	2, 483	0	16.00
17.00	01700 SOCIAL SERVICE	49, 696	10, 628	0	o	0	17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	39, 384	0	0	0	0	19.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	511, 205	584, 364	95, 243	215, 674	278, 202	30.00
31.00	03100 INTENSIVE CARE UNIT	116, 005	99, 586		51, 451	30, 399	31.00
43.00	04300 NURSERY	14, 469	14, 083	639	1, 427	0	43.00
	ANCILLARY SERVICE COST CENTERS	140.000	470 570	1 4/ 070	70.074		
50.00	05000 OPERATING ROOM	142, 833	173, 570		70, 071	0	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	13, 319 2, 287	38, 831 0		6, 641 683	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	320, 209	169, 223		26, 439	0	54.00
60.00	06000 LABORATORY				·	0	60.00
65.00	06500 RESPIRATORY THERAPY	450, 166 132, 201	86, 023 24, 748		19, 674 10, 489	0	65. 00
66.00	06600 PHYSI CAL THERAPY	78, 854	35, 375			0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	36, 187	35, 375 35, 375		20, 020	0	67.00
68. 00	06800 SPEECH PATHOLOGY	4, 002	10, 590		240	0	68.00
69.00	06900 ELECTROCARDI OLOGY	4,002	10, 370	1	0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	126, 044	0		0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	120,044	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	250, 715	30, 731	0	0	0	73. 00
	OUTPATIENT SERVICE COST CENTERS	===,			-1	-	
88. 00	08800 LINTON CLINIC	20, 674	8, 955	0	0	0	88. 00
88. 01	08801 BLOOMFIELD CLINIC	6, 833	5, 128	0	o	0	88. 01
88. 02	08802 WESTGATE CLINIC	3, 456	4, 310	0	o	0	88. 02
91.00	09100 EMERGENCY	375, 611	210, 989	96, 095	126, 735	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	1					
118. 00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	3, 686, 446	2, 023, 350	353, 781	572, 295	308, 601	118. 00
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	781	10, 330	0	993	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	604, 228	353, 792		14, 833		192. 00
	07950 FOUNDATION / MOBS	36, 420	0	0	372	0	194.00
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0	O		201. 00
202.00	TOTAL (sum lines 118 through 201)	4, 327, 875	2, 387, 472	362, 836	588, 493	308, 601	202. 00

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared: 5/39/2019 12:35 pm

				'	12/01/2010	5/29/2019 12:	35 pm
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	·		ADMI NI STRATI O	SERVICES &		RECORDS &	
			N	SUPPLY		LI BRARY	
		11. 00	13. 00	14.00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	1, 010, 131					11.00
13. 00	01300 NURSING ADMINISTRATION	59, 135	1, 374, 020				13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0				14.00
15.00	01500 PHARMACY	37, 090	0		965, 540		15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	42, 164	0	522	0	497, 342	16.00
17. 00	01700 SOCIAL SERVICE	17, 495	0	797	o	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	17, 170	0		0	0	19.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	<u> </u>	<u> </u>		17.00
30.00	03000 ADULTS & PEDIATRICS	249, 021	713, 842	7, 404	0	88, 980	30.00
31. 00	03100 I NTENSI VE CARE UNI T	46, 071	132, 069		o	10, 878	1
43. 00	04300 NURSERY	6, 532	0		o	2, 510	1
10.00	ANCILLARY SERVICE COST CENTERS	0,002		<u> </u>	<u> </u>	2,0.0	1 .0.00
50.00	05000 OPERATING ROOM	45, 663	130, 899	4, 348	0	17, 294	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 616			o	4, 045	52.00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	102, 815	o o	1, 772	0	39, 888	
60.00	06000 LABORATORY	114, 012	o o		0	75, 731	60.00
65. 00	06500 RESPI RATORY THERAPY	60, 126	l ő	2, 238	o	25, 662	65.00
66.00	06600 PHYSI CAL THERAPY	37, 382	o o	782	0	8, 089	
67. 00	06700 OCCUPATI ONAL THERAPY	10, 497	o o	0	o	976	
68. 00	06800 SPEECH PATHOLOGY	2, 158	l ő	0	o	837	68.00
69.00	06900 ELECTROCARDI OLOGY	2, 130 N	l o	0	0	0.57	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	-	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	15, 746	1	-	965, 540	837	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	13, 740		1 430	703, 340	037	73.00
88. 00	08800 LINTON CLINIC	0	0	0	ol	0	88. 00
88. 01	08801 BLOOMFI ELD CLINI C	0	0		Ö	0	88. 01
88. 02	08802 WESTGATE CLINIC	0	o o	0	0	0	88. 02
91.00	09100 EMERGENCY	138, 564	397, 210	-	0	221, 615	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	100,001	077,210	0, 7,2	Ğ	221,010	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		988, 087	1, 374, 020	257, 490	965, 540	497, 342	118 00
110.00	NONREI MBURSABLE COST CENTERS	700,007	1,071,020	207, 170	700,010	177, 012	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	22, 044	0		0		192.00
	07950 FOUNDATION / MOBS	0	ا م	0	o o		194. 00
200.00	1 1	Ü	l		Ĭ	Ü	200.00
201.00		n	n	n	n	n	201.00
202.00		1, 010, 131	1, 374, 020	257, 490	965, 540	497, 342	
	1 (.,	., ., ., 020		, 0 . 0	, 0.12	

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1317 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 12:35 pm Cost Center Description SOCI AL NONPHYSI CI AN Subtotal Intern & Total SERVI CE **ANESTHETISTS** Resi dents Cost & Post Stepdown Adjustments 17. 00 19.00 24.00 25. 00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00700 OPERATION OF PLANT 7.00 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11 00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 385, 203 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 282, 350 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 250, 538 6, 148, 212 6, 148, 212 30.00 03100 INTENSIVE CARE UNIT 1, 284, 724 0 1, 284, 724 31.00 61, 591 0 31.00 04300 NURSERY 128, 921 0 128, 921 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 1, 482, 122 0 1, 482, 122 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 148, 618 0 148, 618 52.00 0 299, 623 53.00 05300 ANESTHESI OLOGY 0 0 282, 350 299, 623 53 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 C 2, 683, 824 2, 683, 824 54.00 60.00 06000 LABORATORY 3, 675, 711 0 3, 675, 711 60.00 06500 RESPIRATORY THERAPY 65.00 00000 0 1,071,042 0 0 1,071,042 65.00 06600 PHYSI CAL THERAPY 749, 574 749, 574 66 00 Ω 66 00 06700 OCCUPATIONAL THERAPY 67.00 C 306, 527 306, 527 67.00 06800 SPEECH PATHOLOGY 0 42, 276 0 42, 276 68.00 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 984, 164 984, 164 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 2, 810, 722 73.00 0 2, 810, 722 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 LINTON CLINIC 0 157, 174 0 157, 174 88 00 0 88.01 08801 BLOOMFIELD CLINIC 0 0 54, 118 0 54, 118 88.01 29, 084 88.02 08802 WESTGATE CLINIC 0 0 0 29, 084 88.02 09100 EMERGENCY 0 91.00 73,074 91.00 0 3, 961, 094 3, 961, 094 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 385, 203 282, 350 26, 017, 530 26, 017, 530 118. 00 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 16, 925 0 16, 925 190. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 4, 731, 627 0 4, 731, 627 192. 00 0 261, 474 194. 00 194. 00 07950 FOUNDATION / MOBS 0 0 261, 474 0 200.00 200.00 Cross Foot Adjustments r 0

385, 203

282, 350

31, 027, 556

0 201.00

31, 027, 556 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1317

				То	12/31/2018	Date/Time Pre 5/29/2019 12:	
			CAPITAL REI	LATED COSTS		3/29/2019 12.	33 piii
			07.1.1.1.1.2.1.2.1	21125 00010			
	Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs	1 00	2.00	2.4	4.00	
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	2A	4. 00	
	00100 CAP REL COSTS-BLDG & FLXT						1.00
4	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	o	o	0	4.00
	DOSOO ADMINISTRATIVE & GENERAL	0	85, 229	-	115, 145	0	5. 00
	00700 OPERATION OF PLANT	0	121, 759		164, 498	0	7. 00
	00800 LAUNDRY & LINEN SERVICE	0	6, 379		8, 618	0	8.00
4	00900 HOUSEKEEPI NG	0	7, 072		9, 555	0	9.00
10.00	01000 DI ETARY	0	33, 386	11, 719	45, 105	0	10.00
11.00	01100 CAFETERI A	0	36, 672		49, 544	0	11.00
13.00	D1300 NURSING ADMINISTRATION	0	4, 595	1, 613	6, 208	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	43, 770	15, 364	59, 134	0	14.00
15.00	D1500 PHARMACY	0	20, 537	7, 209	27, 746	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	13, 683	4, 803	18, 486	0	16. 00
	01700 SOCIAL SERVICE	0	3, 671	1, 289	4, 960	0	17. 00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						
	D3000 ADULTS & PEDIATRICS	0			272, 704	0	30.00
	03100 INTENSIVE CARE UNIT	0			46, 475	0	31.00
	04300 NURSERY	0	4, 865	1, 708	6, 573	0	43. 00
	ANCILLARY SERVICE COST CENTERS		F0.0F/	21 045	01 001	0	
	05000 OPERATING ROOM	0	,		81, 001	0	50. 00 52. 00
4	D5200 DELIVERY ROOM & LABOR ROOM D5300 ANESTHESIOLOGY	0	13, 413 0		18, 121 0	0	52.00
	05400 RADI OLOGY-DI AGNOSTI C	0	58, 454	"	78, 972	0	54.00
	06000 LABORATORY	0	29, 715		40, 145	0	60.00
1	06500 RESPIRATORY THERAPY	0	8, 549		11, 550	0	65.00
	06600 PHYSI CAL THERAPY	0	12, 220		16, 509	0	66.00
1	06700 OCCUPATI ONAL THERAPY	0	12, 220		16, 509	0	67. 00
1	06800 SPEECH PATHOLOGY	0	3, 658		4, 942	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ó		o	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	10, 615	3, 726	14, 341	0	73.00
	DUTPATIENT SERVICE COST CENTERS						
88. 00	D8800 LINTON CLINIC	0	3, 093	1, 086	4, 179	0	88. 00
	08801 BLOOMFIELD CLINIC	0	1, 771	622	2, 393	0	88. 01
	D8802 WESTGATE CLINIC	0	1, 489	523	2, 012	0	88. 02
	09100 EMERGENCY	0	72, 881	25, 582	98, 463	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
-	SPECIAL PURPOSE COST CENTERS						
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	905, 905	317, 983	1, 223, 888	0	118. 00
	NONREI MBURSABLE COST CENTERS	1	0.540	1 4 050	4 004		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			4, 821		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	122, 209		165, 106		192.00
200.00	07950 FOUNDATION / MOBS Cross Foot Adjustments		0	0	0	U	194. 00 200. 00
200.00	Negative Cost Centers		_	0	0	0	200.00
201.00	TOTAL (sum lines 118 through 201)	0	1, 031, 682	1	1, 393, 815		201.00
202.00	TIVIAL (Sum Titles 110 till bugil 201)	ı o	1,031,002	302, 133	1, 373, 013	U	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-1317

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2018 | Part II |
| To | 12/31/2018 | Date/Time | Prepared: | 5/79/2019 | 12:35 pm

				•		5/29/2019 12:	35 pm
	Cost Center Description	ADMINISTRATIV E & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 00	7. 00	8.00	9. 00	10. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	115, 145					5.00
7. 00	00700 OPERATION OF PLANT	8, 861	173, 359				7.00
8.00	00800 LAUNDRY & LI NEN SERVI CE	1, 278	1, 341	11, 237			8.00
9. 00	00900 HOUSEKEEPI NG	2, 108	1, 487	0	13, 150		9.00
10.00	01000 DI ETARY	787	7, 018			52, 910	
11. 00	01100 CAFETERI A	3, 355	7, 709	0		02, 710	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	4, 831	966	0	-	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	455	9, 201	40		0	14. 00
15. 00	01500 PHARMACY	3, 197	4, 317	0		0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 531	2, 876	0	I .	0	16.00
17. 00	01700 SOCIAL SERVICE	1, 322	772	0	I .	0	17.00
	01900 NONPHYSI CI AN ANESTHETI STS	1, 048	0	0	0	0	19.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	1,040		0	<u> </u>		17.00
30.00	03000 ADULTS & PEDI ATRI CS	13, 602	42, 431	2, 950	4, 820	47, 698	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 087	7, 231	626		5, 212	
43. 00	04300 NURSERY	3, 087	1, 023	20	,	0, 212	
43.00	ANCILLARY SERVICE COST CENTERS	303	1,023	20	52		43.00
50.00	05000 OPERATING ROOM	3, 800	12, 603	504	1, 566	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	354	2, 820		148	0	52.00
53. 00	05300 ANESTHESI OLOGY	61	2,020	0	15	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 520	12, 288			0	54.00
60.00	06000 LABORATORY	11, 978	6, 246	0		0	60.00
65.00	06500 RESPIRATORY THERAPY	3, 518	1, 797			0	65.00
66.00	06600 PHYSI CAL THERAPY	2, 098	2, 569		595	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	963	2, 569	2, 354		0	67.00
68. 00	06800 SPEECH PATHOLOGY	106	769	0	-	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 354	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 334	0			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	6, 671	2, 231	0		0	1
73.00	OUTPATIENT SERVICE COST CENTERS	0,071	2,231		١		73.00
88. 00	08800 LINTON CLINIC	550	650	0	O	0	88.00
88. 01	08801 BLOOMFIELD CLINIC	182	372			0	88. 01
88. 02	08802 WESTGATE CLINIC	92	313			0	88. 02
91. 00	09100 EMERGENCY	9, 994	15, 320		2, 832	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	7, 7, 7	15, 520	2, 773	2,002	O	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118. 00		98, 088	146, 919	10, 957	12, 789	52, 910	118 00
110.00	NONREI MBURSABLE COST CENTERS	70,000	140, 717	10, 737	12,707	32, 710	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	21	750	0	22	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	16, 067	25, 690				192.00
	07950 FOUNDATION / MOBS	969	23, 070	0			194. 00
200.00		707	O		١	O	200.00
200.00	1 1		Λ	0	٥	Λ	201.00
202.00		115, 145	173, 359	11, 237	13, 150	52, 910	
202.00	TOTAL (Sum TINGS TO LITTOUGH 201)	1 113, 143	173,339	1 11,237	13, 130	JZ, 710	1202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1317

Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

5/29/2019 12:35 pm Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL ADMI NI STRATI O SERVICES & RECORDS & **SUPPLY** LI BRARY Ν 11. 00 15.00 13.00 14 00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 60,608 11.00 01300 NURSING ADMINISTRATION 3, 548 15, 553 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 68, 985 14.00 14.00 15.00 01500 PHARMACY 2, 225 C 205 37, 840 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,530 0 140 25, 618 16.00 01700 SOCIAL SERVICE 1, 050 17.00 17.00 C 214 0 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 14, 940 30.00 8.080 1. 984 4.583 30.00 0 03100 INTENSIVE CARE UNIT 31.00 2, 764 1, 495 215 0 560 31.00 04300 NURSERY 392 0 43.00 43.00 129 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 891 50.00 2,740 1, 482 1, 165 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 217 0 0 208 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 475 2,055 6.169 0 54.00 3, 901 06000 LABORATORY 6, 841 60. nn 0 40.969 60.00 0 65.00 06500 RESPIRATORY THERAPY 3,608 0 600 1, 322 65.00 06600 PHYSI CAL THERAPY o 417 66.00 2, 243 210 66.00 06700 OCCUPATIONAL THERAPY 67.00 630 0 0 0 50 67.00 0 06800 SPEECH PATHOLOGY 0 43 68.00 129 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 21, 574 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 945 0 117 37, 840 43 73.00 OUTPATIENT SERVICE COST CENTERS 08800 LINTON CLINIC 88.00 0 0 0 0 88.00 88 01 08801 BLOOMFIELD CLINIC 0 O 0 88 01 C 0 88.02 08802 WESTGATE CLINIC 0 C 0 0 0 88.02 91.00 09100 EMERGENCY 8, 314 0 4, 496 1,064 11, 416 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 59, 285 15, 553 68, 985 37, 840 25, 618 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 1, 323 0 0 0 192.00 194.00 07950 FOUNDATION / MOBS C 0 0 0 194.00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 0 202.00 TOTAL (sum lines 118 through 201) 60,608 15, 553 68, 985 37, 840 25, 618 202. 00

