This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-1317 Worksheet S Peri od: From 01/01/2021 Parts I-III AND SETTLEMENT SUMMARY 12/31/2021 Date/Time Prepared: 5/27/2022 11:27 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/27/2022 Time: 11:27 am Manually prepared cost report use only] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status 6. Date Received: 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for this Provider CCN (3) Settled with Audit 9. [N] Final Report for this Provider CCN (10. NPR Date: 11. Contractor's Vendor Code: 4. (2. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9. Contractor use only (3) Settled with Audit number of times reopened = 0-9. (4) Reopened

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

(5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GREENE COUNTY GENERAL HOSPITAL (15-1317) for the cost reporting period beginning 01/01/2021 and ending 12/31/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

		Title	XVIII			
Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
	1. 00	2.00	3. 00	4. 00	5. 00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospi tal	0	130, 873	-411, 606	0	0	1.00
2.00 Subprovi der - IPF	0	0	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	127, 181	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
10.00 RURAL HEALTH CLINIC I	0		87, 701		0	10.00
10.01 RURAL HEALTH CLINIC II	0		96, 469		0	10. 01
10.02 RURAL HEALTH CLINIC III	0		18, 267		0	10.02
10.03 RURAL HEALTH CLINIC IV	0		31, 039		0	10.03
200. 00 Total	0	258, 054	-178, 130	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.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1317 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 11:27 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: P0 Box: 1000 1.00 Street: R. R 1 1.00 Zip Code: 47441-9457 County: GREENE 2.00 City: LINTON State: IN 2.00 Provi der Component Name CCN CBSA Date Payment System (P, T, O, or N)

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

Health Financial Systems GREENE COU HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		L HOSPITAL Provider CO	CN: 15-1317	Peri od:	In Lieu		m CMS-:	
THOSE TIME AND THOSE THE TENETH OF THE COMMERCE TO PERSON TO THE		TOVI GOT OC	JN. 10 1017	From 01/0		Part I Date/T	ime Pre 022 11:	pared:
			1.00	2	00	3.		-
23.00 Which method is used to determine Medicaid days on libelow? In column 1, enter 1 if date of admission, 2 if date of discharge. Is the method of identifying the reporting period different from the method used in the reporting period? In column 2, enter "Y" for yes or	f census one days in ne prior co	lays, or 3 this cost ost	1.00	0	00	J.	00	23. 00
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days 2.00	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid 4.00	Medicai HMO day	ys Med	other di cai d days 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 other Medicaid days in column 6. 25.00 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,	0	0	0	0		0		24.00
out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.								
					Rural S 00	Date of 2.		_
26.00 Enter your standard geographic classification (not wa		at the be	ginning of		2			26. 00
cost reporting period. Enter "1" for urban or "2" for 27.00 Enter your standard geographic classification (not wareporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status - "2" for r cation in	rural. 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	Begi n		Endi		35.00
36.00 Enter applicable beginning and ending dates of SCH st	tatus Subs	cript line	: 36 for num		00	2.	00	36.00
of periods in excess of one and enter subsequent date 37.00 If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	es.	•			0			37. 00
37.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for instructions)								37. 01
38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 00
					/N 00	Y/ 2.		-
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 (ii or "N" for no. (see instructions)	, (ii), or the mileage	(iii)? En e requireme	ter in colu nts in	ume ľ	N		V	39.00
40.00 Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	oer 1. Ente	er "Y" for			N	N	I	40.00
Prospective Payment System (PPS)-Capital	(555				V 1. 00	XVIII 2. 00	XI X 3. 00	
45.00 Does this facility qualify and receive Capital paymer	nt for disp	roporti ona	te share ir	accordance	e N	N	N	45. 00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	•		,		N	N	N	46. 00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS of the facility electing full federal capital payment	•		-		N N	N N	N N	47. 00 48. 00
Teaching Hospitals 56.00 Is this a hospital involved in training residents in "N" for no in column 1. For column 2, if the response was involved in training residents in approved GME pr year, and are you are impacted by CR 11642 (or applic	e to columr rograms in cable CRs)	n 1 is "Y", the prior	or if this year or per	s hospital nultimate				56. 00
Enter "Y" for yes; otherwise, enter "N" for no in col 1f line 56 is yes, is this the first cost reporting process. GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first monifor yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	period duri yes or "N th of this (", complet	l" for no i cost repor e Workshee	n column 1. ting period	If column ? Enter "	Y"			57.00

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter

"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

Health Financial Systems	GREENE CO	UNTY GENERAL HOSPITAL		In lie	u of Form CMS-2	2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE			CN: 15-1317 Pe	eriod: rom 01/01/2021	Worksheet S-2 Part I Date/Time Pre 5/27/2022 11:	pared:		
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
Section 5504 of the ACA Base	Voor FTF Dooldonto in M	Nannnavi dan Catti nga	1. 00	2.00	3.00			
period that begins on or aft			- IIII'S base year	rs your cost	r epor tring			
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio								
of (column 1 divided by (col	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col.			
	, and the second	3	FTEs Nonprovi der Si te	FTEs in Hospital	3/ (col. 3 + col. 4))			
	1. 00	2. 00	3. 00	4. 00	5. 00			
65.00 Enter in column 1, if line is yes, or your facility trained residents in the bas year period, the program nam 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 column 4, the number of unweighted primary care resident FTEs that trained i your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	in n		0.00	0.00	0.000000 Ratio (col.	65. 00		
			FTEs Nonprovi der Si te	FTEs in Hospital	1/ (col . 1 + col . 2))			
			1.00	2. 00	3. 00			
Section 5504 of the ACA Curr		n Nonprovider Setting	gsEffective f	or cost report	ing periods			
beginning on or after July 1 66.00 Enter in column 1 the number		ary care resident	0.00	0. 00	0. 000000	66. 00		
FTEs attributable to rotation								
Enter in column 2 the number FTEs that trained in your ho								
(column 1 divided by (column	1 + column 2)). (see ir	nstructions)						
	Program Name	Program Code	Unweighted FTEs	Unweighted FTEs in	Ratio (col. 3/ (col. 3 +			
			Nonprovi der	Hospi tal	col. 4))			
	1. 00	2.00	Si te 3. 00	4. 00	5. 00			
67.00 Enter in column 1, the progr	am	2.00	0.00	0.00		67.00		
name associated with each of your primary care programs i which you trained residents. Enter in column 2, the prograced. Enter in column 3, the number of unweighted primary care FTE residents attributato rotations occurring in al non-provider settings. Enter column 4, the number of unweighted primary care resident FTEs that trained i your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	n nam ole in n							

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1317 Peri od: Worksheet S-2 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 11:27 am 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 | Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no. If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 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) Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75 00 N 75 00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 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) 1.00 Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 80.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter Ν 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 85.00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 $\S413.40(f)(1)(ii)$? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section Ν 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1. 00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for 90 00 Ν yes or "N" for no in the applicable column. 91.00 is this hospital reimbursed for title V and/or XIX through the cost report either in Ν Υ 91.00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. 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. Ν 92.00 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. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the 94.00 Ν Ν applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν N 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 0.00 0.00 97.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post Ν 98.00 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. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 Ν C,Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V,and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 N 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. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) 98.03 Ν 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. 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 98.04 N N 98.04 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on 98.05 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. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Ν Υ 98.06 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. Rural Providers 105.00 Does this hospital qualify as a CAH? 105 00 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) N 107.00 Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)

Health Financial Systems GREENE COUNTY GENE	ERAL HOSPITAL		In Lie	u of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CC		eriod: rom 01/01/2021	Worksheet S Part I Date/Time P	-2 repared:
			V	5/27/2022 1 XI X	1: 27 am
108.00 s this a rural hospital qualifying for an exception to the	CDNA foo scho	dul o2 Soo 42	1. 00 Y	2.00	108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA LEE SCHE		Y		108.00
	Physi cal 1.00	Occupational 2.00	Speech 3. 00	Respiratory 4.00	У
109.00 If 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 N	N N	109.00
		1.00			
110.00 Did this hospital participate in the Rural Community Hospital Demonstration) for the current cost reporting period? Enter "complete Worksheet E, Part A, lines 200 through 218, and Worksheet E. Part A, lines 218, and Worksheet E. Part A, lines 218, and lines	N	110.00			
			1. 00	2. 00	
111.00 of this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this compared for yes or "N" for no in column 1. If the response to compared integration prong of the FCHIP demoin which this CAH is participated all that apply: "A" for Ambulance services; "B" for additional for tele-health services.	N		111.00		
		1. 00	2. 00	3.00	
112.00 Did this hospital participate in the Pennsylvania Rural Heal demonstration for any portion of the current cost reporting Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital cear participation in the demonstration, if applicable.	peri od? "Y", enter e	N	2.33	0.00	112.00
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no	N			0115.00
in column 1. If column 1 is yes, enter the method used (A, B in column 2. If column 2 is "E", enter in column 3 either "9 for short term hospital or "98" percent for long term care (psychiatric, rehabilitation and long term hospitals provider the definition in CMS Pub. 15-1, chapter 22, §2208.1.	3" percent includes				
116.00 Is this facility classified as a referral center? Enter "Y"	for yes or	N			116. 00
"N" for no. 117.00 s this facility legally-required to carry malpractice insur-	ance? Enter	Y			117. 00
"Y" for yes or "N" for no. 118.00 s the malpractice insurance a claims-made or occurrence pol	icy? Enter 1	 1			118. 00
if the policy is claim-made. Enter 2 if the policy is occurr	ence.	Premi ums	Losses	Insurance	
		T T OIII GIIIS	203303	Trisur direc	
110 011 int annual of naturality and anid to annual animal and animal and animal and animal an		1.00	2.00	3.00	0110 01
118.01 List amounts of malpractice premiums and paid losses:		369, 560)	0118.01
118.02 Are mal practice premiums and paid losses reported in a cost	contor other	than the	1. 00 N	2.00	118. 02
Administrative and General? If yes, submit supporting schedland amounts contained therein. 119.00 D0 NOT USE THIS LINE			, iv		119.00
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y alifies for t	" for yes or he Outpatient	N	N	120. 00
121.00 Did this facility incur and report costs for high cost impla	ntable device	s charged to	Y		121. 00
patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.	N		122. 00		
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo	N		125. 00		
yes, enter certification date(s) (mm/dd/yyyy) below.	14				
126.00 f this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2			126. 00		
127.00 If this is a Medicare certified heart transplant center, enting in column 1 and termination date, if applicable, in column 2		ication date			127. 00
128.00 If this is a Medicare certified liver transplant center, ent	er the certif	cation date			128. 00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, ente		cation date in			129. 00
column 1 and termination date, if applicable, in column 2.					

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPL	GREENE COUNTY G EX IDENTIFICATION DATA	Provi der CC	N: 15-1317	Peri od:	:	u of Form CMS Worksheet S	5-2		
				From O	1/01/2021 2/31/2021	Part I Date/Time P 5/27/2022 1	repare		
					1. 00	2. 00	_		
0.00 f this is a Medicare certified p	pancreas transplant center	, enter the cer	ti fi cati on		1.00	2.00	130.		
date in column 1 and termination 1.00 f this is a Medicare certified i			orti fi cati o				131.		
date in column 1 and termination			ertification	"			131.		
2.00 If this is a Medicare certified i			ication date	e			132.		
in column 1 and termination date, 3.00Removed and reserved	if applicable, in column	1 2.					133		
134.00 If this is an organ procurement organization (0P0), enter the 0P0 number in column 1 and termination date, if applicable, in column 2. All Providers									
D. 00 Are there any related organizatio					N		140		
chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th				ts					
1.00		00	trons)		3. 00				
If this facility is part of a cha			ugh 143 the	name an	nd address	of the home	:		
office and enter the home office	Contractor name and contractor's Name:	ractor number.	Contrac	tor's Nu	ımher:		141		
2.00Street:	PO Box:		Contrac	tor 3 Nu	iiiibCi .		142		
3. 00 Ci ty:	State:		Zi p Cod	e:			143		
						1.00			
. 00 Are provider based physicians' co	osts included in Worksheet	: A?				Y Y	144		
i.00 f costs for renal services are c	claimed on Wkst A line 7	M are the cost	s for		1. 00	2. 00	145		
inpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N"	(" for yes or "N" for no i nclude Medicare utilizatio	n column 1. If	column 1 is				140		
.00 Has the cost allocation methodolo	ay changed from the provi	ously filed cos	t report?	1	N		146		
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Pub.		40, §4020)	lf	IV .				
Enter "Y" for yes or "N" for no i	n column 1. (See CMS Pub.		40, §4020)	lf	N .	1.00			
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00Was there a change in the statist	n column 1. (See CMS Pub. /dd/yyyy) in column 2. :ical basis? Enter "Y" for	15-2, chapter	no.	lf	IV	N			
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist 3.00 Was there a change in the order of	n column 1. (See CMS Pub. /dd/yyyy) in column 2. ical basis? Enter "Y" for of allocation? Enter "Y" f	15-2, chapter of the state of t	no. or no.		IV	N N	147		
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Pub. /dd/yyyy) in column 2. ical basis? Enter "Y" for of allocation? Enter "Y" f	15-2, chapter yes or "N" for or yes or "N" for Enter "Y" for ye	no. or no. es or "N" fo	or no.		N N N	148 149		
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/	n column 1. (See CMS Pub. /dd/yyyy) in column 2. cical basis? Enter "Y" for of allocation? Enter "Y" for ied cost finding method?	yes or "N" for yes or	no. or no. es or "N" fo Part B 2.00	or no.	itle V 3.00	N N N Title XIX 4.00	148 149		
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/2000) was there a change in the statist 0.00 Was there a change in the order of 0.00 Was there a change to the simplification.	n column 1. (See CMS Pub. /dd/yyyy) in column 2. cical basis? Enter "Y" for allocation? Enter "Y" fied cost finding method?	yes or "N" for yes or "N" for yes or "N" for ye Fart A 1.00 an exemption fro	no. or no. es or "N" fo Part B 2.00 m the appli	or no.	itle V 3.00 of the low	N N Title XIX 4.00 er of costs	148 149		
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/2000). .00 Was there a change in the statist complete the control of the statist complete the statist complet	n column 1. (See CMS Pub. /dd/yyyy) in column 2. cical basis? Enter "Y" for allocation? Enter "Y" fied cost finding method?	yes or "N" for yes or "N" for yes or "N" for ye Fart A 1.00 an exemption fro	no. or no. es or "N" fo Part B 2.00 m the appli	or no.	itle V 3.00 of the low	N N Title XIX 4.00 er of costs	148		
Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ .00 Was there a change in the statist .00 Was there a change in the order of .00 Was there a change to the simplif Does this facility contain a provor charges? Enter "Y" for yes or .00 Hospital .00 Subprovider - IPF	n column 1. (See CMS Pub. /dd/yyyy) in column 2. cical basis? Enter "Y" for allocation? Enter "Y" fied cost finding method?	yes or "N" for yes or "N" for yes or "N" for ye Part A 1.00 an exemption fro	no. or no. es or "N" fo Part B 2.00 m the appli and Part B	or no.	itle V 3.00 of the low 12 CFR §41	N N Title XIX 4.00 er of costs 3.13)	148 149 155 156		
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Enter "Y" for yes or "N" for no i yes, enter the approval date (mm/ 7.00 Was there a change in the statist is 0.00 Was there a change in the order of 0.00 Was there a change to the simplify Does this facility contain a provor charges? Enter "Y" for yes or 0.00 Hospital is 0.00 Subprovider - IPF 1.00 Subprovider - IRF 1.00 SUBPROVIDER	n column 1. (See CMS Pub. /dd/yyyy) in column 2. cical basis? Enter "Y" for allocation? Enter "Y" fied cost finding method?	yes or "N" for yes or "N" N"	no. or no. es or "N" fo Part B 2.00 m the appli and Part B N N	or no.	itle V 3.00 of the low 12 CFR §41 N N	N N N Title XIX 4.00 er of costs 3.13) N N	148 149 155 156 157 158		
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Health Financial Systems	GREENE COUNTY GENE	In Lieu of Form CMS-2552			
HOSPITAL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DATA	Peri od: From 01/01/2021	Worksheet S-2 Part I	2	
			To 12/31/2021	Date/Time Pre 5/27/2022 11:	epared: 27 am
			Begi nni ng	Endi ng	
			1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)			170. 00		
			1. 00	2. 00	
171.00 If line 167 is "Y", does this pr section 1876 Medicare cost plans "Y" for yes and "N" for no in co 1876 Medicare days in column 2.	N on	(171.00		

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 01/01/2021 To 12/31/2021	Worksheet S-2 Part II	epared:
				Y/N	Date 11.	Z/ dill
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	esponses. Ent	er all dates in	the	
1. 00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	N		1.00		
1.00	reporting period? If yes, enter the date of the change in					1.00
			Y/N	Date	V/I	
0.00	II		1.00	2. 00	3. 00	0.00
2. 00	Has the provider terminated participation in the Medicare yes, enter in column 2 the date of termination and in colu voluntary or "I" for involuntary.	mn 3, "V" for	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 proviofficers, 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	
	Et		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		4.00
	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.	for Compiled, ailable in		A		
5. 00	Are the cost report total expenses and total revenues diff		N			5. 00
	those on the filed financial statements? If yes, submit re	conciliation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
6. 00	Column 1: Are costs claimed for a nursing program? Column is the legal operator of the program?	2: If yes, is	s the provide	r N		6.00
7. 00	Are costs claimed for Allied Health Programs? If "Y" see i			N		7.00
8. 00	Were nursing programs and/or allied health programs approved to reporting period? If yes, see instructions.		-			8.00
9. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instructio		cal education	N		9. 00
10. 00	Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.	or renewed in	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	
	Bad Debts				1.00	
12. 00		s, see instruc	ti ons.		Υ	12.00
13. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N	13. 00
14. 00	1.	ents waived? I	f yes, see in	structions.	N	14. 00
15. 00	Did total beds available change from the prior cost report				N-t B	15.00
		Y/N	t A 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?	Υ	03/31/2022	Y	03/31/2022	16.00
16.00	If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	'	03/31/2022	1	03/31/2022	16.00
17. 00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N		17. 00
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	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

Heal th	Financial Systems GREENE COUNTY GE	ENERAL HOSPITAL	_	In Lie	u of Form CM	IS-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-1317	Peri od: From 01/01/2021 To 12/31/2021	Worksheet S Part II Date/Time F 5/27/2022	Prepared:
			i pti on	Y/N	Y/N	
20. 22	161: 1/ 17:		0	1.00	3.00	00.05
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	EPT CHILDRENS	HOSPI TALS)		1.00	
	Capital Related Cost					
22. 00	Have assets been relifed for Medicare purposes? If yes, se				N	22. 00
23.00	Have changes occurred in the Medicare depreciation expense	due to apprai	sals made du	ing the cost	N	23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	rea into auring	this cost re	eporting perioa?	N	24.00
25. 00	Have there been new capitalized Leases entered into during	the cost reno	rting period	2 If ves see	N	25. 00
20.00	instructions.	, 110 0031 1 epo	g period	yes, see	'*	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period?	f yes, see	N	26. 00
	instructions.	·	0 .			
27.00	Has the provider's capitalization policy changed during th	ne cost reporti	ng period? I	ges, submit	N	27. 00
	copy.					
20.00	Interest Expense				N.	
28. 00	Were new Loans, mortgage agreements or Letters of credit e period? If yes, see instructions.	enterea into au	ring the cos	reporting	N	28. 00
29. 00	Did the provider have a funded depreciation account and/or	hond funds (D	eht Service I	Reserve Fund)	Y	29. 00
27.00	treated as a funded depreciation account? If yes, see inst		CDL SCIVICE I	(caci ve Tuliu)	'	27.00
30.00	Has existing debt been replaced prior to its scheduled mat		debt? If yes	s, see	N	30.00
	i nstructi ons.	,	,			
31.00	Has debt been recalled before scheduled maturity without i	ssuance of new	debt? If yes	s, see	N	31.00
	instructions.					
22 00	Purchased Services	rui coc furni ch	od through o	ntractual	N	22.00
32. 00	Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ea through co	ontractual	IN IN	32.00
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 ap		na to competi	tive bidding? If	N	33.00
	no, see instructions.	p p				
	Provi der-Based Physi ci ans					
34.00	Are services furnished at the provider facility under an a	rrangement wit	h provider-ba	ased physicians?	Υ	34.00
	If yes, see instructions.					
35. 00	If line 34 is yes, were there new agreements or amended ex		nts with the	provi der-based	N	35. 00
	physicians during the cost reporting period? If yes, see i	nstructions.		Y/N	Doto	
				1.00	2. 00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office			37.00
	If yes, see instructions.					
38. 00	If line 36 is yes , was the fiscal year end of the home of			N		38. 00
00.00	the provider? If yes, enter in column 2 the fiscal year en					00.05
39. 00	If line 36 is yes, did the provider render services to oth	ier cnain compo	nents? If yes	s, N		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	home office?	If was soo	N		40.00
4 0.00	instructions.	, nome office!	11 yes, see	IN		70.00
		1.	00	2.	00	
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position	KERRY		BEJARANO		41.00
	held by the cost report preparer in columns 1, 2, and 3,					
42.00	respectively.	BKU IID				42.00
42. 00	Enter the employer/company name of the cost report preparer.	BKD, LLP				42.00
43.00	Enter the telephone number and email address of the cost	3173834000		KBEJARANO@BKD.	COM	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th	Financial Systems GREENE COUNTY	GENI	ERAL HOSPITAL	In Lieu	n Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provider CCN: 15-1317	Fr	eriod: com 01/01/2021	Worksheet S-2 Part II	
				To	12/31/2021	Date/Time Pre 5/27/2022 11:	pared: 27 am
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position		I RECTOR				41.00
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report						42.00
	preparer.						
43.00	Enter the telephone number and email address of the cost						43.00
	report preparer in columns 1 and 2, respectively.						

| Period: | Worksheet S-3 | From 01/01/2021 | Part | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems GREENE COUNTY GENERAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC Provider CCN: 15-1317

						То	12/31/2021	Date/Time Pre 5/27/2022 11:	
								I/P Days /	27 (3.11)
								0/P Visits /	
								Tri ps	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	
	•	Line Number 1.00		2. 00	Available 3.00		4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		2.00		0	47, 952. 00	5.00	1.00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		20	7,30	U	47, 732.00	0	1.00
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2.00
3.00	HMO IPF Subprovider								3.00
4.00	HMO IRF Subprovider								4.00
5.00	Hospital Adults & Peds. Swing Bed SNF							0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF				7 00	_	47 050 00	0	
7. 00	Total Adults and Peds. (exclude observation			20	7, 30	O	47, 952. 00	0	7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	31. 00		5	1, 82	5	6, 312. 00	0	8.00
9. 00	CORONARY CARE UNIT	31.00		5	1, 02	5	0, 312.00	U	9.00
10.00	BURN INTENSIVE CARE UNIT								10.00
11. 00	SURGICAL INTENSIVE CARE UNIT								11.00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13.00	NURSERY	43.00						0	13.00
14.00	Total (see instructions)			25	9, 12	5	54, 264. 00	0	14.00
15.00	CAH visits							0	15. 00
16.00	SUBPROVIDER - IPF								16. 00
17. 00	SUBPROVI DER - I RF								17.00
18.00	SUBPROVI DER								18.00
19. 00 20. 00	SKILLED NURSING FACILITY								19. 00 20. 00
21.00	NURSING FACILITY OTHER LONG TERM CARE								20.00
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	RURAL HEALTH CLINIC	88. 00						0	26. 00
26. 01	RURAL HEALTH CLINIC II	88. 01						0	26. 01
26. 02	RURAL HEALTH CLINIC III	88. 02						0	
26. 03	RURAL HEALTH CLINIC IV	88. 03						0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		0.5				0	26. 25
27. 00	Total (sum of lines 14-26)			25				0	27.00
28. 00 29. 00	Observation Bed Days Ambulance Trips							U	28. 00 29. 00
30.00	Employee discount days (see instruction)								30.00
31. 00	Employee discount days (see Fristraction)								31.00
32.00	Labor & delivery days (see instructions)			0		0			32.00
32. 01	Total ancillary labor & delivery room			_					32. 01
	outpatient days (see instructions)								
33.00	LTCH non-covered days								33. 00
33. 01	LTCH site neutral days and discharges								33. 01

Provider CCN: 15-1317

Peri od: Worksheet S-3
From 01/01/2021 Part I
To 12/31/2021 Date/Time Prepared: 5/27/2022 11: 27 am

						5/27/2022 11:	27 am
		I/P Days	/ O/P Visits	/ Tri ps	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns		
				Pati ents	& Residents	Payrol I	
	I	6. 00	7. 00	8.00	9. 00	10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 030	33	1, 987			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)	120	0				2 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider	130	0				2.00 3.00
4. 00	•		0				4.00
5. 00	HMO I RF Subprovi der	306	0				5.00
6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF	300	0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 336	33				7.00
7.00	beds) (see instructions)	1, 330	33	2,372			7.00
8. 00	INTENSIVE CARE UNIT	156	5	263			8.00
9. 00	CORONARY CARE UNIT	130	3	203			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		6	120			13.00
14. 00	Total (see instructions)	1, 492	44			313. 56	
15. 00	CAH visits	0	0	0	0.00		15.00
16. 00	SUBPROVIDER - I PF		_	_			16.00
17. 00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	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)			0			24. 10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC	3, 444	571			l e	
26. 01	RURAL HEALTH CLINIC II	1, 228	92		0. 00	l e	26. 01
26. 02	RURAL HEALTH CLINIC III	334	20			8. 00	1
26. 03	RURAL HEALTH CLINIC IV	558	77			l e	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		l e	ł
27. 00	Total (sum of lines 14-26)				0. 00	368. 20	1
28. 00	Observation Bed Days	_	93	1, 035			28. 00
29. 00	Ambul ance Tri ps	0		_			29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF		0.5	0			31.00
32.00	Labor & delivery days (see instructions)	0	35				32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0		I	l	I	33. 01

| Peri od: | Worksheet S-3 | From 01/01/2021 | Part | To 12/31/2021 | Date/Time Prepared: Provider CCN: 15-1317

				T	o 12/31/2021	Date/Time Pre 5/27/2022 11:	
		Full Time		Di sch	arges	0/2//2022 11.	27 am
		Equi val ents			3		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and			0 308	54	786	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)						0.00
2.00	HMO and other (see instructions)			33	0		2. 00 3. 00
3.00	HMO IPF Subprovi der				0		4. 00
4. 00 5. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF				U		5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						6. 00
7. 00	Total Adults and Peds. (exclude observation						7. 00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00		0 308	54	786	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 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						23. 00 24. 00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 01	RURAL HEALTH CLINIC II	0.00					26. 01
26. 02	RURAL HEALTH CLINIC III	0.00					26. 02
26. 03	RURAL HEALTH CLINIC IV	0.00					26. 03
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26. 25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
00.05	outpatient days (see instructions)			_			00.00
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33. 01

ו ואכע			ENERAL HOSPITAL		Peri od:		2552-
	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	UN: 15-131/	Period: From 01/01/2021	Worksheet S-	3
			Component	CCN: 15-8535	To 12/31/2021		
						5/27/2022 11:	27 ar
					RHC I		1
					1.	00	-
	Clinic Address and Identification				1.	00	
00	Street				1210 N. 1000 W.		1.
-			Ci	ty	State	ZIP Code	1
				00	2.00	3. 00	
00	City, State, ZIP Code, County		LINTON		IN	47441	2.
						1.00	
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for rur	al or "U" for			(3.
					nt Award	Date	
	Source of Federal Funds				1. 00	2. 00	
00	Community Health Center (Section 330(d), PHS	Ac+)					4.
00	Migrant Health Center (Section 329(d), PHS A						5.
00	Health Services for the Homeless (Section 34)						6.
00	Appal achi an Regional Commission	S(a), THO ACT)					7.
00	Look-Alikes						8.
00	OTHER (SPECIFY)						9.
				'			
					1. 00	2. 00	
00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for	N	(10.
	yes or "N" for no in column 1. If yes, indica						
	2. (Enter in subscripts of line 11 the type of	f other operat	ion(s) and the	operati ng			
	hours.)						_
			nday L +a		onday	Tuesday from	+
		1.00	2. 00	from 3.00	4. 00	5. 00	+
	Facility hours of operations (1)	1.00	2.00	3.00	4.00	J. 00	
00	CLINIC						11.
			1				
					1. 00	2. 00	
00	Have you received an approval for an exception	on to the prod	lucti vi ty stand	ard?	1. 00 Y	2. 00	12.
. 00	Is this a consolidated cost report as define	d in CMS Pub.	100-04, chapte	r 9, section			
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y		
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y		
	Is this a consolidated cost report as defined 30.8? Enter "Y" for yes or "N" for no in colu	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	Y N	C	
	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	Y N der name	CCN number	
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the ders and	Y N	C	13.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu	r 9, section mn 2 the ders and Provi	Y N der name 1.00	CCN number	13.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu es of all provi	r 9, section mn 2 the ders and	Y N der name	CCN number	13.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu es of all provi	r 9, section nn 2 the ders and Provi	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu es of all provi	r 9, section nn 2 the ders and Provi	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu es of all provi	r 9, section nn 2 the ders and Provi	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu es of all provi	r 9, section nn 2 the ders and Provi	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu es of all provi	r 9, section nn 2 the ders and Provi	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu es of all provi	r 9, section nn 2 the ders and Provi	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colu es of all provi	r 9, section nn 2 the ders and Provi	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colues of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colurs of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. umn 1. If yes, List the name	100-04, chapte enter in colurs of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00	Y N der name 1.00	CCN number 2.00 Total Visits	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider.	d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	100-04, chapte enter in colurs of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00 nty 00	der name 1.00 XIX 4.00	CCN number 2.00 Total Visits 5.00	14.
00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	100-04, chapte enter in colusts of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00 nty 00 esday	der name 1.00 XIX 4.00	CCN number 2.00 Total Visits 5.00	14.
. 00	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in columber of providers included in this report. numbers below. RHC/FQHC name, CCN number Have you provided all or substantially all GME cost? Enter "Y" for yes or "N" for no in column 1. If yes, enter in columns 2, 3 and 4 the number of program visits performed by Intern & Residents for titles V, XVIII, and XIX, as applicable. Enter in column 5 the number of total visits for this provider. (see instructions)	d in CMS Pub. umn 1. If yes, List the name Y/N 1.00	100-04, chapte enter in colurs of all provi	r 9, section mn 2 the ders and Provi XVIII 3.00 nty 00	der name 1.00 XIX 4.00	CCN number 2.00 Total Visits 5.00	12. 13.