		EENE COUNTY GE				u or Form CMS	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provi der Co	CN: 15-1317 Pe Fi To	eriod: com 01/01/2018 o 12/31/2018		pared:
	Cost Center Description	SOCI AL	NONPHYSI CI AN	Subtotal	Intern &	Total	JO PIII
	occi contor boson per on	SERVI CE	ANESTHETI STS	oub to tu.	Resi dents		
					Cost & Post		
					Stepdown		
					Adjustments		
		17. 00	19. 00	24. 00	25. 00	26.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						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 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE	8, 318	l .				17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	1, 048				19. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				. 1		
30.00	03000 ADULTS & PEDI ATRI CS	5, 410	l .	419, 202	0	419, 202	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 330	l e	70, 145	0	70, 145	
43.00	04300 NURSERY	0		8, 554	0	8, 554	43.00
	ANCILLARY SERVICE COST CENTERS	_		405 750		105 750	
50.00		0	ł	105, 752	0	105, 752	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM	0		21, 868	0	21, 868	1
	05300 ANESTHESI OLOGY	0		129	0	129	
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0		110, 558 110, 520	0	110, 558 110, 520	
65. 00	06500 RESPIRATORY THERAPY	0		22, 629	0	22, 629	65.00
66. 00	06600 PHYSI CAL THERAPY	0		26, 995	0	26, 995	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0		20, 773	0	20, 773	67.00
68. 00	06800 SPEECH PATHOLOGY	0		5, 989	0	5, 989	68.00
69. 00	06900 ELECTROCARDI OLOGY	0		3, 707	ő	0,707	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		24, 928	Ö	24, 928	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	Ö		21,720	Ö	0.7720	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o o		62, 188	Ö	62, 188	
	OUTPATIENT SERVICE COST CENTERS				-1		
88. 00	08800 LINTON CLINIC	0		5, 379	0	5, 379	88. 00
88. 01	08801 BLOOMFIELD CLINIC	0		2, 947	0	2, 947	88. 01
88. 02	08802 WESTGATE CLINIC	0		2, 417	0	2, 417	88. 02
91.00	09100 EMERGENCY	1, 578		156, 452	0	156, 452	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		8, 318	0	1, 177, 379	0	1, 177, 379	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	l .	5, 614	0		190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0		208, 797	0	208, 797	
	07950 FOUNDATION / MOBS	0		977	0		194. 00
200.00	· · · · · · · · · · · · · · · · · · ·		1, 048	1, 048	0	•	200. 00
201.00		0	0	0	0		201.00
202.00	TOTAL (sum lines 118 through 201)	8, 318	1, 048	1, 393, 815	0	1, 393, 815	202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1317 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS F & GENERAL n (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 80, 376 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 80, 376 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 15, 291, 978 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 6.640 1,667,913 26, 699, 681 5.00 5.00 6,640 -4, 327, 875 7.00 00700 OPERATION OF PLANT 9, 486 9, 486 563, 544 2, 054, 455 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 497 497 0 296, 334 8.00 488, 788 00900 HOUSEKEEPI NG 288.509 0 9 00 551 551 9 00 10.00 01000 DI ETARY 2,601 2,601 62, 122 0 182, 386 10.00 11.00 01100 CAFETERI A 2,857 2, 857 500,072 777, 877 11.00 01300 NURSING ADMINISTRATION 13.00 358 358 781, 250 0 0 1, 120, 031 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 3 410 3, 410 105, 455 14 00 0 15.00 01500 PHARMACY 1,600 1,600 517,060 741, 358 15.00 01600 MEDICAL RECORDS & LIBRARY 0 355, 015 16.00 1.066 1.066 255, 822 16.00 01700 SOCIAL SERVICE ol 306, 587 17.00 17.00 286 286 236, 963 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 242, 966 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 15, 726 15, 726 2, 577, 045 0 3, 153, 739 30.00 03100 INTENSIVE CARE UNIT 715, 662 31 00 2,680 2,680 519, 769 0 31 00 43.00 04300 NURSERY 379 379 67,609 0 89, 261 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4.671 4.671 500, 887 0 881, 166 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 1,045 1, 045 37, 670 82, 166 52 00 53.00 05300 ANESTHESI OLOGY 0 14, 107 53.00 4, 554 05400 RADI OLOGY-DI AGNOSTI C 4, 554 937, 993 0 1, 975, 438 54.00 54.00 0 06000 LABORATORY 857, 975 2, 777, 176 60.00 2, 315 2, 315 60.00 06500 RESPIRATORY THERAPY 65.00 666 666 621, 328 815, 578 65.00 o 66.00 06600 PHYSI CAL THERAPY 952 952 355, 213 486, 467 66.00 06700 OCCUPATI ONAL THERAPY 0 67 00 952 952 169, 036 223, 244 67.00 0 06800 SPEECH PATHOLOGY 285 285 16, 010 68.00 24, 689 68.00 69 00 06900 ELECTROCARDI OLOGY 0 C 0 Λ 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 777, 594 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 O 72.00 07300 DRUGS CHARGED TO PATIENTS 827 827 231, 818 1, 546, 715 73.00 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 LINTON CLINIC 241 241 74.915 0 127, 545 88.00 88.01 08801 BLOOMFIELD CLINIC 138 0 42, 157 88.01 138 24, 551 08802 WESTGATE CLINIC 9, 308 21, 318 88.02 116 116 0 88 02 91.00 09100 EMERGENCY 5,678 5,678 1, 143, 683 0 2, 317, 229 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 70, 577 70, 577 13, 018, 065 -4, 327, 875 22, 742, 503 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES 278 278 4, 821 190. 00 0 2, 273, 913 3, 727, 675 192. 00 9,521 9, 521 0 194.00 07950 FOUNDATION / MOBS 0 224, 682 194. 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 1,031,682 362, 133 3, 410, 509 4, 327, 875 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 12.835697 4.505487 0. 162095 203. 00 0.223026 204.00 Cost to be allocated (per Wkst. B, 115, 145 204. 00 Part II) 0.004313 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207 00

Parts III and IV)

		REENE COUNTY GE				u of Form CMS-	
COST A	NLLOCATION - STATISTICAL BASIS		Provi der C	1	Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Pre 5/29/2019 12:	epared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (PIECES OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS)	
		7. 00	8. 00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 17. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	64, 250 497 551 2, 601 2, 857 358 3, 410 1, 600 1, 066 286	25, 566 0 0 0 0 0 90	237, 05(((2, 80(2, 70(1, 00(6, 426 0 0 0 0 0 0	17, 321 1, 014 0 636 723 300 0	13.00 14.00 15.00 16.00 17.00
	INPATIENT ROUTINE SERVICE COST CENTERS	•					Ī
30. 00 31. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04300 NURSERY	15, 726 2, 680 379		86, 879 20, 729 579	633	4, 270 790 112	31.00
F0 00	ANCILLARY SERVICE COST CENTERS	1			-1 -1	700	
50. 00 52. 00 53. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	4, 671 1, 045 0	0	28, 225 2, 675 275	5 5 0	783 62 0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 554	l		1	1, 763	
60. 00 65. 00	06000 LABORATORY 06500 RESPI RATORY THERAPY	2, 315 666	0	7, 925 4, 225	1	1, 955 1, 031	
66.00	06600 PHYSI CAL THERAPY	952	5, 355		1	641	1
67.00	06700 OCCUPATI ONAL THERAPY	952	0	100	1	180	1
68.00	06800 SPEECH PATHOLOGY	285	0	·	0	37	
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0	0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	827	ĺ			270	•
	OUTPATIENT SERVICE COST CENTERS		-				
88. 00	08800 LINTON CLINIC	241	0		0	0	
88. 01 88. 02	08801 BLOOMFIELD CLINIC 08802 WESTGATE CLINIC	138 116	ł		0 0	0	
91.00	09100 EMERGENCY	5, 678	l e	51, 050		2, 376	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,0,0	9,,,,	0.700		2,070	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		54, 451	24, 928	230, 52	6, 426	16, 943	118.00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	0	400	ol lo	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	9, 521	638				192.00
	07950 FOUNDATION / MOBS	0	l e	150			194. 00
200.00	1 1						200.00
201.00		2 207 472	242.024	E00 40'	200 (01	1 010 121	201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2, 387, 472	362, 836	588, 493	308, 601	1, 010, 131	202.00
203. 00 204. 00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	37. 159097 173, 359	14. 192130 11, 237			58. 318284 60, 608	203. 00 204. 00
205. 00	Part II) Unit cost multiplier (Wkst. B, Part 	2. 698195	0. 439529	0. 055474	8. 233738	3. 499105	205. 00
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						

NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0	Heal th Fi	nancial Systems G	REENE COUNTY GEI	NERAL HOSPITAL		In Lie	u of Form CMS-	2552-10
Cost Center Description	COST ALL	OCATION - STATISTICAL BASIS		Provider CO	F	rom 01/01/2018	Date/Time Pre	epared:
GENERAL SERVICE COST CENTERS		Cost Center Description	ADMINISTRATIO N (DIRECT NURS.	SERVICES & SUPPLY (COSTED	(COSTED	RECORDS & LI BRARY	SOCI AL SERVI CE	35 pm
1.00			13. 00	14. 00	15. 00	16.00	17. 00	
2.00								
30.00 03000 ADULTS & PEDIATRICS	2. 00 00 4. 00 00 5. 00 00 7. 00 00 8. 00 00 10. 00 01 13. 00 01 14. 00 01 15. 00 01 16. 00 01 17. 00 01 19. 00 01	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 000 DI ETARY 100 CAFETERIA 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE	0 0 0 0	7, 481 5, 113 7, 808	C	89, 150 0		1
31.00 03100 INTENSIVE CARE UNIT				70 500		45.050	0.10	
SOLOD	31. 00 03 43. 00 04	3100 INTENSIVE CARE UNIT 1300 NURSERY	790	7, 850	С	1, 950	59	31.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 725 0 0 0 0 0 0 0 0 0					_			l
53.00 05300 ANESTHESI OLOGY 0 1,923 0 0 0 0 0 0 0 0 0		· ·	1	42, 575	-			
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 17, 352 0 7, 150 0 0 0 0 0 0 0 0 0			1	1 023	-			
60. 00 06000 LABORATORY 0 1,497,518 0 13,575 0 65. 00 065000 RESPI RATORY THERAPY 0 21,919 0 4,600 0 66. 00 066000 PHYSI CAL THERAPY 0 7,661 0 1,450 0 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 175 0 68. 00 068000 SEECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 788,539 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 788,539 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 4,292 100 150 0 000 07300 DRUGS CHARGED TO PATIENTS 0 4,292 100 150 0 000 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 88. 00 08800 WESTGATE CLINIC 0 0 0 0 0 88. 01 08801 BLOOMFI ELD CLINIC 0 0 0 0 0 88. 01 08801 BLOOMFI ELD CLINIC 0 0 0 0 0 91. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 8,219 2,521,426 100 89,150 369 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 192. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 19000 OCTORS FOOT Adjustments 0 0 0 0 0 190. 00 00 00 00 00 0 0 200. 00 00 00 00 00 00 00			1 -1		_	-		
65.00 06500 RESPIRATORY THERAPY 0 21,919 0 4,600 0 0 0 0 0 0 0 0 0			1		Ċ			•
66. 00 06600 PHYSICAL THERAPY 0 7, 661 0 1,450 0 07.00 0 0 0 0 0 175 0 0 0 0 0 0 0 0 0			o		Ċ			
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 150 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 788,539 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 4,292 100 150 88. 00 08800 LINTON CLINIC 0 0 0 0 0 88. 01 08801 BLOMFIELD CLINIC 0 0 0 0 89. 01 08802 WESTGATE CLINIC 0 0 0 0 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 8,219 2,521,426 100 89,150 369 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 192. 00 19000 Cross Foot Adjustments 0 0 0 0 0 200. 00 Cross Foot Adjustments 0 0 0 0 0 202. 00 Cost to be allocated (per Wkst. B,			0		c		0	66.00
69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0	67.00 06	700 OCCUPATI ONAL THERAPY	0	0	C	175	0	67.00
71. 00			0	0	C	150	0	68. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 4,292 100 150 0 0 0 0 0 0 0 0 0		į	0	0	C	0		
73.00 07300 DRUGS CHARGED TO PATIENTS 0 4,292 100 150 0			1	788, 539	_	-		•
SB. 00			١	0	· ·			
88. 00			0	4, 292	100) 150	0	73.00
88. 01				0		N O		88. 00
88. 02				0				1
91. 00				0				1
92. 00			2, 376	38. 895		-		
SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 8, 219 2, 521, 426 100 89, 150 369								92.00
NONREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTER								
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	8, 219	2, 521, 426	100	89, 150	369	118. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 0 0 0 194.00 07950 FOUNDATION / MOBS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
194. 00 07950 FOUNDATION / MOBS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1 71	0		1 1		190. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part I) 205.00 0. 102121 207.00 0. 102121 208.00 0. 102121 209.00 0. 102121			0	0				192.00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 167.176055 204.00 Cost to be allocated (per Wkst. B, Part I) 167.176055 0.102121 9,655.400000 5.578710 1,043.910569 204.00 Cost to be allocated (per Wkst. B, 15,553 68,985 37,840 25,618 8,318			U	U	_	y Y	Ü	194. 00 200. 00
202.00 Cost to be allocated (per Wkst. B, Part I) 1,374,020 257,490 965,540 497,342 385,203 203.00 Unit cost multiplier (Wkst. B, Part I) 167.176055 0.102121 9,655.400000 5.578710 1,043.910569 204.00 Cost to be allocated (per Wkst. B, 15,553 68,985 37,840 25,618 8,318								200.00
203.00 Unit cost multiplier (Wkst. B, Part I) 167.176055 0.102121 9,655.400000 5.578710 1,043.910569 204.00 Cost to be allocated (per Wkst. B, 15,553 68,985 37,840 25,618 8,318		Cost to be allocated (per Wkst. B,	1, 374, 020	257, 490	965, 540	497, 342	385, 203	
204.00 Cost to be allocated (per Wkst. B, 15,553 68,985 37,840 25,618 8,318	203.00		167 176055	0 102121	9,655,40000	5 578710	1. 043 910569	203 00
								204.00
Part II		Part II)						
	201 25							
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)	206.00	(per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)	207. 00							207. 00

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

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1317 Period: Worksheet B-1

From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm Cost Center Description NONPHYSI CI AN **ANESTHETI STS** (ASSI GNED TIME) 19.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11. 00 01100 CAFETERI A 11.00 13. 00 | 01300 | NURSI NG ADMI NI STRATI ON 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 15. 00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 100 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 31.00 03100 INTENSIVE CARE UNIT 0 31.00 04300 NURSERY 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 53.00 100 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 06000 LABORATORY 60.00 60.00 65. 00 06500 RESPIRATORY THERAPY 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68. 00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 0 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88 00 08800 LINTON CLINIC 88.01 08801 BLOOMFIELD CLINIC 0 88.01 88.02 08802 WESTGATE CLINIC 0 88.02 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS | SUBTOTALS (SUM OF LINES 1 through 117) | NONREIMBURSABLE COST CENTERS 100 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN l190. 00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 194.00 07950 FOUNDATION / MOBS 0 194.00 200.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 282, 350 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B. Part I) 2, 823, 500000 203. 00 204.00 Cost to be allocated (per Wkst. B, 1, 048 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 10. 480000 205.00 II)206.00 NAHE adjustment amount to be allocated 206. 00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm Title XVIII Hospi tal Cost Costs Total Cost Cost Center Description Therapy Limit Total Costs RCF Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 4. 00 5. 00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 148, 212 6, 148, 212 0 0 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 284, 724 1, 284, 724 0 0 31.00 43.00 04300 NURSERY 128, 921 128, 921 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 482, 122 1, 482, 122 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 148, 618 148, 618 0 0 52.00 05300 ANESTHESI OLOGY 299, 623 299, 623 0 0 0 0 0 0 0 0 0 53.00 53.00 0 |05400| RADI OLOGY-DI AGNOSTI C 2, 683, 824 54.00 2, 683, 824 0 54.00 60.00 06000 LABORATORY 3, 675, 711 3, 675, 711 0 60.00 65.00 06500 RESPIRATORY THERAPY 1,071,042 1, 071, 042 0 65.00 06600 PHYSI CAL THERAPY 749, 574 66.00 0 749, 574 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 306, 527 C 306, 527 0 67.00 68.00 06800 SPEECH PATHOLOGY 42, 276 42, 276 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 984, 164 984, 164 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 810, 722 2, 810, 722 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 LINTON CLINIC 157, 174 157, 174 0 0 88.01 08801 BLOOMFIELD CLINIC 54, 118 54, 118 0 0 88.01 08802 WESTGATE CLINIC 29, 084 29, 084 o 88.02 0 88.02 o 91 00 09100 EMERGENCY 3.961.094 3, 961, 094 91.00 Ω 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 915, 049 92.00 1, 915, 049 0 200.00 Subtotal (see instructions) 27, 932, 579 0 27, 932, 579 0 0 200.00 201.00 Less Observation Beds 1, 915, 049 1, 915, 049 0 201.00 Total (see instructions) 0 0

26, 017, 530

26, 017, 530

0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1317 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 12:35 pm Title XVIII Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 164, 992 3, 164, 992 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 545, 745 545, 745 31.00 04300 NURSERY 273, 559 273, 559 43.00 43.00 ANCILLARY SERVICE COST CENTERS 4, 293, 521 0.000000 50.00 05000 OPERATING ROOM 841, 186 3, 452, 335 0.345200 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 193, 832 12, 716 206, 548 0.719533 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 180, 837 513, 850 694, 687 0. 431306 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 20, 025, 762 0. 134019 54.00 722, 453 19, 303, 309 0.000000 54.00 19, 786, 736 06000 LABORATORY 0. 185766 0.000000 60.00 1, 265, 213 18, 521, 523 60.00 65.00 06500 RESPIRATORY THERAPY 1, 238, 121 2, 944, 129 4, 182, 250 0. 256092 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 280, 402 2, 662, 366 2, 942, 768 0. 254717 0.000000 66.00 835, 405 67.00 06700 OCCUPATIONAL THERAPY 0. 317444 0.000000 130, 206 965, 611 67.00 68.00 06800 SPEECH PATHOLOGY 20, 514 98, 373 118, 887 0. 355598 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 408, 765 0.000000 71.00 975, 061 2, 383, 826 0.412851 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 \cap 0.000000 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 1, 938, 597 0. 247349 0.000000 73.00 73.00 9, 424, 807 11, 363, 404 OUTPATIENT SERVICE COST CENTERS 08800 LINTON CLINIC 88.00 90, 635 90,635 88.00 88. 01 08801 BLOOMFIELD CLINIC 0 39, 182 39, 182 88.01 88. 02 88.02 08802 WESTGATE CLINIC 0 20, 228 20, 228 694, 910 91.00 09100 EMERGENCY 23, 512, 584 24, 207, 494 0.163631 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 597, 519 1, 754, 395 156, 876 1.091572 0.000000 92.00

12, 622, 504

12, 622, 504

84, 437, 726

84, 437, 726

97, 060, 230

97, 060, 230

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

Heal th	Financial Systems	GREENE COUNTY GEN	ERAL HOSPITAL	In Lieu	u of Form CMS-2	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1317	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 12:	
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
31.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNIT 04300 NURSERY					30. 00 31. 00 43. 00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATI NG ROOM	0. 000000				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	05300 ANESTHESI OLOGY	0. 000000				53.00
54 00	OSAGO PARI OLOGY_RI ACNOSTI C	0.000000				I 5/1 00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15-1317	Peri od:	Worksheet C

From 01/01/2018 To 12/31/2018 Part I Date/Time Prepared: 5/29/2019 12: 35 pm Title XIX Hospi tal Cost Costs Total Cost Cost Center Description Therapy Limit Total Costs RCE Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 2.00 4. 00 5. 00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 148, 212 6, 148, 212 6, 148, 212 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 284, 724 1, 284, 724 0 1, 284, 724 31.00 43.00 04300 NURSERY 128, 921 128, 921 0 128, 921 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 482, 122 1, 482, 122 1, 482, 122 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 148, 618 148, 618 0 148, 618 52.00 05300 ANESTHESI OLOGY 299, 623 0 299, 623 53.00 299, 623 53.00 |05400| RADI OLOGY-DI AGNOSTI C 2, 683, 824 54.00 2, 683, 824 2, 683, 824 54 00 60.00 06000 LABORATORY 3, 675, 711 3, 675, 711 0 0 0 0 3, 675, 711 60.00 65.00 06500 RESPIRATORY THERAPY 1,071,042 1, 071, 042 1, 071, 042 65.00 06600 PHYSI CAL THERAPY 749, 574 66.00 0 749, 574 749, 574 66.00 06700 OCCUPATI ONAL THERAPY 67.00 306, 527 C 306, 527 306, 527 67.00 68.00 06800 SPEECH PATHOLOGY 42, 276 42, 276 42, 276 68.00 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 0 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 984, 164 984, 164 984, 164 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 2, 810, 722 2, 810, 722 0 2, 810, 722 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 LINTON CLINIC 157, 174 157, 174 0 157, 174 88.00 88.01 08801 BLOOMFIELD CLINIC 54, 118 54, 118 0 54, 118 88.01 08802 WESTGATE CLINIC 29, 084 29, 084 0 29, 084 88.02 88.02 o 91 00 09100 EMERGENCY 3.961.094 3, 961, 094 3, 961, 094 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1, 915, 049 1, 915, 049 1, 915, 049 200.00 Subtotal (see instructions) 27, 932, 579 0 27, 932, 579 0 27, 932, 579 200. 00 201.00 Less Observation Beds 1, 915, 049 1, 915, 049 1, 915, 049 201. 00 0 26, 017, 530 202. 00 202.00 Total (see instructions) 26, 017, 530 26, 017, 530

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1317 Peri od: Worksheet C From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 12:35 pm Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other TEFRA Cost Center Description Inpati ent Outpati ent I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 164, 992 3, 164, 992 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 545, 745 545, 745 31.00 04300 NURSERY 273, 559 273, 559 43.00 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0.000000 50.00 841, 186 3, 452, 335 4, 293, 521 0.345200 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 193, 832 12, 716 206, 548 0.719533 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 180, 837 513, 850 694, 687 0. 431306 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 20, 025, 762 0. 134019 54.00 722, 453 19, 303, 309 0.000000 54.00 19, 786, 736 06000 LABORATORY 0. 185766 0.000000 60.00 1, 265, 213 18, 521, 523 60.00 65.00 06500 RESPIRATORY THERAPY 1, 238, 121 2, 944, 129 4, 182, 250 0. 256092 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 280, 402 2, 662, 366 2, 942, 768 0. 254717 0.000000 66.00 835, 405 06700 OCCUPATIONAL THERAPY 0. 317444 0.000000 67.00 130, 206 965, 611 67.00 68.00 06800 SPEECH PATHOLOGY 20, 514 98, 373 118, 887 0. 355598 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 408, 765 0.000000 71.00 975, 061 2, 383, 826 0.412851 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 \cap 0.000000 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 1, 938, 597 0. 247349 0.000000 73.00 73.00 9, 424, 807 11, 363, 404 OUTPATIENT SERVICE COST CENTERS 08800 LINTON CLINIC 1. 734142 0.000000 88.00 90, 635 90,635 88.00 88. 01 08801 BLOOMFIELD CLINIC 0 39, 182 39, 182 1. 381195 0.000000 88.01 88.02 08802 WESTGATE CLINIC 0 20, 228 20, 228 1.437809 0.000000 88.02 694, 910 91.00 09100 EMERGENCY 23, 512, 584 24, 207, 494 0.163631 0.000000 91.00

156, 876

12, 622, 504

12, 622, 504

1, 597, 519

84, 437, 726

84, 437, 726

1, 754, 395

97, 060, 230

97, 060, 230

1.091572

0.000000

92.00

200.00

201.00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (see instructions)

Less Observation Beds

Subtotal (see instructions)

200.00

201.00

Health Financial Systems GF	REENE COUNTY GENE	ERAL HOSPITAL	In Lieu	of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-1317	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 12:	pared: 35 pm
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
60. 00 06000 LABORATORY	0. 000000				60.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
OUTPATIENT SERVICE COST CENTERS					
88 OU JUSSOULLINTON CLINIC	0 000000				88 00

0. 000000

0.000000

0. 000000 0. 000000

0. 000000

88.00

88. 01

88.02

91.00

92.00

200. 00 201. 00

202.00

88.00

88. 01

200. 00 201. 00

202.00

08800 LINTON CLINIC

88. 02 | 08802 | WESTGATE CLINIC

91. 00 09100 EMERGENCY

08801 BLOOMFIELD CLINIC

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

Total (see instructions)

Subtotal (see instructions) Less Observation Beds

Health Financial Systems	GREENE COUNTY GENER	AL HOSPITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LAIDATIENT	ANGLILADY CEDVICE CADITAL COCTO	D: -I CCN, 1E 1017	Danet and	Wasalialaaa D

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018		
			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. 26)	col. 8)	col. 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	105, 752	4, 293, 521	0. 02463	1 207, 460	5, 110	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	21, 868	206, 548	0. 10587	4 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	129	694, 687	0. 00018	6 95, 673	18	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	110, 558	20, 025, 762	0. 00552	1 479, 464	2, 647	54.00
60. 00 06000 LABORATORY	110, 520	19, 786, 736	0. 00558	6 808, 133	4, 514	60.00
65. 00 06500 RESPIRATORY THERAPY	22, 629	4, 182, 250	0. 00541	1 790, 053	4, 275	65.00
66. 00 06600 PHYSI CAL THERAPY	26, 995		1		1, 268	
67. 00 06700 OCCUPATI ONAL THERAPY	20, 727		1			67.00
68. 00 06800 SPEECH PATHOLOGY	5, 989	118, 887			572	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.0000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	24, 928	2, 383, 826			1, 066	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.00000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	62, 188	11, 363, 404	0. 00547	3 1, 610, 637	8, 815	73.00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 LI NTON CLI NI C	5, 379				0	00.00
88. 01 08801 BLOOMFIELD CLINIC	2, 947		1		0	88. 01
88. 02 08802 WESTGATE CLINIC	2, 417		1		0	88. 02
91. 00 09100 EMERGENCY	156, 452				345	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	130, 574		1		0	1 /2.00
200.00 Total (lines 50 through 199)	810, 052	93, 075, 934	.[4, 333, 816	29, 437	200.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCI LLARY SERVI CE OTHER PASS Provi der CCN: 15-1317	Period: Worksheet D

From 01/01/2018 Part IV To 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm THROUGH COSTS Title XVIII Hospi tal Cost Nursi ng Cost Center Description Non Physician Nursi ng Allied Health Allied Health Anesthetist School School Post-Stepdown Post-Stepdown Adjustments Cost Adjustments 1. 00 3A 2.00 3.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 0 53. 00 | 05300 | ANESTHESI OLOGY 282, 350 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 0 0 0 0 0 0 0 0 0 0 54.00 06000 LABORATORY 0 60.00 60.00 0 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 Ω 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 0 72.00 0 0 72.00 0 73.00 0 0 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 LINTON CLINIC 0 0 0 0 0 88.00 0 0 0 08801 BLOOMFIELD CLINIC 88.01 0 0 88.01 88. 02 | 08802 | WESTGATE CLINIC 0 0 88.02 91.00 09100 EMERGENCY 0 0 0 0 0 91.00 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 0 0 200.00 200.00 Total (lines 50 through 199) 0 282, 350

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu of Form CM	S-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-1317	Period: Worksheet D	
THROUGH COSTS			From 01/01/2018 Part IV	

THROUGH COSTS 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm Title XVIII Hospi tal Cost Cost Center Description All Other Total Cost Ratio of Cost Total Total Charges to Charges Medi cal (sum of cols. Outpati ent (from Wkst. Educati on 1, 2, 3, and Cost (sum of C, Part I, (col. 5 ÷ 4) Cost col s. 2, 3, col. 8) col. 7) and 4) 4. 00 5.00 6. 00 7. 00 8. 00 ANCILLARY SERVICE COST CENTERS 50 00 4, 293, 521 0.000000 50 00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 206, 548 0.000000 52.00 0 0 0 0 0 0 0 0 0 05300 ANESTHESI OLOGY 282, 350 0 694, 687 0. 406442 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 20, 025, 762 0.000000 54.00 54.00 0 19, 786, 736 06000 LABORATORY 0.000000 60.00 0 60.00 65.00 06500 RESPIRATORY THERAPY 0 4, 182, 250 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0 2, 942, 768 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 0 965, 611 67.00 0 0.000000 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 118, 887 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 2, 383, 826 0.000000 71.00 0 07200 I MPL. DEV. CHARGED TO PATIENTS C 0.000000 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 11, 363, 404 0.000000 73.00 OUTPATIENT SERVICE COST CENTERS 0 0 88.00 08800 LINTON CLINIC 90, 635 0.000000 88.00 0 0 0 0 0 88. 01 08801 BLOOMFIELD CLINIC 0 39, 182 0.000000 88.01 88. 02 08802 WESTGATE CLINIC 0 20, 228 0.000000 88.02 0 0 24, 207, 494 91.00 09100 EMERGENCY 0.000000 91.00 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1, 754, 395 0.000000 92.00 200.00 Total (lines 50 through 199) 282, 350 93, 075, 934 200.00

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCI LLARY SERVI CE OTHER PASS	Provider CCN: 15-1317	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D Part IV Date/Time Prepared: 5/29/2019 12:35 pm
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				10	5 12/31/2018	Date/lime Pre 5/29/2019 12:	
			Title	XVIII	Hospi tal	Cost	33 piii
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	•	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col. 8		Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
-	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 000000	207, 460	0	0	0	50.00
1	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	0	0	0	52.00
	05300 ANESTHESI OLOGY	0. 000000	95, 673		0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	479, 464		0	0	54.00
	06000 LABORATORY	0. 000000	808, 133		0	0	60.00
	06500 RESPI RATORY THERAPY	0. 000000	790, 053		0	0	65.00
	06600 PHYSI CAL THERAPY	0. 000000	138, 205		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0. 000000	37, 575		0	0	67.00
	06800 SPEECH PATHOLOGY	0. 000000	11, 353	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	101, 925	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, 610, 637	0	0	0	73.00
C	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 LINTON CLINIC	0. 000000	0	0	0	0	88. 00
88. 01	08801 BLOOMFIELD CLINIC	0. 000000	0	0	0	0	88. 01
88. 02	08802 WESTGATE CLINIC	0. 000000	0	0	0	0	88. 02
91.00	09100 EMERGENCY	0. 000000	53, 338	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, 333, 816	38, 886	0	0	200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1317 Peri od: Worksheet D From 01/01/2018 To 12/31/2018 Part V Date/Time Prepared: 5/29/2019 12:35 pm Title XVIII Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 4. 00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 345200 861, 775 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0.719533 52.00 52.00 0 0 0 53. 00 | 05300 | ANESTHESI OLOGY 0. 431306 0 257, 693 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 134019 7, 108, 278 0 0 0 0 54.00 60.00 06000 LABORATORY 0. 185766 7, 589, 546 0 60.00 1, 249, 273 06500 RESPIRATORY THERAPY 65.00 0. 256092 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 254717 0 1,050,480 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 317444 267, 434 0 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0. 355598 0 8,003 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 69.00 Ω 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.412851 0 454, 127 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 72.00 72.00 2, 306 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 0. 247349 4, 124, 011 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 LINTON CLINIC 0.000000 0 88.00 08801 BLOOMFIELD CLINIC 88. 01 0.000000 0 88.01 08802 WESTGATE CLINIC 0.000000 88. 02 88 02 Ω 09100 EMERGENCY 91.00 0.163631 0 7, 577, 730 25 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 091572 638, 072 0 92.00 0 200.00 200.00 Subtotal (see instructions) 0 31, 186, 422 2, 331 Less PBP Clinic Lab. Services-Program 201.00 201.00

31, 186, 422

2, 331

0 202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu of Form CMS-2552-10
APPORTI ONMENT OF MEDI CAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1317	Period: Worksheet D From 01/01/2018 Part V

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND) VACCINE COST	Provider Ci	UN: 15-1317	From 01/01/2018 To 12/31/2018	Part V Date/Time Pr 5/29/2019 12	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLILIARY OFFICE OCCUPANTED	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	007.405		1			
50. 00 05000 OPERATING ROOM	297, 485	0				50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	111, 145	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	952, 644					54.00
60. 00 06000 LABORATORY	1, 409, 880					60.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	319, 929					65. 00 66. 00
	267, 575					
67. 00 06700 OCCUPATI ONAL THERAPY	84, 895	0				67. 00 68. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	2, 846	0				69.00
69.00 06900 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	107 407	0				71.00
72.00 07700 MEDICAL SUPPLIES CHARGED TO PATIENTS	187, 487	0				71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	1, 020, 070	570	•			73.00
OUTPATIENT SERVICE COST CENTERS	1,020,070	570				13.00
88. 00 08800 LINTON CLINIC	0	0				88.00
88. 01 08801 BLOOMFI ELD CLI NI C	0	0				88. 01
88. 02 08802 WESTGATE CLINIC	0	0				88. 02
91. 00 09100 EMERGENCY	1, 239, 952	4				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	696, 502	1				92.00
200.00 Subtotal (see instructions)	6, 590, 410	574				200.00
201.00 Less PBP Clinic Lab. Services-Program	0, 575, 410	374				201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	6, 590, 410	574				202.00

Health Financial Systems GREE		GREENE COUNTY GENER	AL HOSPITAL		In Lieu of Form CMS-2552-10
	ADDODTIONMENT OF MEDICAL	OTHER HEALTH SERVICES AND VACCINE COST	Providor CCN: 15 1217	Pari ad:	Workshoot D

Period: From 01/01/2018 To 12/31/2018 Part V Component CCN: 15-Z317 Date/Time Prepared: 5/29/2019 12:35 pm Title XVIII Swing Beds - SNF Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 345200 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0.719533 52.00 0 52.00 05300 ANESTHESI OLOGY 0 53.00 0. 431306 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 134019 0 0 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0. 185766 60.00 06500 RESPIRATORY THERAPY 0. 256092 0 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 254717 0 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 317444 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0. 355598 0 0 68.00 0 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 C 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.412851 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 0. 247349 0 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 LINTON CLINIC 0. 000000 0 88.00 08801 BLOOMFIELD CLINIC 88. 01 0.000000 0 88.01 08802 WESTGATE CLINIC 88. 02 88 02 0.000000 Ω 09100 EMERGENCY 91.00 0.163631 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 091572 0 92.00 0 0 0 200.00 200.00 Subtotal (see instructions) 0 Less PBP Clinic Lab. Services-Program 0 201.00 201.00

0

0 202.00

Only Charges

Net Charges (line 200 - line 201)

Health Financial Systems	GREENE COUNTY GENER	AL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1317	Peri od: From 01/01/2018	Worksheet D Part V
		Component CCN: 15-Z317		
		Title XVIII	Swing Beds - SNF	Cost
	Costs			

		Component	CCN: 15-Z31/	10	12/31/2	2018	5/29/2019 12:	
		Title	XVIII	Swi ng	Beds -	SNF	Cost	
	Cos	sts						
Cost Center Description	Cost	Cost	1					
	Rei mbursed	Rei mbursed						
	Servi ces	Services Not						
	Subject To	Subject To						
	Ded. & Coins.	Ded. & Coins.						
	(see inst.)	(see inst.)						
1	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								00.00
88. 00 08800 LINTON CLINIC	0	0	?					88.00
88. 01 08801 BLOOMFI ELD CLINI C	0	0	<u>'</u>					88. 01
88. 02 08802 WESTGATE CLINIC 91. 00 09100 EMERGENCY	0	0	<u>'</u>					88. 02 91. 00
	0	0						
	0	0	()					92. 00 200. 00
200.00 Subtotal (see instructions) 201.00 Less PBP Clinic Lab. Services-Program			'					200.00
Only Charges								201.00
202.00 Net Charges (line 200 - line 201)	0	0						202.00
202.00 Net charges (Title 200 - Title 201)	1	1	' I					1202.00

In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1317 Peri od: Worksheet D From 01/01/2018 To 12/31/2018 Part V Date/Time Prepared: 5/29/2019 12:35 pm Title XIX Hospi tal Cost Charges Costs PPS PPS Services Cost Center Description Cost to Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, inst.) Subject To Subject To Ded. & Coins. Ded. & Coins. Part I, col. 9 (see inst.) (see inst.) 1.00 2.00 4. 00 5.00 3.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 345200 600, 084 50.00 05200 DELIVERY ROOM & LABOR ROOM 3, 179 0 0.719533 52.00 52.00 0 0 53. 00 | 05300 | ANESTHESI OLOGY 0. 431306 0 3, 509 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 134019 1, 578, 481 0 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0. 185766 1, 568, 630 0 60.00 06500 RESPIRATORY THERAPY 65.00 0. 256092 222, 265 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 254717 134, 850 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0. 317444 35, 973 0 67.00 68.00 06800 SPEECH PATHOLOGY 0. 355598 0 47, 278 0 68.00 0 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.412851 121, 157 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 0 0 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 542, 905 73.00 73.00 0. 247349 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 LINTON CLINIC 1. 734142 0 88.00 08801 BLOOMFIELD CLINIC 88. 01 1. 381195 0 88.01 08802 WESTGATE CLINIC 88. 02 88 02 1. 437809 Ω 09100 EMERGENCY 91.00 0.163631 0 3, 297, 072 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 1. 091572 161, 049 0 92.00 0 0 200.00 200.00 Subtotal (see instructions) 0 8, 316, 432

0

8, 316, 432

201.00

0 202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

201.00

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-1317	Peri od: From 01/01/2018	Worksheet D

From 01/01/2018 Part v To 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6. 00 7. 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 207, 149 50.00 05200 DELIVERY ROOM & LABOR ROOM 2, 287 0 52.00 52.00 53.00 05300 ANESTHESI OLOGY 1, 513 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 211, 546 0 54.00 60.00 06000 LABORATORY 291, 398 60.00 06500 RESPIRATORY THERAPY 56, 920 0 65.00 65.00 06600 PHYSI CAL THERAPY 0 66.00 34, 349 66.00 67.00 06700 OCCUPATI ONAL THERAPY 11, 419 67.00 0 68.00 06800 SPEECH PATHOLOGY 16, 812 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 50, 020 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 134, 287 ol 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 LINTON CLINIC 0 0 88.00 08801 BLOOMFIELD CLINIC 0 88. 01 0 88.01 08802 WESTGATE CLINIC 0 88 02 0 88 02 09100 EMERGENCY 539, 503 0 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 175, 797 0 92.00 Subtotal (see instructions) 0 200.00 200.00 1, 733, 000 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 1, 733, 000 0 202.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1317	Peri od: From 01/01/2018		
		To 12/31/2018	Date/Time Pre 5/29/2019 12:	pared: 35 pm
	Title XVIII	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