Health Financial Systems GF	REENE COUNTY GEI	NERAL HOSPITAL	=	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1317	Peri od:	Worksheet S-8	i
				From 01/01/2021		
		Component	CCN: 15-8535	To 12/31/2021	Date/Time Pre 5/27/2022 11:	
				RHC I		
	Frid	day	Sa	turday		
	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
11. 00 CLINIC						11.00

ealth Financial Systems		ENE COUNTY GE	NERAL HOSPITAL			u of Form CMS-	
OSPITAL-BASED RHC/FQHC STATISTICA	L DATA			CN: 15-1317	Period: From 01/01/2021	Worksheet S-8	
			Component	CCN: 15-8533	To 12/31/2021	Date/Time Pre 5/27/2022 11:	
					RHC II	3/2//2022 11.	27 GI
					1.	00	
Clinic Address and Identific	cation				N WD05 0T		
00 Street			Ci	+>/	55 N. JUDGE ST	ZIP Code	1.
				00	State 2.00	3. 00	
00 City, State, ZIP Code, Count	tv		BLOOMFIELD '.	00		47424	2.
oo jorty, state, zir soae, soan	<u> </u>		DECOMI TEED			17 12 1	
						1.00	
00 HOSPITAL-BASED FQHCs ONLY: [Designation - Ente	r "R" for rur	al or "U" for			0	3.
					nt Award	Date	
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OO Community Health Center (Section 1) Community Health Center (Section 2)							4. 5.
00 Health Services for the Home							6.
OO Appal achi an Regional Commiss	•	(u), This Act)					7.
00 Look-Alikes	31 011						8.
00 OTHER (SPECIFY)							9.
				1			
					1. 00	2. 00	
.00 Does this facility operate a yes or "N" for no in column 2. (Enter in subscripts of li	1. If yes, indica	te number of	other operatio	ns in column		0	10.
hours.)		Cum	,day,	1	landay	Tuesday	
		from	iday To	from	londay to	from	+
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		·			1.00	2. 00	
.00 Have you received an approva .00 Is this a consolidated cost .30.8? Enter "Y" for yes or ' number of providers included	report as defined "N" for no in colu	in CMS Pub. mn 1. If yes,	100-04, chapte enter in colu	r 9, section mn 2 the	Y N	O	12. 13.
numbers below.	_		,	Drov	der name	CCN number	
				PIOV	1. 00	2. 00	
. 00 RHC/FQHC name, CCN number					1. 00	2.00	14.
		Y/N	V	XVIII	XIX	Total Visits	
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.00 Have you provided all or sub GME cost? Enter "Y" for yes column 1. If yes, enter in o	or "N" for no in columns 2, 3 and its performed by						15.
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Health Financial Systems GF	REENE COUNTY GEI	NERAL HOSPITAL	=	In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1317	Peri od:	Worksheet S-8	
			0011 45 0500	From 01/01/2021	D . (T) D	
		Component	CCN: 15-8533	To 12/31/2021	Date/Time Pre 5/27/2022 11:	
			_	RHC II		
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	from	to	from	to		
	11. 00	12. 00	13. 00	14. 00		
Facility hours of operations (1)						
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City State ZIP Code 2.00 City, State ZIP Code 3.00 2.00 3.00 2.00 3.00	Heal th	Financial Systems GR	REENE COUNTY GE	NERAL HOSPITAL		In Li	eu of Form CMS	-2552-10
Component COL: 15-8534 To 12/31/2021 Date/Time Preparation S727/2022 17:27 am S1101 Address and Identification	HOSPI T	AL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1317			8
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1.00				'				
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9.00 OTHER (SPECIFY) 1.00 2.00 1.00 1.00 2.00 1.0								8.00
10.00 Does this facility operate as other than a hospital –based RHC or FOHC? Enter "" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operations) and the operating hours.) Sunday								9.00
10.00 Does this facility operate as other than a hospital –based RHC or FOHC? Enter "" for yes or "N" for no in column 1. If yes, indicate number of other operations in column 2. (Enter in subscripts of line 11 the type of other operations) and the operating hours.) Sunday								
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2 (Enter in subscripts of line 11 the type of other operation(s) and the operating hours.) Sunday	10. 00					N		0 10.00
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1.00 2.00 12.00 13.00 15 this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 30.8? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN number 1.00 2.00	44 00							44.00
12.00 Have you received an approval for an exception to the productivity standard? 13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 3.08? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN number 1.00 2.00	11.00	CLINI _C						11.00
12.00 Have you received an approval for an exception to the productivity standard? 13.00 Is this a consolidated cost report as defined in CMS Pub. 100-04, chapter 9, section 3.08? Enter "Y" for yes or "N" for no in column 1. If yes, enter in column 2 the number of providers included in this report. List the names of all providers and numbers below. Provider name CCN number 1.00 2.00						1 00	2 00	
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14.00 RHC/FQHC name, CCN number								
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	44 00							11.00

Health Financial Systems GF	REENE COUNTY GEI	NERAL HOSPITAL		In Lieu of Form CMS		2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der Co	Provider CCN: 15-1317		Worksheet S-8	
				From 01/01/2021		
		Component	CCN: 15-8534	To 12/31/2021		
					5/27/2022 11:	27 am
				RHC III		
	Frid	day	Sa ⁻	turday		
	from	to	from	to		
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OSPI T		CLLINE COUNTY GE	NERAL HOSPITAL			u of Form CMS-	
	TAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C	CN: 15-1317	Peri od: From 01/01/2021	Worksheet S-8	3
			Component	CCN: 15-8538	To 12/31/2021	Date/Time Pre	epare
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00	City, State, ZIP Code, County		WORTHI NGTON	00		47471	2.
-	jointy, otato, 211 odao, odanty		inorcini ito roit			.,.,	
						1. 00	
00	HOSPITAL-BASED FQHCs ONLY: Designation - Ent	er "R" for run	al or "U" for	urban		0	3.
				Gran	nt Award	Date	
					1. 00	2. 00	
	Source of Federal Funds			1			
00	Community Health Center (Section 330(d), PHS					I	4.
00	Migrant Health Center (Section 329(d), PHS A					I	5.
00	Health Services for the Homeless (Section 34	u(a), PHS Act)				I	6.
00	Appal achi an Regional Commission					I	7.
00 00	Look-Alikes OTHER (SPECIFY)					l	8.
00	OTHER (SPECIFY)						9.
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. 00	Does this facility operate as other than a h	ospi tal -based	RHC or FQHC? E	nter "Y" for	N N	0	10.
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	hours.)						
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	Facility have af anomaticae (1)	1. 00	2. 00	3. 00	4. 00	5. 00	-
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	Have you received an approval for an excepti	on to the prod	uctivity stand	ard?	Y		
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	Is this a consolidated cost report as define 30.8? Enter "Y" for yes or "N" for no in col number of providers included in this report.	ed in CMS Pub. umn 1. If yes,	100-04, chapte enter in colu	mn 2 the	N	0	
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Health Financial Systems GF	REENE COUNTY GEN	ERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL-BASED RHC/FQHC STATISTICAL DATA		Provi der C		Peri od:	Worksheet S-8	
				From 01/01/2021		
		Component	CCN: 15-8538	To 12/31/2021		
		· ·			5/27/2022 11:	27 am
				RHC IV		
	Fri d	ay	Sa ⁻	turday		
	from	to	from	to		
	11. 00	12. 00	13.00	14.00		
Facility hours of operations (1)						
11. 00 CLINIC						11.00

Heal th	Financial Systems	GREENE COUNTY GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10	
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der CC		Peri od:	Worksheet S-1		
					From 01/01/2021 To 12/31/2021	Date/Time Pre	narod:	
					10 12/31/2021	5/27/2022 11:		
						1. 00		
	Uncompensated and indigent care cost comput	ation				1.00		
1.00	Cost to charge ratio (Worksheet C, Part I I		vided by li	ne 202 colum	า 8)	0. 329154	1.00	
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid	M I' IO				3, 047, 678 Y	2. 00 3. 00	
3. 00 4. 00								
5. 00	If line 4 is no, then enter DSH and/or supp				11 U ?	N 599, 048	4. 00 5. 00	
6. 00	Medicaid charges	oremental payments i	Tolli Mcarcar	u		34, 179, 405	6. 00	
7. 00	Medicaid cost (line 1 times line 6)					11, 250, 288	7. 00	
8.00	Difference between net revenue and costs fo	or Medicaid program	(line 7 min	us sum of li	nes 2 and 5; if	7, 603, 562	8.00	
	< zero then enter zero)							
	Children's Health Insurance Program (CHIP)	(see instructions f	for each lin	e)				
9.00	Net revenue from stand-alone CHIP					0	9.00	
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10	1)				0	10. 00 11. 00	
12.00	Difference between net revenue and costs fo		(line 11 mi	nus line 0	f / zero then	0	12.00	
12.00	enter zero)	or Stand arone chiri	(11116 11 1111	nus i i ne 7,	1 \ Zero then	J	12.00	
	Other state or local government indigent ca	re program (see ins	tructions f	or each line				
13.00	Net revenue from state or local indigent ca					0	13.00	
14.00	Charges for patients covered under state or	local indigent car	re program (Not included	in lines 6 or	0	14.00	
	10)					_		
15.00	State or local indigent care program cost (0	15.00	
16. 00	Difference between net revenue and costs fo 13; if < zero then enter zero)	or state or rocal in	idigent care	program (II	ie is minus iine	0	16. 00	
	Grants, donations and total unreimbursed co	st for Medicaid CH	IIP and state	e/Local indi	ment care progra	ıms (see		
	instructions for each line)				, o			
	Private grants, donations, or endowment inc					0	17. 00	
18.00	Government grants, appropriations or transf				o (oum of lines	7 (02 5(2)	18.00	
19. 00	Total unreimbursed cost for Medicaid, CHIP 8, 12 and 16)	and State and roca	ii illui gelit	care program:	s (Suii Oi TTHES	7, 603, 562	19. 00	
				Uni nsured	Insured	Total (col. 1		
			-	patients 1.00	pati ents 2.00	+ col . 2) 3.00		
	Uncompensated Care (see instructions for ea	ch line)		1.00	2.00	3.00		
20.00	Charity care charges and uninsured discount		ncility	221, 97	9 0	221, 979	20.00	
	(see instructions)		,					
21. 00	Cost of patients approved for charity care	and uninsured disco	ounts (see	73, 06	5 0	73, 065	21.00	
22. 00	<pre>instructions) Payments received from patients for amounts</pre>	nroviously writton	off ac		0 0	0	22. 00	
22.00	charity care	s previously writter	I UII as		0	U	22.00	
23.00	Cost of charity care (line 21 minus line 22	2)		73, 06	5 0	73, 065	23.00	
0.4.00	I December 20 and 10 an	La characte Constitution			. 6 . 1 11 1	1. 00	04.00	
24.00	Does the amount on line 20 column 2, includ imposed on patients covered by Medicaid or			ond a Length	or stay limit	N	24. 00	
25. 00	If line 24 is yes, enter the charges for pa			care progra	n's length of	0	25. 00	
	stay limit							
26. 00	Total bad debt expense for the entire hospi		,			6, 725, 052		
27. 00	Medicare reimbursable bad debts for the ent		•			707, 478		
27. 01 28. 00	Medicare allowable bad debts for the entire Non-Medicare bad debt expense (see instruct		see instruc	LI ONS)		1, 088, 428 5, 636, 624		
29.00	Cost of non-Medicare and non-reimbursable M		nense (see	i nstructi ons	1	5, 636, 624 2, 236, 267	28.00	
	Cost of uncompensated care (line 23 column		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	5	•	2, 309, 332		
	Total unreimbursed and uncompensated care c		ine 30)			9, 912, 894		
	•	•	•					

Heal th	Health Financial Systems GREENE COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552-10								
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co		eri od:	Worksheet A			
				F	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/27/2022 11:			
	Cost Center Description	Sal ari es	0ther	,	Recl assi fi cat	Recl assi fi ed			
				+ col. 2)	ions (See	Trial Balance			
					A-6)	(col. 3 +-			
						col. 4)			
		1. 00	2. 00	3. 00	4. 00	5. 00			
	GENERAL SERVICE COST CENTERS								
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 225, 913	1, 225, 913	66, 539	1, 292, 452	1.00		
2.00	00200 CAP REL COSTS-MVBLE EQUIP		634, 533	634, 533	0	634, 533	2.00		
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 508, 445	4, 508, 445	83, 669	4, 592, 114	4.00		
5.00	00500 ADMINISTRATIVE & GENERAL	2, 518, 258	6, 752, 642	9, 270, 900		9, 715, 502	5.00		
7. 00	00700 OPERATION OF PLANT	692, 226	1, 041, 009		0	1, 733, 235	7. 00		
8.00	00800 LAUNDRY & LINEN SERVICE	0	266	266	205, 187	205, 453	8. 00		
9. 00	00900 HOUSEKEEPI NG	318, 364	338, 310		-205, 187	451, 487	9. 00		
10.00	01000 DI ETARY	630, 111	389, 629	1, 019, 740	-829, 456	190, 284	10.00		
11. 00	01100 CAFETERI A	030, 111	0 0	1,017,740	829, 456	829, 456	11. 00		
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 043, 241	193, 422		-308, 119	928, 544	13.00		
14. 00	01400 CENTRAL SERVICES & SUPPLY	1,043,241	45, 673	45, 673	-308, 119	45, 673	14.00		
15. 00	01500 PHARMACY	424 972	100, 751		0	· ·	15. 00		
		626, 872		727, 623	0	727, 623			
16.00	01600 MEDICAL RECORDS & LIBRARY	264, 376	35, 083			299, 459	16.00		
17.00	01700 SOCI AL SERVI CE	250, 953	20, 268		0	271, 221	17.00		
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	509, 479	509, 479	19. 00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000 ADULTS & PEDI ATRI CS	2, 512, 135	302, 599		671, 883	3, 486, 617	30. 00		
31. 00	03100 INTENSIVE CARE UNIT	569, 813	49, 864		0	619, 677	31.00		
43.00	04300 NURSERY	0	4, 840	4, 840	48, 780	53, 620	43.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	550, 663	162, 474		-2, 250	710, 887	50.00		
52.00	05200 DELIVERY ROOM & LABOR ROOM	237, 229	803		-236, 388	1, 644	52.00		
53.00	05300 ANESTHESI OLOGY	0	658, 519	658, 519	-507, 229	151, 290	53.00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 030, 478	768, 862	1, 799, 340		1, 799, 340			
60.00	06000 LABORATORY	885, 689	2, 188, 109		0	3, 073, 798	60.00		
65.00	06500 RESPI RATORY THERAPY	730, 710	89, 709	820, 419	-5, 062	815, 357	65.00		
66.00	06600 PHYSI CAL THERAPY	545, 958	79, 299	625, 257	0	625, 257	66.00		
67.00	06700 OCCUPATI ONAL THERAPY	178, 357	69	178, 426	0	178, 426	67.00		
68.00	06800 SPEECH PATHOLOGY	43, 720	0	43, 720	0	43, 720	68. 00		
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1, 356, 830	1, 356, 830	-538, 836	817, 994	71.00		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	538, 836	538, 836	72.00		
73.00	07300 DRUGS CHARGED TO PATIENTS	263, 639	2, 096, 846	2, 360, 485	0	2, 360, 485	73.00		
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800 RURAL HEALTH CLINIC	2, 543, 783	1, 374, 834	3, 918, 617	-194, 101	3, 724, 516	88. 00		
88. 01	08801 RURAL HEALTH CLINIC II	625, 516	352, 749	978, 265	72, 851	1, 051, 116	88. 01		
88. 02	08802 RURAL HEALTH CLINIC III	251, 498	170, 411	421, 909	-17, 016	404, 893	88. 02		
88. 03	08803 RURAL HEALTH CLINIC IV	244, 458	129, 387	373, 845	-113, 227	260, 618	88. 03		
91.00	09100 EMERGENCY	2, 923, 913	914, 470	3, 838, 383	5, 062	3, 843, 445	91.00		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00		
	SPECIAL PURPOSE COST CENTERS								
118.00		20, 481, 960	25, 986, 618	46, 468, 578	519, 473	46, 988, 051	118. 00		
	NONREI MBURSABLE COST CENTERS								
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00		
192.00	19200 PHYSICIANS' PRIVATE OFFICES	2, 489, 643	434, 379	2, 924, 022	-519, 473	2, 404, 549	192.00		
194.00	07950 FOUNDATION / MOBS	O	0	0	0	0	194.00		
200.00	TOTAL (SUM OF LINES 118 through 199)	22, 971, 603	26, 420, 997	49, 392, 600	0	49, 392, 600	200. 00		

Provi der CCN: 15-1317

| Period: | Worksheet A | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared: 5/27/2022 11: 27 am

			5/27/20	022 11: 27 am
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
GENERAL SERVICE COST CENTERS				
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-56, 919	1, 235, 533		1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP	0	634, 533		2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	4, 592, 114		4. 00
5. 00 00500 ADMINI STRATI VE & GENERAL	-2, 866, 368	6, 849, 134		5. 00
7.00 O0700 OPERATION OF PLANT	-3, 637	1, 729, 598		7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	205, 453		8. 00
9. 00 00900 HOUSEKEEPI NG	0	451, 487		9. 00
10. 00 01000 DI ETARY	0	190, 284		10.00
11. 00 01100 CAFETERI A	-236, 051	593, 405		11. 00
13. 00 O1300 NURSING ADMINISTRATION	0	928, 544		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	45, 673		14.00
15. 00 01500 PHARMACY	0	727, 623		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-4, 622	294, 837		16. 00
17. 00 01700 SOCI AL SERVI CE	0	271, 221		17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	-258, 197	251, 282		19. 00
INPATIENT ROUTINE SERVICE COST CENTERS	500 740	0.044.077		
30. 00 03000 ADULTS & PEDI ATRI CS	-539, 740	2, 946, 877		30.00
31. 00 03100 I NTENSI VE CARE UNI T 43. 00 04300 NURSERY	0	619, 677		31.00
43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS	l U	53, 620		43.00
50. 00 05000 OPERATING ROOM	0	710, 887		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 644		52.00
53. 00 05300 ANESTHESI OLOGY	0	151, 290		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 799, 340		54.00
60. 00 06000 LABORATORY	0	3, 073, 798		60.00
65. 00 06500 RESPIRATORY THERAPY	-11, 040	804, 317		65.00
66. 00 06600 PHYSI CAL THERAPY	0	625, 257		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	178, 426		67.00
68. 00 06800 SPEECH PATHOLOGY	0	43, 720		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-71, 141	746, 853		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	538, 836		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	-331, 485	2, 029, 000		73. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0	3, 724, 516		88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	1, 051, 116		88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	404, 893		88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0	260, 618		88. 03
91. 00 09100 EMERGENCY	-1, 291, 424	2, 552, 021		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
SPECIAL PURPOSE COST CENTERS				
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-5, 670, 624	41, 317, 427		118. 00
NONRE MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	-40, 214	2, 364, 335		192. 00
194.00 07950 FOUNDATION / MOBS	0	0		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-5, 710, 838	43, 681, 762		200. 00

Health Financial Systems		GREENE COUNTY GENERAL HOSPITAL				In Lieu of Form CMS-2552-10			
RECLAS	SI FI CATI ONS			Provi der (CCN: 15-1317	Peri od: From 01/01/2021	Worksheet A-	6	
						To 12/31/2021	Date/Time Pro 5/27/2022 11	epared: :27 am	
		Increases		<u> </u>					
	Cost Center	Li ne #	Sal ary	Other					
	2. 00	3.00	4. 00	5. 00					
	A - CRNA RECLASS								
1.00	NONPHYSICIAN ANESTHETISTS	19. 00	0	509, 479				1.00	
2.00		0.00	O	0				2.00	
			0	509, 479					
	B - LABOR & DELIVERY							1	
1.00	ADULTS & PEDIATRICS	30.00	236, 388	0				1.00	
			236, 388						
	C - DIETARY RECLASS							1	
1.00	CAFETERI A	11. 00	512, 532	316, 924				1.00	
	0 — — — — —		512, 532	316, 924					
	D - RHC ALLOCATION								
1.00	RURAL HEALTH CLINIC	88. 00	164, 324	0				1.00	
2.00	RURAL HEALTH CLINIC II	88. 01	111, 183	0				2.00	
3.00	RURAL HEALTH CLINIC III	88. 02	64, 572	0				3.00	
4.00	RURAL HEALTH CLINIC	88. 00	25, 274	0				4.00	
5.00	RURAL HEALTH CLINIC II	88. 01	7, 338	0				5.00	
6.00	RURAL HEALTH CLINIC II	88. 01	41, 713	0				6.00	
7.00	RURAL HEALTH CLINIC IV	88. 03	36, 063	0				7.00	
8.00	RURAL HEALTH CLINIC	88. 00	22, 721	0				8.00	
	laa			_	I			1	