		Title XVIII	Hospi tal	Cost			
	Cost Center Description			1. 00			
	PART I - ALL PROVIDER COMPONENTS			1.00			
	I NPATI ENT DAYS						
1.00	Inpatient days (including private room days and swing-bed day			3, 432	1.00		
2.00	Inpatient days (including private room days, excluding swing-		iliata maam daya	2, 992	2. 00 3. 00		
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.						
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		1, 923	4.00		
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	440	5.00		
/ 00	reporting period	d) -6+ D	21 -6 +1+				
6. 00	Total swing-bed SNF type inpatient days (including private roreporting period (if calendar year, enter 0 on this line)	om days) after becember	31 of the cost	0	6. 00		
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00		
	reporting period						
8. 00	Total swing-bed NF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	m days) after December 3	31 of the cost	0	8. 00		
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 288	9. 00		
	newborn days)		,				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days)	433	10.00		
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		nom days) after	0	11. 00		
11.00	December 31 of the cost reporting period (if calendar year, e		days) arter		11.00		
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12.00		
12.00	through December 31 of the cost reporting period	V only (including privat	e zoom dovo)	0	12 00		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			U	13. 00		
14.00	Medically necessary private room days applicable to the Progr			0	14. 00		
	Total nursery days (title V or XIX only)			0			
16. 00	Nursery days (title V or XIX only)			0	16. 00		
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost		17. 00		
17.00	reporting period	es through becember 51 c	inc cost		17.00		
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18. 00		
10.00	reporting period	a through December 21 of	: +bo ooo+	120 07	10.00		
19. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	s through becember 31 of	the cost	138. 07	19.00		
20.00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20.00		
	reporting period						
21. 00 22. 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing pariod (lind	6, 148, 212 9	21. 00 22. 00		
22.00	5 x line 17)	er 31 of the cost report	ing perrod (inte	o	22.00		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.00		
04.00	x line 18)	04 - 6 11-			04.00		
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00		
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00		
	x line 20)						
26. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		788, 234			
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TTHE 21 III HUS TTHE 26)		5, 359, 978	27.00		
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed ch	narges)	0	28. 00		
29. 00	Private room charges (excluding swing-bed charges)		,	0	29. 00		
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00		
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000			
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00			
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nus line 22) (see instrus	stions)	0.00			
34.00	Average per diem private room charge differential (line 32 mi		, (1 0115)	0. 00 0. 00			
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)					
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room cost di	fforontial (line	0 5 250 079	36.00		
37. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	rrefericial (IINe	5, 359, 978	37. 00		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 791. 44	38. 00		
39. 00	Program general inpatient routine service cost per diem (see	•		2, 307, 375			
40. 00	Medically necessary private room cost applicable to the Progr			0	40.00		
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		2, 307, 375	41.00		

	reporting period		
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	1, 288	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	433	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	ol	16.00
	SWING BED ADJUSTMENT	J	
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	138. 07	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	6, 148, 212	21 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5×10^{-2} km = 17)		22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line (x,y)) in (1) (x,y)) with (x,y) $(x$	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7×1 line 19)	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	788, 234	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 359, 978	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29. 00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	ol	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	5, 359, 978	
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	1 701 44	20.00
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 791. 44	
39.00	Program general inpatient routine service cost (line 9 x line 38)	2, 307, 375	
	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 2, 307, 375	40. 00 41. 00
11.00	1. Section 1. Section of the control of the object (11110 07 1 11110 40)	2, 307, 373	11.00

	Financial Systems GR ATION OF INPATIENT OPERATING COST	REENE COUNTY GEN		CN: 15-1317	In Lie Period:	u of Form CMS-2 Worksheet D-1	
55m 01	S. C.		ovi dei 0	5 .5.7	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			T: +1 -			5/29/2019 12:	35 pm
	Cost Center Description	Total	Total	Average Per	Hospital Program Days	Cost Program Cost	
	· ·	Inpati ent	I npati ent	Diem (col.		(col. 3 x	
		1.00	<u>Days</u> 2. 00	÷ col . 2) 3.00	4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	0	2.00 C				42.00
	Intensive Care Type Inpatient Hospital Units		0.1.1			4 000 000	
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	1, 284, 724	211	6, 088. 7	74 168	1, 022, 908	43.00
45. 00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					1, 029, 951	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(s	see instructi	ons)		4, 360, 234	49.00
50. 00	Pass through costs applicable to Program inp	atient routine s	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
	[111)		•				
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53.00	Total Program inpatient operating cost exclu		ated, non-ph	ysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)	ing cost and to	agat amaumt (lina E/ minua	ling E2)	0	
57.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tai	rget amount (line 56 minus	11 ne 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	endi ng 1996,	updated and c	ompounded by the		
(0.00	market basket					0.00	(0.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0. 00 0	1
000	which operating costs (line 53) are less tha	n expected costs				Ū	011.00
42.00	amount (line 56), otherwise enter zero (see	instructions)					42.00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0 0	1
	PROGRAM INPATIENT ROUTINE SWING BED COST						1
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decer	mber 31 of th	e cost report	ing period (See	775, 694	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the	cost reportin	g period (See	0	65.00
44 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	no costo (lino d	(4 plug lipa	(E) (+: +1 o V)//	II only) For	775 404	44 00
66. 00	CAH (see instructions)	ne costs (iine o	54 prus rine	65)(title XVI	ii oniy). For	775, 694	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	0	67.00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	a costs after D	acember 31 of	the cost ren	orting period	0	68.00
00.00	(line 13 x line 20)	e costs after be	scember 31 or	the cost rep	of tring period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil)		70.00
71.00	Adjusted general inpatient routine service c	•			,		71.00
72.00	Program routine service cost (line 9 x line	•					72.00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv	9	•				73.00
75.00	Capital-related cost allocated to inpatient	•		•	Part II, column		75.00
	26, line 45)	->			·		
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces	, ,		,			79.00
80.00	Total Program routine service costs for comp		ost limitatio	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I)				81. 00 82. 00
83.00	Reasonable inpatient routine service costs (see instructions					83.00
84.00	Program inpatient ancillary services (see in						84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
30.00	PART IV - COMPUTATION OF OBSERVATION BED PAS		ougii oo)				1 55.00
87. 00	Total observation bed days (see instructions	i)				1, 069	•
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			1, 791. 44 1, 915, 049	•
89.00	Observation bed cost (line 87 x line 88) (se	e instructions)				1, 915, 049	89. C

Health Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	419, 202	6, 148, 212	0. 06818	3 1, 915, 049	130, 574	90.00
91.00 Nursing School cost	0	6, 148, 212	0.00000	0 1, 915, 049	0	91.00
92.00 Allied health cost	0	6, 148, 212	0.00000	0 1, 915, 049	0	92.00
93.00 All other Medical Education	0	6, 148, 212	0. 00000	0 1, 915, 049	0	93. 00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-1317	Peri od: From 01/01/2018		
		To 12/31/2018	Date/Time Pre 5/29/2019 12:	pared: 35 pm
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				
I NPATI ENT DAYS				

		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed day	s, excluding newborn)		3, 432	1. 00
2.00	Inpatient days (including private room days, excluding swing-			2, 992	2. 00
3.00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3.00
	do not complete this line.				
4. 00	Semi-private room days (excluding swing-bed and observation b		04 6 11	1, 923	4.00
5. 00	Total swing-bed SNF type inpatient days (including private ro reporting period	om days) through Decembe	er 31 of the cost	440	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becomber	01 01 1110 0031	· ·	0.00
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roo	m days) after December 3	11 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	a the Drogram (avaluding	cwing had and	29	9. 00
7.00	newborn days)	o the Frogram (excluding	swifig-bed and	27	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instruc	tions)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, e			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	x only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar y	3 (3)	, ,	_	
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.00
	Total nursery days (title V or XIX only)			191	
16. 00	Nursery days (title V or XIX only)			109	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	of the cost		17. 00
17.00	reporting period	es till odgir becember 51 c	in the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0. 00	20. 00
20.00	reporting period			0.00	20.00
21.00	Total general inpatient routine service cost (see instruction			6, 148, 212	
22. 00	Swing-bed cost applicable to SNF type services through Decemb	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line A	0	23. 00
23.00	x line 18)	31 of the cost reportin	ig period (Title 0	O	23.00
24.00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
26. 00	x line 20) Total swing-bed cost (see instructions)			788, 234	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 359, 978	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		<u>'</u>		
28. 00		d and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
30. 00	Semi-private room charges (excluding swing-bed charges)	>		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nuo lino 22)/ !!	v+i ono)	0.00	
34.00	Average per diem private room charge differential (line 32 mi		tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x li	ile 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	0 5, 359, 978	36. 00 37. 00
37.00	27 minus line 36)	and private room cost dr	Treferitial (TITIE	5, 357, 770	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 791. 44	
39.00	Program general inpatient routine service cost (line 9 x line	•		51, 952	
40. 00 41. 00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	,		0 51, 952	40. 00 41. 00
41.00	Trotal Trogram general Tripatrent routine service cost (TINE 39	11116 40)		51, 752	41.00

4. 00 5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	440	5.00
5.00	reporting period	440	5.00
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ŭ.	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7.00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	29	9.00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
	through December 31 of the cost reporting period (see instructions)		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
	through December 31 of the cost reporting period		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15.00	Total nursery days (title V or XIX only)	191	
16. 00	Nursery days (title V or XIX only)	109	16. 00
47.00	SWING BED ADJUSTMENT		47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
10 00	reporting period		10 00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0. 00	19. 00
17.00	reporting period	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20.00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	6, 148, 212	21.00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
	5 x line 17)	_	
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	0	23.00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
	x line 20)		
26.00	Total swing-bed cost (see instructions)	788, 234	
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5, 359, 978	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)	0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	5, 359, 978	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	1 701 44	38. 00
	Program general inpatient routine service cost per diem (see instructions)	1, 791. 44 51, 952	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	51, 952	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	51, 952	
41.00	Total Frogram general impatrent routine service cost (Tine 39 + Tine 40)	51, 952	41.00

COMPUT	Financial Systems GR TATION OF INPATIENT OPERATING COST	REENE COUNTY GEI	Provi der C	CN: 15-1317	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2018 To 12/31/2018		
			Ti +I	e XIX	Hospi tal	5/29/2019 12: Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 128, 921	2. 00 191	3. 00 674. 9	4. 00 8 109	5. 00 73, 573	42.00
	Intensive Care Type Inpatient Hospital Units						
		1, 284, 724	211	6, 088. 7	4 4	24, 355	43. 00 44. 00 45. 00 46. 00 47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					163, 642	
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	ons)		313, 522	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, sur	n of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpaland IV)	atient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines!	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		elated, non-phy	ysician anesth	netist, and	0	53.00
54. 00	Program di scharges					0	54.00
55.00							55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and ta	arget amount (line 56 minus	line 53)	0	56.00 57.00
58.00	Bonus payment (see instructions)	3	,		,	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996, i	updated and co	ompounded by the	0.00	59.00
60.00		cost report, up	odated by the i	market basket		0. 00	60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see	n expected cost				0	61.00
62. 00	Relief payment (see instructions)	riisti ucti olis)				0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ng period (See	0	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of the (cost reportino	g period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient roution CAH (see instructions)</pre>	ne costs (line	64 plus line	65)(title XVII	I only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	3				0	67.00
	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)				orting period		68.00
69. 00	Total title V or XIX swing-bed NF inpatient IPART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facili	ity/ICF/IID rou	ıtine service (cost (line 37))		70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line	,	ine 70 ÷ line	2)			71.00
73.00	Medically necessary private room cost applica		n (line 14 x li	ine 35)			73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient				Part II, column		74. 00 75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line	,					77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		provi der record	ds)			78.00 79.00
80.00				*.	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li		1)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (* .				83.00
84.00	Program inpatient ancillary services (see in	structi ons)	•				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	,	,				85. 00 86. 00
55. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS		cagii 00)				35.50
	Total observation bed days (see instructions))				1, 069	87.00
87. 00 88. 00	,	•	line 2)		ŀ	1, 791. 44	

Health Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	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	419, 202	6, 148, 212	0. 06818	3 1, 915, 049	130, 574	90.00
91.00 Nursing School cost	0	6, 148, 212	0.00000	0 1, 915, 049	0	91.00
92.00 Allied health cost	0	6, 148, 212	0.00000	0 1, 915, 049	0	92.00
93.00 All other Medical Education	0	6, 148, 212	0. 00000	0 1, 915, 049	0	93. 00

Health Financial Systems GREENE COUNTY (GENERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1317	Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018		
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col . 2)	
LABATI FAIT DOUTLAS OFFICE OF CONT. OFFITFE		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		1	
30. 00 03000 ADULTS & PEDI ATRI CS			1, 835, 400		30.00
31. 00 03100 INTENSI VE CARE UNI T			399, 672		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		0.04500	007.440	74 /45	F0 00
50. 00 05000 OPERATING ROOM		0. 34520			
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESIOLOGY		0. 71953			52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 43130 0. 13401			53. 00 54. 00
60, 00 06000 LABORATORY		0. 13401	·		
65. 00 06500 RESPI RATORY THERAPY		0. 18576	·		
66. 00 06600 PHYSI CAL THERAPY		0. 25471	·		
67. 00 06700 OCCUPATI ONAL THERAPY		0. 25471	·		67.00
68. 00 06800 SPEECH PATHOLOGY		0. 35559	·		68.00
69. 00 06900 ELECTROCARDI OLOGY		0. 00000	·	4,037	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 41285			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 00000	·	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 24734		398, 389	
OUTPATIENT SERVICE COST CENTERS			., ., ., ., ., ., ., ., ., ., ., ., ., .	210/001	
88. 00 08800 LINTON CLINIC		0.00000	00	0	88.00
88. 01 08801 BLOOMFIELD CLINIC		0. 00000	00	0	88. 01
88. 02 08802 WESTGATE CLINIC		0.00000		0	88. 02
91. 00 09100 EMERGENCY		0. 16363		8, 728	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 09157	2 0	0	92.00
200 00 Total (sum of Lines 50 through 04 and 06 through 09)	\	1	1 222 016	1 020 051	lann nn

91.00 OPTION EMERGENCY
92.00 OP200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

8, 728 91. 00 0 92. 00 1, 029, 951 200. 00 201. 00

202.00

4, 333, 816

Health Financial Systems GREENE COUNTY GEN		U. 1E 1017		u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCI		Peri od: From 01/01/2018	Worksheet D-3	
	Component CO		To 12/31/2018	Date/Time Pre	
	· ·			5/29/2019 12:	35 pm
	Title		Swing Beds - SNF		
Cost Center Description	F	Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col . 1 x	
	_	1 00	0.00	col . 2)	
INDATIONE CONTINUE CONTINUE CONTINUE CONTINUE		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 INTENSIVE CARE UNIT			0		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS		0.04500	0 011	=,,	
50. 00 05000 OPERATING ROOM		0. 34520		764	
52. 00 O5200 DELI VERY ROOM & LABOR ROOM		0. 71953		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 43130		152	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13401	· ·	2, 662	
60. 00 06000 LABORATORY		0. 18576	· ·	7, 858	
65. 00 06500 RESPI RATORY THERAPY		0. 25609	· ·	28, 035	
66. 00 06600 PHYSI CAL THERAPY		0. 25471		25, 843	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 31744		26, 924	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 35559	· ·		
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 41285	· ·	31, 872	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 00000		0	72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 24734	9 159, 625	39, 483	73.00
OUTPATIENT SERVICE COST CENTERS			-1		
88. 00 08800 LINTON CLINIC		0. 00000		0	88. 00
88. 01 08801 BLOOMFI ELD CLI NI C		0. 00000		0	88. 01
88. 02 08802 WESTGATE CLINIC		0. 00000		0	88. 02
91. 00 09100 EMERGENCY		0. 16363		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 09157		0	92.00
200.00 Total (sum of Lines 50 through 94 and 96 through 98)			605 032	166 343	1200 00

91.00 O9100 EMERGENCY
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

92.00 0 166, 343 200. 00

201.00

202.00

605, 032

605, 032

Health Financial Systems GREENE COUNTY GEN				u of Form CMS-2	<u> 2552-10</u>
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2018		
			To 12/31/2018	Date/Time Pre 5/29/2019 12:	parea: 35 pm
	Ti +I	e XIX	Hospi tal	Cost	JJ PIII
Cost Center Description	11 (1	Ratio of Cos		I npati ent	
Sost Senter Beserretten		To Charges		Program Costs	
		l o onal goo	Charges	(col . 1 x	
			orial ges	col . 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			94, 006		30.00
31. 00 03100 INTENSIVE CARE UNIT			19, 032		31. 00
43. 00 04300 NURSERY			152, 475		43.00
ANCILLARY SERVICE COST CENTERS			102,		
50. 00 05000 OPERATING ROOM		0. 34520	74, 936	25, 868	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 71953		27, 449	52.00
53. 00 05300 ANESTHESI OLOGY		0. 43130		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13401		2, 304	54.00
60. 00 06000 LABORATORY		0. 18576	'		
65. 00 06500 RESPIRATORY THERAPY		0. 25609		8, 535	
66. 00 06600 PHYSI CAL THERAPY		0. 25471		•	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 31744		189	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 35559		0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 41285		18, 171	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.00000		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 24734		15, 235	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 LINTON CLINIC		1. 73414	2 0	0	88. 00
88. 01 08801 BLOOMFI ELD CLI NI C		1. 38119		0	88. 01
88. 02 08802 WESTGATE CLINIC		1. 43780		Ō	88. 02
91. 00 09100 EMERGENCY		0. 16363		16, 801	
02 00 00200 ODCEDVATION DEDC (NON DISTINCT DADT)		1 0015		20 542	

91.00 O9100 EMERGENCY
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)
200.00 Total (sum of lines 50 through 94 and 96 through 98)
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)

Net charges (line 200 minus line 201)

163, 642 200. 00 201. 00

92.00

202.00

16, 801 30, 543

0. 163631 1. 091572

102, 679 27, 981

499, 157

499, 157

Health Financial Systems	GREENE COUNTY GENERAL H	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Pro	ovi der CCN: 15-1317		Worksheet E Part B Date/Time Prepared: 5/29/2019 12:35 pm