24, 689

18, 452

37, 635

24, 755

594, 810

1, 195, 514

6, 438

9,773

5, 774

0

0

531, 685

531, 685

4<u>8, 7</u>80 48, 780

2, 524, 899

88. 01

88.01

88. 00

88. 03

192. 00

88. 01

192.00

1.00

4.00

8. 00

72.00

30.00

43.00

91.00

5.00

0

0

0

0

66, 539

83, 669

150, 208

205, 187

205, 187

538, 836

538, 836

0 Ō

0

0

5, 062

5, 062

1, 725, 696

9.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

1.00

2.00

1.00

1.00

1.00

1.00

1.00

500.00

RURAL HEALTH CLINIC II

RURAL HEALTH CLINIC II

RURAL HEALTH CLINIC IV

RURAL HEALTH CLINIC II

- INSURANCE RECLASS

CAP REL COSTS-BLDG & FIXT

LAUNDRY & LINEN SERVICE

IMPL. DEV. CHARGED TO

I - HOSPITALIST RECLASS

K - EKG RECLASSIFICATION

ADULTS & PEDIATRICS

J - NURSERY RECLASS

PATI ENTS _

NURSERY

EMERGENCY

500.00 Grand Total: Increases

EMPLOYEE BENEFITS DEPARTMENT

G - IMPLANTABLE DEVICES RECLASS

F - LAUNDRY AND HOUSEKEEPING RECLASS

ADMINISTRATIVE & GENERAL

PHYSICIANS' PRIVATE OFFICES

PHYSICIANS' PRIVATE OFFICES

RURAL HEALTH CLINIC

9.00

10.00

11.00

12.00

13.00

14.00

15.00

16.00

1.00

2.00

1.00

1.00

1.00

1.00

1.00

| Peri od: | Worksheet A-6 | From 01/01/2021 | To 12/31/2021 | Date/Time Prepared:

						io 12/31/2021 Date/Iime 5/27/2022	e Prepared: 2 11:27 am
		Decreases		'		0,2,,,202	11127 (
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	A - CRNA RECLASS						
1.00	OPERATING ROOM	50.00	0	2, 250			1.00
2.00	ANESTHESI OLOGY	5300	0	507, 229	<u> </u>		2.00
	0		0	509, 479)		
	B - LABOR & DELIVERY						
1.00	DELIVERY ROOM & LABOR ROOM	52. 00	236, 388	0			1.00
	0		236, 388	0)		
	C - DIETARY RECLASS						
1. 00	DI ETARY	1000	51 <u>2, 5</u> 32	31 <u>6, 9</u> 24			1.00
	0		512, 532	316, 924			
	D - RHC ALLOCATION						
1. 00	NURSING ADMINISTRATION	13. 00	275, 507	0			1.00
2. 00	RURAL HEALTH CLINIC II	88. 01	64, 572	0		l .	2. 00
3. 00	NURSI NG ADMI NI STRATI ON	13. 00	32, 612	0			3.00
4.00	RURAL HEALTH CLINIC	88. 00	77, 776	0			4.00
5. 00	ADULTS & PEDIATRICS	30.00	47, 410	0	-		5. 00
6. 00	RURAL HEALTH CLINIC III	88. 02	80, 842	0			6.00
7. 00	RURAL HEALTH CLINIC	88. 00	6, 438	0			7.00
8.00	RURAL HEALTH CLINIC	88. 00	347, 307	0			8.00
9.00	RURAL HEALTH CLINIC II	88. 01	74, 079	0			9.00
10.00	RURAL HEALTH CLINIC IV	88. 03	173, 424	0			10.00
11.00	RURAL HEALTH CLINIC	88. 00	9, 773	0			11.00
12.00	RURAL HEALTH CLINIC	88. 00	2, 761	0	,		12.00
13.00	RURAL HEALTH CLINIC II	88. 01	1, 646	0			13.00
14.00	RURAL HEALTH CLINIC III	88. 02	746	0			14. 00 15. 00
15.00	RURAL HEALTH CLINIC IV	88. 03	621	0	-		
16. 00			1, 195, 514	0			16. 00
	E - INSURANCE RECLASS		1, 195, 514		γ <u></u>		
1. 00	ADMINISTRATIVE & GENERAL	5. 00	ol	150, 208	3 12		1.00
2. 00	ADMINISTRATIVE & GENERAL	0.00	0	150, 200			2.00
2.00				150, 208			2.00
	F - LAUNDRY AND HOUSEKEEPING	DECLASS	<u> </u>	130, 200	<u>'</u>		
1. 00	HOUSEKEEPI NG	9.00	0	205, 187	0		1.00
1.00	0		— — — }	205, 187		1	1.00
	G - IMPLANTABLE DEVICES RECLA	ASS	<u> </u>	200, 107			
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	538, 836	0		1.00
00	PATI ENTS	, 55	J	000,000			
	0	+		538, 836			
	I - HOSPITALIST RECLASS	·	-		1		
1.00	PHYSICIANS' PRIVATE OFFICES	192. 00	531, 685	C	0		1.00
			531, 685	0)		
	J - NURSERY RECLASS	·			,		
1.00	ADULTS & PEDIATRICS	30.00	48, 780	C	0		1.00
		+	48, 780	0)		
	K - EKG RECLASSIFICATION		<u> </u>				
1.00	RESPI RATORY THERAPY	65. 00	0	5, 062	2 0		1.00
	0			5, 062	2		
500.00	Grand Total: Decreases		2, 524, 899	1, 725, 696			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-1317 Peri od: Worksheet A-7 From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 11:27 am 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 Land 947, 777 947, 777 1.00 0 303, 546 2.00 Land Improvements -89, 984 2.00 3.00 6, 411, 574 Buildings and Fixtures 2, 679, 202 2, 679, 202 0 3.00 0 4.00 Building Improvements 0 4.00 Fi xed Equi pment 4, 196, 806 0 248, 714 5.00 248, 714 0 5.00 3, 857, 112 1, 090, 658 6.00 Movable Equipment 1, 090, 658 0 6.00 0 7.00 HIT designated Assets 115, 036 -30,000 7.00 8.00 Subtotal (sum of lines 1-7) 15, 535, 272 4, 966, 351 0 4, 966, 351 -119, 984 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 15, 535<u>, 272</u> 4, 966, 351 -119, 984 4, 966, 351 10.00 O 10.00 Endi ng Ful I y Bal ance Depreciated Assets 6. 00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES Land 1, 598, 975 1.00

Heal th	Financial Systems GF	REENE COUNTY GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-1317		Period: Worksheet A- From 01/01/2021 Part II To 12/31/2021 Date/Time Pro 5/27/2022 11			
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	958, 092	0	267, 82	1 0	0	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	634, 533	0		0 0	0	2.00	
3.00	Total (sum of lines 1-2)	1, 592, 625	0	267, 82	1 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					

	·				(see	instructions)	
					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	958, 092	0	267, 821	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	634, 533	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	1, 592, 625	0	267, 821	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, 225, 913				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	634, 533				2.00
3.00	Total (sum of lines 1-2)	0	1, 860, 446				3.00

Heal th	n Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der Co		Period: From 01/01/2021 To 12/31/2021		pared:
		COMI	COMPUTATION OF RATIOS ALLOCATION OF OTH				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 -			
		1. 00	2, 00	col. 2) 3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FLXT	15, 433, 869	0	15, 433, 86	9 0. 757244	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	4, 947, 770	0	4, 947, 77	0. 242756	0	2.00
3. 00	Total (sum of lines 1-2)	20, 381, 639		20, 381, 63			3.00
ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL						OF CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	f Depreciation	Lease	
			Capi tal -Rel at		·		
			ed Costs	through 7)			
	DART III DECONOLILATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS	0		0 901, 173	0	1.00
2.00	CAP REL COSTS-BLDG & FIXI	0	0		0 634, 533		2.00
3. 00	Total (sum of lines 1-2)	0	0		0 1, 535, 706		3.00
0.00	Total (Sam of Times 1 2)		SL	JMMARY OF CAPI		0	0.00
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)			
			instructions)		ed Costs (see instructions)	9 through 14)	
		11. 00	12. 00	13. 00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C		12.00	13.00	14.00	13.00	
1. 00	CAP REL COSTS-BLDG & FIXT	267, 821	66, 539		0 0	1, 235, 533	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	· ·	•	0 0		2.00
3.00	Total (sum of lines 1-2)	267, 821	66, 539		0 0	1, 870, 066	3.00

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-1317 Peri od: Worksheet A-8 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/27/2022 11:27 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time 0.00 4.00 di scounts (chapter 8) 5.00 Refunds and rebates of 5.00 0.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 Α -3,637 OPERATION OF PLANT 7 00 7.00 stations excluded) (chapter 8.00 Television and radio service 0.00 8.00 0 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 10.00 Provi der-based physici an -1, 842, 204 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -171, 429 CAFETERI A 14.00 В 11.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical 16.00 16.00 0 0.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0.00 17.00 pati ents Sale of medical records and 18.00 -4, 622 MEDI CAL RECORDS & LIBRARY В 16.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 0 education (tuition, fees, books, etc.) -64, 622 CAFETERI A 20.00 Vending machines В 11 00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) Utilization review 0 *** Cost Center Deleted *** 25.00 25.00 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant 28.00 ONONPHYSICIAN ANESTHETISTS 19.00 28.00 29 00 0.00 29 00 Adjustment for occupational O OCCUPATIONAL THERAPY 30.00 30.00 A-8-3 67.00 therapy costs in excess of

OADULTS & PEDIATRICS

30.00

30.99

30.99

limitation (chapter 14) Hospice (non-distinct) (see

instructions)

-40, 982 CAP REL COSTS-BLDG & FIXT

-331, 485 DRUGS CHARGED TO PATIENTS

-258, 197 NONPHYSI CI AN ANESTHETI STS

-2, 727, 129 ADMINISTRATIVE & GENERAL

PATI ENTS

-5, 710, 838

-40, 214 PHYSICIANS' PRIVATE OFFICES

15, 244 CAP REL COSTS-BLDG & FIXT

-31, 181 CAP REL COSTS-BLDG & FIXT

-71, 141 MEDI CAL SUPPLIES CHARGED TO

-12 ADMINISTRATIVE & GENERAL

OADMINISTRATIVE & GENERAL

ODELIVERY ROOM & LABOR ROOM

5.00

1.00

5.00

73.00

19.00

52.00

192.00

5.00

1.00

5.00

1.00

71.00

0

0 33.06

o 33.08

0 33.10

0 33.13

33 05

33.07

33.09

33.11

33.12

33.16

33.17

50.00

Α

В

В

Α

Α

B

Α

Α

Α

Α

В

В

TOTAL (sum of lines 1 thru 49)

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

RENTAL OF PROVIDER SPACE -

CRNA TO MARKET ADJUSTMENT

HOSPITAL ASSESSMENT FEE

MISC EXPENSE - ADMIN

BOND AMORTIZATION EXPENSE

ORTHO CLINIC - START-UP COSTS

INUSRANCE PROCEEDS - CAPITAL

33.04

33 05

33.06

33.07

33.08

33.09

33. 10

33. 11

33. 12

33. 13

33. 16

33.17

50.00

BENEFITS

GIFT CARD USAGE

OB ON CALL TIME

340B EXPENSE

AD JUSTMENT

REBATES

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

⁽²⁾ Basis for adjustment (see instructions)

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

B. Amount Received - if cost cannot be determined.

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

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1317

						To 12/31/202	Date/Time Pre 5/27/2022 11:	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professiona Component	Provider Component	RCE Amount	Physician/Prov ider Component	
		ruentiriei	Remuner at 1 on	Component	Component		Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADULTS & PEDLATRICS	580, 366					1.00
2.00	65. 00	RESPIRATORY THERAPY	11, 040	11, 0		l .	0	2.00
3.00	91.00	EMERGENCY	1, 844, 891	1, 291, 4	24 553, 46 ⁻	7 O	0	3.00
4.00	0.00		0		0	0	0	4. 00
5.00	0.00		0		0	0	0	5. 00
6.00	0.00		0		0	0	0	6. 00
7.00	0.00		0		0	0	0	7. 00
8.00	0.00		0		0	0	0	8. 00
9.00	0. 00		0		0	0	0	9. 00
10.00	0. 00		0		0	0	0	10.00
200.00			2, 436, 297			3	0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
		l denti fi er	Limit		CE Memberships &		of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
1.00	1.00	2.00	8. 00	9. 00	12. 00	13. 00	14.00	1 00
1.00		ADULTS & PEDIATRICS	0		0	-1	-	
2.00		RESPIRATORY THERAPY	0		0	۷ ۲	-	
3.00		EMERGENCY	0		0	-1	-	
4.00	0.00		0		0	0	1	4.00
5.00	0.00		0		0	0	0	
6.00	0.00		0		0		0	6.00
7.00	0.00		0			0		7.00
8. 00	0.00		0					8.00
9.00	0.00		0		0	۳ ۳	1	9.00
10.00	0. 00		0				1	10.00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RC	E RCE	Adjustment	0	200.00
	WKSt. A LINE #	I denti fi er	Component	Limit	Di sal I owance	Adjustillent		
		rdentiffer	Share of col.	Limit	Di Sai i Owance			
			14					
	1.00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADULTS & PEDLATRICS	0			539, 740)	1. 00
2.00		RESPIRATORY THERAPY	0		0		•	2.00
3. 00		EMERGENCY	0		0			3. 00
4.00	0.00		0		0		•	4.00
5.00	0.00		0		0	ol o		5. 00
6.00	0.00		0		0	o o		6.00
7.00	0.00		0		0	ol o		7. 00
8.00	0.00		0		0	0		8. 00
9.00	0.00		0		0	0		9. 00
10.00	0.00		0		0	0		10.00
200.00			0		0	1, 842, 204	.	200. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1317 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 11:27 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1, 235, 533 1, 235, 533 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 634, 533 634, 533 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 592, 114 4, 592, 114 4.00 4.00 0 5.00 00500 ADMINISTRATIVE & GENERAL 107, 336 44.854 622, 315 5.00 6, 849, 134 7, 623, 639 7.00 00700 OPERATION OF PLANT 1, 729, 598 161, 285 67, 398 138, 379 2,096,660 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 205, 453 8, 586 3,588 217, 627 8.00 00900 HOUSEKEEPI NG 451, 487 8.569 3.581 527, 279 9.00 9 00 63 642 01000 DI ETARY 279, 579 10.00 190, 284 46, 400 19.390 23, 505 10.00 11.00 01100 CAFETERI A 593, 405 46, 400 19, 390 102, 457 761, 652 11.00 01300 NURSING ADMINISTRATION 13.00 928, 544 8, 433 3, 524 146, 954 1,087,455 13.00 01400 CENTRAL SERVICES & SUPPLY 24 299 128, 120 14 00 45.673 58, 148 14 00 15.00 01500 PHARMACY 727, 623 21,831 9, 123 125, 314 883, 891 15.00 01600 MEDICAL RECORDS & LIBRARY 294, 837 18, 125 7,574 52, 850 373, 386 16.00 16.00 01700 SOCIAL SERVICE 271, 221 2,032 328, 283 17.00 17.00 4,863 50, 167 01900 NONPHYSICIAN ANESTHETISTS 19.00 251, 282 0 251, 282 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 2, 946, 877 288, 276 120, 465 636, 495 3, 992, 113 30.00 03100 INTENSIVE CARE UNIT 19 041 113, 908 798, 193 31 00 619, 677 45.567 31 00 04300 NURSERY 43.00 53,620 6, 444 2,693 9, 751 72, 508 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 710, 887 83, 380 34, 843 110,080 939, 190 50.00 05200 DELIVERY ROOM & LABOR ROOM 6, 779 52 00 1, 644 3, 503 1, 464 168 52 00 53.00 05300 ANESTHESI OLOGY 151, 290 0 151, 290 53.00 32, 356 05400 RADI OLOGY-DI AGNOSTI C 1, 799, 340 77, 429 205, 997 54.00 2, 115, 122 54.00 06000 LABORATORY 3, 073, 798 177, 053 3, 313, 795 60.00 44.393 18, 551 60.00 06500 RESPIRATORY THERAPY 1, 989 146, 072 953, 209 65.00 804.317 831 65 00 66.00 06600 PHYSI CAL THERAPY 625, 257 15, 353 6, 416 109, 139 756, 165 66.00 15, 353 06700 OCCUPATI ONAL THERAPY 6, 416 67 00 178, 426 35, 654 235, 849 67.00 8, 740 68.00 06800 SPEECH PATHOLOGY 43, 720 8, 229 3, 439 64, 128 68.00 06900 ELECTROCARDI OLOGY 69 00 r 0 0 Λ 69 00 \cap 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 746, 853 746, 853 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 538, 836 0 538, 836 72.00 07300 DRUGS CHARGED TO PATIENTS 2,029,000 13,058 2, 100, 217 5, 457 52, 702 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 3, 724, 516 43.845 469.711 4, 238, 072 88.00 88.01 08801 RURAL HEALTH CLINIC II 1, 051, 116 25, 535 139, 606 1, 216, 257 88.01 0 46, 874 88 02 08802 RURAL HEALTH CLINIC III 404.893 21, 542 473, 309 88 02 Ω 88.03 08803 RURAL HEALTH CLINIC IV 260, 618 27, 304 26, 234 314, 156 88.03 91.00 09100 EMERGENCY 2, 552, 021 96, 540 40, 342 584, 502 3, 273, 405 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 41, 317, 427 1, 189, 490 615, 293 4, 198, 269 40, 858, 299 118. 00 NONREI MBURSABLE COST CENTERS 6, 702 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1 975 4,727 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 2, 364, 335 41, 316 17, 265 393, 845 2, 816, 761 192. 00 194.00 07950 FOUNDATION / MOBS 0 194.00 0 0 Cross Foot Adjustments 200.00 0 200.00 201.00 Negative Cost Centers 0 201, 00

43, 681, 762

1, 235, 533

634, 533

4, 592, 114

43, 681, 762 202. 00

202.00

TOTAL (sum lines 118 through 201)

Provider CCN: 15-1317

Peri od: Worksheet B From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/27/2022 11:27 am

						5/27/2022 11:	27 am
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	· · · · · · · · · · · · · · · · · · ·	E & GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & 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	7, 623, 639					5.00
7. 00	00700 OPERATION OF PLANT	443, 288	2, 539, 948				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	46, 012	17, 449				8.00
9. 00	00900 HOUSEKEEPI NG	111, 480	17, 415	·	656, 174		9.00
10.00	01000 DI ETARY	59, 110	94, 295		030, 174	432, 984	10.00
11. 00	01100 CAFETERI A	161, 033	94, 295		0	432, 704	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	229, 916	17, 138		335	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	27, 088	118, 171		0	0	
15. 00	01500 PHARMACY	186, 878	44, 366		19, 524	0	15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	78, 944	36, 833		670	0	16.00
17. 00			9, 882		0	0	17.00
	01700 SOCIAL SERVICE	69, 408					
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	53, 128	0	0	0	0	19. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	044.007	F0F 040	(4.000	200 204	202 202	00.00
30.00	03000 ADULTS & PEDIATRICS	844, 036	585, 842	· ·	208, 224	303, 092	30.00
31.00	03100 I NTENSI VE CARE UNI T	168, 759	92, 602		73, 150	129, 892	
43.00	04300 NURSERY	15, 330	13, 096	0	14, 412	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	198, 569	169, 447		69, 128	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 433	7, 118		9, 217	0	
53.00	05300 ANESTHESI OLOGY	31, 987	0	_	1, 676	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	447, 192	157, 354		19, 607	0	54.00
60.00	06000 LABORATORY	700, 622	90, 218		27, 819	0	60.00
65.00	06500 RESPI RATORY THERAPY	201, 533	4, 043	70	8, 714	0	65.00
66.00	06600 PHYSI CAL THERAPY	159, 873	31, 201	52, 403	24, 300	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	49, 865	31, 201	17, 236	3, 854	0	67.00
68.00	06800 SPEECH PATHOLOGY	13, 558	16, 724	0	503	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	157, 904	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	113, 924	0	0	o	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	444, 040	26, 537	0	o	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	896, 053	213, 226	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	257, 148	124, 183	l o	ol	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	100, 070	104, 764		0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	66, 421	132, 787		o	0	1
91.00	09100 EMERGENCY	692, 083	196, 191		145, 211	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	072,000	170, 171	00,700	110, 211	Ü	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		7, 026, 685	2, 446, 378	281, 088	626, 344	432, 984	118 00
110.00	NONREI MBURSABLE COST CENTERS	7,020,003	2, 440, 370	201,000	020, 344	432, 704	1110.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 417	9, 606	0	2, 849	0	190. 00
102.00	19200 PHYSICIANS' PRIVATE OFFICES	595, 537	83, 964		20, 278		192.00
	07950 FOUNDATION / MOBS	373, 337	03, 704		6, 703		194.00
200.00			U		0, 703	U	200.00
200.00	1 1		^		0	0	200.00
201.00		7, 623, 639	2, 539, 948	281, 088	656, 174	432, 984	
202.00	TOTAL (Suil Titles To thi bugh 201)	1,023,039	2, 557, 940	201,000	050, 174	432, 904	1202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1317

Peri od: Worksheet B From 01/01/2021 Part I To 12/31/2021 Date/Time Prepared:

5/27/2022 11:27 am 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 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 1,016,980 11.00 01300 NURSING ADMINISTRATION 1, 407, 520 13.00 13.00 72, 676 01400 CENTRAL SERVICES & SUPPLY 273, 379 14.00 14.00 15.00 01500 PHARMACY 42, 195 737 1, 177, 591 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 36, 947 526, 864 16.00 0 84 01700 SOCIAL SERVICE 17.00 16, 645 0 17.00 C 230 0 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 238, 276 9. 557 93, 747 30.00 755, 173 0 03100 INTENSIVE CARE UNIT 31.00 40, 287 123, 932 1, 368 0 24, 231 31 00 04300 NURSERY 43.00 3, 287 3, 178 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 49, 617 59.453 50.00 152, 537 4, 268 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 53 0 3, 708 52.00 53.00 05300 ANESTHESI OLOGY 0 0 259 0 530 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 100, 823 3, 191 31, 117 0 54.00 0 06000 LABORATORY 60. nn 112, 326 0 110, 977 79, 579 60.00 65.00 06500 RESPIRATORY THERAPY 59, 900 C 3,887 0 16,816 65.00 06600 PHYSI CAL THERAPY 48, 556 0 66.00 639 5, 694 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 9.966 0 3.443 67.00 0 06800 SPEECH PATHOLOGY 68.00 4, 453 C 0 1, 589 68.00 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 0 75,061 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 49 445 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 177, 591 73.00 15, 214 0 254 0 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 5, 164 88.00 08801 RURAL HEALTH CLINIC II 88 01 0 0 O 0 5, 164 88 01 88.02 08802 RURAL HEALTH CLINIC III 0 C 0 0 5, 164 88.02 08803 RURAL HEALTH CLINIC IV 0 88.03 88.03 5, 164 91.00 09100 EMERGENCY 122, 239 375, 878 7 557 0 183, 123 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 973, 460 1, 407, 520 267, 514 1, 177, 591 526, 864 118. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 43, 520 0 5,865 0 0 192.00 194. 00 07950 FOUNDATION / MOBS ol 0 194.00 C 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 202.00 1, 407, 520 1, 177, 591 526, 864 202. 00 TOTAL (sum lines 118 through 201) 1,016,980 273, 379

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1317 Peri od: Worksheet B From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 11:27 am 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 424, 448 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 304, 410 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 236, 041 7, 327, 400 7, 327, 400 30.00 03100 INTENSIVE CARE UNIT 1, 535, 498 0 1, 535, 498 31.00 31.00 65, 625 0 04300 NURSERY 121, 811 0 121, 811 43.00 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 1,669,564 0 1,669,564 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 1,058 29, 366 0 29, 366 52.00 0 490, 152 53.00 05300 ANESTHESI OLOGY 304, 410 490, 152 53 00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 C 2, 925, 934 2, 925, 934 54.00 60.00 06000 LABORATORY 0 4, 435, 336 0 4, 435, 336 60.00 06500 RESPIRATORY THERAPY 65.00 0 0 0 1, 248, 172 0 0 1, 248, 172 65.00 06600 PHYSI CAL THERAPY 1. 078. 831 66 00 Ω 1, 078, 831 66 00 06700 OCCUPATIONAL THERAPY 67.00 C 351, 414 351, 414 67.00 06800 SPEECH PATHOLOGY 0 100, 955 0 100, 955 68.00 68.00 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 979, 818 979, 818 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 C 702, 205 0 702, 205 72.00 07300 DRUGS CHARGED TO PATIENTS 0 3, 763, 853 73.00 3, 763, 853 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 5, 352, 515 0 5, 352, 515 88 00 88.01 08801 RURAL HEALTH CLINIC II 0 0 1, 602, 752 0 1, 602, 752 88.01 88 02 08802 RURAL HEALTH CLINIC III 0 0 683, 307 0 683, 307 88 02 08803 RURAL HEALTH CLINIC IV 88.03 518, 528 0 0 0 518, 528 88.03 09100 EMERGENCY 0 91.00 121, 724 r 5, 171, 149 5, 171, 149 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 118.00 424, 448 304, 410 40, 088, 560 0 40, 088, 560 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 20, 574 20, 574 190. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 3, 565, 925 0 3, 565, 925 192. 00 0 0 194. 00 07950 FOUNDATION / MOBS 0 0 Ω 6,703 6, 703 194. 00

424.448

304.410

0

o

0

43, 681, 762

0 200.00

0 201.00

43, 681, 762 202. 00

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

| Peri od: | Worksheet B | From 01/01/2021 | Part | I | To | 12/31/2021 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1317

				То	12/31/2021	Date/Time Pre 5/27/2022 11:	
			CAPI TAL REI	LATED COSTS		3/2//2022 11.	Z1 alli
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2.00	2A	4. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	ZN	4.00	
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	0	0	0	0	0	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	107, 336		152, 190	0	5.00
7. 00	00700 OPERATION OF PLANT	0	161, 285		228, 683	0	7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE	0	8, 586		12, 174	0	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	8, 569 46, 400		12, 150 65, 790	0	9. 00 10. 00
11. 00	01100 CAFETERI A	0	46, 400		65, 790	0	11. 00
13. 00	01300 NURSING ADMINISTRATION	0	8, 433		11, 957	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	58, 148		82, 447	0	14.00
15.00	01500 PHARMACY	0	21, 831	9, 123	30, 954	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	18, 125	7, 574	25, 699	0	16.00
17. 00	01700 SOCI AL SERVI CE	0	4, 863		6, 895	0	17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		200 27/	120 4/5	400 741	0	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	288, 276 45, 567		408, 741 64, 608	0	30. 00 31. 00
	04300 NURSERY	0	6, 444		9, 137	0	43. 00
10.00	ANCILLARY SERVICE COST CENTERS	<u> </u>	0, 111	2,070	7, 107		10.00
50.00	05000 OPERATI NG ROOM	0	83, 380	34, 843	118, 223	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 503	1, 464	4, 967	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	-	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	77, 429		109, 785	0	54.00
60.00	06000 LABORATORY	0	44, 393		62, 944	0	60.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	1, 989 15, 353		2, 820 21, 769	0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	15, 353		21, 769	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	8, 229		11, 668	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	o o	0,227		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	13, 058	5, 457	18, 515	0	73.00
	OUTPATIENT SERVICE COST CENTERS	1		10.045	10.015		
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	0	0		43, 845	0	88.00
88. 01 88. 02	08801 RURAL HEALTH CLINIC II	0	0		25, 535 21, 542	0	88. 01 88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	0		27, 304	0	88. 03
91. 00	09100 EMERGENCY	0	96, 540		136, 882	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		70,010	10,012	0	Ü	92.00
	SPECIAL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
118.00		0	1, 189, 490	615, 293	1, 804, 783	0	118. 00
	NONREI MBURSABLE COST CENTERS	1 .1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 727		6, 702		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 FOUNDATION / MOBS	0	41, 316 0	17, 265	58, 581 0		192. 00 194. 00
200.00		"	0		0	Ü	194. 00 200. 00
200.00			n	0	0	Ω	200.00
202.00	9	0	1, 235, 533	1	1, 870, 066		202.00
		1					1

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared: | To 12/31/2021 | T Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS GREENE COUNTY GENERAL HOSPITAL Provider CCN: 15-1317

				10	J 12/31/2021	5/27/2022 11:	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	27 (3111
	5551 5511151 B5551 F11 611	E & GENERAL	PLANT	LINEN SERVICE	HOUGENEEL THO	512171111	
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS			0.00			
1. 00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	152, 190					5.00
7. 00	00700 OPERATION OF PLANT	8, 850	237, 533				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	919	1, 632				8.00
9. 00	00900 HOUSEKEEPI NG	2, 226	1, 629		16, 005		9.00
10.00	01000 DI ETARY	1, 180	8, 818		0	75, 788	10.00
11. 00	01100 CAFETERI A	3, 215	8, 818		0	75, 750	11.00
13. 00	01300 NURSING ADMINISTRATION	4, 590	1, 603		8	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	541	11, 051	0	0	0	14.00
15. 00	01500 PHARMACY	3, 731	4, 149	-	476	0	15.00
16. 00		1	3, 445		16	0	16.00
	01600 MEDICAL RECORDS & LIBRARY	1, 576			-	_	
17.00	01700 SOCIAL SERVICE	1, 386	924		0	0	17.00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	1, 061	0	0	0	0	19. 00
00.00	INPATIENT ROUTINE SERVICE COST CENTERS	47.054	E 4 70/	0.044	F 070	E0.0E0	00.00
30.00	03000 ADULTS & PEDIATRICS	16, 851	54, 786		5, 078	53, 052	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 369	8, 660		1, 784	22, 736	31.00
43.00	04300 NURSERY	306	1, 225	0	352	0	43. 00
	ANCILLARY SERVICE COST CENTERS	T					
50. 00	05000 OPERATING ROOM	3, 964	15, 847		1, 686	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	29	666		225	0	52.00
53. 00	05300 ANESTHESI OLOGY	639	0	_	41	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 928	14, 716		478	0	54.00
60.00	06000 LABORATORY	13, 988	8, 437	0	679	0	60.00
65.00	06500 RESPI RATORY THERAPY	4, 023	378	4	213	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 192	2, 918		593	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	996	2, 918	903	94	0	67.00
68. 00	06800 SPEECH PATHOLOGY	271	1, 564	0	12	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 152	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 274	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	8, 865	2, 482	0	0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	17, 875	19, 941	0	0	0	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	5, 134	11, 613	0	0	0	88. 01
88. 02	08802 RURAL HEALTH CLINIC III	1, 998	9, 797	0	0	0	88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	1, 326	12, 418	0	0	0	88. 03
91.00	09100 EMERGENCY	13, 817	18, 348	2, 815	3, 542	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00		140, 272	228, 783	14, 725	15, 277	75, 788	118. 00
	NONREI MBURSABLE COST CENTERS				-,	.,	
190. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	28	898	0	69	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	11, 890			495		192. 00
	07950 FOUNDATION / MOBS	0	0		164		194. 00
200.00				Ĭ	101		200.00
201.00	, ,	0	n	0	0	n	201.00
202.00		152, 190	237, 533	_	16, 005		
202.00	1.57.12 (5a 1.1.55 116 till 6agil 201)	102, 170	207,000	1 11, 725	10, 000	75,700	52.00

In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2021 | Part II | To 12/31/2021 | Date/Time Prepared:

				10	12/31/2021	5/27/2022 11:	
	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 & 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						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		77, 823					11.00
13. 00		5, 561					13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0,301		94, 039			14.00
15. 00		3, 229		254	42, 793		15.00
16. 00		2, 827		29	42, 743	33, 592	16.00
					۰		•
17.00	01700 SOCIAL SERVICE	1, 274		79	0	0	17.00
19. 00		0	0	0	0	0	19. 00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00	1	18, 234		3, 288	0	5, 977	30.00
31. 00		3, 083		471	0	1, 545	1
43.00		251	0	0	0	203	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00		3, 797	2, 570	1, 468	0	3, 791	50.00
52.00		4	0	0	0	236	52.00
53.00	05300 ANESTHESI OLOGY	0	0	89	0	34	53.00
54.00		7, 715	0	1, 098	0	1, 984	54.00
60.00	06000 LABORATORY	8, 596	0	38, 174	0	5, 074	60.00
65.00	06500 RESPI RATORY THERAPY	4, 584	0	1, 337	0	1, 072	65.00
66.00	06600 PHYSI CAL THERAPY	3, 716	0	220	0	363	66.00
67.00	06700 OCCUPATI ONAL THERAPY	763	o	0	o	220	67.00
68.00	06800 SPEECH PATHOLOGY	341	O	0	o	101	68.00
69.00		0	o	0	ol	0	69.00
71. 00	1	0	o	25, 820	0	0	71.00
72. 00	l l	0		17, 008	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 164		87	42, 793	0	73.00
70.00	OUTPATIENT SERVICE COST CENTERS	1, 101	<u> </u>	07	12, 7,0		70.00
88. 00		0	0	0	O	329	88. 00
88. 01	08801 RURAL HEALTH CLINIC II	Ö	-	Ö	o	329	
88. 02	08802 RURAL HEALTH CLINIC III	Ö		Ö	o	329	1
88. 03	08803 RURAL HEALTH CLINIC IV	0	0	0	0	329	88. 03
91. 00		9, 354	1 "	2, 599	0	11, 676	91.00
91.00		9, 334	0, 334	2, 399	٩	11,070	92.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118. 00		74, 493	23, 719	92, 021	42, 793	33, 592	110 00
118.00	NONREI MBURSABLE COST CENTERS	14, 493	23, /19	92, 021	42, 793	33, 592	1118.00
100 00	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	0	ol	0	190. 00
	0 19000 GTFT, PLOWER, COPPEE SHOP & CANTEEN	3, 330		2, 018	0		190.00
	007950 FOUNDATION / MOBS	3, 330		2,010	0		194.00
	1		1	ا	Ч	Ü	1
200.00	1 1	_				^	200. 00 201. 00
201.00		77 000	22 740	04 030	40 700		
202.00	0 TOTAL (sum lines 118 through 201)	77, 823	23, 719	94, 039	42, 793	33, 592	J2U2. UU

	TITION OF CAPITAL RELATED COSTS	ELNE COUNTY GE	Provider Co	CN: 15-1317 F	Period: From 01/01/2021 To 12/31/2021	Worksheet B Part II Date/Time Pre 5/27/2022 11:	
	Cost Center Description	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17. 00	19. 00	24. 00	25. 00	26. 00	
	GENERAL SERVI CE 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 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8. 00	00800 LAUNDRY & LI NEN SERVI CE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG						9. 00 10. 00
11. 00	01000 DI ETARY 01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00	01500 PHARMACY						15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00	01700 SOCI AL SERVI CE	10, 558					17. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	1, 061				19.00
17.00	INPATIENT ROUTINE SERVICE COST CENTERS	J	1,001				17.00
30.00	03000 ADULTS & PEDIATRICS	5, 872		587, 817	0	587, 817	30.00
31. 00	03100 INTENSIVE CARE UNIT	1, 632		110, 891		110, 891	
43.00	04300 NURSERY	0		11, 474			
	ANCILLARY SERVICE COST CENTERS		<u> </u>	<u> </u>		·	1
50.00	05000 OPERATING ROOM	0		152, 779	0	152, 779	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	26		6, 153	0	6, 153	52.00
53.00	05300 ANESTHESI OLOGY	0		803	0	803	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		147, 403	0	147, 403	54.00
60.00	06000 LABORATORY	0		137, 892	0	137, 892	60.00
65.00	06500 RESPI RATORY THERAPY	0		14, 431		14, 431	
66.00	06600 PHYSI CAL THERAPY	0		35, 516		35, 516	
67.00	06700 OCCUPATI ONAL THERAPY	0		27, 663		27, 663	
68. 00	06800 SPEECH PATHOLOGY	0		13, 957		13, 957	
69.00	06900 ELECTROCARDI OLOGY	0		0	1	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		28, 972			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		19, 282		19, 282	
73. 00	07300 DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICE COST CENTERS	0		73, 906	0	73, 906	73.00
88. 00	08800 RURAL HEALTH CLINIC	0		81, 990	0	81, 990	88.00
88. 01	08801 RURAL HEALTH CLINIC II	0		42, 611		42, 611	
88. 02	08802 RURAL HEALTH CLINIC III	0		33, 666		33, 666	
88. 03	08803 RURAL HEALTH CLINIC IV	0		41, 377		41, 377	
91. 00	09100 EMERGENCY	3, 028		208, 395		208, 395	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0,020		200, 070	o		92.00
72.00	SPECIAL PURPOSE COST CENTERS				<u> </u>		72.00
118. 00		10, 558	0	1, 776, 978	0	1, 776, 978	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		7, 697	0	7, 697	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	0		84, 166			192.00
	07950 FOUNDATION / MOBS	0		164			194. 00
200.00			1, 061	1, 061		1, 061	200.00
201.00		0	0	C			201.00
202.00	TOTAL (sum lines 118 through 201)	10, 558	1, 061	1, 870, 066	0	1, 870, 066	202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1317 Peri od: Worksheet B-1 From 01/01/2021 12/31/2021 Date/Time Prepared: 5/27/2022 11:27 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (SQUARE FEET) BENEFITS F & GENERAL n DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1. 00 2.00 4.00 5A 5. 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 72.668 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 89, 308 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 22, 971, 603 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 6, 313 5.00 3, 113, 068 36, 058, 123 6, 313 -7, 623, 639 5.00 7.00 00700 OPERATION OF PLANT 9, 486 9, 486 692, 226 2,096,660 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 505 505 0 217, 627 8.00 00900 HOUSEKEEPI NG 504 504 318.364 0 527, 279 9 00 9 00 279, 579 10.00 01000 DI ETARY 2,729 2, 729 117.579 0 10.00 2, 729 11.00 01100 CAFETERI A 2, 729 512, 532 761, 652 11.00 01300 NURSING ADMINISTRATION 13.00 496 496 735, 122 0 0 1,087,455 13.00 01400 CENTRAL SERVICES & SUPPLY 3 420 14 00 3, 420 128, 120 14 00 0 1, 284 15.00 01500 PHARMACY 1, 284 626, 872 883, 891 15.00 01600 MEDICAL RECORDS & LIBRARY 0 373, 386 16.00 1.066 1.066 264, 376 16.00 ol 01700 SOCIAL SERVICE 250, 953 328, 283 17.00 17.00 286 286 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 251, 282 19.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 16, 955 16, 955 3, 184, 018 0 3, 992, 113 30.00 03100 INTENSIVE CARE UNIT 569 813 798, 193 31 00 2.680 2,680 0 31 00 43.00 04300 NURSERY 379 379 48, 780 0 72, 508 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 904 4, 904 550, 663 0 939, 190 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 6, 779 52 00 206 206 841 52 00 53.00 05300 ANESTHESI OLOGY 0 151, 290 53.00 05400 RADI OLOGY-DI AGNOSTI C 1, 030, 478 0 54.00 4.554 4,554 2, 115, 122 54.00 0 06000 LABORATORY 3, 313, 795 60.00 2,611 2,611 885.689 60.00 06500 RESPIRATORY THERAPY 730, 710 65.00 117 117 953, 209 65.00 o 66.00 06600 PHYSI CAL THERAPY 903 903 545, 958 756, 165 66.00 06700 OCCUPATI ONAL THERAPY 178, 357 0 67 00 903 903 235, 849 67.00 0 06800 SPEECH PATHOLOGY 484 484 68.00 68.00 43, 720 64, 128 69 00 06900 ELECTROCARDI OLOGY 0 C 0 Λ 69 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 746, 853 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS o 72.00 0 O 538, 836 72.00 07300 DRUGS CHARGED TO PATIENTS 768 768 263, 639 0 2, 100, 217 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 6, 171 2, 349, 682 0 4, 238, 072 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 3, 594 698, 367 o 1, 216, 257 88.01 08802 RURAL HEALTH CLINIC III 3, 032 234, 482 0 473, 309 88 02 0 88 02 88.03 08803 RURAL HEALTH CLINIC IV 0 3,843 131, 231 0 314, 156 88.03 91.00 09100 EMERGENCY 5,678 5,678 2, 923, 913 0 3, 273, 405 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 69, 960 86, 600 21, 001, 433 -7, 623, 639 33, 234, 660 118. 00 NONREIMBURSABLE COST CENTERS 6, 702 190.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 278 278 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 2, 430 2,430 1, 970, 170 0 2, 816, 761 192. 00 194.00 07950 FOUNDATION / MOBS 0 194.00 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 235, 533 634, 533 4, 592, 114 7, 623, 639 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 17.002436 7.104996 0.199904 0. 211426 203. 00 152, 190 204. 00 204.00 Cost to be allocated (per Wkst. B, 0 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.004221 205.00 11) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

	FINANCIAI SYSTEMS LLOCATION - STATISTICAL BASIS	REENE COUNTY GE	Provi der C		eriod:	Worksheet B-1	
0031 7	ELEGONITOR BASIS		Trovider of	F	rom 01/01/2021 o 12/31/2021	Date/Time Pre 5/27/2022 11:	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	CAFETERI A (HOURS)	
		7. 00	8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 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	73, 509 505 504 2, 729 2, 729 496 3, 420	20, 222 0 0 0	195, 775 C C 100	11, 807 0 0 0 0	19, 185 1, 371 0	13. 00 14. 00
15.00	01500 PHARMACY	1, 284	0	5, 825		796	1
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	1, 066 286	0	200		697 314	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS INPATIENT ROUTINE SERVICE COST CENTERS	0	0	C	0	0	19.00
30.00	03000 ADULTS & PEDI ATRI CS	16, 955				4, 495	1
31.00	03100 INTENSIVE CARE UNIT	2, 680	l ·			760	
43. 00	04300 NURSERY	379	0	4, 300	0	62	43. 00
50. 00 52. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	4, 904 206	1, 968	20, 625 2, 750		936	50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	200	0			0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 554	3, 707			1, 902	
60.00	06000 LABORATORY	2, 611	0,707			2, 119	1
65. 00	06500 RESPI RATORY THERAPY	117	5			1, 130	1
66. 00	06600 PHYSI CAL THERAPY	903	3, 770			916	1
67.00	06700 OCCUPATI ONAL THERAPY	903				188	67.00
68.00	06800 SPEECH PATHOLOGY	484	0	150		84	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	C	o	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C		0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	-	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	768	0	C	0	287	73. 00
00.00	OUTPATIENT SERVICE COST CENTERS	(474			ا		00.00
88. 00 88. 01	08800 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II	6, 171 3, 594	0			0	88. 00 88. 01
88. 02	08802 RURAL HEALTH CLINIC III	3, 032	0			0	1
88. 03	08803 RURAL HEALTH CLINIC IV	3, 843	0		ol ol	0	1
91. 00	09100 EMERGENCY	5, 678	ł	43, 325		2, 306	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,			,	92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	5 7	70, 801	20, 222	186, 875	11, 807	18, 364	118. 00
100.00	NONREI MBURSABLE COST CENTERS	070		I 056	ا ما		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	278		850			190. 00 192. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 FOUNDATION / MOBS	2, 430	0	6, 050 2, 000			194.00
200.00			0	2,000	ή	0	200.00
201.00	1 1						201.00
202.00	1 9	2, 539, 948	281, 088	656, 174	432, 984	1, 016, 980	202. 00
203. 00 204. 00		34. 552885 237, 533	l			53. 009122 77, 823	203. 00 204. 00
205.00		3. 231346	0. 728167	0. 081752	6. 418904	4. 056450	205. 00
206.00	1 1 1						206. 00
207. 00	/ / /						207. 00
		•			·		

Health Fir	nancial Systems G	REENE COUNTY GET	NERAL HOSPITAL	-	In Lie	u of Form CMS-	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
					rom 01/01/2021	Date/Time Pre	narod:
				'	o 12/31/2021	5/27/2022 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
	·	ADMI NI STRATI O	SERVICES &	(COSTED	RECORDS &	SERVI CE	
		N	SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		(DI RECT NURS.	(COSTED		(TIME SPENT)		
		HRS.)	REQUI S.)				
		13. 00	14. 00	15. 00	16.00	17. 00	
	ERAL SERVICE COST CENTERS						
	00 CAP REL COSTS-BLDG & FIXT						1.00
	CAP REL COSTS-MVBLE EQUIP						2.00
	OO EMPLOYEE BENEFITS DEPARTMENT						4.00
	OO ADMINISTRATIVE & GENERAL						5.00
	OO OPERATION OF PLANT						7. 00
	300 LAUNDRY & LINEN SERVICE						8.00
	100 HOUSEKEEPI NG						9.00
	000 DI ETARY						10.00
1	OO CAFETERI A	170 (10					11.00
	NURSI NG ADMI NI STRATI ON	179, 648	0 070 000				13.00
	OO CENTRAL SERVICES & SUPPLY	0	2, 979, 203	l .			14.00
	OO PHARMACY	0	8, 037	l .			15.00
	000 MEDICAL RECORDS & LIBRARY	0	913		1	401	16.00
	OO SOCIAL SERVICE	0	2, 508	1		401	
	NONPHYSICIAN ANESTHETISTS	0	0	<u> </u>) 0	0	19.00
	ATIENT ROUTINE SERVICE COST CENTERS	0/ 20/	104 151		17 700	222	20.00
	OO ADULTS & PEDIATRICS	96, 386	104, 151			223	1
1	OO INTENSIVE CARE UNIT	15, 818	14, 906	1		62	1
	NURSERY	0	0	<u> </u>	600	0	43. 00
	ILLARY SERVICE COST CENTERS	10.460	44 F14	1	11 225	0	E0 00
	OOO OPERATING ROOM	19, 469	46, 514	1		0	1
	DELIVERY ROOM & LABOR ROOM	0	0 001			1	
	OO ANESTHESI OLOGY	0	2, 821	1		0	
	OO RADI OLOGY-DI AGNOSTI C	0	34, 776		-,	0	
	OO LABORATORY	0	1, 209, 392	i			
1	000 RESPI RATORY THERAPY 000 PHYSI CAL THERAPY	0	42, 356 6, 962	1	3, 175 1, 075	0	
	OO OCCUPATIONAL THERAPY		0, 902			0	
	SOO SPEECH PATHOLOGY		0			0	
	OO ELECTROCARDI OLOGY		0			0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	817, 994	1	1	0	
	100 IMPL. DEV. CHARGED TO PATIENTS		538, 836		-	0	
	OD DRUGS CHARGED TO PATIENTS		2, 769	l .		0	
	PATIENT SERVICE COST CENTERS	<u> </u>	2, 107	100	,ı		73.00
	OO RURAL HEALTH CLINIC	0	0		975	0	88. 00
	01 RURAL HEALTH CLINIC II	0	0			0	
	02 RURAL HEALTH CLINIC III	0	0			0	
	03 RURAL HEALTH CLINIC IV		0			0	1
	OO EMERGENCY	47, 975	82, 350	1		115	
	OO OBSERVATION BEDS (NON-DISTINCT PART)	,	,		1 .,		92.00
	CIAL PURPOSE COST CENTERS			1			/2.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	179, 648	2, 915, 285	100	99, 475	401	118.00
	REI MBURSABLE COST CENTERS	,					
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		ol	0	190.00
	OO PHYSICIANS' PRIVATE OFFICES	o	63, 918				192.00
	50 FOUNDATION / MOBS	o	0		ol		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, 407, 520	273, 379	1, 177, 591	526, 864	424, 448	
	Part I)	, ,					
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 834877	0. 091762	11, 775. 910000	5. 296446	1, 058. 473815	203.00
204.00	Cost to be allocated (per Wkst. B,	23, 719	94, 039	42, 793	33, 592	10, 558	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 132030	0. 031565	427. 930000	0. 337693	26. 329177	205.00
	11)						
206. 00	NAHE adjustment amount to be allocated						206.00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

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 01/01/2021 12/31/2021 Date/Time Prepared: 5/27/2022 11:27 am Cost Center Description NONPHYSI CI AN **ANESTHETI STS** (ASSI GNED TIME) 19.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2 00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11. 00 01100 CAFETERI A 11.00 13.00 | 01300 | NURSI NG ADMINI 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 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING 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 IMPL. 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 RURAL HEALTH CLINIC 08801 RURAL HEALTH CLINIC II 88.01 0 88.01 08802 RURAL HEALTH CLINIC III 0 88.02 88.02 08803 RURAL HEALTH CLINIC IV 88.03 0 88.03 09100 EMERGENCY 0 91 00 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 100 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 194. 00 07950 FOUNDATION / MOBS 194.00 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 304, 410 202.00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 3, 044. 100000 203.00 204.00 Cost to be allocated (per Wkst. B, 1,061 204.00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 10.610000 205.00 II)NAHE adjustment amount to be allocated 206.00 206.00 (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 207.00 207.00 Parts III and IV)

From 01/01/2021 Part I 12/31/2021 Date/Time Prepared: 5/27/2022 11:27 am Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCE Total Costs Di sal I owance (from Wkst. Adj B, Part I, col. 26) 1. 00 4. 00 5. 00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7, 327, 400 7, 327, 400 0 0 30.00 03100 INTENSIVE CARE UNIT 1, 535, 498 1, 535, 498 0 0 31.00 31.00 43.00 04300 NURSERY 121, 811 121, 811 0 0 43.00 ANCILLARY SERVICE COST CENTERS 1, 669, 564 50.00 05000 OPERATING ROOM 1, 669, 564 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 29, 366 29, 366 0 0 52.00 05300 ANESTHESI OLOGY 490, 152 490, 152 0 0 0 0 0 0 0 0 0 53.00 53.00 0 |05400| RADI OLOGY-DI AGNOSTI C 2, 925, 934 2, 925, 934 54.00 0 54.00 60.00 06000 LABORATORY 4, 435, 336 4, 435, 336 0 60.00 65.00 06500 RESPIRATORY THERAPY 1, 248, 172 1, 248, 172 0 65.00 06600 PHYSI CAL THERAPY 66.00 1, 078, 831 0 1,078,831 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 351, 414 C 351, 414 0 67.00 68.00 06800 SPEECH PATHOLOGY 100, 955 100, 955 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0 69.00 0 979, 818 979, 818 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 702, 205 702, 205 0 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 763, 853 3, 763, 853 0 0 73.00 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 88.00 08800 RURAL HEALTH CLINIC 5, 352, 515 5, 352, 515 0 0 0 88.01 08801 RURAL HEALTH CLINIC II 1,602,752 1, 602, 752 0 88.01 0 08802 RURAL HEALTH CLINIC III 683, 307 88.02 683, 307 0 88.02 518, 528 88 03 08803 RURAL HEALTH CLINIC IV 518 528 Ω 88.03 09100 EMERGENCY 0 91.00 91.00 5, 171, 149 5, 171, 149 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 225, 964 2, 225, 964 0 92.00 200.00 Subtotal (see instructions) 42. 314. 524 0 42. 314. 524 ol 0 200, 00

2, 225, 964

40, 088, 560

2, 225, 964

40, 088, 560

0 201.00

0 202.00

0

201.00

202.00

Less Observation Beds

Total (see instructions)

near tii	rinanciai systems or	REEINE COUNTY GET	VERAL HUSFITAL		III LI E	u or Form CM3-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Pre	narod:
					10 12/31/2021	5/27/2022 11:	:pareu. 27 am
-			Title	XVIII	Hospi tal	Cost	27 4111
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	'	'	+ col. 7)	Ratio	I npati ent	
				,		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	•					
30.00	03000 ADULTS & PEDIATRICS	3, 433, 522		3, 433, 52	2		30.00
31.00	03100 INTENSIVE CARE UNIT	813, 800		813, 80	0		31.00
43.00	04300 NURSERY	188, 518		188, 51	8		43.00
	ANCILLARY SERVICE COST CENTERS				·		
50.00	05000 OPERATING ROOM	904, 626	5, 047, 271	5, 951, 89	7 0. 280510	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	136, 684	3, 474	140, 15	8 0. 209521	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	287, 936	1, 029, 595	1, 317, 53	0. 372023	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	811, 357	23, 885, 227	24, 696, 58	0. 118475	0.000000	54.00
60.00	06000 LABORATORY	1, 491, 173	20, 893, 404	22, 384, 57	7 0. 198142	0.000000	60.00
65.00	06500 RESPI RATORY THERAPY	1, 449, 985	3, 006, 116	4, 456, 10	0. 280104	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	395, 091	3, 309, 516	3, 704, 60	7 0. 291213	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	137, 212	1, 032, 467	1, 169, 67	9 0. 300436	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	25, 626	173, 512	199, 13	0. 506960	0.000000	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0.000000	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 429, 717	2, 327, 320	3, 757, 03	7 0. 260795	0.000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	202, 122	377, 484	579, 60	6 1. 211521	0.000000	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3, 350, 386	11, 856, 580	15, 206, 96	6 0. 247508	0.000000	73.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	4, 569, 575	4, 569, 57	5		88. 00
88. 01	08801 RURAL HEALTH CLINIC II	0	1, 302, 515	1, 302, 51	5		88. 01
88. 02	08802 RURAL HEALTH CLINIC III	0	441, 720	441, 72	0		88. 02
88. 03	08803 RURAL HEALTH CLINIC IV	0	585, 614	585, 61	4		88. 03
91.00	09100 EMERGENCY	918, 781	24, 150, 422	25, 069, 20	0. 206275	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	222, 220	1, 602, 051	1, 824, 27	1 1. 220194	0.000000	92.00
200.00	Subtotal (see instructions)	16, 198, 756	105, 593, 863	121, 792, 61	9		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	16, 198, 756	105, 593, 863	121, 792, 61	9	ĺ	202. 00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-1317	Peri od: From 01/01/2021 To 12/31/2021	Worksheet C Part I Date/Time Prepared: 5/27/2022 11:27 am

				To 12/31/2021	Date/Time Prepared 5/27/2022 11:27 am	
			Title XVIII	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	IPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDIATRICS				30.0	
	3100 INTENSIVE CARE UNIT				31.0	
	1300 NURSERY				43. C)()
	ICILLARY SERVICE COST CENTERS					
	5000 OPERATING ROOM	0. 000000			50.0	
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0)()
	300 ANESTHESI OLOGY	0. 000000			53. C	
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000			54. C)()
60.00 06	5000 LABORATORY	0. 000000			60.0	
	5500 RESPIRATORY THERAPY	0. 000000			65.0	
66. 00 06	6600 PHYSI CAL THERAPY	0. 000000			66.0	
	5700 OCCUPATI ONAL THERAPY	0. 000000			67.0	
	800 SPEECH PATHOLOGY	0. 000000			68.0	
69. 00 06	900 ELECTROCARDI OLOGY	0. 000000			69.0)()
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000			71. C	
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. C)()
	7300 DRUGS CHARGED TO PATIENTS	0. 000000			73. C)()
	ITPATIENT SERVICE COST CENTERS					
	8800 RURAL HEALTH CLINIC				88.0	
	8801 RURAL HEALTH CLINIC II				88.0	
	8802 RURAL HEALTH CLINIC III				88.0	
	8803 RURAL HEALTH CLINIC IV				88.0	
91. 00 09	P100 EMERGENCY	0. 000000			91.0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.0	
200.00	Subtotal (see instructions)				200. C	
201.00	Less Observation Beds				201. C)()
202.00	Total (see instructions)				202. C)()