Motified And Other Harth Stoylers 1.00				10 12/01/2010	5/29/2019 12:	35 pm
MART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 6.590,964 1.00			Title XVIII	Hospi tal	Cost	
MART B - MEDICAL AND OTHER HEALTH SERVICES 1.00 Medical and other services (see instructions) 6.590,964 1.00					1 00	
Medical and other services reinbursed under OPPS (see instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES			11.00	
0 00 00 00 00 00 00 00	1.00				6, 590, 984	1.00
0.00 2011 in Payment (see Instructions) 0.4.00 0.00 1.00 0.00 1.00 0			ctions)			2.00
0.001 0.001 0.001 0.001 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000		1 3				
Enter the hospital specific payment to cost ratio (see instructions)						
		,	iati ana)			
			ictions)			
Transit ional corridor payment (see Instructions) 0.800 0.000						
Ancillary service other pass through costs from West. D, Pt. IV, col. 13, Iline 200						8.00
10.00 Organ acquisitions 0,599,884		, , , , , , , , , , , , , , , , , , , ,	IV, col. 13, line 200		0	
COMPUTATION OF LESSER OF COST OR CHARGES	10.00				0	10.00
Reasonable charges	11. 00				6, 590, 984	11.00
12.00 Ancil lary service charges 0 12.00 12.00 17.10 17.						
13.00 Organ acquisition charges (from Wikst. D-4, Pt. III, col. 4, line 69) 0 13.00 0 14.00 Total reasonable charges (sum of lines 12 and 13) 0 14.00 0 14.00 0 14.00 0 14.00 0 14.00 0 14.00 0 14.00 0 14.00 0 14.00 0 14.00 0 14.00 0 15.00 0 0 15.00 0 0 15.00 0 0 15.00 0 0 15.00 0 0 15.00 0 0 15.00 0 0 15.00 0 0 15.00 0 0 15.00 0 0 0 0 0 0 0 0 0	12 00				0	12.00
14.00 Total reasonable charges (sum of lines 12 and 13) 15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00 Aggregate amount actually collected from patients liable for payment for services on a chargebasis 0 16.00 16.00 16.00 17.			ino 60)			
Customery charges			1116 07)		-	
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00	11.00					11.00
had such payment been made in accordance with 42 CFR \$413.13(e)	15. 00		payment for services on	a charge basis	0	15. 00
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 18.00 17.00 18.00 17.00 18.00	16.00	Amounts that would have been realized from patients liable for	or payment for services o	on a chargebasis	0	16.00
18.00 Total customary charges (see instructions) 0 18.00 19.			(e)		l	
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19. 00 19. 00 18. 00 19. 00 18. 00 18. 00 18. 00 19. 00		· · · · · · · · · · · · · · · · · · ·				
instructions				11) (-	
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19.00		ily it line 18 exceeds li	ne II) (see	l O	19.00
Instructions	20 00		dy if line 11 exceeds li	ne 18) (see	0	20 00
21.00 Lesser of cost or charges (see instructions) 6,656,894 21.00	20.00		if y 11 1111c 11 execeds 11	110 10) (300	l	20.00
23.00 Cost of physicians' services in a teaching hospital (see instructions) 0.23.00	21.00	1			6, 656, 894	21.00
24. 00 Total prospective payment (sum of lines 3. 4, 4. 01, 8 and 9) 24. 00 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00	22.00	Interns and residents (see instructions)			0	22.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instructions) 108,096 25.00 26.00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 4,718,647 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) 1,830,151 27.00 27		, , , , , , , , , , , , , , , , , , , ,	ructions)		-	
25.00 Deductible sand coin surance amounts (for CAH, see instructions) 108,096 25.00	24. 00				0	24.00
26 00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 4,718,647 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) 1,830,151 27.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 1,830,151 30.00 30.00 Subtotal (line 30 minus line 31) 1,829,979 31.00 32.00 Subtotal (line 30 minus line 31) 1,829,979 32.00 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 1,129,395 34.00 35.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 90,876 35.00 36.00 Misched reimbursable bad debts for dual eligible beneficiaries (see instructions) 90,876 36.00 38.00 MSP-LCC reconciliation amount from PS&R 2,564,086 37.00 39.00 MSP-LCC reconciliation amount beneficiaries (see instructions) 39.00 39.99 RECOVERY OF ACCELERA	25 00		>		100,007	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) 1,830,151 27.00		1	•	sustions)		
Instructions			•	'		
28. 00	27.00		prus the sum of Tries 22	20] (300	1,000,101	27.00
30.00 Subtotal (sum of lines 27 through 29) 1,830,151 30.00 71 mary payer payments 172 31.00 71 mary payer payments 1,829,979 32.00 32.0	28.00		ine 50)		0	28.00
31.00 Primary payer payments 172 31.00 Subtotal (line 30 minus line 31) 1,829,979 32.00 1,829,979 32.00 1,829,979 32.00 32.00	29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
32.00 Subtotal (ine 30 minus line 31) 1,829,979 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I - 5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 1,129,395 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 902,876 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 902,876 36.00 37.00 Subtotal (see instructions) 902,876 36.00 37.00 Subtotal (see instructions) 902,876 36.00 37.00 Subtotal (see instructions) 902,876 36.00 37.00 Subtotal (see instructions) 99.00 38.00 MSP-LCC reconciliation amount from PS&R 99.00 07HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 99.00 99.9		,				
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wast. I5, line 11) 0 33.00 33.00 34.00 Allowable bad debts (see instructions) 1,129,395 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 734,107 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 902,876 36.00 37.00 Subtotal (see instructions) 2,564,086 37.00 Subtotal (see instructions) 2,564,086 37.00 39.00						
33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 33.00 33.00 34.00 Allowable bad debts (see instructions) 1,129,395 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 734,107 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 902,876 36.00 37.00 Subtotal (see instructions) 2,564,086 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 39.50 90.00 0.	32.00		CES)		1, 829, 979	32.00
34.00	33 00	· · · · · · · · · · · · · · · · · · ·	CE3)		0	33 00
35.00 Adjusted reimbursable bad debts (see instructions) 734,107 35.00 Adjusted reimbursable bad debts (see instructions) 902,876 36.00 37.00 Subtotal (see instructions) 902,876 36.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.90 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.01 Sequestration adjustment (see instructions) 51,282 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 2,959,158 41.00 42.00 Tentative settlement (for contractors use only) -446,354 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		, ,				
36. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 902,876 36.00 37. 00 Subtotal (see instructions) 2,564,086 37.00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38.00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39.90 39. 97 Demonstration payment adjustment amount before sequestration 0 39.97 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 40. 01 Sequestration adjustment (see instructions) 2,564,086 40.00 40. 02 Demonstration payment adjustment amount after sequestration 0 40.02 41. 00 Interim payments 2,564,086 40.02 42. 00 Tentative settlement (for contractors use only) 2,959,158 41.00 43. 00 Balance due provider/program (see instructions) -446,354 43.00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115.2 0 44.00 70. 00 Diginal outlier amount (see instructions) 0 9		, , , , , , , , , , , , , , , , , , , ,				
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Demonstration payment adjustment (see instructions) 39.97 Demonstration payment adjustment amount before sequestration 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment after sequestration 40.02 Demonstration payment adjustment after sequestration 40.02 Demonstration payment adjustment amount after sequestration 40.02 Interim payments 42.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 70.00 Outlier reconciliation adjustment amount (see instructions) 71.00 Outlier reconciliation adjustment amount (see instructions) 72.00 The rate used to calculate the Time Value of Money 73.00 Time Value of Money (see instructions) 74.00 Op 93.00	36.00		ructions)		902, 876	36.00
39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 50 39. 70 39.	37. 00				2, 564, 086	
39. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 39. 99 Subtotal (see instructions) 40. 00 Subtotal (see instructions) 40. 01 Demonstration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Protested instructions 94. 00 Outlier are used to calculate the Time Value of Money 95. 00 Time Value of Money (see instructions) 97. 00 Outlier reconciliation adjustment amount (see instructions) 98. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 99. 00 Outlier reconciliation adjustment amount (see instructions) 90. 00 Outlier reconciliation adjustment amount (see instructions)						
39. 97 Demonstration payment adjustment amount before sequestration 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Interim payments 42. 00 Balance due provider/program (see instructions) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 515. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 0 93. 00 93. 00 1 Time Value of Money (see instructions) 0 93. 00		, , , ,	>		0	
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Demonstration payment (see instructions) 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		, , , , , , , , , , , , , , , , , , , ,	is)			
39. 99 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 50 Sequestration adjustment (see instructions) 40. 01 Demonstration payment adjustment amount after sequestration 40. 02 Demonstration payment adjustment amount after sequestration 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		, , , , , , , , , , , , , , , , , , , ,	aced devices (see instru	rtions)		
40.00 Subtotal (see instructions) 2,564,086 40.00 40.01 Sequestration adjustment (see instructions) 51,282 40.01 40.02 Demonstration payment adjustment amount after sequestration 0 40.02 41.00 Interim payments 2,959,158 41.00 42.00 Tentative settlement (for contractors use only) 0 42.00 43.00 Balance due provider/program (see instructions) -446,354 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.00 Subtotal (see instructions) 0 90.00 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 (see instructions) 0 93.00 93.00 Time Value of Money (see instructions) 0 93.00		!	iced devices (see mistrate	211 0113)	-	
40.01 Sequestration adjustment (see instructions) 40.02 Demonstration payment adjustment amount after sequestration 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, \$\frac{1}{5}\$15.2 \$\frac{1}{10}\$ BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 O O O O O O O O O O O O O O O O O O						
41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions)		Sequestration adjustment (see instructions)			51, 282	1
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 \$\frac{115.2}{5115.2}\$ 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 42.00 42.00 -446,354 43.00 -446,354 43.00 -446,354 43.00 -446,354 43.00 -446,354 43.00 -446,354 43.00 -446,354 -	40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions)		1 3				1
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 10 90.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 10 93.00 Time Value of Money (see instructions) 11 0 94.00 Outlier reconciliation adjustment amount (see instructions) 12 0 93.00 Outlier reconciliation adjustment amount (see instructions) 13 0 90.00 Outlier reconciliation adjustment amount (see instructions) 14 0 0 90.00 Outlier reconciliation adjustment amount (see instructions)		,				
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Outlier reconciliation adjustment amount (see instructions) 0 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 1 Time Value of Money (see instructions) 0 93.00			anno with CMC Duty 15 0	obonton 1		
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 0.00 92.00 Time Value of Money (see instructions) 0 93.00	44.00		ance with CMS Pub. 15-2,	cnapter 1,	0	44.00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 90.00 91.00 92.00 93.00		o ·				1
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 0.00 92.00 93.00	90.00				0	90.00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 0.00 93.00						
93.00 Time Value of Money (see instructions) 0 93.00		· · · · · · · · · · · · · · · · · · ·			0.00	
94.00 Total (sum of lines 91 and 93) 0 94.00		,				
	94. 00	Total (sum of lines 91 and 93)			, 0	94.00

 Heal th Financial
 Systems
 GREENE

 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 | Peri od: | Worksheet E-1 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-1317

				0 12/31/2018	5/29/2019 12:	
		Title	XVIII	Hospi tal	Cost	оо ріп
		I npati en	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	I -	1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		4, 095, 363		2, 959, 158	1.00
2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for		(,	0	2. 00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(0	3. 01
3. 02			(0	3. 02
3. 03			(0	3. 03
3.04			(0	3. 04 3. 05
3. 05	Provider to Program)	0	3.05
3. 50	ADJUSTMENTS TO PROGRAM			1	0	3. 50
3. 51	ABSOSTWENTS TO TROOMAW					3. 51
3. 52					l ol	3. 52
3. 53					0	3. 53
3.54					0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		4, 095, 363	3	2, 959, 158	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		()	0	5. 01
5.02			()	0	5.02
5.03			()	0	5.03
	Provi der to Program				_	
5. 50	TENTATI VE TO PROGRAM		(0	5. 50
5. 51					0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 52 5. 99
5. 77	5. 50-5. 98)			΄	ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					5. 55
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
6. 02	SETTLEMENT TO PROGRAM		185, 740		446, 354	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 909, 623		2, 512, 804	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor	()	1. 00	2. 00	8. 00
8. 00	Name of Contractor				ı l	8.00

 RAL HOSPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 15-1317
 Period: From 01/01/2018 | From 01/01/2018 | To 12/31/2018 | To 12/31/2018 | To 12/31/2018 | To 25/31/2018 | To 25/
 Heal th Financial
 Systems
 GREENE

 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	CCN: 15-Z317 1	0 12/31/2018	5/29/2019 12:	
		Title XVIII Sw Inpatient Part A		wing Beds - SNF Cost Part B		оо рііі
					1	
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy	Amount 4.00	
1. 00	Total interim payments paid to provider	1.00	958, 720	3. 00	4.00	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,		938, 720		0	
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
2 01	Program to Provider ADJUSTMENTS TO PROVIDER	I	1 0		1 0	2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER	•			0	
3. 02					0	
3. 04					0	
3. 05			l o		0	
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3. 51			0		0	
3. 52			0		0	
3. 53			0		0	1
3. 54	Subtatal (our of lines 2 01 2 40 minus our of lines		0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)					3. 99
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)		958, 720		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
F 04	Program to Provider TENTATIVE TO PROVIDER		0		0	- 01
5. 01 5. 02	TENTATIVE TO PROVIDER				0	
5. 02					0	
0.00	Provider to Program					0.00
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		l 0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		31, 545		0	
7. 00	Total Medicare program liability (see instructions)		927, 175		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
0.00	In a Control		0	1. 00	2. 00	0.65
8. 00	Name of Contractor	İ			İ	8.00

Heal th	Financial Systems GREENE COUNTY GEN	IFRAL HOSPITAL	In Lie	u of Form CMS-	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1317 Period: Wo From 01/01/2018 Pa To 12/31/2018 Da				epared:
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				_
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wks		e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12			2.00
3. 00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	0.40			3.00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	11			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3		WI		6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of line 168	certified Hil 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	n (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,	,		1
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00					31.00
32. 00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)		32.00

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1317	Peri od:	Worksheet E-2
			From 01/01/2018	
		Component CCN: 15-Z317	To 12/31/2018	
				5/29/2019 12:35 pm
		Ti +l \(\text{YVIII}	Swing Rade - SNE	Cost

				5/29/2019 12:	35 pm
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient routine services - swing bed-SNF (see instructions)		783, 451	0	1.00
00	Inpatient routine services - swing bed-NF (see instructions)				2.00
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		168, 006	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins				
00	Per diem cost for interns and residents not in approved teachi	ng program (see		0. 00	4.00
	instructions)				
00	Program days		433	0	5.00
00	Interns and residents not in approved teaching program (see in			0	6.00
00	Utilization review - physician compensation - SNF optional met	thod only	0		7.00
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		951, 457	0	8.00
00	Primary payer payments (see instructions)		0	0	9.00
0. 00	Subtotal (line 8 minus line 9)		951, 457	0	10.00
. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11.00
	professional services)		054 457		40.00
2. 00	Subtotal (line 10 minus line 11)		951, 457	0	12.00
3. 00	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	5, 360	0	13.00
	for physician professional services)				
1. 00	80% of Part B costs (line 12 x 80%)			0	14.00
5. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	14)	946, 097	0	15.00
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
. 50	Pioneer ACO demonstration payment adjustment (see instructions		_		16. 50
. 55	Rural community hospital demonstration project (§410A Demonstr	ration) payment	0		16. 55
	adjustment (see instructions)		_	_	
. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
. 00	Allowable bad debts (see instructions)		0	0	17.00
. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructi ons)	0	0	18.00
00	Total (see instructions)		946, 097	0	19.00
. 01	Sequestration adjustment (see instructions)		18, 922	0	19. 01
0. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
0. 00	Interim payments		958, 720	0	20.00
	Tentative settlement (for contractor use only)		0	0	21.00
. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	•	-31, 545	0	22.00
. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr				ļ
0.00	Is this the first year of the current 5-year demonstration per	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				ļ
1. 00	Medicare swing-bed SNF inpatient routine service costs (from V	Wkst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
2.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, lin	e		202.00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203.00
	Medicare swing-bed SNF discharges (see instructions)				204.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-year demons	trati on	
	peri od)		1		
	Medicare swing-bed SNF target amount				205.00
	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
	<u>Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs</u>				ļ
	Program reimbursement under the §410A Demonstration (see instr	•			207.00
8.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines	1		208.00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
0. 00	Reserved for future use				210.00
	Comparision of PPS versus Cost Reimbursement				
5 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215.00
0.00					

Heal th	alth Financial Systems GREENE COUNTY GENERAL HOSPITAL In Lieu			of Form CMS-2	552-10	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT			Worksheet E-3		
				From 01/01/2018		
				To 12/31/2018	Date/Time Prep	pared:
					5/29/2019 12:	35 pm_
	Title XVIII Hospital					
					1.00	
	PART V - CALCULATION OF REIMBURSEMENT SET	TLEMENT FOR MEDICARE	PART A SERVICES - COST	REIMBURSEMENT		
1.00	1.00 Inpatient services					1.00
2.00	Nursing and Allied Health Managed Care pa	ayment (see instructio	ons)		0	2.00
3.00	Organ acquisition				0	3.00

		1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT	1.00	
1. 00	Inpatient services	4, 360, 234	1.00
2.00	Nursing and Allied Health Managed Care payment (see instructions)	0	2.00
3. 00	Organ acqui si ti on	0	3.00
4. 00	Subtotal (sum of lines 1 through 3)	4, 360, 234	4.00
5. 00	Primary payer payments	0	5.00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)	4, 403, 836	6.00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES	17 1007 000	0.00
	Reasonable charges		
7. 00	Routi ne servi ce charges	0	7.00
8. 00	Anci II ary servi ce charges	ő	8.00
9. 00	Organ acquisition charges, net of revenue	0	9.00
10.00		o l	10.00
10.00	Customary charges	Ŭ	10.00
11. 00		0	11.00
12. 00	Amounts that would have been realized from patients liable for payment for services on a charge basis		12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	Ĭ	12.00
13.00	Ratio of line 11 to line 12 (not to exceed 1.00000)	0. 000000	13.00
14. 00	Total customary charges (see instructions)	0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see	ő	15. 00
	instructions)	ا	10.00
16. 00	,	0	16.00
	instructions)	·	
17.00	Cost of physicians' services in a teaching hospital (see instructions)	ol	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
18.00	Direct graduate medical education payments (from Worksheet E-4, line 49)	0	18.00
	Cost of covered services (sum of lines 6, 17 and 18)	4, 403, 836	19.00
20.00	Deductibles (exclude professional component)	442, 176	
21.00	Excess reasonable cost (from line 16)	0	21.00
22.00	Subtotal (line 19 minus line 20 and 21)	3, 961, 660	22.00
23.00	· · · · · · · · · · · · · · · · · · ·	8, 710	
24.00	Subtotal (line 22 minus line 23)	3, 952, 950	
25.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	56, 094	25.00
26.00	Adjusted reimbursable bad debts (see instructions)	36, 461	26.00
27.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27, 438	27.00
28.00	Subtotal (sum of lines 24 and 25, or line 26)	3, 989, 411	28. 00
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	29.00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)	ol	29. 50
29. 99	Demonstration payment adjustment amount before sequestration	ol	29, 99
30.00	Subtotal (see instructions)	3, 989, 411	30.00
30. 01	Sequestration adjustment (see instructions)	79, 788	
30. 02	Demonstration payment adjustment amount after sequestration	0	30. 02
31. 00	Interim payments	4, 095, 363	
32. 00	Tentative settlement (for contractor use only)	0	32.00
33. 00		-185, 740	
34. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	34.00
· · · · ·	§115. 2	·	
	· ·	'	•

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1317	Peri od: From 01/01/2018 Part VII To 12/31/2018 Date/Ti me Prepared: 5/29/2019 12:35 pm

		7	o 12/31/2018	Date/Time Pre 5/29/2019 12:	
		Title XIX	Hospi tal	Cost	00 piii
			Inpatient	Outpati ent	
			1. 00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI			
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		313, 522		1.00
2. 00	Medical and other services		,	1, 733, 000	2.00
3. 00	Organ acquisition (certified transplant centers only)		0	.,	3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		313, 522	1, 733, 000	
5. 00	Inpatient primary payer payments		0.0,022	1,700,000	5.00
6. 00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		313, 522	1, 733, 000	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		0.07022	1,700,000	,,,,,,
	Reasonable Charges				
8.00	Routine service charges		0		8.00
9. 00	Ancillary service charges		499, 157	8, 316, 432	
10.00	Organ acquisition charges, net of revenue		o	.,	10.00
11. 00	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		499, 157	8, 316, 432	12.00
	CUSTOMARY CHARGES		, , , , ,	.,,	
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	Č			
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 4	12 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16. 00	Total customary charges (see instructions)		499, 157	8, 316, 432	16. 00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	185, 635	6, 583, 432	17. 00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
	16) (see instructions)			_	
19. 00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instr		0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		313, 522	1, 733, 000	21.00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provid	ers.	0	22.00
22. 00	Other than outlier payments		-	0	
23. 00	Outlier payments		0	U	23.00
24. 00	Program capital payments		0		24. 00 25. 00
26. 00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	•
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29. 00	Titles V or XIX (sum of lines 21 and 27)		313, 522	1, 733, 000	•
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		313, 322	1, 733, 000	27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		313, 522	1, 733, 000	
	Deductibles		313, 322	1, 733, 000	1
33. 00	Coinsurance		0	0	33.00
34. 00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review			Ü	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	313, 522	1, 733, 000	1
37. 00			-313, 522	-1, 733, 000	1
				0	38.00
	Direct graduate medical education payments (from Wkst. E-4)		o	_	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		o	0	
41. 00	Interim payments		ol	0	1
42. 00	Balance due provider/program (line 40 minus line 41)		Ö	0	1
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	o	0	1
	chapter 1, §115.2				