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

From 01/01/2021 To 12/31/2021 Part I Date/Time Prepared: 5/27/2022 11:27 am Title XIX Hospi tal Cost Costs Cost Center Description Total Cost 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 7, 327, 400 7, 327, 400 7, 327, 400 30.00 03100 INTENSIVE CARE UNIT 1, 535, 498 1, 535, 498 0 1, 535, 498 31.00 31.00 43.00 04300 NURSERY 121, 811 121, 811 0 121, 811 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 669, 564 1, 669, 564 1, 669, 564 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 29, 366 29, 366 0 29, 366 52.00 05300 ANESTHESI OLOGY 0 53.00 490, 152 490, 152 490, 152 53.00 |05400| RADI OLOGY-DI AGNOSTI C 2, 925, 934 2, 925, 934 2, 925, 934 54.00 54 00 60.00 06000 LABORATORY 4, 435, 336 4, 435, 336 0 4, 435, 336 60.00 65.00 06500 RESPIRATORY THERAPY 1, 248, 172 1, 248, 172 0 0 0 1, 248, 172 65.00 1, 078, 831 06600 PHYSI CAL THERAPY 66.00 1, 078, 831 1,078,831 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 351, 414 C 351, 414 351, 414 67.00 68.00 06800 SPEECH PATHOLOGY 100, 955 100, 955 100, 955 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 0 979, 818 0 979, 818 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 979, 818 71 00 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 702, 205 702, 205 0 702, 205 72.00 07300 DRUGS CHARGED TO PATIENTS 3, 763, 853 0 3, 763, 853 73.00 3, 763, 853 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 5, 352, 515 5, 352, 515 0 5, 352, 515 88.00 88.01 08801 RURAL HEALTH CLINIC II 1,602,752 1, 602, 752 0 1, 602, 752 88.01 08802 RURAL HEALTH CLINIC III 683, 307 0 88.02 683, 307 683, 307 88.02 0 88 03 08803 RURAL HEALTH CLINIC IV 518, 528 518, 528 518, 528 88 03 09100 EMERGENCY 0 91.00 5, 171, 149 5, 171, 149 5, 171, 149 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 2, 225, 964 2, 225, 964 2, 225, 964 92.00 200.00 Subtotal (see instructions) 42. 314. 524 0 42. 314. 524 ol 42, 314, 524 200. 00 2, 225, 964 2, 225, 964 2, 225, 964 201. 00 201.00 Less Observation Beds 202.00 Total (see instructions) 40, 088, 560 40, 088, 560 40, 088, 560 202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1317 Peri od: Worksheet C From 01/01/2021 Part I Date/Time Prepared: 12/31/2021 5/27/2022 11:27 am Title XIX Hospi tal Cost Charges Total (col. 6 Cost or Other Cost Center Description Inpati ent Outpati ent TEFRA I npati ent + col. 7) Ratio Ratio 6. 00 7.00 8.00 9.00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 3, 433, 522 3, 433, 522 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 813, 800 813, 800 31.00 188, 518 04300 NURSERY 188, 518 43.00 43.00 ANCILLARY SERVICE COST CENTERS 5, 951, 897 5, 047, 271 0.000000 50.00 904, 626 0 280510 50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 136, 684 3, 474 140, 158 0.209521 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 287, 936 1, 029, 595 1, 317, 531 0.372023 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 811, 357 23, 885, 227 24, 696, 584 0.118475 0.000000 54.00 22, 384, 577 06000 LABORATORY 20, 893, 404 0. 198142 0.000000 60.00 1, 491, 173 60.00 65.00 06500 RESPIRATORY THERAPY 1, 449, 985 3,006,116 4, 456, 101 0. 280104 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 395, 091 3, 309, 516 3, 704, 607 0. 291213 0.000000 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 137, 212 1,032,467 1, 169, 679 0.300436 67.00 68.00 06800 SPEECH PATHOLOGY 25, 626 173, 512 199, 138 0.506960 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1, 429, 717 3, 757, 037 0.000000 71.00 2, 327, 320 0. 260795 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 202, 122 377, 484 579,606 1. 211521 0.000000 72 00 07300 DRUGS CHARGED TO PATIENTS 3, 350, 386 11, 856, 580 0.247508 0.000000 73.00 15, 206, 966 73.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 4, 569, 575 0.000000 88.00 4, 569, 575 1.171338 88.00 88.01 08801 RURAL HEALTH CLINIC II 0 1, 302, 515 1, 302, 515 1. 230506 0.000000 88.01 88.02 08802 RURAL HEALTH CLINIC III 0 441, 720 441, 720 1.546923 0.000000 88.02 88.03 08803 RURAL HEALTH CLINIC IV 0 585, 614 585, 614 0.885443 0.000000 88.03 09100 EMERGENCY 0. 206275 91 00 918, 781 24, 150, 422 25, 069, 203 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 222, 220 1,602,051 1, 824, 271 1.220194 0.000000 92.00 200.00 16, 198, 756 121, 792, 619 200.00 Subtotal (see instructions) 105, 593, 863

16, 198, 756

105, 593, 863

121, 792, 619

201.00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provider CCN: 15	From 01/01/2021	Worksheet C Part I Date/Time Prepared: 5/27/2022 11:27 am
	Ti +I A VI V	(Hospital	Cost

				10 12/31/2021	5/27/2022 11: 27 am
			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 RESPI RATORY THERAPY	0. 000000			65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000			69.00
71. 00		0. 000000			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00		0. 000000			73. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00		0. 000000			88.00
88. 01	08801 RURAL HEALTH CLINIC II	0. 000000			88. 01
88. 02		0. 000000			88. 02
88. 03		0. 000000			88. 03
91.00	09100 EMERGENCY	0. 000000			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
200.00					200. 00
201.00					201.00
202.00	Total (see instructions)				202.00

Health Financial Systems GR	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part II Date/Time Pre 5/27/2022 11:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	152, 779		1		5, 859	
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 153	140, 158	1		0	52.00
53. 00 05300 ANESTHESI OLOGY	803		1		74	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	147, 403		1			
60. 00 06000 LABORATORY	137, 892					
65. 00 06500 RESPI RATORY THERAPY	14, 431	4, 456, 101	0. 00323	8 693, 808	2, 247	65.00
66. 00 06600 PHYSI CAL THERAPY	35, 516	3, 704, 607	0. 00958			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	27, 663	1, 169, 679			448	
68. 00 06800 SPEECH PATHOLOGY	13, 957	199, 138	0. 07008	7 10, 370	727	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 972	3, 757, 037	0. 00771	1 204, 999	1, 581	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 282	579, 606	0. 03326	7 118, 626	3, 946	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	73, 906	15, 206, 966	0. 00486	0 1, 815, 977	8, 826	73.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	81, 990	4, 569, 575	0. 01794	3 0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	42, 611	1, 302, 515	0. 03271	4 0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	33, 666	441, 720	0. 07621	6 0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	41, 377	585, 614	0. 07065	6 0	0	88. 03
91. 00 09100 EMERGENCY	208, 395	25, 069, 203	0. 00831	3 61, 750	513	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	178, 571	1, 824, 271	0. 09788	6 1, 406	138	92.00
200.00 Total (lines 50 through 199)	1, 245, 367	117, 356, 779		4, 473, 184	32, 163	200.00

THROUGH COSTS

				To 12/31/2021	Date/Time Pre	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	Anesthetist	Program	Program	Post-Stepdown		
	Cost	Post-Stepdown		Adjustments		
		Adjustments				
	1. 00	2A	2. 00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATING ROOM	0	0		0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00 05300 ANESTHESI OLOGY	304, 410	0		0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
60. 00 06000 LABORATORY	0	0		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	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
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS				_		
88. 00 08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0	0		0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0	0		0	0	88. 02
88.03 08803 RURAL HEALTH CLINIC IV	0	0		0	0	88. 03
91. 00 09100 EMERGENCY	0	0		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	304, 410	0		0 0	0	200. 00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
ADDODTI ONMENT OF INDATIENT/OUTDATIENT	ANCILLARY SERVICE OTHER DASS Drovi dor CCN: 15 1217	Pariod: Warkshoot D

Period: From 01/01/2021 To 12/31/2021 Part IV THROUGH COSTS Date/Time Prepared: 5/27/2022 11:27 am Title XVIII Hospi tal Cost Cost Center Description All Other Total Cost Total Charges Ratio of Cost Total to Charges Medi cal (sum of cols. (from Wkst. Outpati ent C, Part I, (col. 5 ÷ Educati on 1, 2, 3, and Cost (sum of 4) Cost col s. 2, 3, col. 8) col. 7) and 4) (see instructions) 7. 00 4. 00 5.00 6.00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 5, 951, 897 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 140, 158 0.000000 52.00 52.00 0 0 05300 ANESTHESI OLOGY 304, 410 1, 317, 531 0 0.231046 53.00 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 24, 696, 584 0.000000 C 54.00 60.00 06000 LABORATORY 0 0 0 0 0 0 0 0 22, 384, 577 0.000000 60.00 65.00 06500 RESPIRATORY THERAPY 0 4, 456, 101 0.000000 65.00 06600 PHYSI CAL THERAPY 0 3, 704, 607 66.00 0 0.000000 66.00 0 67.00 06700 OCCUPATI ONAL THERAPY 0 1, 169, 679 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 199, 138 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 3, 757, 037 0.000000 71.00 71.00 C 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 579, 606 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0.000000 73.00 0 15, 206, 966 73.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 4, 569, 575 0.000000 88.00 88. 01 08801 RURAL HEALTH CLINIC II 0 0 0 1, 302, 515 0.000000 88.01 88. 02 08802 RURAL HEALTH CLINIC III 441, 720 0 0 0 0.000000 88.02 88.03 08803 RURAL HEALTH CLINIC IV 0 0.000000 0 585, 614 88 03 0 91. 00 | 09100 | EMERGENCY 0 25, 069, 203 0.000000 91.00

0

0

304, 410

1, 824, 271

117, 356, 779

0

0.000000

92.00

200.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

200.00

Total (lines 50 through 199)

Health Financial Systems	GREENE COUNTY GE	NERAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PAS	S Provider CCN: 15-1317	From 01/01/2021	Worksheet D Part IV Date/Time Prepared:

Inkough COSIS				o 12/31/2021	Date/Time Pre 5/27/2022 11:	pared:
		Title	XVIII	Hospi tal	Cost	21 alli
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	Charges	Pass-Through	
	(col. 6 ÷	Ü	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						
50.00 05000 OPERATING ROOM	0. 000000	228, 269	(0	0	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	(0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	121, 701	28, 119	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	386, 230		0	0	54.00
60. 00 06000 LABORATORY	0. 000000	664, 453		0	0	60.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	693, 808		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	146, 666		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	18, 929		0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	10, 370	(0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	(0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	204, 999		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	118, 626		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 815, 977	(0	0	73. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0	(0	0	88. 00
88.01 08801 RURAL HEALTH CLINIC II	0. 000000	0	(0	0	88. 01
88.02 08802 RURAL HEALTH CLINIC III	0. 000000	0	(0	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	0. 000000	0	(0	0	88. 03
91. 00 09100 EMERGENCY	0. 000000	61, 750		0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 406		0	0	92.00
200.00 Total (lines 50 through 199)		4, 473, 184	28, 119	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1317 Peri od: Worksheet D From 01/01/2021 To 12/31/2021 Part V Date/Time Prepared: 5/27/2022 11:27 am 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 1, 095, 454 50.00 0. 280510 05200 DELIVERY ROOM & LABOR ROOM 0 0.209521 52.00 52.00 0 0 0 53. 00 | 05300 | ANESTHESI OLOGY 0. 372023 0 464, 337 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.118475 6, 445, 850 0 0 0 0 0 0 0 54.00 60.00 06000 LABORATORY 0. 198142 6, 215, 343 0 60.00 06500 RESPIRATORY THERAPY 65.00 0. 280104 828, 156 0 65.00 66.00 06600 PHYSI CAL THERAPY 0. 291213 0 1, 179, 998 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0.300436 343, 030 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.506960 0 45, 811 0 68.00 0 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 260795 0 501,006 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1. 211521 0 72.00 113, 845 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 401 73.00 0. 247508 4, 926, 145 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 08801 RURAL HEALTH CLINIC II 88. 01 88.01 08802 RURAL HEALTH CLINIC III 88. 02 88 02 08803 RURAL HEALTH CLINIC IV 88.03 88.03 91.00 09100 EMERGENCY 0. 206275 6, 042, 583 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 1. 220194 0 456, 559 0 Subtotal (see instructions) 200.00 Ω 28, 658, 117 0 200.00 1, 401 201.00 Less PBP Clinic Lab. Services-Program 0 201.00

28, 658, 117

1, 401

0 202.00

Only Charges

202.00

Net Charges (line 200 - line 201)

Peri od: Worksheet D From 01/01/2021 Part V

				To 12/31/2021	Date/Time Prep 5/27/2022 11:2	
		Title	XVIII	Hospi tal	Cost	
	Cos	sts				
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	007.00/	_	1			
50. 00 05000 OPERATI NG ROOM	307, 286	0				50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	172, 744					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	763, 672	l e				54.00
60. 00 06000 LABORATORY	1, 231, 520	l .				60.00
65. 00 06500 RESPI RATORY THERAPY	231, 970	l e				65.00
66. 00 06600 PHYSI CAL THERAPY	343, 631					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	103, 059	l e				67.00
68. 00 06800 SPEECH PATHOLOGY	23, 224	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	130, 660	l e				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	137, 926					72.00
73. 00 O7300 DRUGS CHARGED TO PATIENTS	1, 219, 260	347				73.00
OUTPATIENT SERVICE COST CENTERS		Γ				00.00
88. 00 08800 RURAL HEALTH CLINIC						88.00
88. 01 08801 RURAL HEALTH CLINIC II						88. 01
88. 02 08802 RURAL HEALTH CLINIC III						88. 02
88. 03 08803 RURAL HEALTH CLINIC IV	1 04/ 404					88. 03
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 246, 434	0				91. 00 92. 00
	557, 091	347				
200.00 Subtotal (see instructions)	6, 468, 477	347				200.00
201.00 Less PBP Clinic Lab. Services-Program	0				•	201. 00
Only Charges 202.00 Net Charges (line 200 - line 201)	6, 468, 477	347			ļ.	202. 00
202.00	0,400,477	1 347	I		l·	202.00

Heal th Financ	cial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTI ONMEN	T OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider Co		Period: From 01/01/2021 To 12/31/2021	Worksheet D Part V Date/Time Pre 5/27/2022 11:	
			Ti tl	e XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see		Services Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9		(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ARY SERVICE COST CENTERS	0.00510					
	OPERATI NG ROOM	0. 280510	0	684, 37	0	0	
	DELIVERY ROOM & LABOR ROOM	0. 209521	0		0	0	
	ANESTHESI OLOGY	0. 372023	0	11, 59		0	
	RADI OLOGY-DI AGNOSTI C	0. 118475	0	2, 000, 00		0	
	LABORATORY	0. 198142	0	2, 198, 03		0	
	RESPI RATORY THERAPY	0. 280104	0	290, 56		0	65.00
	PHYSI CAL THERAPY	0. 291213	0	158, 57		0	66.00
	OCCUPATI ONAL THERAPY	0. 300436		34, 84		0	67.00
	SPEECH PATHOLOGY	0. 506960		85, 79	2 0	0	68. 00
	ELECTROCARDI OLOGY	0. 000000			0	0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 260795	0	176, 68	1 0	0	71.00
	IMPL. DEV. CHARGED TO PATIENTS	1. 211521	0		0	0	72.00
	DRUGS CHARGED TO PATIENTS	0. 247508	0	558, 95	5 0	0	73. 00
	TIENT SERVICE COST CENTERS	T		T			
	RURAL HEALTH CLINIC						88. 00
	RURAL HEALTH CLINIC II						88. 01
	RURAL HEALTH CLINIC III						88. 02
	RURAL HEALTH CLINIC IV		_		_	_	88. 03
	EMERGENCY	0. 206275	0	3, 233, 38		0	
	OBSERVATION BEDS (NON-DISTINCT PART)	1. 220194	0	159, 31		0	,
	Subtotal (see instructions)		0	9, 592, 11	1 0	0	200.00
	Less PBP Clinic Lab. Services-Program				U 0		201.00
	Only Charges			0 500 11	1	_	202 00
202. 00	Net Charges (line 200 - line 201)	l	0	9, 592, 11	1 0	0	202. 00

Period: Worksheet D From 01/01/2021 Part V To 12/31/2021 Date/Time Pr

			To	12/31/2021	Date/Time Pre 5/27/2022 11:	
		Ti tl e	e XIX	Hospi tal	Cost	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subj ect To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	101 070					
50. 00 05000 OPERATI NG ROOM	191, 973	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	4, 313	0				53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	236, 950	0				54.00
60. 00 06000 LABORATORY	435, 523	0				60.00
65. 00 06500 RESPIRATORY THERAPY	81, 389	0				65.00
66. 00 06600 PHYSI CAL THERAPY	46, 179	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 468	0				67.00
68. 00 06800 SPEECH PATHOLOGY	43, 493	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	U 51 51 51 51 51 51 51 51 51 51 51 51 51	0				69.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	TIENTS 46, 078	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	120 244	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	138, 346	0				73.00
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC						88. 00
88.01 08800 RURAL HEALTH CLINIC						88.00
88. 02 08802 RURAL HEALTH CLINIC III		+				88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		+				88. 03
91. 00 09100 EMERGENCY	666, 966	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT		0				91.00
200.00 Subtotal (see instructions)	2, 096, 073	0				200.00
201.00 Less PBP Clinic Lab. Services-F		U				200.00
Only Charges	1 Ogi aiii					201.00
202.00 Net Charges (line 200 - line 20	2, 096, 073	О				202.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-1317	Peri od: From 01/01/2021	Worksheet D-1	
			Date/Time Prep 5/27/2022 11:2	
	Title XVIII	Hospi tal	Cost	
Cost Center Description				

1.00			Title XVIII	Hospi tal	Cost	21 alli_
NAME		Cost Center Description		110061 101	3331	
MPATIENT IMANS					1. 00	
Inpatient days (including private room days and swing-bed days, excluding neeborn) 3,407 1,00 2,00 1,00 2,00 1,00 2,00 2,00 1,00 2,00						
1. Injustient days (including private room days, excluding swing-bed and newborn days) 1. 1. 1. 1. 1. 1. 1. 1	1. 00		s. excluding newborn)		3, 407	1.00
do not complete this line. 4. 00 Seing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10. 00 Sing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newbork days) (see instructions) 11. 00 Sing-bed SNF type inpatient days applicable to the cost including private room days) after becomes a first type inpatient days applicable to the swing swing-bed SNF type inpatient days applicable to the swing swing-bed SNF type inpatient days applicable to the swing swing-bed SNF type inpatient days applicable to the swing swing-bed SNF type inpatient days applicable to the swing swing-bed SNF type inpatient days applicable to the swing swing-bed SNF type inpatient days applicable to the swing swing-bed SNF type inpatient days applicable to swing-bed SNF type inpatient days applicable to swing-bed SNF type swing swing-bed SNF type					· ·	
	3.00		ys). If you have only pr	ivate room days,	0	3. 00
Total xwi ng-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line)		·			4 007	
reporting period (or 21 of the cost		
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 9. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 9. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost 10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12. 00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to titles V or XX xonly (including private room days) 14. 00 Modically necessary private room days applicable to titles V or XX xonly (including private room days) 15. 00 Total nursery days (title V or XX xonly) 16. 00 Nursery days (title V or XX xonly) 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18. 00 Medically necessary private room days applicable to services through December 31 of the cost 18. 00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medical rate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medical rate for swing-bed SNF services after December 31 of the cost reporting period (line 5 x x line 19) 22. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 19) 23. 00 Sing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x	5.00		oni days) trii odgii becembe	i 31 of the cost	365	3.00
7.00 Total swing-bed NF type inpatient days (including private room days) after becember 31 of the cost reporting period (17 calendar year, enter 0 on this line) 7.00 Total inpatient days including private room days apricable to the Program (excluding swing-bed and private room days applicable to the Program (excluding swing-bed and provide room days applicable to the Program (excluding swing-bed and provide room days) 7.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and provide room days) 7.00 Swing-bed SNF type inpatient days applicable to the trial tax VIII entry (including private room days) 7.00 Swing-bed SNF type inpatient days applicable to the trial Excluding private room days) 7.00 Swing-bed SNF type inpatient days applicable to the vice of this line) 7.00 Swing-bed NF type inpatient days applicable to the Vice Vor XIX only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.02 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.03 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.04 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.05 Total nursery days (title V or XIX only) 7.06 Swing-Bo ANIISTWENT 7.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 7.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days) 7.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (including swing-bed cost applicable to SNF type services aft	6.00		om days) after December	31 of the cost	0	6. 00
reporting period No. 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) Total inpatient days including private room days applicable to the Program (excluding swing-bed and nowborn days) (see Instructions) No. Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) and to the private room days (see Instructions) No. Swing-bed SNF type Inpatient days applicable to title XVIII only (including private room days) after the private private private private period (see instructions) No. Swing-bed SNF type Inpatient days applicable to titles XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) No. 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 (see instructions) No. 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 (see instructions) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nursery days (title V or XIX only) No. Of total nurs						
7. 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) 7. Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 8. Do Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after solved through becember 31 of the cost reporting period (see instructions) 8. Journal of the cost reporting period (see instructions) 9. Do Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after solved through becember 31 of the cost reporting period to title XVIII only (including private room days) after solved SNF type inpatient days applicable to title XVIII only (including private room days) solved SNF type Inpatient days applicable to title XVIII only (including private room days) solved SNF type Inpatient days applicable to title XVIII only (including private room days) solved SNF type Inpatient days applicable to titles V or XIX only (including private room days) solved SNF type Inpatient days applicable to titles V or XIX only (including private room days) solved SNF solved SNF solved SNF solved SNF solved SNF SNF solved SNF solv	7. 00		m days) through December	31 of the cost	0	7.00
reporting period (if calendar year, enter 0 on this I ine) 0.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Exceeded 1.00 The cost reporting period (see instructions) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (for calendar year, enter 0 on this iine) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 1	8 00		m davs) after December 3	1 of the cost	0	8 00
newborn days) (see instructions) 306 10.00 307 307 308 309			,		_	
10.00 Swing-bed Shif type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed Shif type inpatient days applicable to title XVIII only (including private room days) after become 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed Shif type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed Nif type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed Nif type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Swing-bed Nife V type inpatient days applicable to the Program (excluding swing-bed days) 17.00 Swing-bed (title V or XIX only) 18.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19	9. 00		o the Program (excluding	swing-bed and	1, 030	9. 00
through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 0 11.00 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 (including private room days) 1 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 1 14.00 Nedical In necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 Nedical In precessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 Nedical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 1 14.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 1 14.00 Nedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 1 14.00 Nedical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 1 14.00 Nedical drate for swing-bed NF services applicable to services after December 31 of the cost 1 14.00 Nedical drate for swing-bed NF services applicable to services after December 31 of the cost 1 14.00 Nedical drate for swing-bed NF services applicable to services after December 31 of the cost 1 14.00 Nedical drate for swing-bed NF services after December 31 of the cost reporting period (line 2 2 2.00 Nedical drate for swing-bed NF services after December 31 of the cost reporting period (line 3 2 2.00 Nedical drate for swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 3 2 2.00 Nedical Archives) NF NF NF NF NF NF	10 00		nly (including private r	coom dove)	204	10.00
11.00 Swing-bed SNF type Inpatient days applicable to fittle XVIII only (Including private room days) after 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 ItItles V or XIX only (Including private room days) 13.00 Swing-bed NF type inpatient days applicable to ItItles V or XIX only (Including private room days) 14.00 Medically necessary private room days applicable to ItItles V or XIX only (Including private room days) 15.00 Necessary private room days applicable to ItItles V or XIX only (Including private room days) 16.00 Nursery days (ItItle V or XIX only) 17.00 Nursery days (ItITle V or XIX only) 18.00 Nursery days (ItITle V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period of reporting reporting	10.00			Oolii days)	300	10.00
12.00 Swing-bed NF type inpatient days applicable to titles \(\tilde{V} \) or XIX only \(\tilde{V} \) including private room days \(\tilde{V} \) or Swing-bed NF type inpatient days applicable to titles \(\tilde{V} \) or XIX only \(\tilde{V} \) including private room days \(\tilde{V} \) or XIX only \(\tilde{V} \) including private room days \(\tilde{V} \) or XIX only \(\tilde{V} \) on XIX only \(\tilde{V} \) or XIX only \(\tilde{V}	11.00			oom days) after	0	11.00
through December 31 of the cost reporting period 31.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 41.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 51.00 51.00 Total nursery days (title V or XIX only) 51.00 Total nursery days (title V or XIX only) 51.00 51.00 Norsery days (title V or XIX only) 51.00 51.00 Norsery days (title V or XIX only) 51.00 51.00 51.00 Norsery days (title V or XIX only) 51.00 51.00 51.00 51.00 Norsery days (title V or XIX only) 51.00 51.00 51.00 Norsery days (title V or XIX only) 51.00 51.						
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only V (including private room days) 13.00 13.00 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 0 15.00 1	12. 00		X only (including privat	e room days)	0	12.00
after December' 31 of the cost reporting period (if calendar year, enter 0 on this line) 14.00 15.00 16.00 1	13 00		X only (including privat	e room davs)	Λ	13 00
15.00 Total nursery days (title V or XIX only) 0 15.00	10.00				G	10.00
16.00 Nursery days (title V or XIX only) Note BED ADJUSTMENT 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting p	14.00		am (excluding swing-bed	days)	0	
SWING BED ADJUSTMENT						
17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18. 00 19. 00	16.00				0	16.00
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Sowii OT	ATION OF INPATIENT OPERATING COST		Provi der C		Peri od:	Worksheet D-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	pared:
			Ti +Lo	e XVIII	Hospi tal	5/27/2022 11: Cost	27 am
	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)	
40.00	NUDCEDY (1'11 - W o WIV - 1)	1. 00	2.00	3.00	4.00	5. 00	40.00
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.00
43. 00 44. 00 45. 00 46. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	1, 535, 498	263	5, 838. 4	0 156	910, 790	43. 00 44. 00 45. 00 46. 00 47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wk					1, 195, 819	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		4, 321, 820	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	n of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services (f	rom Wkst. D, s	sum of Parts II	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ding capital re	lated, non-ph	ysician anestl	netist, and	0	
54.00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					-	55.00
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raot amount (lino 54 minus	lino 52)	0	
	Bonus payment (see instructions)	ring cost and ta	rget amount (Title 50 III lius	111le 33)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59.00
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see	s 55, 59 or 60 on expected costs	enter the Les	ser of 50% of		0.00	60. 00 61. 00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ŕ	ctions)			0	
64. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of th	e cost reporti	ng period (See	658, 111	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the	cost reportino	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line	65)(title XVII	I only). For	658, 111	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19) $$	e costs through	December 31	of the cost re	eporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)			·	orting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37))		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71.00
73. 00	Medically necessary private room cost applic	,	(line 14 x l	ine 35)			73.00
74.00	Total Program general inpatient routine serv	•		•			74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)		costs (from	Worksheet B, F	Part II, column		75.00
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	s line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces	, ,		,	70)		79.00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ust limitatio	n (IINe /8 mir	nus IIne /9)		80. 00 81. 00
82. 00	Inpatient routine service cost per drem I millimitation (I)				82.00
83.00	Reasonable inpatient routine service costs (see instruction					83.00
	Program inpatient ancillary services (see in		nc)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
55. 66	PART IV - COMPUTATION OF OBSERVATION BED PASS		. cagii 00)				33.00
	Total observation bed days (see instructions	•				1, 035	1
87. 00 88. 00	Adjusted general inpatient routine cost per					2, 150. 69	

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 CO		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 11:	
		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	587, 817	7, 327, 400	0. 08022	2 2, 225, 964	178, 571	90.00
91.00 Nursing Program cost	0	7, 327, 400	0.00000	0 2, 225, 964	0	91.00
92.00 Allied health cost	0	7, 327, 400	0.00000	0 2, 225, 964	0	92.00
93.00 All other Medical Education	0	7, 327, 400	0. 00000	0 2, 225, 964	0	93. 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 01/01/2021	Worksheet D-1	
			Date/Time Pre 5/27/2022 11:	pared: 27 am
	Title XIX	Hospi tal	Cost	
Cost Center Description				
			1 00	

No. No. No. No. No. No. No.			Title XIX	Hospi tal	5/21/2022 TT: Cost	27 alli_
NAMED MAN NAME		Cost Center Description	THE ALK	nospi tui	0031	
MARTIERT DAYS 1.00 Inpatient days (including private room days and saing-bed days, excluding envirorm) 3, 407 1.00 Inpatient days (including private room days, excluding saing-bed and member days) 3, 207 2, 208		<u> </u>			1. 00	
1.00 Ingatient days (including private room days and swing-bed days, excluding newborn) 3.407 1.00						
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Private room days (excluding swing-bed and observation bed days) If you have only private room days 0 3 0			,		•	
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reporting period (if callendar year, enter 0 on this line) 7. 00	4.00	Semi-private room days (excluding swing-bed and observation b	ed days)		1, 987	4.00
10	5.00		om days) through Decembe	er 31 of the cost	385	5. 00
reporting period (if Calendar year, enter 0 on this line) 7. 00 Total swing-bed Nr type inpatient days (including private room days) strough December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 8. 00 Total swing-bed Nr type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 10. 00 Swing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) 11. 00 Swing-bed SW type inpatient days applicable to tille SWIII only (including private room days) after 0 through December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 12. 00 Swing-bed SW type inpatient days applicable to tille SWIII only (including private room days) after 0 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 tilles V or XIX only (including private room days) 13. 00 Swing-bed NF type inpatient days applicable to the Program (excluding private room days) 14. 00 Medically necessary private room days applicable to the Program (excluding private room days) 15. 00 Total nursery days (title V or XIX only) 16. 00 Nursery days (title V or XIX only) 17. 00 Medicare rate for swing-bed SW services applicable to services through December 31 of the cost cost in the cost cost in the cost cost applicable to SW services after December 31 of the cost opporting period (including private room days) 18. 00 Medical drate for swing-bed SW services applicable to services through December 31 of the cost cost in post of the cost cost applicable to SW services after December 31 of the cost cost opporting period (including private room days) 18. 00 Medical drate for swing-bed SW services applicable to services after December 31 of the cost cost applicable to SW type services after December 31 of the cost reporting period (line 0 x x including swing-bed cost applicable to SW type services after					_	
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20.00 Medical d'rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 7, 327, 400 21.00 20.00	19.00		s through December 31 of	the cost	0. 00	19. 00
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21.00 Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost see instructions) 27.00 Experimental and the cost reporting period (line 8 x line 20) 28.00 Total swing-bed cost (see instructions) 29.00 Total swing-bed cost (see instructions) 20.00 Total swing-bed cost applicable to NF type service safter December 31 of the cost reporting period (line 8 of the cost reporting period (line 9 of th	20.00		s after December 31 of t	ne cost	0.00	20.00
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 x line 20) 26.00 7 x line 19) 26.00 27.00 28.00 27.00 28.00 27.00 28.00 27.00 28.00 28.00 27.00 28.0	21. 00	' 3 '	s)		7, 327, 400	21.00
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27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 150. 69 38.00 Program general inpatient routine service cost (line 9 x line 38) 70, 973 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,				
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PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 2, 150.69 38.00 Program general inpatient routine service cost (line 9 x line 38) 70, 973 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
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		,	•			39. 00
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 70,973 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41. 00	Iotal Program general inpatient routine service cost (line 39	+ line 40)		70, 973	41.00

	Financial Systems GR FATION OF INPATIENT OPERATING COST	REENE COUNTY GEI	Provi der C		Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2021 To 12/31/2021	Date/Time Pre	
			T: +1	o VIV		5/27/2022 11:	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	e XIX Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 121, 811	2. 00	3. 00 1, 015. 0	4.00	5. 00	42.00
72.00	Intensive Care Type Inpatient Hospital Units		120	1,013.	,,,	0,071	1 42.00
	CORONARY CARE UNIT	1, 535, 498	263	5, 838. 4	5	29, 192	43. 00 44. 00 45. 00 46. 00 47. 00
	<u> </u>					1. 00	
48.00	Program inpatient ancillary service cost (Wks			>		179, 392	
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruction	ons)		285, 648	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m 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,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines!	,				0	
53. 00	Total Program inpatient operating cost excluded medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		elated, non-phy	ysician anest	hetist, and	0	53.00
54.00	Program di scharges					0	54.00
55.00							55.00
56. 00 57. 00	,	ing cost and ta	arget amount (line 56 minus	line 53)	0	1
58.00	1					0	
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996,	updated and c	ompounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year					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	0	61.00				
62.00	Relief payment (see instructions)	0	62.00				
63.00	Allowable Inpatient cost plus incentive paymore PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00				
64. 00		0	64.00				
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cosi instructions)(title XVIII only)</pre>	ts after Decemb	per 31 of the (cost reportin	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
67. 00	(line 12 x line 19)	3			. 31	0	
	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)				orting period		69.00
57.00	Total title V or XIX swing-bed NF inpatient of PART III - SKILLED NURSING FACILITY, OTHER NU						07.00
70.00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of)		70.00
71. 00 72. 00	, , ,	,	THE TO - TIME	۷)			71.00
73.00	Medically necessary private room cost application						73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient (26, line 45)				Part II, column		74. 00 75. 00
76.00	Per diem capital-related costs (line 75 ÷ li						76.00
77. 00 78. 00	,	,					77.00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p		*.			79.00
80.00			cost limitation	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		1)				81.00
83. 00	Reasonable inpatient routine service costs (see instruction	* .				83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		nns)				84.00
86. 00	1	,	,				86.00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1 025	07.00
	Total observation bed days (see instructions)	•				1, 035	
87. 00 88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷	- line 2)			2, 150. 69	88.00

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 CO		Peri od:	Worksheet D-1	
				From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 11:	
		Ti tl	e XIX	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	587, 817	7, 327, 400	0. 08022	2 2, 225, 964	178, 571	90.00
91.00 Nursing Program cost	0	7, 327, 400	0.00000	0 2, 225, 964	0	91.00
92.00 Allied health cost	0	7, 327, 400	0.00000	0 2, 225, 964	0	92.00
93.00 All other Medical Education	0	7, 327, 400	0. 00000	0 2, 225, 964	0	93. 00

Heal th Financial Systems GREENE COUNTY GEN	_			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-1317	Peri od: From 01/01/2021	Worksheet D-3	3
			To 12/31/2021	Date/Time Pre	nared.
			10 12/01/2021	5/27/2022 11:	
	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)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 604, 694		30.00
31.00 O3100 INTENSIVE CARE UNIT			405, 448		31.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2805		64, 032	
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 20952		0	
53. 00 05300 ANESTHESI OLOGY		0. 37202	·	45, 276	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1184	·		
60. 00 06000 LABORATORY		0. 1981	·		
65. 00 06500 RESPI RATORY THERAPY		0. 28010	·		
66. 00 06600 PHYSI CAL THERAPY		0. 2912			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 30043	·		
68. 00 06800 SPEECH PATHOLOGY		0. 50696	·	5, 257	
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26079			
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 21152			
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 24750	08 1, 815, 977	449, 469	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
88. 01 08801 RURAL HEALTH CLINIC II		0.00000		0	00.0.
88. 02 08802 RURAL HEALTH CLINIC III		0.00000		0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		0.00000		0	88. 03
91. 00 09100 EMERGENCY		0. 2062			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 22019	·		
200.00 Total (sum of lines 50 through 94 and 96 through 98)			4, 473, 184		1
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (Line 61)		0		201 00

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

201. 00 202. 00

4, 473, 184

201.00

202.00

Health Financial Systems GREENE COUNTY GE				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
	C		From 01/01/2021	D-+- /T: D	
	component	CCN: 15-Z317	To 12/31/2021	Date/Time Pre 5/27/2022 11:	
	Title	e XVIII	Swing Beds - SNF		27 4111
Cost Center Description	11 11	Ratio of Cos		I npati ent	
5550 551151 55551 Pt 1511		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
			3	col . 2)	
		1.00	2. 00	3. 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. 28051	0 2, 419	679	50.00
52. OO 05200 DELIVERY ROOM & LABOR ROOM		0. 20952	1 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 37202	3 1, 379	513	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11847	5 12, 707	1, 505	54.00
60. 00 06000 LABORATORY		0. 19814	2 33, 729	6, 683	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 28010	53, 211	14, 905	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 29121	3 127, 970	37, 267	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 30043	6 83, 078	24, 960	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 50696	0 5, 124	2, 598	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26079	5 34, 214	8, 923	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 21152	1 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 24750	124, 021	30, 696	73.00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0. 00000		0	88.00
88. 01 08801 RURAL HEALTH CLINIC II		0. 00000		0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III		0. 00000		0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		0. 00000		0	88. 03
01 00 00100 EMEDGENCY		0 20/27		_	01 00

0. 206275

1. 220194

201. 00 202. 00

0 91.00 0 92.00 128,729 200.00

91. 00 09100 EMERGENCY

200.00

201.00 202.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

Health Financial Systems GREENE COUNTY GENE	RAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
			From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 11:	
	Ti tl	e XIX	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)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			163, 590	l	30.00
31.00 03100 NTENSIVE CARE UNIT			59, 800	l	31.00
43. 00 04300 NURSERY			146, 452		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 28051			50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 20952	1 24, 318	5, 095	52.00
53. 00 05300 ANESTHESI OLOGY		0. 37202		2, 689	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11847	5 38, 052	4, 508	54.00
60. 00 06000 LABORATORY		0. 19814		28, 159	60.00
65. 00 06500 RESPI RATORY THERAPY		0. 28010	4 107, 519	30, 117	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 29121	3 8, 661	2, 522	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 30043	6 1, 432	430	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 50696	0 622	315	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00000	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 26079	5 68, 371	17, 831	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 21152	1 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 24750	8 188, 173	46, 574	73.00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		1. 17133	8 0	0	88. 00
88. 01 08801 RURAL HEALTH CLINIC II		1. 23050	6 0	0	88. 01
88. 02 08802 RURAL HEALTH CLINIC III		1. 54692	3 0	0	88. 02
88. 03 08803 RURAL HEALTH CLINIC IV		0. 88544	3 0	0	88. 03
01 00 00100 EMERCENCY		0 20/27	1 1 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	01 711	01 00

201. 00 202. 00

31, 711 91. 00 0 92. 00 179, 392 200. 00

0. 206275 1. 220194

91. 00 | 09100 | EMERGENCY | 92. 00 | 09200 | OBSERVATION BEDS (NON-DISTINCT PART)

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

200.00

201.00 202.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-1317	Peri od: From 01/01/2021 To 12/31/2021	Worksheet E Part B Date/Time Prepared: 5/27/2022 11:27 am

	Title Will Head to	5/27/2022 11:	27 am
	Title XVIII Hospital	Cost	
		1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES	/ 4/0 024	1 1 0
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	6, 468, 824	1. 00 2. 00
3. 00	OPPS payments		
4. 00	Outlier payment (see instructions)	O	
4. 01	Outlier reconciliation amount (see instructions)	0	4.0
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	
6.00	Line 2 times line 5	0	6. 00 7. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)	0.00	
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		
10.00	Organ acqui si ti ons	O	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	6, 468, 824	11.0
	COMPUTATION OF LESSER OF COST OR CHARGES		
12. 00	Reasonable charges Ancillary service charges	0	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
	Total reasonable charges (sum of lines 12 and 13)	0	l
	Customary charges		[
	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16. 00	Amounts that would have been realized from patients liable for payment for services on a chargebasis	0	16.00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17.00
	Total customary charges (see instructions)	0.000000	18.0
	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	0	ı
	instructions)		
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.0
21 00	instructions) Lesser of cost or charges (see instructions)	6, 533, 512	21.0
	Interns and residents (see instructions)	0, 555, 512	
	Cost of physicians' services in a teaching hospital (see instructions)	0	ı
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
	Deductibles and coinsurance amounts (for CAH, see instructions)	40,046	
	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	4, 504, 750 1, 988, 716	
27.00	instructions)	1, 700, 710	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.0
	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.0
	Subtotal (sum of lines 27 through 29)	1, 988, 716	1
	Primary payer payments Subtotal (line 30 minus line 31)	258 1, 988, 458	1
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)	1,700,100	02.0
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.0
	Allowable bad debts (see instructions)	1, 007, 328	
	Adjusted reimbursable bad debts (see instructions)	654, 763	
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	4, 659 2, 643, 221	
	MSP-LCC reconciliation amount from PS&R	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		39. 5
	Demonstration payment adjustment amount before sequestration	0	
	Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION	0	39. 9 39. 9
	Subtotal (see instructions)	2, 643, 221	
	Sequestration adjustment (see instructions)	2, 043, 221	1
	Demonstration payment adjustment amount after sequestration	0	1
	Sequestration adjustment-PARHM pass-throughs		40.0
	Interim payments	3, 054, 827	41.0
	Interim payments-PARHM Tentative settlement (for contractors use only)	0	41. 0 42. 0
	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)		42.0
	Balance due provider/program (see instructions)	-411, 606	
	Balance due provider/program-PARHM (see instructions)	, , , , ,	43.0
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	44.0
	§115. 2		
90 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)	0	90.0
	Outlier reconciliation adjustment amount (see instructions)	0	
	The rate used to calculate the Time Value of Money	0.00	
92.00			
93.00	Time Value of Money (see instructions) Total (sum of lines 91 and 93)	0	1

Health Financial Systems GREENE
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2021 | Part I | Date/Time Prepared: | From 01/01/2021 | Date/Time Prepared: | From 01/01/2021 | Part I | Part I | Prepared: | Part I | Provi der CCN: 15-1317

			'	0 12/31/2021	5/27/2022 11:	
		Title	XVIII	Hospi tal	Cost	27 am
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Transfer to the control of the contr	1. 00	2.00	3. 00	4. 00	4 00
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either		3, 974, 555 0		2, 565, 327 0	1. 00 2. 00
2.00	submitted or to be submitted to the contractor for				ا	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)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			10/04/2021	489, 500	3. 01
3. 02	ADJUSTIMENTS TO FROVIDER				489, 300	3. 01
3. 03					0	3. 03
3. 04			l c		0	3. 04
3.05			C	1	0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51			C		0	3. 51
3. 52 3. 53					0	3. 52 3. 53
3. 53 3. 54						3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				489, 500	3. 99
0. 77	3. 50-3. 98)				107,000	0.77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		3, 974, 555		3, 054, 827	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after		Γ			5.00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider			'		
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5. 03			C		0	5. 03
F F0	Provi der to Program					
5. 50 5. 51	TENTATI VE TO PROGRAM		l C		0	5. 50 5. 51
5. 52					0	5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROCEDAM		130, 873		0	6. 01
6. 02	SETTLEMENT TO PROGRAM Total Medicare program Liability (see instructions)		1 105 429		411, 606	6. 02
7.00	Total Medicare program liability (see instructions)		4, 105, 428	Contractor	2, 643, 221 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00

 Heal th Financial
 Systems
 GREENE

 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED
 Provi der CCN: 15-1317 | Peri od: | Worksheet E-1 | From 01/01/2021 | Part I | To 12/31/2021 | Date/Time Prepared: | 5/27/2022 11: 27 am

Inpatient Part A			'			5/27/2022 11:	27 am
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 2.00 3.00 4.00 1.00 3.00 3.00 4.00 3.00 3.00 4.00 3.00 3.00 4.00 3.00 3.00 4.00 3.00							
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00			Inpatien	it Part A	Par	rt B	
Total interim payments paid to provider 0 0 0 0 0 0 0 0 0			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interin payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1. 00	2. 00	3. 00	4. 00	
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 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) 3.01 3.02 3.03 3.03 3.04 3.05 3	1.00	Total interim payments paid to provider		663, 817		0	1.00
Services rendered in the cost reporting period. If none, write "NoNE" or enter a zero that 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	2.00			0		0	2.00
write "NONE" or enter a zero .0 List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider .0 .0 .0 .0 .0 .0 .0 .0 .0 .0 .0 .0 .0 .							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 0 0 0 3.00 3.00 3.00 3.00 3.00 3.00 3							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider ADJUSTMENTS TO PROVIDER 0 0 0 3.01		normant of none write "NONE" or optor a zero (1)					
ADJUSTMENTS TO PROVIDER							
3.02 0	3 01			1 0		1 0	3 01
3.03 0		NBSGSTMENTS TO TROVIDER					
3.04 0 0 0 3.04 3.05							
3.05						-	
Provider to Program						1	
3.51 3.52 3.53 0 0 0 3.51 3.52 3.53 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.53 3.54 0 0 0 0 3.54 3.59 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 663,817 0 4.00 4.00 663,817 0 4.00 663,817 0 4.00 663,817 6		Provider to Program					
3.52 3.53 3.54 3.99 3.50-3.98	3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.53 3.54 0 0 0 3.53 3.54 0 0 0 3.53 3.50 3.99 3.50 - 3.98 0 0 0 3.53 3.50 - 3.98 0 0 0 3.59 3.50 - 3.98 0 0 0 3.59 3.50 - 3.98 0 0 0 3.59 3.50 - 3.98 0 0 0 3.59 3.50 - 3.98 0 0 0 3.59 3.50 - 3.98 0 0 0 3.59 3.50 - 3.98 0 0 0 0 3.59 3.50 - 3.98 0 0 0 0 4.00 0 0 0 0 0 0 0 0 0	3. 51			0		0	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.3.50-3.98) 0 0 3.54 3.99 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 663,817 0 4.00 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 52			0		0	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	3. 53			0		0	3. 53
3.50-3.98 Total Interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To BE COMPLETED BY CONTRACTOR							
A. 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) TO BE COMPLETED BY CONTRACTOR	3. 99			0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4.00			663, 817		0	4.00
TO BE COMPLETED BY CONTRACTOR							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00						5.00
Write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Program to Provider							
5.02 0				•		•	
5.03 Provider to Program	5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATI VE TO PROGRAM	5.03			0		0	5. 03
5.51 5.52 5.52 5.53 5.55							
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 127,181 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 790,998 Contractor Number (Mo/Day/Yr)		TENTATI VE TO PROGRAM					
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 127,181 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 790,998 Contractor NPR Date (Mo/Day/Yr) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				1		-	
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00				1			0.02
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5.99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	4 00	,					/ 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.00						0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			127 191		1	6.01
7.00 Total Medicare program liability (see instructions) 790,998 Contractor Number (Mo/Day/Yr) 0 1.00 2.00				127, 101		1	
Contractor NPR Date Number (Mo/Day/Yr) 0 1.00 2.00				790 998			
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	1.222		, , , , ,			7.50
0 1.00 2.00							
8.00 Name of Contractor 8.00			(0	1. 00		
	8.00	Name of Contractor					8. 00

Health Financial Systems GREENE COUNTY GENERAL HOSPITAL In Lieu of Form CMS-2552 CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1317 Period: From 01/01/2021 Part II	ed:
To 12/31/2021 Date/Time Prepare	ım
Title XVIII Hospital Cost	
1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION	
	00
	00
reporting periods beginning on or after 10/01/2013, line 32)	
	00
	00
reporting periods beginning on or after 10/01/2013, line 32)	
	00
	00
3	00
line 168	
	00
	00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.	00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	
30.00 Initial/interim HIT payment adjustment (see instructions) 30.	
31.00 Other Adjustment (specify)	00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 32.	00

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu	ı of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provider CCN: 15-1317	Peri od:	Worksheet E-2
			From 01/01/2021	
		Component CCN: 15-Z317	To 12/31/2021	Date/Time Prepared:
				5/27/2022 11:27 am

			To 12/31/2021	Date/Time Pre 5/27/2022 11:	pared: 27 am
		Title XVIII	Swing Beds - SNF		
			Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		664, 692	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Par		130, 016	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swiinstructions)	ng-bed pass-through, see			
3. 01	Nursing and allied health payment-PARHM (see instructions)				3. 01
4.00	Per diem cost for interns and residents not in approved teach	ing program (see		0. 00	4.00
	instructions)			_	
5. 00 6. 00	Program days Interns and residents not in approved teaching program (see i	netrueti one)	306	0	5. 00 6. 00
7. 00	Utilization review - physician compensation - SNF optional me		0	U	7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	thou only	794, 708	0	8.00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		794, 708	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts appli	cable to physician	0	0	11.00
12. 00	professional services) Subtotal (line 10 minus line 11)		794, 708	0	12.00
13. 00	Coinsurance billed to program patients (from provider records) (exclude coinsurance	3, 710	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)		700 000	0	14.00
15. 00 16. 00	Subtotal (see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		790, 998	0	15. 00 16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instruction	5)	0	U	16.50
16. 55	Rural community hospital demonstration project (§410A Demonst		0		16. 55
	adjustment (see instructions)	, , ,			
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17. 00 17. 01	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	17. 00 17. 01
17.01	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18.00
19. 00	Total (see instructions)	1 40 11 0113)	790, 998	0	19.00
19. 01	Sequestration adjustment (see instructions)		0	0	19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0	0	19. 02
19. 03	Sequestration adjustment-PARHM pass-throughs			0	19. 03
19. 25 20. 00	Sequestration for non-claims based amounts (see instructions) Interim payments		663, 817	0	19. 25 20. 00
20. 01	Interim payments-PARHM		003,017	O	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
21. 01	Tentative settlement-PARHM (for contractor use only)				21. 01
22. 00	Balance due provider/program (line 19 minus lines 19.01, 19.0	2, 19.25, 20, and 21)	127, 181	0	22.00
22. 01 23. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2	0	0	22. 01 23. 00
23.00	chapter 1, §115.2	nee with ows rub. 13 2,		O	25.00
	Rural Community Hospital Demonstration Project (§410A Demonst	ration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration pe	riod under the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from	Wkst. D-1. Pt. II. line			201. 00
201100	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (fro	m Wkst. D-3, col. 3, line	e		202. 00
000 00	200 (title XVIII swing-bed SNF))				000 00
	Total (sum of lines 201 and 202) Medicare swing-bed SNF discharges (see instructions)				203. 00 204. 00
204.00	Computation of Demonstration Target Amount Limitation (N/A in	first year of the curre	nt 5-vear demons	trati on	204.00
	peri od)	, , , , , , , , , , , , , , , , , , ,			
	Medicare swing-bed SNF target amount				205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 t				206. 00
207.00	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs Program reimbursement under the §410A Demonstration (see inst				207. 00
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-	•	1		208.00
_00.00	and 3)	,, 01 111103			
	Adjustment to Medicare swing-bed SNF PPS payments (see instru	ctions)			209. 00
210.00	Reserved for future use				210. 00
215 00	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line	200 plus lino 210) (ccc			215. 00
Z 13. UU	instructions)	207 prus rine 210) (see			2 10.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-2552-		
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1317	Peri od: From 01/01/2021	Worksheet E-3	
			Date/Time Prepared:	
			5/27/2022 11:27 am	
	Title XVIII	Hospi tal	Cost	