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

Provider CCN: 15-1317

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm

——————————————————————————————————————					5/29/2019 12:	35 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
1. 00	Cash on hand in banks	1, 639, 314	0	0	0	1.00
2.00	Temporary investments	1, 770, 720	1	0	0	
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	5, 393, 526	1	0	0	
5. 00	Other receivable	1, 711, 625	1	0	0	
6.00	Allowances for uncollectible notes and accounts receivable		0	0	0	
7.00	Inventory Prepai d expenses	340, 254 228, 513		0	0	
8. 00 9. 00	Other current assets	220, 313		0	0	8. 00 9. 00
10.00	Due from other funds	0	Ö	0	0	
11. 00	Total current assets (sum of lines 1-10)	11, 083, 952	- 1	0		
	FIXED ASSETS	,				
12.00	Land	651, 198	0	0	0	12. 00
13.00	Land improvements	313, 468	0	0	0	13.00
14. 00	Accumulated depreciation	-123, 168	1	0	0	
15. 00	Bui I di ngs	8, 071, 059	1	0	0	
16.00	!	-3, 285, 342		0	0	
17. 00 18. 00	Leasehold improvements	0	0	0	0	
19.00	Accumulated depreciation Fixed equipment	3, 839, 989	· ·	0	0	18. 00 19. 00
20.00	Accumulated depreciation	-1, 456, 548		0	0	20.00
21. 00		1, 430, 340	Ö	0	0	21.00
22. 00	Accumulated depreciation	0	Ö	0	0	22.00
	Major movable equipment	2, 498, 901	l o	0	0	
24.00	Accumul ated depreciation	-962, 286	0	0	0	1
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26.00
27. 00		0	0	0	0	
28. 00	· •	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	0 547 074	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	9, 547, 271	0	0	0	30.00
31 00	Investments	915, 375	O	0	0	31.00
32. 00	Deposits on Leases	713, 379		0	0	
33. 00	į ·	Ö	Ö	0	0	1
34.00	Other assets	88, 098	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1, 003, 473		0	0	35.00
36. 00	Total assets (sum of lines 11, 30, and 35)	21, 634, 696	0	0	0	36.00
	CURRENT LI ABI LI TI ES		TT			
37.00		747, 574	1	0	0	
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	2, 432, 013	1	0	0	
40.00	Notes and Loans payable (short term)	250, 581 1, 978, 700	1	0	0	
41. 00	Deferred income	1, 770, 700	0	0	0	1
42. 00	Accel erated payments	Ö		Ü	J	42.00
43. 00	Due to other funds	Ö	o	0	0	1
44.00	Other current liabilities	1, 340, 439	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6, 749, 307	0	0	0	45. 00
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	0	0	0	
47. 00	Notes payable	8, 411, 410		0	0	
48. 00	Unsecured Loans	0	0	0	0	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	8, 411, 410	1	0	0	
51.00	Total liabilities (sum of lines 45 and 50)	15, 160, 717		0		1
31.00	CAPITAL ACCOUNTS	13, 100, 717	١		J	31.00
52.00	General fund balance	6, 473, 979				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	6, 473, 979	0	^	0	59.00
60.00	1	21, 634, 696	1	0	0	
55. 55	[59]	21,007,070	1	0		55. 55
		•	. '			•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10
Worksheet G-1 Peri od: From 01/01/2018 Provi der CCN: 15-1317

					To	12/31/2018	Date/Time Pro 5/29/2019 12	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fund	
		1.00	2. 00	3. 00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) INTERCOMPANY TRANSFERS 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	908, 984 0 0 0 0 0 0	2.00 5, 938, 453 -373, 458 5, 564, 995 908, 984 6, 473, 979		0 0 0 0 0 0 0	4.00 0 0		5. 00 6. 00 7. 00
19.00	sheet (line 11 minus line 18)	Endowment	0, 473, 979 Pl ant			0		19.00
		Fund	Franc	i unu				
		6. 00	7. 00	8. 00				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) INTERCOMPANY TRANSFERS	0	0 0 0 0		0			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	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	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	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0			0			18. 00 19. 00

| Peri od: | Worksheet G-2 | From 01/01/2018 | Parts | & II | To | 12/31/2018 | Date/Time | Prepared: Health Financial Systems GREE STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1317

			To 12/31/2018	Date/Time Pre 5/29/2019 12:	
	Cost Center Description	Inpatient	Outpati ent	Total	00 p
		1, 00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	2, 973, 21	8	2, 973, 218	1.00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4.00
5.00	Swing bed - SNF		o	0	5.00
6.00	Swing bed - NF		0	0	6.00
7. 00	SKILLED NURSING FACILITY				7. 00
8.00	NURSI NG FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	2, 973, 21	8	2, 973, 218	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	545, 74	5	545, 745	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSI 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	545, 74	5	545, 745	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	3, 518, 96	3	3, 518, 963	17.00
18.00	Ancillary services	9, 715, 41	7 90, 352, 606	100, 068, 023	18.00
19.00	Outpati ent servi ces		0	0	19.00
20.00	LINTON CLINIC		0 90, 635	90, 635	20.00
20. 01	BLOOMFI ELD CLI NI C		0 39, 172	39, 172	20. 01
20.02	WESTGATE CLINIC		0 20, 228	20, 228	20. 02
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25.00
26.00	HOSPI CE				26.00
27.00	OTHER (SPECIFY)		0	0	27.00
28.00	Total patient revenues (sum of lines 17-27) (transfer column 3 to Wks	t. 13, 234, 38	0 90, 502, 641	103, 737, 021	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		34, 344, 533		29. 00
30.00	BAD DEBT EXPENSE	7, 874, 78	9		30.00
31.00			0		31.00
32.00			0		32.00
33.00			0		33.00
34.00			0		34.00
35.00			0		35.00
36.00	Total additions (sum of lines 30-35)		7, 874, 789		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)(trans	sfer	42, 219, 322		43.00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems GREENE COUNTY GENE	RAI HOSPITAI	In lie	u of Form CMS-2	2552-10
			Worksheet G-3		
			From 01/01/2018		pared:
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			103, 737, 021	1.00
2.00	Less contractual allowances and discounts on patients' accounts	nts		63, 379, 853	
3.00	Net patient revenues (line 1 minus line 2)			40, 357, 168	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		42, 219, 322	
5.00	Net income from service to patients (line 3 minus line 4)			-1, 862, 154	5. 00
	OTHER I NCOME			1	
6.00	Contributions, donations, bequests, etc			0	6.00
7. 00	Income from investments			0	7. 00 8. 00
	8.00 Revenues from telephone and other miscellaneous communication services				
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	
14.00	Revenue from meals sold to employees and guests			0	
15. 00	Revenue from rental of living quarters			0	10.00
16. 00	Revenue from sale of medical and surgical supplies to other	than patients		0	10.00
17. 00	Revenue from sale of drugs to other than patients			0	17.00
	Revenue from sale of medical records and abstracts			0	10.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	
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	OTH GRANTS, PURCHASE DISC, RENT INC			1, 488, 696	24.00
25.00	Total other income (sum of lines 6-24)			1, 488, 696	25. 00
26.00	Total (line 5 plus line 25)			-373, 458	26.00
27 00	OTHER EXPENSES (SPECLEY)			0	27 00

0 28.00

-373, 458 29.00

0 27.00

27. 00 OTHER EXPENSES (SPECIFY)

28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

Health Financial Systems	GREENE COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C	CN: 15-1317	Peri od:	Worksheet M-1	
				From 01/01/2018		
		Component	CCN: 15-8535	To 12/31/2018		
					5/29/2019 12:	35 pm
				RHC I		
	Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
			+ col . 2)	i ons	Trial Balance	
					(col. 3 +	
					col. 4)	

		Compensation	Other Costs	Total (col. 1	Reclassi fi cat	Recl assi fi ed	
		compensati on	other costs	+ col . 2)	ions	Tri al Balance	
						(col. 3 +	
						col . 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	26, 244	0	26, 244	0	26, 244	1.00
2. 00	Physician Assistant	0	0	0	_	0	2.00
3. 00	Nurse Practitioner	12, 708	0	12, 708	0	12, 708	3.00
4.00	Visiting Nurse	0	0	0	0	0	4.00
5. 00	Other Nurse	5, 856	0	5, 856	0	5, 856	5.00
6. 00	Clinical Psychologist	0	0	0	0	0	6.00
7. 00	Clinical Social Worker	2, 500	0	2, 500	0	2, 500	7. 00
8. 00	Laboratory Techni ci an	0	0	0	0	0	8.00
9. 00	Other Facility Health Care Staff Costs	6, 061	0	6, 061	0	6, 061	9. 00
10.00	Subtotal (sum of lines 1 through 9)	53, 369	0	53, 369	0	53, 369	10.00
	Physician Services Under Agreement	0	0	0	0	0	11.00
	Physician Supervision Under Agreement	0	0	0	0	0	12.00
	Other Costs Under Agreement	0	10, 260			10, 260	13.00
	Subtotal (sum of lines 11 through 13)	0	10, 260			10, 260	14.00
	Medical Supplies	0	6, 390			6, 390	15.00
	Transportation (Health Care Staff)	0	222	222	0	222	16.00
	Depreciation-Medical Equipment	0	0	0	0	0	17. 00
	Professional Liability Insurance	0	0	0	0	0	18.00
	Other Health Care Costs	0	0	0	0	0	19.00
	Allowable GME Costs						20.00
	Subtotal (sum of lines 15 through 20)	0	6, 612		0	6, 612	21.00
22.00	Total Cost of Health Care Services (sum of	53, 369	16, 872	70, 241	0	70, 241	22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	ام		1	_	1	
	Pharmacy	0	0	1	_	1	23.00
24.00	Dental	0	0	0	0	1	24.00
	Optometry	0	0	0	0	0	25.00
25. 01	Tel eheal th	0	0	0	0	0	25. 01
	Chronic Care Management	0	0	0	0	0	25. 02
	All other nonreimbursable costs	0	0	0	0	0	26.00
27. 00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0	0	0	0	28. 00
	through 27)						
20.00	FACILITY OVERHEAD		11 050	11, 858	0	11, 858	20.00
29. 00 30. 00	Facility Costs Administrative Costs	0 21, 546	11, 858 3, 013				29. 00 30. 00
			3, 013 14, 871				
31. 00	Total Facility Overhead (sum of lines 29 and 30)	21, 546	14, 8/1	36, 417		36, 417	31.00
32. 00	Total facility costs (sum of lines 22, 28	74, 915	31, 743	106, 658	0	106, 658	32.00
32.00	and 31)	74, 913	31, 743	100,036		100, 636	32.00
	19.00	l l		1	I	ı	1

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Period: Worksheet M-1 From 01/01/2018
	Component CCN: 15-8535	To 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm

Adjustments				Component	CCN. 13-6555	10	12/31/2010	5/29/2019	
Adjustments							RHC I	0,2,,,201,	12. 00 piii
FACILITY HEALTH CARE STAFF COSTS			Adiustments	Net Expenses					
COL. 5 + col. 6 COL. 5 + col. 6 COL. 6 C			, l						
FACILITY HEALTH CARE STAFF COSTS				Allocation					
FACILITY HEALTH CARE STAFF COSTS									
FACILITY HEALTH CARE STAFF COSTS									
FACILITY HEALTH CARE STAFF COSTS 1.00			6, 00		1				
1.00		FACILITY HEALTH CARE STAFF COSTS			'				
2.00	1.00		0	26, 244					1.00
3.00	2.00	Physician Assistant	ol		1				2.00
4.00	3.00	Nurse Practitioner	ol	12, 708					3.00
5.00			o	, 0					
6.00			ol	5. 856	,				
7.00		1	ol		1				
8. 00 Caboratory Technician 0 0 0 0 0 0 0 0 0			ol	2 500					
9. 00 Other Facility Heal th Care Staff Costs 0 6,061 9,00 10. 00 Subtotal (sum of lines 1 through 9) 0 53,369 10.00 11. 00 Physician Services Under Agreement 0 0 12.00 12. 00 Physician Supervision Under Agreement 0 10,260 13.00 14. 00 Subtotal (sum of lines 11 through 13) 0 10,260 14.00 15. 00 Medical Supplies 0 6,390 15.00 17. 00 Depreciation-Medical Equipment 0 0 17.00 18. 00 Orfessional Liability Insurance 0 0 17.00 19. 00 Other Health Care Costs 0 0 19.00 20. 00 Allowable GME Costs 20.00 19.00 21. 00 Voltotal (sum of lines 15 through 20) 0 6,612 21.00 22. 00 Total Cost of Health Care Services (sum of lines 15 through 20) 0 6,612 22.00 22. 00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00 23.00 25. 01 Dental 0 0 0 25. 02 Optometry 0 0 0 26. 00 All other nonreimbursable costs 0			ol		1				
10. 00 Subtotal (sum of lines 1 through 9) 0 53, 369 10. 00			Ö	•	1				
11.00 Physician Services Under Agreement 0 0 0 12.00 12.00 12.00 12.00 13.00 0 10.260 13.00 0 10.260 13.00 14.00 0 10.260 13.00 14.00 0 14.00 0 14.00 0 15.00 14.00 0 15.00 15.00 15.00 16.00 16.00 17.00 0 0 0 0 0 16.00 16.00 17.00 0 0 0 0 0 18.00 17.00 0 0 0 0 0 18.00 19.00 0 0 0 0 0 0 0 0 0			0						
12.00			0		1				
13. 00 Other Costs Under Agreement 0 10, 260 13. 00			0		1				
14.00 Subtotal (sum of lines 11 through 13) 0 10,260 10,260 15.00 16.00 17.00 15.00 16.00 17.00 15.00 16.00 17.00 15.00 16.00 17.00 15.00 16.00 17.00 15.00 16.00 17.00 15.00 16.00 17.00 15.00 16.00 17.00 15.00 16.00 17.00 16.00 17.00 17.00 17.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 19.00			0	-	1				
15.00 Medical Supplies			o o		1				
16.00 Transportation (Health Care Staff) 0 222 16.00 17.00 Depreciation-Medical Equipment 0 0 0 17.00 18.00 Professional Liability Insurance 0 0 0 18.00 19.00 1		,	U O	•	1				
17. 00		1 ''	U	•	1				
18. 00 Professional Liability Insurance 0 0 18. 00 19. 00 Other Heal th Care Costs 0 0 0 20. 00 Allowable GME Costs 20. 00 20. 00 21. 00 Subtotal (sum of lines 15 through 20) 0 6, 612 21. 00 22. 00 Total Cost of Heal th Care Services (sum of lines 10, 14, and 21) 22. 00 22. 00 23. 00 Pharmacy 0 0 23. 00 24. 00 Dental 0 0 24. 00 25. 00 Optometry 0 0 25. 01 25. 01 Tel eheal th 0 0 0 25. 01 25. 02 Chronic Care Management 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 26. 00 27. 00 Ownall owable GME costs 0 0 0 28. 00 40. 00 Total Nonreimbursable costs (sum of lines 23 through 27) 0 0 0 0 28. 00 50. 00 Total Facility Costs 0 0 0 0 <		' ' '	U		•				
19.00 Other Health Care Costs 19.00 20		1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	0		1				
20.00 Allowable GME Costs 20.00 21.00 22.00			0		1				
21.00 Subtotal (sum of lines 15 through 20) 0 6,612 70,241 22.00		4	U	Ü	7				
22.00 Total Cost of Health Care Services (sum of lines 10, 14, and 21) 22.00									
Lines 10, 14, and 21) COSTS OTHER THAN RHC/FOHC SERVICES 23.00 Pharmacy 0 0 0 0 24.00 24.00 25.00 0 0 0 25.00 25.00 25.00 0 0 0 25.00 25.00 25.01 Tel eheal th 0 0 0 0 25.01 25.02 26.00 All other nonreimbursable costs 0 0 0 25.02 26.00 All other nonreimbursable costs 0 0 0 26.00 27.00 Nonal lowable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 through 27) FACILITY OVERHEAD 29.00 Facility Costs 0 11,858 29.00 30.00 Administrative Costs 0 24,559 30.00 36,417 31.00 36,417 30.00 36,417 32.00 Total facility costs (sum of lines 22, 28 0 106,658 32.00 32.00 32.00 Total facility costs (sum of lines 22, 28 0 106,658 33.00			0	•	•				
COSTS OTHER THAN RHC/FOHC SERVICES Pharmacy	22.00		O	70, 241					22.00
23.00 Pharmacy									
24. 00 Dental 0 0 0 0 24. 00 25. 00 Optometry 0 0 0 0 25. 01 Tel eheal th 0 0 0 0 25. 02 Chronic Care Management 0 0 0 0 26. 00 All other nonreimbursable costs 0 0 0 27. 00 Nonall owable GME costs 0 0 0 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	00.00		ام						
25. 00		1	-		1				
25. 01 Tel eheal th		1	0		1				
25. 02 Chronic Care Management 0 0 0 0 25. 02 26. 00 All other nonreimbursable costs 0 0 0 0 27. 00 Nonallowable GME costs 27. 00 28. 00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1'	0	-	1				
26. 00		4	0		1				
27.00 Nonallowable GME costs 27.00 28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 28.00			0	-	1				
28.00 Total Nonreimbursable Costs (sum of lines 23 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			O	0)				
through 27) FACILITY OVERHEAD 29. 00 Facility Costs 30. 00 Administrative Costs 31. 00 Total Facility Overhead (sum of lines 29 and 30) Total facility costs (sum of lines 22, 28									
FACILITY OVERHEAD 29.00 Facility Costs 30.00 Administrative Costs Total Facility Overhead (sum of lines 29 and 30) 30) Total facility costs (sum of lines 22, 28 Total facility costs (sum of lines 22, 28 Total Facility Costs 32.00	28. 00	,	0	0)				28. 00
29.00 Facility Costs 0 11,858 29.00 30.00 Administrative Costs 0 24,559 30.00 31.00 30) Total Facility Costs (sum of lines 22, 28 0 106,658 32.00 32.00 32.00 33.0									
30.00 Administrative Costs 0 24,559 30.00 31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 106,658 32.00			.1						
31.00 Total Facility Overhead (sum of lines 29 and 30) 32.00 Total facility costs (sum of lines 22, 28 0 106,658 32.00				•	•				
30) 32.00 Total facility costs (sum of lines 22, 28 0 106,658 32.00		4	0	•	•				
32.00 Total facility costs (sum of lines 22, 28 0 106,658 32.00	31. 00		0	36, 417					31.00
[and 31)	32. 00	,	0	106, 658	3				32.00
		and 31)	l		I				I

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Period: Worksheet M-1 From 01/01/2018
	Component CCN: 15-8533	To 12/31/2018 Date/Time Prepared: 5/29/2019 12:35 pm
		RHC II