2.00 Nursing and Allied Health Managed Care payment (see instructions) 0 2.00 3.00 4.201,820 4.00 3.00 3.00 3.00 3.00 3.00 4.321,820 4.00 3.00 5.00 4.321,820 4.00 5.00 5.00 7.00 7.00 5.00 5.00 6.00 7.00 4.365,038 6.00 5.00 6.00 7.00 6.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 7.00 8.00 7.00 8.00 9.00					5/27/2022 11:	27 am
PART V - CALCULATION OF RETMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RETMBURSEMENT			Title XVIII	Hospi tal	Cost	
PART V - CALCULATION OF RETMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST RETMBURSEMENT						
Impatient services 4,321,820 1.00 1.					1. 00	
2.00 Nursing and Allied Health Managed Care payment (see instructions) 0 2.00 2.00 0 0 0 0 0 0 0 0 0		PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	Γ REI MBURSEMENT		
3.00 Organ acquisition 4, 232, 282 4, 00 5, 00 Frimary payer payments 4, 232, 282 4, 00 5, 00 Frimary payer payments 4, 265, 038 6, 00 Collection 6, 00 Total cost (Ilne 4 less line 5). For CAH (see Instructions) 6, 00 Collection 6, 00 Total cost (Ilne 4 less line 5). For CAH (see Instructions) 7, 00 CoMPUTATION OF LESSER OF COST OR CHARGES 7, 00 Routine service charges 0 7, 00	1.00	Inpatient services			4, 321, 820	1.00
3.00 Subtotal (sum of lines 1 through 3) 4.321,820 4.05 5.00 Primary payer payments 4.365,038 6.00 For Company payer payments 4.365,038 6.00 For Company payer payments 4.365,038 6.00 For Company payer payments 7.00 7.00 For Company payer payments 7.00 7.	2.00	Nursing and Allied Health Managed Care payment (see instructi	ons)		0	2.00
Primary payer payments	3.00	Organ acquisition			0	3.00
Total cost (line 4 less line 5). For CAH (see instructions) 4, 365,038 6. 00	4.00	Subtotal (sum of lines 1 through 3)			4, 321, 820	4.00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Cost of physicians' service charges Cost of physicians' service charges Cost of physicians' services on a charge basis Cost of physicians' services on a cacradance with 42 CFR 413.13(e) Cost of physicians' services in a teaching hospital (see instructions) Cost of physicians' services in a teaching hospital (see instructions) Cost of physicians' services in a teaching hospital (see instructions) Cost of physicians' services in a teaching hospital (see instructions) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 17 and 18) Cost of covered services (sum of lines 6, 18 and 18	5.00	Primary payer payments			0	5.00
Reasonable charges 0	6.00	Total cost (line 4 less line 5). For CAH (see instructions)			4, 365, 038	6.00
7.00		COMPUTATION OF LESSER OF COST OR CHARGES				
R.00		Reasonable charges				
0.00 Total reasonable charges 0 0 0.00	7.00	Routine service charges				7.00
10. 00 Total reasonable charges 0 0. 00	8.00	Ancillary service charges				8.00
Customary, charges Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00		Organ acquisition charges, net of revenue				9.00
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00	10.00	Total reasonable charges			0	10.00
12. 00 Amount's that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 44.2 CFR 413.13(e) 0.000000 13.00 13.00 14.00 15.00						
had such payment been made in accordance with 42 CFR 413.13(e)						
13.00	12.00			on a charge basis	0	12.00
14.00 Total customary charges (see instructions) 0 14.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see 0 15.00)			
15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 17.00 17.00 18.00 19.0						
Instructions Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 16. 00 16. 00 17. 0						14.00
16. 00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17. 00 17. 00 17. 00 18. 00 18. 00 19. 00	15. 00		ly if line 14 exceeds li	ne 6) (see	0	15.00
17. 00 Cost of physicians' services in a teaching hospital (see instructions) 17. 00 17. 00 ComPUTATION OF REIMBURSEMENT SETTLEMENT 18. 00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 18. 00 18. 00 19. 0						
17.00	16. 00		ly if line 6 exceeds lir	ne 14) (see	0	16.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT 18.00 18.00 19						
18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 18.00 19.00 Cost of covered services (sum of lines 6, 17 and 18) 310,080 20.00 20.00 Deductibles (exclude professional component) 310,080 20.00 21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 Subtotal (line 19 minus line 20 and 21) 4,054,958 22.00 23.00 Coinsurance 1,113 23.00 24.00 Subtotal (line 22 minus line 23) 4,053,845 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 51,583 26.00 Adjusted reimbursable bad debts (see instructions) 51,583 26.00 Adjusted reimbursable bad debts (see instructions) 51,583 26.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 13,581 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 4,105,428 28.00 Subtotal (sum of lines 24 and 25, or line 26) 4,105,428 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions) 0 29.00 29.00 29.90	17. 00		ructions)		0	17. 00
19. 00 Cost of covered services (sum of lines 6, 17 and 18) 4, 365, 038 19, 00 20. 00 Deductibles (exclude professional component) 310,080 20.00 21. 00 Subtotal (line 19 minus line 20 and 21) 4,054,958 22.00 23. 00 Coinsurance 4,053,845 24.00 24. 00 Subtotal (line 22 minus line 23) 4,053,845 24.00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 79,359 25.00 26. 00 Adjusted reimbursable bad debts (see instructions) 51,563 26.00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 13,351 27.00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 4,105,428 28.00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29. 50 Recovery of accelerated depreciation. 0 29.96 29. 99 Bemonstration payment adjustment amount before sequestration 0 29.96 30. 01 Sequestration adjustment (see instructions) 0 30.01 30. 02 Demonstration payment adjustment amount after sequestration 0						
20.00 Deductibles (exclude professional component) 310,080 20.00 21.00 Excess reasonable cost (from line 16) 0 21.00 23.00 Coinsurance 1,113 23.00 23.00 Coinsurance 1,113 23.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 79,359 25.00 Adjusted reimbursable bad debts (see instructions) 13,581 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 13,581 27.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 13,581 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 4,105,428 28.00 29.50			4, line 49)			
21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 23.00 20.00 23.00 20.01 23.00 20.00 24.00 25.00						
22.00 Subtotal (line 19 minus line 20 and 21) 4,054,958 22.00 23.00 Coinsurance 1,113 23.00 24.00 Subtotal (line 22 minus line 23) 4,053,845 24.00 25.00 All owable bad debts (exclude bad debts for professional services) (see instructions) 79,359 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 51,583 26.00 27.00 All owable bad debts for dual eligible beneficiaries (see instructions) 13,581 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 4,105,428 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.98 Recovery of accelerated depreciation. 0 29.50 29.99 Pemonstration payment adjustment amount before sequestration 0 29.95 30.01 Sequestration adjustment (see instructions) 4,105,428 30.00 30.02 Demonstration payment adjustment amount after sequestration 0 29.96 30.03 Sequestration adjustment-PARHM 30.02 31.01 Interim payments-PARHM 30.03 32.01 Tentative settlement (for contr						
23.00 Coinsurance 1,113 23.00 24.00 Subtotal (line 22 minus line 23) 4,053,845 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 79,359 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 51,583 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 13,581 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 4,105,428 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0,29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0,29.50 29.98 Recovery of accelerated depreciation. 0,29.50 29.99 Demonstration payment adjustment amount before sequestration 0,29.50 30.01 Sequestration adjustment (see instructions) 4,105,428 30.02 Demonstration payment adjustment amount after sequestration 0,29.50 30.03 Sequestration adjustment (see instructions) 30.00 31.00 Interim payments 3,974,555 31.00 31.01 Interim payments-PARHM 31.00 31.00						
24.00 Subtotal (line 22 minus line 23) 4,055,845 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 79,359 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 51,583 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 13,581 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 4,105,428 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29.50 29.99 Recovery of accelerated depreciation. 0 29.95 29.99 Demonstration payment adjustment amount before sequestration 0 29.95 30.01 Sequestration adjustment (see instructions) 4,105,428 30.00 30.02 Demonstration payment adjustment amount after sequestration 0 30.02 30.01 31.01 Interim payments 3,974,555 31.00 31.01 Interim payments -PARHM 31.01 31.01 32.01 Tentative settlement (for contractor use only) 0 32.00 32.01 33.01 B						
25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26.00 Adjusted reimbursable bad debts (see instructions) 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment (see instructions) 30.04 Interim payments 30.05 Interim payments 30.06 Interim payments 30.07 Interim payments 30.07 Interim payments 30.08 Interim payments 30.09 Interim payments 30.00 Interim payments 30.						
26.00 Adj usted reimbursable bad debts (see instructions) 51,583 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 13,581 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 4,105,428 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0,29.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 0,29.00 29.98 Recovery of accelerated depreciation. 0,29.90 29.99 Demonstration payment adjustment amount before sequestration 0,29.90 30.01 Sequestration adjustment (see instructions) 4,105,428 30.02 Balance due prowider/program (for contractor use only) 30.00 31.01 Interim payments 31.00 31.01 Tentative settlement-PARHM (for contractor use only) 32.00 32.01 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 13,581 27.00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 4,105,428 28.00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.00 29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 29.50 29. 99 Recovery of accelerated depreciation. 0 29.99 30. 00 Subtotal (see instructions) 4,105,428 30.00 30. 01 Sequestration adjustment (see instructions) 4,105,428 30.00 30. 02 Sequestration adjustment amount after sequestration 0 30.01 30. 03 Sequestration adjustment-PARHM 0 30.02 31. 01 Interim payments 3,974,555 31.00 31. 01 Interim payments-PARHM 31.01 31.01 32. 00 Tentative settlement (for contractor use only) 32.01 33. 00 Bal ance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 33. 01 Bal ance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub.			ces) (see instructions)			
28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment (see instructions) 30.01 Interim payments 31.01 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pi oneer ACO demonstration payment adjustment (see instructions) 29.98 Recovery of accelerated depreciation. 29.99 Demonstration payment adjustment amount before sequestration 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,			ructions)			
Pi oneer ACO demonstration payment adjustment (see instructions) 29. 98 Recovery of accelerated depreciation. Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 31. 00 Interim payments Interim payments-PARHM Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
29. 98 Recovery of accel erated depreciation. 29. 98 Demonstration payment adjustment amount before sequestration 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 31. 00 Interim payments 31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
29. 99 Demonstration payment adjustment amount before sequestration Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 02 Demonstration payment adjustment amount after sequestration 30. 03 Sequestration adjustment amount after sequestration 30. 03 Sequestration adjustment-PARHM 30. 03 31. 01 Interim payments 31. 01 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		, , , , , , , , , , , , , , , , , , , ,	S)			
30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 30.03 Sequestration adjustment-PARHM 30.03 Interim payments 31.01 Interim payments-PARHM 31.01 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
30.01 Sequestration adjustment (see instructions) 30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 30.03 Sequestration adjustment-PARHM 30.03 Sequestration adjustment-PARHM 30.03 Sequestration adjustment amount after sequestration 30.02 Tentarious payments 30.03 Sequestration adjustment (see instructions) 30.02 Sequestration (see instructions) 30.02 Sequestration (see instructions) 30.02 Sequestration (see instructions) 31.02 Sequestration (see instructions) 32.03 Sequestration (see instructions) 33.04 Sequestration (see instructions) 34.05 Sequestration (see instructions) 34.06 Sequestration (see instructions) 35.07 Sequestration (see instructions) 36.07 Sequestration (see instructions) 37.08 Sequestration (see instructions) 38.09 Sequestration (see instructions) 39.00 Sequestration (see instructions) 30.01 Sequestration (see instructions) 30.02 Sequestrations 30.02 Sequestration (see instructions) 31.02 Sequestrations 31.03 Sequestration (see instructions) 32.01 Tentative settlement (for contractor use only) 32.01 Tentative						
30.02 Demonstration payment adjustment amount after sequestration 30.03 Sequestration adjustment-PARHM 30.03 Sequestration adjustment-PARHM 31.00 Interim payments 31.01 Interim payments-PARHM 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		,				
30.03 Sequestration adjustment-PARHM 30.03 31.00 Interim payments 3,974,555 31.00 31.01 Interim payments-PARHM 31.01 32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 32.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 130,873 33.00 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
31.00 Interim payments 31.01 Interim payments - PARHM 32.00 Interim payments-PARHM 32.01 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00					0	
31. 01 Interim payments-PARHM 32. 00 Tentative settlement (for contractor use only) 32. 01 Tentative settlement-PARHM (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30. 01, 30. 02, 31, and 32) 33. 01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30. 03, 31. 01, and 32. 01) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00						
32.00 Tentative settlement (for contractor use only) 32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00					3, 974, 555	
32.01 Tentative settlement-PARHM (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
33.00 Balance due provider/program (line 30 minus lines 30.01, 30.02, 31, and 32) 33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00					0	
33.01 Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus lines 30.03, 31.01, and 32.01) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		,				
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00					130, 873	
						33. 01
[§115. 2	34. 00	,	nce with CMS Pub. 15-2,	chapter 1,	0	34.00
		19115. 2		l		I

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 01/01/2021 Worksheet E-3 Part VI To 12/31/2021 Date/Ti me Prepared: 5/27/2022 11: 27 am

		1	o 12/31/2021	Date/Time Pre 5/27/2022 11:	
		Title XIX	Hospi tal	Cost	27 am
			Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		285, 648		1.00
2.00	Medical and other services			2, 096, 073	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		285, 648	2, 096, 073	4. 00
5. 00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6.00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		285, 648	2, 096, 073	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
0.00	Reasonable Charges				0.00
8.00	Routine service charges		772 075	0 500 111	8.00
9. 00 10. 00	Ancillary service charges		773, 875 0	9, 592, 111	9. 00 10. 00
11. 00	Organ acquisition charges, net of revenue Incentive from target amount computation		0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)		773, 875	9, 592, 111	
12.00	CUSTOMARY CHARGES		773,073	7, 372, 111	12.00
13. 00	Amount actually collected from patients liable for payment for	services on a charge	O	0	13.00
	basis			_	
14.00	Amounts that would have been realized from patients liable for	payment for services on	o	0	14.00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15. 00
	Total customary charges (see instructions)		773, 875	9, 592, 111	16.00
17. 00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	488, 227	7, 496, 038	17. 00
40.00	line 4) (see instructions)				40.00
18. 00	Excess of reasonable cost over customary charges (complete onl	y IT line 4 exceeds line	0	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1	•	285, 648	2, 096, 073	1
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			=/ 0.2/ 0.2	
22.00	Other than outlier payments	<u> </u>	0	0	22.00
23.00	Outlier payments		o	0	23.00
24.00	Program capital payments		o		24.00
25.00	Capital exception payments (see instructions)		0		25. 00
26.00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		0	0	
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)		285, 648	2, 096, 073	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		285, 648	2, 096, 073	1
	Deducti bl es		0	0	02.00
33.00	Coinsurance		0	0	33.00
34. 00 35. 00	Allowable bad debts (see instructions) Utilization review		0	U	34. 00 35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 22)	285, 648	2, 096, 073	
37. 00	TO ZERO OUT MEDICALD	33)	-285, 648	-2, 096, 073	
	Subtotal (line 36 ± line 37)		-203, 040	-2, 0,0, 0,73	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)		Ö	0	
41. 00	Interim payments		l 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	ice with CMS Pub 15-2,	0	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: Worksheet G From 01/01/2021 To 12/31/2021 Date/Ti me Prepared: 5/27/2022 11: 27 am

y,		General Fund	Specific Purpose Fund	Endowment Fund	5/27/2022 11: Plant Fund	27 am
		1.00	2. 00	3. 00	4. 00	
4 00	CURRENT ASSETS	10 740 747		ام		
1. 00 2. 00	Cash on hand in banks Temporary investments	10, 742, 767 2, 516, 244	1	ol ol	0	1. 00 2. 00
3. 00	Notes receivable	2,510,244	0	0	0	3.00
4. 00	Accounts receivable	5, 617, 301	l o	o	0	4.00
5.00	Other receivable	1, 832, 674	0	O	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7. 00	Inventory	523, 662	1	0	0	7.00
8.00	Prepaid expenses	341, 920	0	0	0	8.00
9. 00 10. 00	Other current assets Due from other funds	0	0	U O	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	21, 574, 568		0	0	11.00
11.00	FIXED ASSETS	21, 374, 300		<u> </u>		111.00
12.00	Land	1, 598, 975	0	0	0	12.00
13.00	Land improvements	213, 562	0	O	0	13.00
14.00	Accumulated depreciation	-94, 160		0	0	14.00
15. 00	Bui I di ngs	9, 090, 776	1	0	0	15.00
16.00	Accumulated depreciation	-2, 128, 042	0	0	0	16.00
17. 00 18. 00	Leasehold improvements Accumulated depreciation	0	0	0	0	17. 00 18. 00
19. 00	Fi xed equi pment	4, 445, 520	_	0	0	19.00
20. 00	Accumul ated depreciation	-1, 927, 129	1	0	0	20.00
21. 00	Automobiles and trucks	0	O	Ö	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22. 00
23.00	Major movable equipment	5, 032, 806	0	0	0	23. 00
24.00	Accumulated depreciation	-1, 626, 873	0	0	0	24.00
25. 00	Mi nor equipment depreciable	0	0	0	0	25.00
26. 00	Accumulated depreciation	0	0	0	0	26.00
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0		U O	0	27. 00 28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29)	14, 605, 435		0	0	30.00
	OTHER ASSETS			-1		
31.00	Investments	1, 259, 843	0	0	0	31.00
32.00	Deposits on Leases	0	0	0	0	32.00
33. 00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7, 753	1	0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	1, 267, 596 37, 447, 599		0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	37,447,377	0	<u> </u>		30.00
37.00	Accounts payable	1, 787, 230	0	0	0	37.00
38.00	Salaries, wages, and fees payable	2, 230, 158	1	О	0	38. 00
39. 00	Payroll taxes payable	594, 557	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	2, 403, 317	1	0	0	40.00
41.00	Deferred income	130, 554	0	0	0	41.00
42. 00 43. 00	Accel erated payments Due to other funds	1, 800, 609		0	0	42. 00 43. 00
44. 00	Other current liabilities	2, 089, 268		0	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	11, 035, 693		Ö		
	LONG TERM LIABILITIES	,		- 1		
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	15, 034, 990	0	0	0	47. 00
48. 00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	15 004 000	0	0	0	49.00
50. 00 51. 00	Total long term liabilities (sum of lines 46 thru 49) Total liabilities (sum of lines 45 and 50)	15, 034, 990 26, 070, 683	1	ol Ol	0	50. 00 51. 00
31.00	CAPITAL ACCOUNTS	20,070,083	0	U _I		31.00
52.00	General fund balance	11, 376, 916				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	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	11, 376, 916	0	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	37, 447, 599	1	Ö	0	60.00
	59)					

| Period: | Worksheet G-1 | To | 12/21/2021 | To Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Provider CCN: 15-1317

					To 12/31/2021	Date/Time Pre 5/27/2022 11:	pared: 27 am
		General	Fund	Special F	Purpose Fund	Endowment Fund	
		1. 00	2. 00	3.00	4.00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0 0 0	2. 00 10, 449, 172 927, 744 11, 376, 916 0 11, 376, 916		4.00 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
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 11, 376, 916		0 0	0	17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6. 00	7. 00	8.00	_		
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0		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	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		19.00

| Peri od: | Worksheet G-2 | From 01/01/2021 | Parts | & II | To 12/31/2021 | Date/Time Prepared: Health Financial Systems GREE
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1317

				Γο 12/31/2021	Date/Time Pre 5/27/2022 11:	
	Cost Center Description		Inpatient	Outpati ent	Total	27 aiii
	555 Conton 5555 FER 511		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				2. 22	
	General Inpatient Routine Services					
1.00	Hospi tal		3, 323, 05		3, 323, 050	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		()	0	5.00
6.00	Swing bed - NF		(O	0	6.00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)		3, 323, 05	0	3, 323, 050	10.00
	Intensive Care Type Inpatient Hospital Services		040.00	-I	040.000	44.00
11.00	INTENSIVE CARE UNIT		813, 80	ו	813, 800	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14. 00 15. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)					14. 00 15. 00
16. 00	Total intensive care type inpatient hospital services (sum of	Linos	813, 80		813, 800	16.00
10.00	11-15)	Titles	013, 00		013, 000	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		4, 136, 85)	4, 136, 850	17. 00
18. 00	Ancillary services		13, 049, 56		119, 764, 690	
19. 00	Outpatient services			0	0	19. 00
20. 00	RURAL HEALTH CLINIC		(4, 569, 575	4, 569, 575	20. 00
20. 01	RURAL HEALTH CLINIC II		(1, 302, 515	1, 302, 515	20. 01
20. 02	RURAL HEALTH CLINIC III		(441, 720	441, 720	
20. 03	RURAL HEALTH CLINIC IV		(585, 614	585, 614	20. 03
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 Wkst.	17, 186, 41	113, 614, 549	130, 800, 964	28. 00
	G-3, line 1)					
20.00	PART II - OPERATING EXPENSES			40, 202, 700		20.00
29. 00 30. 00	Operating expenses (per Wkst. A, column 3, line 200) BAD DEBT EXPENSE		6, 947, 03	49, 392, 600		29. 00 30. 00
31. 00	DAD DEBT EXPENSE					31. 00
32. 00						32.00
33. 00						33. 00
34. 00						34. 00
35. 00						35. 00
36. 00	Total additions (sum of lines 30-35)			6, 947, 031		36.00
37. 00	DEDUCT (SPECIFY)		()		37. 00
38.00			(38.00
39.00			(o l		39.00
40.00			(o l		40.00
41.00			(O .		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		56, 339, 631		43.00
	to Wkst. G-3, line 4)					

llool +h	CDEFNE COUNTY CENE	DAL LIOCDI TAL	In Lie	u of Form CMC 3	DEE2 10
	Financial Systems GREENE COUNTY GENER MENT OF REVENUES AND EXPENSES	Provider CCN: 15-1317	Peri od:	u of Form CMS-2 Worksheet G-3	
			From 01/01/2021 To 12/31/2021		pared:
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lir			130, 800, 964	1.00
2.00	Less contractual allowances and discounts on patients' accour	nts		80, 632, 740	2.00
3.00	Net patient revenues (line 1 minus line 2)			50, 168, 224	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		56, 339, 631	4.00
5.00	Net income from service to patients (line 3 minus line 4)			-6, 171, 407	5.00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous communication	n servi ces		0	8.00
9.00	Revenue from television and radio service			0	9.00
10.00	Purchase di scounts			0	10.00
11. 00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other t	than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	OTHER GRANTS, PURCHASING DISCOUNTS			2, 583, 247	24.00
24. 50	COVI D-19 PHE Fundi ng			4, 515, 904	24.50
25.00	Total other income (sum of lines 6-24)			7, 099, 151	25.00
26.00	Total (line 5 plus line 25)			927, 744	26.00
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			927, 744	29.00

		EENE COUNTY GE				u of Form CMS-2	
ANALYS	SIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der Co		Period: From 01/01/2021	Worksheet M-1	
			Component		Γο 12/31/2021	Date/Time Pre 5/27/2022 11:	
					RHC I		
		Compensati on	Other Costs		Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		4 00	0.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
1 00	FACILITY HEALTH CARE STAFF COSTS	2 542 702		2 542 70	1 501 200	1 042 202	1 1 00
1. 00 2. 00	Physi ci an Physi ci an Assi stant	2, 543, 783	0	2, 543, 783		1, 042, 393 0	1.00 2.00
3. 00	Nurse Practitioner	0	0		0	686, 437	3.00
4. 00	Visiting Nurse	0	0)	686, 437	080, 437	4.00
5. 00	Other Nurse	0	0)		0	5.00
6. 00	Clinical Psychologist	0	0)		0	6.00
7. 00	Clinical Social Worker	0	0)	76, 355	76, 355	7.00
8. 00	Laboratory Techni ci an	0	0		70, 333	70, 333	8.00
9. 00	Other Facility Health Care Staff Costs	0	0		655, 547	655, 547	9.00
10. 00	Subtotal (sum of lines 1 through 9)	2, 543, 783	0	2, 543, 783	·	2, 460, 732	
11. 00	Physician Services Under Agreement	2, 545, 765	0	2, 545, 766	00,001	2, 400, 732	11.00
12. 00	Physician Supervision Under Agreement	0	0	ì		0	12.00
13. 00	Other Costs Under Agreement	0	936, 560	936, 560		936, 560	1
14. 00	Subtotal (sum of lines 11 through 13)	0	936, 560	936, 560		936, 560	
15. 00	Medical Supplies	0	133, 237	133, 23		133, 237	15.00
16. 00	Transportation (Health Care Staff)	0	30, 978	30, 978		30, 978	16.00
17. 00	Depreciation-Medical Equipment	0	0	(0	0	17.00
18.00	Professional Liability Insurance	0	0		0	0	18.00
19.00	Other Health Care Costs	0	0		0	0	19.00
20.00	Allowable GME Costs						20.00
21.00	Subtotal (sum of lines 15 through 20)	0	164, 215	164, 215	5 0	164, 215	21.00
22.00	Total Cost of Health Care Services (sum of	2, 543, 783	1, 100, 775	3, 644, 558	-83, 051	3, 561, 507	22.00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0	(0	0	23.00
24. 00	Dental	0	0	(0	0	24. 00
25. 00	Optometry	0	0	(21, 525	21, 525	•
25. 01	Tel eheal th	0	0		0	0	25. 01
25. 02	Chronic Care Management	0	0	(0	0	25. 02
26. 00	All other nonreimbursable costs	0	0	(0	01	26. 00
27. 00	Nonallowable GME costs						27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	0		21, 525	21, 525	28. 00
	through 27)						

0

2, 543, 783

220, 503 53, 556

274, 059

1, 374, 834

220, 503

53, 556

274, 059

3, 918, 617

29.00

30.00

31.00

32.00

220, 503

115, 082

335, 585

3, 918, 617

61, 526

61, 526

FACILITY OVERHEAD
29.00 Facility Costs

31.00

30.00 Administrative Costs

Total Facility Overhead (sum of lines 29 and

32.00 Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu of Form CMS-255			
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Peri od: From 01/01/2021	Worksheet M-1		
	Component CCN: 15-8535	To 12/31/2021	Date/Time Prepared: 5/27/2022 11:27 am		

						5/27/2022 11	27 am
					RHC I		
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	-164, 147	878, 246				1.00
2.00	Physician Assistant	0	0				2.00
3.00	Nurse Practitioner	25, 101	711, 538				3. 00
4.00	Visiting Nurse	0	0				4. 00
5. 00	Other Nurse	0	0				5. 00
6.00	Clinical Psychologist	0	0				6. 00
7. 00	Clinical Social Worker	-55, 055	21, 300				7. 00
8.00	Laboratory Techni ci an	0	0				8. 00
9.00	Other Facility Health Care Staff Costs	0	655, 547				9. 00
10.00	Subtotal (sum of lines 1 through 9)	-194, 101	2, 266, 631				10.00
11. 00	Physician Services Under Agreement	0	0	1			11. 00
12. 00	Physician Supervision Under Agreement	0	0				12.00
13. 00	Other Costs Under Agreement	0	936, 560				13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	936, 560				14.00
15.00	Medical Supplies	0	133, 237				15. 00
16.00	·	0	30, 978				16. 00
17. 00		0	0	1			17. 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		0	164, 215	1			21.00
22. 00	Total Cost of Health Care Services (sum of	-194, 101	3, 367, 406	1			22. 00
	lines 10, 14, and 21)						
	COSTS OTHER THAN RHC/FQHC SERVICES	_	_				
	Pharmacy	0	0				23. 00
24.00	Dental	0	0	1			24.00
25.00	1' ,	0	21, 525	1			25. 00
25. 01	Tel eheal th	0	0				25. 01
25. 02	,	0	0	1			25. 02
26.00	All other nonreimbursable costs	0	0	1			26.00
27. 00	Nonallowable GME costs		04 505				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	21, 525				28. 00
	through 27)						
20 00	FACILITY OVERHEAD Facility Costs	0	220, 503	1			29. 00
30.00	Administrative Costs	0	115, 082				30.00
30.00	Total Facility Overhead (sum of lines 29 and	0	335, 585				30.00
31.00	30)	U	ააა, 585	1			31.00
32. 00	Total facility costs (sum of lines 22, 28	-194, 101	3, 724, 516				32.00
32.00	and 31)	-174, 101	3, 724, 310				32.00
	14.14 0.7	ļ	ı	I .			1

Heal th	Financial Systems	GREENE COUNTY GE	NERAL HOSPITAL	_	In Lie	u of Form CMS-2	2552-10
ANALYS	IS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component		From 01/01/2021 To 12/31/2021		narad.
			Component	CCN: 15-8533	To 12/31/2021	Date/Time Pre 5/27/2022 11:	pareu: 27 am
					RHC II		
	·	Compensati on	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
						col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	625, 516	C	625, 51	6 -262, 442	363, 074	1.00
2.00	Physician Assistant	0	C		0 0	0	2.00
3.00	Nurse Practitioner	0	C		0 137, 589	137, 589	3.00
4.00	Visiting Nurse	0	C)	0	0	4.00
5.00	Other Nurse	0	C		0	0	5.00

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-1317	Peri od: From 01/01/2021	Worksheet M-1
	Component CCN: 15-853	To 12/31/2021	Date/Time Prepared: 5/27/2022 11:27 am

			Component	CCN. 15-6555	10	12/31/2021	5/27/2022	
						RHC II		
		Adjustments	Net Expenses					
			for					
			Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7. 00					
	FACILITY HEALTH CARE STAFF COSTS							
1. 00	Physi ci an	-21, 369	341, 705					1.00
2.00	Physician Assistant	0	0					2.00
3.00	Nurse Practitioner	27, 818	165, 407					3. 00
4. 00	Visiting Nurse	0	0					4.00
5.00	Other Nurse	0	0	1				5. 00
6.00	Clinical Psychologist	0	0					6. 00
7. 00	Clinical Social Worker	66, 402	66, 402					7.00
8.00	Laboratory Techni ci an	0	0					8. 00
9. 00	Other Facility Health Care Staff Costs	0	113, 273	1				9. 00
10.00	Subtotal (sum of lines 1 through 9)	72, 851	686, 787					10.00
11. 00		0	0					11. 00
12. 00	, ,	0	0					12.00
	Other Costs Under Agreement	0	167, 660	1				13. 00
14. 00	Subtotal (sum of lines 11 through 13)	0	167, 660					14. 00
15.00	Medical Supplies	0	57, 596					15. 00
16. 00	Transportation (Health Care Staff)	0	10, 729	1				16. 00
17. 00		0	0	1				17. 00
18. 00		0	0	1				18. 00
19. 00	•	0	0	1				19.00
20.00	•							20.00
21.00		70.054	68, 325					21.00
22. 00	Total Cost of Health Care Services (sum of	72, 851	922, 772					22. 00
	lines 10, 14, and 21)							
22 00	COSTS OTHER THAN RHC/FQHC SERVICES	0	0	J				23.00
23. 00 24. 00	Pharmacy Dental	0	0	1				24.00
25.00	1	0	0					25.00
25. 00	Tel eheal th	0	11, 580					25. 00
25. 02	•	0	11, 300	1				25. 02
26. 00	1	0	0					26.00
27. 00	1	O	0	Ï				27.00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	11, 580					28.00
20.00	through 27)	Ö	11,000					20.00
	FACILITY OVERHEAD			1				
29. 00	Facility Costs	0	100, 145					29. 00
30.00		0	16, 619					30.00
31. 00	•	0	116, 764	1				31.00
	30)							
32.00	Total facility costs (sum of lines 22, 28	72, 851	1, 051, 116					32.00
	and 31)							