			Component	CCN: 15-8533	10 12/31/2018	5/29/2019 12:	
					RHC II	0/2//2017 12:	оо ріп
		Compensation	Other Costs	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
				_		(col. 3 +	
						col. 4)	
		1. 00	2. 00	3.00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	14, 645	0	14, 64	5 0	14, 645	1.00
2.00	Physician Assistant	0	0		0		2.00
3.00	Nurse Practitioner	3, 877	0	3, 87	7 0	3, 877	3.00
4.00	Visiting Nurse	0	0	1	0	0	4.00
5.00	Other Nurse	4, 201	0	4, 20	1 0	4, 201	5.00
6.00	Clinical Psychologist	0	0	1	0	0	6. 00
7. 00	Clinical Social Worker	0	0		0	0	7. 00
8.00	Laboratory Techni ci an	0	0		0	0	8. 00
9.00	Other Facility Health Care Staff Costs	0	0		0	0	9. 00
10. 00	Subtotal (sum of lines 1 through 9)	22, 723	0	22, 72	3 0	,,	10.00
11. 00	Physician Services Under Agreement	0	0		0	0	11. 00
12.00	Physician Supervision Under Agreement	0	0	1	0	0	12.00
13.00	Other Costs Under Agreement	0	622	1		622	13.00
14. 00	Subtotal (sum of lines 11 through 13)	0	622			622	14. 00
15. 00	The second section of the second seco	0	4, 093			4, 093	
16. 00	Transportation (Health Care Staff)	0	67	l .		67	16. 00
17. 00	1 '	0	0		0	0	17. 00
18. 00	3	0	0	1	0	0	18. 00
19. 00	Other Health Care Costs	0	0	1	0	0	19. 00
20.00							20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	4, 160				21. 00
22. 00	Total Cost of Health Care Services (sum of	22, 723	4, 782	27, 50	5 0	27, 505	22. 00
	lines 10, 14, and 21)						
00.00	COSTS OTHER THAN RHC/FQHC SERVICES						00.00
23.00	,	0	0		0	1	23. 00
24.00	Dental	0	0	1	0	1	24.00
25. 00	Optometry	U	0		0	0	25. 00
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	U	0		0	0	25. 02
26.00	All other nonreimbursable costs	U	U	1	U	0	26.00
27. 00	Nonallowable GME costs	0	0				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	U	0	'	0	0	28. 00
	through 27) FACILITY OVERHEAD						
20 00	Facility Costs	O	4, 167	4, 16	7 0	4, 167	29. 00
30.00	Administrative Costs	1, 828	788				30.00
31. 00	Total Facility Overhead (sum of lines 29 and		4, 955			_, -,	31.00
31.00	30)	1,020	4, 900	0, 78		0, 763	31.00
32. 00	Total facility costs (sum of lines 22, 28	24, 551	9, 737	34, 28	8 0	34, 288	32. 00
02.00	and 31)	21, 331	7, 131	37,20		31,200	32.00
	1	'		1	1	ı	1

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of	f Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Peri od: Wo From 01/01/2018	rksheet M-1
	Component CCN: 15-8533	To 12/31/2018 Da	te/Time Prepared: 29/2019 12:35 pm

			Component CC	N: 15-8533	10	12/31/2018	5/29/2019	
						RHC II	3/ 27/ 2017	12. 33 piii
	·	Adjustments	Net Expenses			INIO II		
		Adj d3tilici1t3	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00					
1. 00	Physi ci an	O	14, 645					1.00
2. 00	Physician Assistant	0	0					2.00
3. 00	Nurse Practitioner		3, 877					3.00
		o o	3, 877					
4. 00	Visiting Nurse	U	٩					4.00
5. 00	Other Nurse	U O	4, 201					5.00
6.00	Clinical Psychologist	0	0					6.00
7.00	Clinical Social Worker	0	0					7.00
8. 00	Laboratory Techni ci an	O	0					8. 00
9. 00	Other Facility Health Care Staff Costs	0	0					9. 00
10.00	Subtotal (sum of lines 1 through 9)	0	22, 723					10. 00
11. 00	Physician Services Under Agreement	0	0					11. 00
12.00	Physician Supervision Under Agreement	0	0					12.00
13.00	Other Costs Under Agreement	0	622					13.00
14.00	Subtotal (sum of lines 11 through 13)	0	622					14.00
15.00	Medical Supplies	0	4, 093					15. 00
16.00	Transportation (Health Care Staff)	o	67					16.00
17.00	Depreciation-Medical Equipment	ol	o					17.00
18.00		ol	ol					18.00
19.00	Other Health Care Costs	0	0					19.00
20.00	Allowable GME Costs	آ ا	1					20.00
21. 00	Subtotal (sum of lines 15 through 20)	ol	4, 160					21.00
22. 00	Total Cost of Health Care Services (sum of	ol	27, 505					22. 00
22.00	lines 10, 14, and 21)	Ĭ	27,000					22.00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23 00	Pharmacy	O	0					23. 00
24. 00	Dental	ol	o					24.00
25. 00	Optometry	ol Ol	0					25. 00
25. 00	Tel eheal th	0	0					25. 01
25. 01		0	0					25. 02
26. 00	All other nonreimbursable costs		0					26.00
27. 00	Nonallowable GME costs	٩	o _l					27.00
	1							
28. 00	Total Nonreimbursable Costs (sum of lines 23	Ч	0					28. 00
	through 27) FACILITY OVERHEAD							
20.00		O	1 1/7					29, 00
	Facility Costs	-	4, 167					
30.00	Administrative Costs	0	2, 616					30.00
31. 00	Total Facility Overhead (sum of lines 29 and	O	6, 783					31.00
22.00	30)		24 200					22.00
32. 00	Total facility costs (sum of lines 22, 28	٥	34, 288					32.00
	and 31)	I	I					I

Health Financial Systems	GREENE COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od: From 01/01/2018	Worksheet M-1	
		Component	CCN: 15-8534	To 12/31/2018	Date/Time Pre 5/29/2019 12:	
			_	RHC III		
	Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
			+ col . 2)	i ons	Trial Balance	

						5/29/2019 12:	35 pm_
					RHC III		
		Compensation	Other Costs	Total (col 1	Recl assi fi cat	Reclassi fi ed	
		Compensation	Other Costs				
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
		1.00	2.00	3.00	4.00	5.00	
	FACILITY HEALTH CARE STAFF COSTS						
1. 00	Physi ci an	0	0		0	0	1.00
2.00	Physi ci an Assi stant	0	0		0 (0	2.00
3. 00	Nurse Practitioner	4, 838	0	4, 83	0	4, 838	3.00
	· ·	4, 030	0	4,03	0		
4.00	Visiting Nurse	0	0	1	0	0	4.00
5.00	Other Nurse	1, 561	0	1, 56	1 0	1, 561	5.00
6.00	Clinical Psychologist	0	0		0 (0	6. 00
7. 00	Clinical Social Worker	0	0		0	l o	7. 00
		U	0		٥	1	
8.00	Laboratory Techni ci an	0	0		0 0	0	8. 00
9.00	Other Facility Health Care Staff Costs	2, 091	0	2, 09	1 0	2, 091	9.00
10.00	Subtotal (sum of lines 1 through 9)	8, 490	0	8, 49	o	8, 490	10.00
11. 00	Physician Services Under Agreement	0, 170	0	1	0		11.00
		U	0	1	-	1	
12.00	Physician Supervision Under Agreement	0	0		0 (C	0	12.00
13.00	Other Costs Under Agreement	0	663	66	3 0	663	13.00
14.00	Subtotal (sum of lines 11 through 13)	0	663	66	3 0	663	14.00
		0 0					
15.00	Medical Supplies	U	2, 434	1			15. 00
16.00	Transportation (Health Care Staff)	0	196	19	6 0	196	16. 00
17.00	Depreciation-Medical Equipment	0	0		ol o	0	17.00
18.00	Professional Liability Insurance	0	0		0	l o	18.00
	Other Health Care Costs	0	0	1	0	l ő	19.00
		U	U		٥		
20.00	Allowable GME Costs						20. 00
21.00	Subtotal (sum of lines 15 through 20)	0	2, 630	2, 63	0 (C	2, 630	21.00
22. 00	Total Cost of Health Care Services (sum of	8, 490	3, 293	11, 78	3 0	11, 783	22. 00
22.00	lines 10, 14, and 21)	0, 1, 0	0,270	1, , ,		11,700	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES						
00.00							00.00
	Pharmacy	0	0		0		23. 00
24.00	Dental	0	0		0	0	24.00
25.00	Optometry	0	0		0 (0	25. 00
25. 01	Tel eheal th	0	0			0	25. 01
		0	0				
25. 02	Chronic Care Management	U	0		J _I 0	0	25. 02
26.00	All other nonreimbursable costs	0	0		0	0	26.00
27.00	Nonallowable GME costs						27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		0	0	28. 00
20.00		U	0		9	٥	20.00
	through 27)						
	FACILITY OVERHEAD						
29.00	Facility Costs	0	3, 846	3, 84	6 0	3, 846	29. 00
30.00	Administrative Costs	818	783			1, 601	30.00
						,	
31. 00	Total Facility Overhead (sum of lines 29 and	818	4, 629	5, 44	/ 0	5, 447	31. 00
	30)			1			
32.00	Total facility costs (sum of lines 22, 28	9, 308	7, 922	17, 23	0 (0	17, 230	32.00
	and 31)						
		'			1	1	'

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Peri od: From 01/01/2018	Worksheet M-1
	Component CCN: 15-8534		Date/Time Prepared: 5/29/2019 12:35 pm

			Component	CCN: 15-8534	10	12/31/2018	5/29/2019	
						RHC III	3/27/2017	12. 33 piii
	·	Adjustments	Net Expenses			KIIC III		
		Adj d3tilici1t3	for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00	_				
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00					
1. 00	Physi ci an	O						1.00
2. 00	Physician Assistant	ol O						2.00
3. 00	Nurse Practitioner	ol Ol	4, 838	- 1				3.00
4. 00	Visiting Nurse	0	4, 030					4.00
5. 00	Other Nurse		1, 56	1				5.00
6. 00	Clinical Psychologist	0		ol				6.00
7. 00	Clinical Social Worker	0						7.00
8. 00	Laboratory Techni ci an	0						8.00
		o o						9.00
9.00	Other Facility Health Care Staff Costs	U	2, 09					
10.00	Subtotal (sum of lines 1 through 9)	U	8, 490	1				10.00
11.00	Physician Services Under Agreement	U		0				11.00
12.00	Physician Supervision Under Agreement	U O		0				12.00
	Other Costs Under Agreement	0	663	1				13.00
14.00	Subtotal (sum of lines 11 through 13)	O	663	1				14.00
15. 00	Medical Supplies	O	2, 43					15. 00
16. 00	Transportation (Health Care Staff)	0	190					16. 00
	Depreciation-Medical Equipment	0		0				17. 00
18. 00	Professional Liability Insurance	0		0				18. 00
	Other Health Care Costs	0	(0				19. 00
20.00	Allowable GME Costs							20. 00
21. 00	Subtotal (sum of lines 15 through 20)	0	2, 630					21. 00
22. 00	Total Cost of Health Care Services (sum of	0	11, 78	3				22. 00
	lines 10, 14, and 21)							
	COSTS OTHER THAN RHC/FQHC SERVICES							
	Pharmacy	0		0				23. 00
24. 00	Dental	0	(0				24. 00
25.00	Optometry	0	(0				25. 00
25. 01	Tel eheal th	0	(0				25. 01
25. 02		0	(0				25. 02
26.00	All other nonreimbursable costs	0	(0				26. 00
27. 00	Nonallowable GME costs							27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	(0				28. 00
	through 27)							
	FACILITY OVERHEAD	1						
	Facility Costs	0	3, 84					29. 00
30.00	Administrative Costs	0	1, 60					30.00
31.00	Total Facility Overhead (sum of lines 29 and	0	5, 44	7				31.00
	30)			_				
32.00	Total facility costs (sum of lines 22, 28	0	17, 230	U				32.00
	and 31)	ļ						1

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 12:	
					RHC I		
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)		col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons		Г	T	. T		
1.00	Physi ci an	0.00					1.00
2. 00	Physician Assistant	0.00		_,			2. 00
3. 00	Nurse Practitioner	0.00	l e	2, 10	0	_	3. 00
4.00	Subtotal (sum of lines 1 through 3)	0.00	l e		0	0	
5.00	Visiting Nurse	0.00				0	
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00	l .			0	7.00
7. 01 7. 02	Medical Nutrition Therapist (FQHC only)	0. 00 0. 00				0	
7.02	Diabetes Self Management Training (FQHC only)	0.00	٥	'		U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	0.00	0			0	8.00
0.00	through 7)	0.00	٥	1		O	0.00
9. 00	Physician Services Under Agreements		0			0	9. 00
7.00	Triyst of all services offact rigit coments			1		Ü	7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SE	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			70, 241	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line:	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			70, 241	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1.000000	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr	om Worksheet. I	M-1, col. 7, I	ine 31)		36, 417	14.00
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			50, 516	15. 00
16.00	Total overhead (sum of lines 14 and 15)					86, 933	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					86, 933	
	Overhead applicable to hospital-based RHC/FC					•	19. 00
20.00	Total allowable cost of hospital-based RHC/F	FQHC services (:	sum of lines 1	0 and 19)		157, 174	20.00

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od: From 01/01/2018	Worksheet M-2	
			Component	CCN: 15-8533	To 12/31/2018	Date/Time Pre 5/29/2019 12:	
					RHC II		
		Number of FTE	Total Visits			Greater of	
		Personnel		Standard (1)	Visits (col.	col. 2 or	
					1 x col. 3)	col. 4	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1	_	1			
1.00	Physi ci an	0.00					1.00
2. 00	Physician Assistant	0.00					2.00
3.00	Nurse Practitioner	0.00		2, 10	0		3.00
4.00	Subtotal (sum of lines 1 through 3)	0.00			0	0	
5.00	Visiting Nurse	0.00				0	5.00
6.00	Clinical Psychologist	0.00				0	6.00
7.00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 02	Diabetes Self Management Training (FQHC only)	0.00	U			0	7. 02
8. 00	Total FTEs and Visits (sum of lines 4	0.00	o			0	8. 00
0.00	through 7)	0.00				U	0.00
9. 00	Physician Services Under Agreements		o			0	9. 00
7. 00	Triysi ci air Sei vi ces brider Agreements						7.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPITAL-BASE	ED RHC/FQHC SE	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			27, 505	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			27, 505	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13.00
14.00	14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					6, 783	14.00
15.00	15.00 Parent provider overhead allocated to facility (see instructions)					19, 830	15.00
16.00						26, 613	16.00
17. 00						0	
	Enter the amount from line 16					26, 613	18. 00
	Overhead applicable to hospital-based RHC/FC						19.00
20.00	Total allowable cost of hospital-based RHC/F	QHC services (sum of lines 1	0 and 19)		54, 118	20.00

Heal th	Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	ATION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet M-2 Date/Time Pre	
						5/29/2019 12:	
	RHC III						
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	,	col. 2 or	
		1. 00	2.00	3.00	1 x col . 3) 4.00	<u>col . 4</u> 5. 00	
	VISITS AND PRODUCTIVITY	1.00	2.00	3.00	4.00	5.00	
	Posi ti ons						
1. 00	Physi ci an	0.00	0	4, 20	00		1.00
2. 00	Physician Assistant	0.00					2.00
3. 00	Nurse Practitioner	0.00		2, 10			3.00
4.00	Subtotal (sum of lines 1 through 3)	0.00	O	,	0	0	4.00
5.00	Visiting Nurse	0.00	0			0	5.00
6.00	Clinical Psychologist	0.00	0			0	6.00
7.00	Clinical Social Worker	0.00				0	
7. 01	Medical Nutrition Therapist (FQHC only)	0.00	l .			0	
7. 02	Diabetes Self Management Training (FQHC	0.00	0			0	7. 02
	onl y)		_			_	
8. 00	Total FTEs and Visits (sum of lines 4	0.00	0			0	8. 00
0.00	through 7)		0			0	0.00
9. 00	Physician Services Under Agreements		0			U	9. 00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	FD RHC/FOHC SEI	RVICES		1.00	
10.00	Total costs of health care services (from Wk	kst. M-1, col.	7, line 22)			11, 783	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line :	28)			0	11.00
12.00	Cost of all services (excluding overhead) (s	sum of lines 10	and 11)			11, 783	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I	ine 10 divided	by line 12)			1. 000000	13.00
14.00	14.00 Total hospital-based RHC/FQHC overhead - (from Worksheet. M-1, col. 7, line 31)					5, 447	14.00
15.00						11, 854	1
	16.00 Total overhead (sum of lines 14 and 15)					17, 301	
17. 00						0	
	Enter the amount from line 16	200	40	10)		17, 301	1
	Overhead applicable to hospital-based RHC/FC					17, 301	
20.00	Total allowable cost of hospital-based RHC/F	-unc services (Sum of Tines I	o and 19)		29, 084	20.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL	L-BASED RHC/FQHC	Provider CCN: 15-1317	Peri od:	Worksheet M-3	
SERVI CES		Component CON 15 0525	From 01/01/2018	Doto/Time Dro	
		Component CCN: 15-8535	To 12/31/2018	Date/Time Pre 5/29/2019 12:	35 pm
		Title XVIII	RHC I		
DETERMINATION OF DATE FOR HOCKLIAN DACED BUG	YEOUG CERVILOEC			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/ Total Allowable Cost of hospital-based RHC/FC		m Wkst M 2 lino 20)		157, 174	1.0
2.00 Cost of vaccines and their administration (fr	,	· · · · · · · · · · · · · · · · · · ·		2, 269	2.0
.00 Total allowable cost excluding vaccine (line		110 10)		154, 905	3.
.00 Total Visits (from Wkst. M-2, column 5, line				0	4.
.00 Physicians visits under agreement (from Wkst.	M-2, column 5,	line 9)		0	5.
.00 Total adjusted visits (line 4 plus line 5)				0	6.
.00 Adjusted cost per visit (line 3 divided by li	ne 6)		Calaviatian	0.00	7. (
			Calculation	or Limit (1)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
.00 Per visit payment limit (from CMS Pub. 100-04	l. chapter 9. §20	.6 or vour contractor)	82. 30	83. 45	8. (
.00 Rate for Program covered visits (see instruct		,	0.00	0.00	
CALCULATION OF SETTLEMENT					
0.00 Program covered visits excluding mental healt	•		0	0	
1.00 Program cost excluding costs for mental healt	•	•	0	0	11.
2.00 Program covered visits for mental health serv 3.00 Program covered cost from mental health servi		•	0	0	12. 13.
	•	•	0	0	
,	, , ,			G	15.
6.00 Total Program cost (sum of lines 11, 14, and	15, columns 1, 2	and 3) *	0	0	16.
6.01 Total program charges (see instructions)(from				0	16.
6.02 Total program preventive charges (see instruc	, , , ,	•		0	16.
6.03 Total program preventive costs ((line 16.02/l		•		0	16.
6.04 Total Program non-preventive costs ((line 16 (Titles V and XIX see instructions.)	minus imes 16.0	3 and 18) times .80)		U	16.
6.05 Total program cost (see instructions)			0	0	16.
7.00 Primary payer amounts				0	17.
8.00 Less: Beneficiary deductible for RHC only (s	see instructions)	(from contractor		0	18.
records)					40
 9.00 Beneficiary coinsurance for RHC/FQHC services records) 	s (see instructio	ns) (from contractor		0	19.
0.00 Net Medicare cost excluding vaccines (see ins	structions)			0	20.
1.00 Program cost of vaccines and their administra		M-4, line 16)		0	21.
2.00 Total reimbursable Program cost (line 20 plus	s line 21)			0	22.
3.00 Allowable bad debts (see instructions)				0	23.
3.01 Adjusted reimbursable bad debts (see instruct 4.00 Allowable bad debts for dual eligible benefic		ructions)		0	23. 24.
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY	•	ructions)		0	24. 25.
			0		
5.99 Demonstration payment adjustment amount befor		•		0	25.
6.00 Net reimbursable amount (see instructions)				0	
6.01 Sequestration adjustment (see instructions)				0	26.
6.02 Demonstration payment adjustment amount after	sequestration			0	26.
7.00 Interim payments 8.00 Tentative settlement (for contractor use only	<i>(</i>)			0	27. 28.
29.00 Balance due component/program (line 26 minus	•	02. 27. and 28)		0	20. 29.
30.00 Protested amounts (nonallowable cost report i			,	0	
chapter I, §115.2			1		1

	TION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1317	Peri od:	Worksheet M-3	
ERVI CE	S	Component CCN: 15-8533	From 01/01/2018 To 12/31/2018	Date/Time Pre	
		Title XVIII	RHC II	5/29/2019 12:	35 P
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FOHC SERVICES				١.
1	Total Allowable Cost of hospital-based RHC/FQHC Services (fro			54, 118	1
1	Cost of vaccines and their administration (from Wkst. M-4, li	ne 15)		1, 055	
1	Total allowable cost excluding vaccine (line 1 minus line 2) Total Visits (from Wkst. M-2, column 5, line 8)			53, 063 0	3
	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.
	Total adjusted visits (line 4 plus line 5)	1111e 7)		0	6
1	Adjusted cost per visit (line 3 divided by line 6)			0. 00	
•			Cal cul ati on	of Limit (1)	
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	6 or your contractor)	82. 30	83. 45	8
1	Rate for Program covered visits (see instructions)	. o or your contractor)	0.00	0. 00	1
-	CALCULATION OF SETTLEMENT				
. 00	Program covered visits excluding mental health services (from	contractor records)	0	0	10
1	Program cost excluding costs for mental health services (line	•	0	0	11
	Program covered visits for mental health services (from contr		0	0	12
	, , ,			0	13
1	· · · · · · · · · · · · · · · · · · ·			0	14
1				0	15 16
	Total program cost (sum of fines fi, 14, and 15, condimis f, 2 Total program charges (see instructions)(from contractor's re	•	ď	0	16
1	, , , , , , , , , , , , , , , , , , , ,			0	16
1	Total program preventive costs ((line 16.02/line 16.01) times	•		0	16
. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		0	16
1	(Titles V and XIX see instructions.)				
	Total program cost (see instructions)		0	0	16
	Primary payer amounts Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		0	17 18
	records)	(Troil contractor		U	10
0. 00	Beneficiary coinsurance for RHC/FQHC services (see instructio	ns) (from contractor		0	19
	records) Net Medicare cost excluding vaccines (see instructions)			0	20
	Program cost of vaccines and their administration (from Wkst.	M-4. line 16)		0	1
1	Total reimbursable Program cost (line 20 plus line 21)	,		0	1
. 00	Allowable bad debts (see instructions)			0	23
	Adjusted reimbursable bad debts (see instructions)			0	
	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	24
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	25
	Pioneer ACO demonstration payment adjustment (see instruction	IS)		0	25 25
	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0	
1	Sequestration adjustment (see instructions)			0	
1	Demonstration payment adjustment amount after sequestration			0	1
	Interim payments			0	
. 00	Tentative settlement (for contractor use only)			0	28
	Balance due component/program (line 26 minus lines 26.01, 26.			0	29
0. 00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-II	.	0	30

CALCULATION OF REIMBURSEN	GREENE COUNTY GENER ENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES		Component CCN: 15-8534	From 01/01/2018 To 12/31/2018	Date/Time Pre	naroo
		Component CCN: 13-8334	10 12/31/2018	5/29/2019 12:	
		Title XVIII	RHC III		
				1. 00	
DETERMINATION OF RA	ATE FOR HOSPITAL-BASED RHC/FQHC SERVICES		<u> </u>	1.00	
	st of hospital-based RHC/FQHC Services (fro	om Wkst. M-2, line 20)		29, 084	1. (
2.00 Cost of vaccines a	nd their administration (from Wkst. M-4, li	ne 15)		0	2. (
	st excluding vaccine (line 1 minus line 2)			29, 084	3.0
1	Wkst. M-2, column 5, line 8)			0	4. (
1 3	under agreement (from Wkst. M-2, column 5,	line 9)		0	5.0
	its (line 4 plus line 5) visit (line 3 divided by line 6)			0 0. 00	6. (7. (
.00 Aujusteu cost per	VISIT (TITLE 3 divided by Title 6)		Cal cul ati on		/. (
			Pri or to Jan.	On or After	
			1 (Rate	Jan. 1 (Rate	
			Peri od 1) 1.00	Peri od 2) 2.00	
.00 Per visit payment	imit (from CMS Pub. 100-04, chapter 9, §20), 6 or your contractor)	82. 30	83. 45	8. (
	overed visits (see instructions)	,	0.00	0.00	1
CALCULATION OF SET	LEMENT				
_	sits excluding mental health services (from		0	0	1
0	ding costs for mental health services (line	*	0	0	1
	sits for mental health services (from contr	•	0	0	1
S .	st from mental health services (line 9 x li	•	0	0	
1	· · · · · · · · · · · · · · · · · · ·			U	14. 15.
4	Fotal Program cost (sum of lines 11, 14, and 15, columns 1, 2 and 3) *		0	1	
9	ges (see instructions)(from contractor's re			0	16.
, ,	entive charges (see instructions)(from prov	•		0	16.
6.03 Total program prev	entive costs ((line 16.02/line 16.01) times	line 16)		0	16.
	preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		0	16.
(Titles V and XIX				0	1,
	(see instructions)		0	0	
1 3 1 3	deductible for RHC only (see instructions)	(from contractor		0	
records)	dedder bre for this only (see this rue trons)	(110m contractor		· ·	
9.00 Beneficiary coinsu records)	rance for RHC/FQHC services (see instruction	ons) (from contractor		0	19.
0.00 Net Medicare cost	excluding vaccines (see instructions)			0	20.
1 9	ocines and their administration (from Wkst.	M-4, line 16)		0	21.
- I	Program cost (line 20 plus line 21)			0	22.
	s (see instructions)			0	23.
1 3	ble bad debts (see instructions) s for dual eligible beneficiaries (see inst	ructions)		0	23.
	(SEE INSTRUCTIONS) (SPECIFY)	i uctions)		0	1
	tration payment adjustment (see instruction	ns)		0	1
4	ent adjustment amount before sequestration	,		0	1
	mount (see instructions)			0	
	stment (see instructions)			0	26.
1	ent adjustment amount after sequestration			0	26.
77.00 Interim payments	at (for contractor ups1:)			0	1
•	nt (for contractor use only)	02 27 and 29)		0	
·	ent/program (line 26 minus lines 26.01, 26. (nonallowable cost report items) in accorda	•		0	
chapter I, §115.2	(nonarrowanie cost report rtems) in accorda	INCE WITH OWS PUD. 15-11	,	U	ا عن

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu	ı of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1317		Worksheet M-4
VACCINE COST		Component CCN: 15-8535	From 01/01/2018	
		Component Colv. 13-0333	10 12/31/2010	5/29/2019 12: 35 pm
		Title XVIII	RHC I	•

		Title XVIII	RHC I		
			Pneumococcal	I nfl uenza	
			1.00	2. 00	
1. 00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		53, 369	53, 369	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0. 001738	0. 003910	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	93	209	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	565	147	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	658	356	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	70, 241	70, 241	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		86, 933	86, 933	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0. 009368	0. 005068	8. 00
	divided by line 6)				1
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	814	441	9. 00
10.00	00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of		1, 472	797	10.00
	lines 5 and 9)				1
11. 00	Total number of pneumococcal and influenza vaccine injections		4	9	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1		368. 00	88. 56	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	0	0	13.00
	benefi ci ari es				1
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	0	0	14.00
	(line 12 x line 13)				1
15. 00				2, 269	15. 00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3				1
16. 00	Total Program cost of pneumococcal and influenza vaccine and			0	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			1
	line 21)			ļ	l

Health Financial Systems	GREENE COUNTY GENE	RAL HOSPITAL	In Lieu	ı of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/F	QHC PNEUMOCOCCAL AND INFLUENZA	Provider CCN: 15-1317	Peri od: From 01/01/2018	Worksheet M-4
VACCI NE COST		Component CCN: 15-8533		
		Title VVIII	DUC II	

		Title XVIII	RHC II		
			Pneumococcal	l nfl uenza	
			1.00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		22, 723	22, 723	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tota	I health care staff time	0. 002112	0. 001408	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (line	e 1 x line 2)	48	32	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (fr	om your records)	423	33	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plus	line 4)	471	65	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Workshe	et M-1, col. 7, line 22)	27, 505	27, 505	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		26, 613	26, 613	7.00
8. 00	Ratio of pneumococcal and influenza vaccine direct cost to tot	al direct cost (line 5	0. 017124	0. 002363	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x l	ine 8)	456	63	9.00
10. 00	Total pneumococcal and influenza vaccine cost and its (their) lines 5 and 9)	administration (sum of	927	128	10.00
11. 00	Total number of pneumococcal and influenza vaccine injections	(from your records)	3	2	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 10	/line 11)	309.00	64. 00	12.00
13. 00	Number of pneumococcal and influenza vaccine injections adminibeneficiaries	stered to Program	0	0	13.00
14. 00	Program cost of pneumococcal and influenza vaccine and its (the $(line 12 \times line 13)$	eir) administration	0	0	14.00
15. 00	Total cost of pneumococcal and influenza vaccine and its (thei of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3,			1, 055	15. 00
16. 00	Total Program cost of pneumococcal and influenza vaccine and i administration (sum of cols. 1 and 2, line 14) (transfer this line 21)			0	16.00

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQH	PNEUMOCOCCAL AND INFLUENZA	Provi der CCN: 15-1317	Peri od:	Worksheet M-4
VACCINE COST			From 01/01/2018	
		Component CCN: 15-8534	To 12/31/2018	Date/Time Prepared:
		•		5/29/2019 12:35 pm
		Ti +1 o V\/I I I	DHC III	

		Title XVIII	RHC III		
			Pneumococcal	I nfl uenza	
			1. 00	2. 00	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)		8, 490	8, 490	1.00
2.00	Ratio of pneumococcal and influenza vaccine staff time to tot	al health care staff time	0.000000	0.000000	2.00
3.00	Pneumococcal and influenza vaccine health care staff cost (li	ne 1 x line 2)	0	0	3.00
4.00	Medical supplies cost - pneumococcal and influenza vaccine (f	rom your records)	0	0	4.00
5.00	Direct cost of pneumococcal and influenza vaccine (line 3 plu	s line 4)	0	0	5.00
6.00	Total direct cost of the hospital-based RHC/FQHC (from Worksh	eet M-1, col. 7, line 22)	11, 783	11, 783	6.00
7.00	Total overhead (from Wkst. M-2, line 19)		17, 301	17, 301	7.00
8.00	Ratio of pneumococcal and influenza vaccine direct cost to to	tal direct cost (line 5	0.000000	0.000000	8.00
	divided by line 6)				
9.00	Overhead cost - pneumococcal and influenza vaccine (line 7 x	line 8)	0	0	9.00
10.00	00 Total pneumococcal and influenza vaccine cost and its (their) administration (sum of		0	0	10.00
	lines 5 and 9)				
11.00	Total number of pneumococcal and influenza vaccine injections	(from your records)	0	0	11.00
12.00	Cost per pneumococcal and influenza vaccine injection (line 1	0/line 11)	0.00	0. 00	12.00
13.00	Number of pneumococcal and influenza vaccine injections admin	istered to Program	0	0	13.00
	benefi ci ari es				
14.00	Program cost of pneumococcal and influenza vaccine and its (t	heir) administration	0	0	14.00
	(line 12 x line 13)				
15.00	Total cost of pneumococcal and influenza vaccine and its (the	ir) administration (sum		0	15.00
	of cols. 1 and 2, line 10) (transfer this amount to Wkst. M-3	, line 2)			
16.00	Total Program cost of pneumococcal and influenza vaccine and	its (their)		0	16. 00
	administration (sum of cols. 1 and 2, line 14) (transfer this	amount to Wkst. M-3,			
	line 21)				

Health Financial Systems	GREENE COUNTY GENER	AL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH SERVICES RENDERED TO PROGRAM BENEFICIARIE		Provider CCN: 15-1317 Component CCN: 15-8535	Peri od: From 01/01/2018 To 12/31/2018	
				5/29/2019 12:35 pm

		component con. 10 coos	10 12/01/2010	5/29/2019 12	
			RHC I		
			Par	rt B	
			mm/dd/yyyy	Amount	
			1. 00	2.00	
00 Total interim	n payments paid to hospital-based RHC/FQHC			(1.
	ents payable on individual bills, either submi	tted or to be submitted to			
	or for services rendered in the cost reporting				ή -
"NONE" or ent	1 9	perrou. It none, write			
	ely each retroactive lump sum adjustment amoun	t based on subsequent			3.
	the interim rate for the cost reporting period.				3.
		. ALSO Show date of each			
	none, write "NONE" or enter a zero. (1)				
Program to Pr	ovi der				
)1				(
)2					
3				(
4				() 3
5				() 3
Provider to P	rogram				
0				() 3
51				() 3
2				() 3
3) 3
54) 3
9 Subtotal (sum	n of lines 3.01-3.49 minus sum of lines 3.50-3.	. 98)) 3
	payments (sum of lines 1, 2, and 3.99) (trans				4
27)	7.3				
	ED BY CONTRACTOR			•	
	ely each tentative settlement payment after des	sk review. Also show date o	f		7 5
	If none, write "NONE" or enter a zero. (1)				-
Program to Pr				<u> </u>	
1					5
2					
3					5
Provider to P	rogram				1
0	. 09. a				5 5
1					
2					- 1
1	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				
	Determined net settlement amount (balance due) based on the cost report. (1)				6
	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM				
				1	- 1
00 Total Medicar	re program liability (see instructions)		0 - 1 1		7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
00 Name of Contr		0	1. 00	2. 00	-
	ractor				8.

Health Financial Systems	GREENE COUNTY GENER	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1317	Peri od: From 01/01/2018	Worksheet M-5 Date/Time Prepared:
		Component CCN: 15-8533		5/29/2019 12:35 pm

				5/29/2019 12:	35 pn
			RHC II		
				t B	
			mm/dd/yyyy	Amount	
1			1. 00	2. 00	
	Total interim payments paid to hospital-based RHC/FQHC			0	1
	Interim payments payable on individual bills, either submit			0	2.
	the contractor for services rendered in the cost reporting	period. If none, write			
	"NONE" or enter a zero				
	List separately each retroactive lump sum adjustment amount				3.
	revision of the interim rate for the cost reporting period.	Also show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
-	Program to Provider				
01				0	
02				0	1 -
03				0	1
04				0	1
05	Described to Describe			0	3.
	Provider to Program			1	
50				0	
51				0	1 -
52				0	_
53				0	
54	0.11.1.1. (2.1	00)		0	1
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.5			0	
	Total interim payments (sum of lines 1, 2, and 3.99) (trans	erer to worksneet M-3, line		0	4.
	27) TO BE COMPLETED BY CONTRACTOR				
	List separately each tentative settlement payment after des	k roviow. Also show data a	F	I	5.
	each payment. If none, write "NONE" or enter a zero. (1)	sk review. Also show date o	I] 5.
	Program to Provider				
01	Program to Provider			l 0	5.
02					
03					
	Provider to Program				1 5.
50 ľ	- Tovider to Frogram			Ιο	5.
51					
2					
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.	00)			1 -
	Determined net settlement amount (balance due) based on the cost report. (1)				6
				0	
	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM				
	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)				1 -
JU	Total wedicale program frability (see instructions)		Contractor	NPR Date	/.
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
00	Name of Contractor	U	1.00	2.00	8.
00	Name of Contractor		I	I	1 0.

Health Financial Systems	GREENE COUNTY GENE	RAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RHC/FG SERVICES RENDERED TO PROGRAM BENEFICIARIES	HC PROVIDER FOR	Provider CCN: 15-1317 Component CCN: 15-8534	Period: From 01/01/2018	Worksheet M-5 Date/Time Prepared:
		Component Con. 15-8534		5/29/2019 12: 35 pm

	Component Con. 10 Coo 1	10 12/01/2010	5/29/2019 12:	
		RHC III		
		Pai	rt B	
		mm/dd/yyyy	Amount	
		1. 00	2, 00	
OO Total interim payments paid to hospital-based	RHC/FOHC		0	1.
OO Interim payments payable on individual bills,			0	
the contractor for services rendered in the co				
"NONE" or enter a zero	set reper tring periods. The mene, will te			
O List separately each retroactive lump sum adju	istment amount based on subsequent			3
revision of the interim rate for the cost repo				ľ
payment. If none, write "NONE" or enter a zero				
Program to Provider	,. (1)			
1			0	3
2			0	
3				-
14			0	
5				-
Provider to Program				1 3
0			0	3
1				
2				
				1 ~
3				
64 Colletatal (com af linea 2 01 2 40 minus com af	1: 2 50 2 00)		-	1 ~
99 Subtotal (sum of lines 3.01-3.49 minus sum of			0	
Total interim payments (sum of lines 1, 2, and	1 3.99) (transter to worksheet M-3, line	9	0	4
27) TO BE COMPLETED BY CONTRACTOR				
	ant often deak new also show date	-£	T	۱.
List separately each tentative settlement paymeach payment. If none, write "NONE" or enter a		OF		5
Program to Provider	i zero. (i)			-
program to provider			1 0	5
			0	
2 3				
			0	1 5
Provider to Program 0			T 0	1 5
1			_	-
2 9 Subtotal (sum of lines 5.01-5.49 minus sum of	Lines F FO F OO)		0	
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	1 -
Determined net settlement amount (balance due) based on the cost report. (1)				6
SETTLEMENT TO PROVIDER			0	
2 SETTLEMENT TO PROGRAM			0	-
O Total Medicare program liability (see instruct	i ons)		0	7
		Contractor	NPR Date	
		Number	(Mo/Day/Yr)	-
	0	1. 00	2. 00	8
O Name of Contractor				