	Financial Systems G GIS OF HOSPITAL-BASED RHC/FQHC COSTS	REENE COUNTY GE		- CN: 15-1317	Peri od:	u of Form CMS-2 Worksheet M-1	
ANALIS	of the trac-based kno/1 and costs				From 01/01/2021		
			Component	CCN: 15-8534	To 12/31/2021	Date/Time Pre 5/27/2022 11:	
-					RHC III	3/2//2022 11.	27 4111
		Compensation	Other Costs	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
				+ col . 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00	0.00	2.00	4.00	col . 4)	
	FACILITY HEALTH CARE STAFF COSTS	1. 00	2. 00	3. 00	4. 00	5. 00	_
1. 00	Physician	251, 498		251, 49	-251, 499	-1	1.00
2. 00	Physician Assistant	251, 470		251, 43	0 143, 340		
3. 00	Nurse Practitioner	0			0 102, 488	·	
4. 00	Visiting Nurse	0	Ĭ		0 102, 100	0	
5. 00	Other Nurse	0	i c		0 0	0	1
6. 00	Clinical Psychologist	0	l d		0 0	0	6.00
7.00	Clinical Social Worker	0	l c		0 0	0	7.00
8.00	Laboratory Techni ci an	0	C		0 0	0	8.00
9.00	Other Facility Health Care Staff Costs	0	C		0 -1, 195	-1, 195	9.00
10.00	Subtotal (sum of lines 1 through 9)	251, 498	C	251, 49	-6, 866	244, 632	
11. 00	Physician Services Under Agreement	0	C)	0	0	
12.00	Physician Supervision Under Agreement	0	[C)	0	0	
13. 00	Other Costs Under Agreement	0	57, 824			57, 824	
14.00	Subtotal (sum of lines 11 through 13)	0	57, 824			57, 824	
15.00	Medical Supplies	0	18, 423			18, 423	
16.00	Transportation (Health Care Staff)	0	699	69	99 0	699	
17.00	Depreciation-Medical Equipment Professional Liability Insurance	0			0	0	
18. 00 19. 00	Other Health Care Costs	0			0	0	19.00
20. 00	Allowable GME Costs	0		'		U	20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	19, 122	19, 12	0	19, 122	
22. 00	Total Cost of Health Care Services (sum of	251, 498				·	
22.00	lines 10, 14, and 21)	2017170	, , , , ,	020, 1		02.7070	22.00
	COSTS OTHER THAN RHC/FQHC SERVICES		ļ.	•			1
23.00	Pharmacy	0	C)	0 0	0	23. 00
24.00	Dental	0	C		0	0	
25. 00	Optometry	0	[C)	0 6, 866		
25. 01	Tel eheal th	0	C		0	0	
25. 02	9	0	C)	0	0	25. 02
	All other nonreimbursable costs	0	C)	0	0	20.00
-)7 NO	Nonal Lowahl o CME costs	1	i	1	1	1	27 00

26. 00 27. 00 0

28.00

29.00

30.00

31.00

32.00

6, 866

83, 368 10, 097

93, 465

421, 909

0

83, 368

10, 097

93, 465

421, 909

83, 368 10, 097

93, 465

170, 411

0

251, 498

6, 866

0

0

27.00 Nonallowable GME costs

through 27) FACILITY OVERHEAD
29.00 Facility Costs

and 31)

30.00 Administrative Costs

28.00

31.00

32.00

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provider CCN: 15-1317	Period: From 01/01/2021	Worksheet M-1
	Component CCN: 15-8534	To 12/31/2021	

			00p00c		1.0 1.2, 01, 2021	5/27/2022 11:	27 am
					RHC III		
		Adjustments	Net Expenses				
			for				
			Allocation				
			(col. 5 +				
			col. 6)				
		6. 00	7. 00				
	FACILITY HEALTH CARE STAFF COSTS						
1.00	Physi ci an	64, 572	64, 571				1.00
2.00	Physician Assistant	-398	142, 942				2.00
3.00	Nurse Practitioner	-81, 190	21, 298				3.00
4.00	Visiting Nurse	0	0				4.00
5.00	Other Nurse	0	0)			5.00
6.00	Clinical Psychologist	0	0)			6.00
7.00	Clinical Social Worker	0	0				7. 00
8.00	Laboratory Techni ci an	0	0				8.00
9.00	Other Facility Health Care Staff Costs	0	-1, 195				9.00
10.00	Subtotal (sum of lines 1 through 9)	-17, 016	227, 616				10.00
11.00	Physician Services Under Agreement	0	0	1			11.00
12.00	Physician Supervision Under Agreement	0	0				12.00
13.00	Other Costs Under Agreement	0	57, 824				13.00
14.00	Subtotal (sum of lines 11 through 13)	0	57, 824	1			14.00
15. 00	Medical Supplies	0	18, 423	1			15.00
16. 00	Transportation (Health Care Staff)	0	699	1			16.00
17. 00	Depreciation-Medical Equipment	0	0	1			17. 00
18. 00	Professional Liability Insurance	0	0	1			18.00
19. 00	Other Health Care Costs	0	0	1			19.00
20. 00	Allowable GME Costs	ū					20.00
21. 00	Subtotal (sum of lines 15 through 20)	0	19, 122				21.00
22. 00	Total Cost of Health Care Services (sum of	-17, 016	· ·	1			22.00
22.00	lines 10, 14, and 21)	177010	001,002				
	COSTS OTHER THAN RHC/FQHC SERVICES						
23. 00	Pharmacy	0	0	1			23.00
24. 00	Dental	0	0				24.00
25. 00	Optometry	0	6, 866				25. 00
25. 01	Tel eheal th	0	0	1			25. 01
25. 02	Chronic Care Management	0	0	1			25. 02
26. 00	All other nonreimbursable costs	0	0				26.00
27. 00	Nonallowable GME costs	ū					27. 00
28. 00	Total Nonreimbursable Costs (sum of lines 23	0	6, 866				28.00
20.00	through 27)	· ·	0,000				20.00
	FACILITY OVERHEAD						
29. 00	Facility Costs	0	83, 368				29. 00
30.00	Administrative Costs	0	10, 097	1			30.00
31. 00	Total Facility Overhead (sum of lines 29 and	n	93, 465	1			31.00
500	30)	J	, , , , , ,				000
32. 00	Total facility costs (sum of lines 22, 28	-17, 016	404, 893				32.00
00	and 31)	.,, 510	, 370				
		!	1	1			

	Financial Systems GF GIS OF HOSPITAL-BASED RHC/FQHC COSTS		Provi der C		Peri od:	Worksheet M-1	
			Component	CCN: 15-8538	From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 11:	pared: 27 am
					RHC IV		
		Compensation	Other Costs		1 Recl assi fi cat	Recl assi fi ed	
				+ col. 2)	i ons	Trial Balance	
						(col. 3 +	
		1.00			1.00	col . 4)	
	FACILITY HEALTH CARE CTAFE COCTO	1. 00	2. 00	3. 00	4. 00	5. 00	
4 00	FACILITY HEALTH CARE STAFF COSTS	0.4.4.50		044.45	74 005	470 400	1
1.00	Physi ci an	244, 458	C	244, 45	-71, 035	173, 423	
2.00	Physician Assistant	0	C		0	0	
3.00	Nurse Practitioner	0	C	1	0	0	1 0.00
4. 00 5. 00	Visiting Nurse	0	C		0	0	4. 00 5. 00
6. 00	Other Nurse	0	C		0	0	6.00
7. 00	Clinical Psychologist Clinical Social Worker	0			0	0	7.00
8. 00	Laboratory Techni ci an	0			0	0	
9. 00	Other Facility Health Care Staff Costs	0			0 69, 238	Ĭ	
10.00	Subtotal (sum of lines 1 through 9)	244, 458		244, 45		242, 661	
11. 00	Physician Services Under Agreement	244, 436		244, 43	0 -1, 797	242,001	
12. 00		0				0	
13. 00	Other Costs Under Agreement	0	53, 628	53, 62	0	53, 628	
14. 00		0	53, 628			53, 628	
15. 00		0	30, 700				15.00
16. 00	· · ·		50, 700			574	
17. 00			0, 1	,	o o	0,1	
	Professional Liability Insurance		Č		0 0	, o	1
19. 00	1	0	C		0 0	o o	19.00
20.00		_					20.00
21. 00		o	31, 274	31, 27	74 0	31, 274	
22. 00	Total Cost of Health Care Services (sum of	244, 458	84, 902				
	lines 10, 14, and 21)	,			,	,	
	COSTS OTHER THAN RHC/FQHC SERVICES			•			
23.00	Pharmacy	0	C		0 0	0	23.00
24.00	Dental	o	C		0 0	0	24.00
25.00	Optometry	0	C		0 1, 797	1, 797	25.00
25.01	Tel eheal th	0	C		0	0	25. 01
25. 02	Chronic Care Management	0	C	1	0	0	25. 02
26.00		0	C	1	0	0	26.00
	Nonallowable GME costs						27. 00
20 00	Total Naprai mburaahla Casta (aum af Linas 22	1 0	0	J	0 1 707	1 707	20 00

28.00

29.00

30.00

31.00

32.00

1, 797

34, 886 9, 599

44, 485

373, 845

0

34, 886 9, 599

44, 485

373, 845

34, 886 9, 599 44, 485

129, 387

0

244, 458

1, 797

0

0

28.00

31.00

32.00

through 27) FACILITY OVERHEAD
29.00 Facility Costs

30.00 Administrative Costs

Total Nonreimbursable Costs (sum of lines 23

Total Facility Overhead (sum of lines 29 and

Total facility costs (sum of lines 22, 28 and 31)

Health Financial Systems	GREENE COUNTY GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF HOSPITAL-BASED RHC/FQHC COSTS	Provi der CCN: 15-131	7 Period: From 01/01/2021	Worksheet M-1
	Component CCN: 15-85	38 To 12/31/2021	Date/Time Prepared: 5/27/2022 11:27 am

			Component	JCN. 15-6556	10	12/31/2021	5/27/2022	
						RHC IV		
		Adjustments	Net Expenses					
			for Allocation					
			(col. 5 +					
			col. 6)					
		6. 00	7.00					
	FACILITY HEALTH CARE STAFF COSTS	0.00	7.00					
1.00	Physi ci an	-173, 423	0					1.00
2.00	Physician Assistant	0	0					2.00
3. 00	Nurse Practitioner	24, 755	24, 755					3. 00
4.00	Visiting Nurse	o	0	l .				4.00
5.00	Other Nurse	o	0					5. 00
6.00	Clinical Psychologist	o	0					6. 00
7.00	Clinical Social Worker	36, 063	36, 063					7.00
8.00	Laboratory Techni ci an	0	0					8. 00
9.00	Other Facility Health Care Staff Costs	0	69, 238					9. 00
10.00	Subtotal (sum of lines 1 through 9)	-112, 605	130, 056					10.00
11. 00	Physician Services Under Agreement	0	0					11. 00
12.00	Physician Supervision Under Agreement	0	0					12.00
	Other Costs Under Agreement	0	53, 628					13. 00
14.00	Subtotal (sum of lines 11 through 13)	0	53, 628					14. 00
15. 00	Medical Supplies	0	30, 700					15. 00
16. 00	Transportation (Health Care Staff)	0	574					16. 00
17. 00	Depreciation-Medical Equipment	0	0					17.00
18. 00	1	0	0					18. 00
	Other Health Care Costs	O	0					19.00
20.00	Allowable GME Costs		04 074					20.00
21. 00	Subtotal (sum of lines 15 through 20)	112 (05)	31, 274					21.00
22. 00	Total Cost of Health Care Services (sum of lines 10, 14, and 21)	-112, 605	214, 958					22. 00
	COSTS OTHER THAN RHC/FQHC SERVICES							
23. 00	Pharmacy	ol	0					23. 00
24. 00	Dental	ol Ol	0					24.00
25. 00	Optometry	ol	1, 797	l .				25. 00
25. 01	Tel eheal th	ol	0	•				25. 01
25. 02	Chronic Care Management	ol	0					25. 02
26. 00	All other nonreimbursable costs	ol	0					26.00
27. 00	Nonallowable GME costs							27. 00
28.00	Total Nonreimbursable Costs (sum of lines 23	o	1, 797					28. 00
	through 27)							
	FACILITY OVERHEAD							
29.00	Facility Costs	0	34, 886				·	29. 00
30.00	Administrative Costs	-622	8, 977					30.00
31.00	Total Facility Overhead (sum of lines 29 and	-622	43, 863					31.00
	30)							
32.00	, ,	-113, 227	260, 618					32.00
	and 31)	l						I

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FOHC S	SERVI CES	Provi der Co		Period: From 01/01/2021	Worksheet M-2	
			Component	CCN: 15-8535	To 12/31/2021	Date/Time Pre 5/27/2022 11:	
					RHC I		
		Number of FTE	Total Visits	Producti vi ty		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			Т			
1.00	Physi ci an	3. 84		•	1 4		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	6. 08			1 6	04 004	3.00
4.00	Subtotal (sum of lines 1 through 3)	9. 92		i e	10		4.00
5.00	Visiting Nurse	0.00				0	5.00
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0. 00 0. 36				0 127	6. 00 7. 00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.36					
7. 01	Diabetes Self Management Training (FQHC	0.00				0	
7.02	only)	0.00	0			U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	10. 28	21, 128			21, 128	8.00
0.00	through 7)	10.20	21, 120			21, 120	0.00
9.00	Physician Services Under Agreements		0			0	9.00
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASE	ED RHC/FQHC SEF	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			3, 367, 406	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,	col. 7, line 2	28)			21, 525	11.00
12.00	Cost of all services (excluding overhead) (s	um of lines 10	and 11)			3, 388, 931	12.00
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 993648	13.00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		335, 585	14.00
15.00	Parent provider overhead allocated to facili	ty (see instruc	ctions)			1, 627, 999	15.00
16. 00	Total overhead (sum of lines 14 and 15)					1, 963, 584	
	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					1, 963, 584	
	Overhead applicable to hospital-based RHC/FC					1, 951, 111	
20. 00	Total allowable cost of hospital-based RHC/F	UHC services (sum of lines 10	o and 19)		5, 318, 517	20.00

Heal th	Financial Systems G	REENE COUNTY GE	NERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC	SERVI CES	Provi der Co		Peri od: From 01/01/2021	Worksheet M-2	
			Component	CCN: 15-8533	To 12/31/2021	Date/Time Pre 5/27/2022 11:	
					RHC II		
		Number of FTE	Total Visits	Producti vi ty		Greater of	
		Personnel		Standard (1)	,	col. 2 or	
					1 x col. 3)	col. 4	
	Luci	1. 00	2. 00	3. 00	4. 00	5. 00	
	VISITS AND PRODUCTIVITY						
	Posi ti ons	1		ı	-1		
1.00	Physi ci an	1. 51		•	1 2		1.00
2.00	Physician Assistant	0.00		1	1 0		2.00
3.00	Nurse Practitioner	1. 29				F 2/0	3.00
4. 00 5. 00	Subtotal (sum of lines 1 through 3) Visiting Nurse	2. 80 0. 00			3	5, 260	4. 00 5. 00
6. 00	Clinical Psychologist	0.00				0	6.00
7. 00	Clinical Social Worker	0.00				581	7.00
7. 00	Medical Nutrition Therapist (FQHC only)	0. 93	l .	1		0	7.00
7. 01	Di abetes Self Management Training (FQHC	0.00	l .			0	7.01
7.02	only)	0.00				0	7.02
8. 00	Total FTEs and Visits (sum of lines 4	3. 75	5, 841			5, 841	8. 00
	through 7)					-, -, -, -,	
9.00	Physician Services Under Agreements		0			0	9. 00
	<u> </u>	•		•	•		
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
10.00	Total costs of health care services (from We					922, 772	
11. 00	Total nonreimbursable costs (from Wkst. M-1,					11, 580	
12.00	Cost of all services (excluding overhead) (s					934, 352	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 987606	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		116, 764	
	15.00 Parent provider overhead allocated to facility (see instructions)					551, 636	
16.00	Total overhead (sum of lines 14 and 15)					668, 400	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	0UC (I		10)		668, 400	
	Overhead applicable to hospital-based RHC/FC Total allowable cost of hospital-based RHC/FC					660, 116 1, 582, 888	
20.00	Tiotal allowable cost of hospital-based knc/f	VIIC SELVICES (Sum ULLITIES II	o and 19)		1, 302, 888	20.00

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 11:	
					RHC III	0,2,,2022 111	
		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						
	Positions		T	T			
1.00	Physi ci an	0. 26			1 0		1.00
2.00	Physician Assistant	0. 85			1 1		2.00
3.00	Nurse Practitioner	0. 18			1 0	0.004	3.00
4.00	Subtotal (sum of lines 1 through 3)	1. 29			'	2, 031	4.00
5.00	Visiting Nurse	0. 98 0. 00				0	5. 00 6. 00
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0.00				0	7.00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.00				0	
7. 01	Diabetes Self Management Training (FQHC	0.00				0	7.01
7.02	only)	0.00	٥				7.02
8. 00	Total FTEs and Visits (sum of lines 4	2. 27	2, 031			2, 031	8.00
0.00	through 7)	2.27	2,001			2,00.	0.00
9.00	Physician Services Under Agreements		l o			0	9.00
	 	•	•				
						1. 00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T			RVI CES			
	Total costs of health care services (from Wk					304, 562	
11.00	Total nonreimbursable costs (from Wkst. M-1,						11.00
12.00	Cost of all services (excluding overhead) (s					311, 428	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 977953	
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		93, 465	
15.00	J (1)					278, 414	
16.00	Total overhead (sum of lines 14 and 15)					371, 879	
17.00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16	NIC (1	! 10 I ! · ·	10)		371, 879	
	Overhead applicable to hospital based RHC/FC					363, 680	
∠∪. ∪∪	Total allowable cost of hospital-based RHC/F	runc services (Sum of fines h	u anu 19)		668, 242	₁ 20.00

Heal th	Financial Systems GF	REENE COUNTY GE	NERAL HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF OVERHEAD TO HOSPITAL-BASED RHC/FQHC S	SERVI CES	Provi der C		Peri od:	Worksheet M-2	
			Component		From 01/01/2021 To 12/31/2021	Date/Time Pre 5/27/2022 11:	
					RHC IV	0,2,,,2022 111	<u> </u>
		Number of FTE	Total Visits		Mi ni mum	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						
	Positions		1 -	T	.1		
1.00	Physi ci an	0.00			1 0		1.00
2.00	Physician Assistant	0.00			1 0		2.00
3.00	Nurse Practitioner	0. 25			1 0	0.070	3.00
4.00	Subtotal (sum of lines 1 through 3)	0. 25	1		U	2, 272	
5.00	Visiting Nurse	1. 41	0	•		0	
6. 00 7. 00	Clinical Psychologist Clinical Social Worker	0. 00 0. 48				0 383	6. 00 7. 00
7. 00 7. 01	Medical Nutrition Therapist (FQHC only)	0.48		•		383	7.00
7. 01	Di abetes Self Management Training (FQHC	0.00				0	7.01
7.02	only)	0.00				U	7.02
8. 00	Total FTEs and Visits (sum of lines 4	2. 14	2, 655			2, 655	8.00
0.00	through 7)	2	2,000			2,000	0.00
9.00	Physician Services Under Agreements		0			0	9. 00
	<u> </u>						
						1.00	
	DETERMINATION OF ALLOWABLE COST APPLICABLE T	O HOSPI TAL-BASI	ED RHC/FQHC SEI	RVI CES			
10.00	Total costs of health care services (from Wk	st. M-1, col.	7, line 22)			214, 958	10.00
11.00	Total nonreimbursable costs (from Wkst. M-1,					1, 797	11.00
12.00	Cost of all services (excluding overhead) (s					216, 755	
13.00	Ratio of hospital-based RHC/FQHC services (I					0. 991710	13. 00
14.00	Total hospital-based RHC/FQHC overhead - (fr			ine 31)		43, 863	
15.00	Parent provider overhead allocated to facili	ty (see instru	ctions)			257, 910	
16. 00	Total overhead (sum of lines 14 and 15)					301, 773	
17. 00	Allowable GME overhead (see instructions)					0	
	Enter the amount from line 16					301, 773	
	Overhead applicable to hospital-based RHC/FC					299, 271	
20.00	Total allowable cost of hospital-based RHC/F	·UHC services (:	sum of lines 1	u and 19)		514, 229	20.00

ALCULATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	RAL HOSPITAL Provider CCN: 15-1317	Peri od:	u of Form CMS-2 Worksheet M-3	
ERVI CES		From 01/01/2021		
	Component CCN: 15-8535	To 12/31/2021	Date/Time Pre 5/27/2022 11:	
	Title XVIII	RHC I		
DETERMINATION OF DATE FOR HOSPITAL DAGED DUG/FOUG CEDVICES			1. 00	
DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES .00 Total Allowable Cost of hospital-based RHC/FQHC Services (fr	om Wkst M-2 line 20)		5, 318, 517	1.0
.00 Cost of injections/infusions and their administration (from)			223, 916	
.00 Total allowable cost excluding injections/infusions (line 1)			5, 094, 601	
.00 Total Visits (from Wkst. M-2, column 5, line 8)	,		21, 128	
.00 Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	5.0
.00 Total adjusted visits (line 4 plus line 5)			21, 128	1
.00 Adjusted cost per visit (line 3 divided by line 6)		C-11 -+:	241. 13	7.0
		Cal cul ati on	OF LIMIT (1)	
			Rate Period 2	
		(01/01/2021	(04/01/2021	
		through 03/31/2021)	through 12/31/2021)	
		1.00	2. 00	
.00 Per visit payment limit (from CMS Pub. 100-04, chapter 9, §2	0.6 or your contractor)	87. 52	224. 22	8.0
.00 Rate for Program covered visits (see instructions)		241. 13	224. 22	9.0
CALCULATION OF SETTLEMENT		705	0.740	1.00
0.00 Program covered visits excluding mental health services (from 1.00 Program cost excluding costs for mental health services (line		725	2, 719	1
1.00 Program cost excluding costs for mental health services (line 2.00 Program covered visits for mental health services (from cont		174, 819 0	609, 654 0	1
3.00 Program covered cost from mental health services (line 9 x l	•	0	Ö	1
4.00 Limit adjustment for mental health services (see instructions	*	0	0	1
5.00 Graduate Medical Education Pass Through Cost (see instruction	ns)			15.0
6.00 Total Program cost (sum of lines 11, 14, and 15, columns 1,		0	784, 473	
6.01 Total program charges (see instructions)(from contractor's r	*		645, 483	
6.02 Total program preventive charges (see instructions) (from pro 6.03 Total program preventive costs ((line 16.02/line 16.01) time			79, 757 96, 931	1
6.04 Total Program non-preventive costs ((Time 16.02/Time 16.07) time:	•		499, 542	
(Titles V and XIX see instructions.)	oo and roy trines . oo,		177, 012	10.0
6.05 Total program cost (see instructions)		0	596, 473	16.0
7.00 Primary payer amounts			0	17. C
8.00 Less: Beneficiary deductible for RHC only (see instructions) (from contractor		63, 115	18.0
records) 9.00 Beneficiary coinsurance for RHC/FQHC services (see instruction	ons) (from contractor		100, 541	19.0
records)	ons) (ITom contractor		100, 541	19.0
0.00 Net Medicare cost excluding vaccines (see instructions)			596, 473	20.0
1.00 Program cost of vaccines and their administration (from Wkst	. M-4, line 16)		68, 385	1
2.00 Total reimbursable Program cost (line 20 plus line 21)			664, 858	1
3.00 Allowable bad debts (see instructions)			960	1
3.01 Adjusted reimbursable bad debts (see instructions) 4.00 Allowable bad debts for dual eligible beneficiaries (see ins	tructions)		624 927	1
5.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	tructrons)		0	1
5.50 Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	
5.99 Demonstration payment adjustment amount before sequestration			0	
6.00 Net reimbursable amount (see instructions)			665, 482	
6.01 Sequestration adjustment (see instructions)			0	1
6.02 Demonstration payment adjustment amount after sequestration			0 577 701	26.0
7.00 Interim payments 8.00 Tentative settlement (for contractor use only)			577, 781	27. C
8.00 Tentative settlement (for contractor use only) 9.00 Balance due component/program (line 26 minus lines 26.01, 26	02 27 and 28)		87, 701	
0.00 Protested amounts (nonallowable cost report items) in accordance		.	07,701	
		'	_	

	· · · · · · · · · · · · · · · · · · ·	RAL HOSPITAL		u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1317	Peri od: From 01/01/2021	Worksheet M-3	
SERVI (ES	Component CCN: 15-8533	To 12/31/2021	Date/Time Pre	pared:
		·		5/27/2022 11:	
		Title XVIII	RHC II		
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		1, 582, 888	1.00
2.00	Cost of injections/infusions and their administration (from W			250, 939	
3.00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		1, 331, 949	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			5, 841	4.00
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6.00	Total adjusted visits (line 4 plus line 5)			5, 841	
7. 00	Adjusted cost per visit (line 3 divided by line 6)		Cal cul ati on	228.03 of limit (1)	7.00
			Carcuration	OI LIMIT (I)	
			Rate Period 1	Rate Period 2	
			(01/01/2021	(04/01/2021	
			through	through	
			03/31/2021)	12/31/2021)	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	1 6 or vour contractor)	1.00	2. 00 128. 21	8. 00
9. 00	Rate for Program covered visits (see instructions)	. o or your contractor)	228. 03	128. 21	9.00
	CALCULATION OF SETTLEMENT			.=	
10.00	Program covered visits excluding mental health services (from	contractor records)	331	897	10.00
11. 00	Program cost excluding costs for mental health services (line	•	75, 478	115, 004	
12.00	Program covered visits for mental health services (from contr	*	0	0	
13.00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions		0	0	13.00
14. 00 15. 00	Graduate Medical Education Pass Through Cost (see instructions	,	0	U	14. 00 15. 00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	*	0	190. 482	
16. 01	Total program charges (see instructions)(from contractor's re	,		248, 909	
16. 02	Total program preventive charges (see instructions) (from prov			4, 649	16. 02
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	*		3, 558	
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		121, 509	16. 04
14 OE	(Titles V and XIX see instructions.)		0	125, 067	14 05
16. 05 17. 00	Total program cost (see instructions) Primary payer amounts		U	125, 007	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		35, 038	
	records)	•			
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		41, 844	19. 00
00 00	records)			405.047	00.00
20. 00 21. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M 4 line 14)		125, 067 80, 232	l
22. 00	,	W-4, TITIE 10)		205, 299	
23. 00	Allowable bad debts (see instructions)			641	1
23. 01	Adjusted reimbursable bad debts (see instructions)			417	
24. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		274	24.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	is)		0	l
25. 99	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 205, 716	
26. 00 26. 01	Sequestration adjustment (see instructions)			205, 716	
26. 02	, ,			0	
27. 00	Interim payments			109, 247	
28. 00	Tentative settlement (for contractor use only)			0	28.00
20 00	Balance due component/program (line 26 minus lines 26.01, 26.			96, 469	
29. 00 30. 00	Protested amounts (nonallowable cost report items) in accorda			0	30.00

	Financial Systems GREENE COUNTY GENER			u of Form CMS-2	
	ATION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC	Provider CCN: 15-1317	Peri od: From 01/01/2021	Worksheet M-3	
SERVI C	E2	Component CCN: 15-8534	To 12/31/2021	Date/Time Pre	pared:
		·		5/27/2022 11:	27 am
		Title XVIII	RHC III		
				1. 00	
	DETERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1.00	
1. 00	Total Allowable Cost of hospital-based RHC/FQHC Services (fro	m Wkst. M-2, line 20)		668, 242	1.00
2. 00	Cost of injections/infusions and their administration (from W			44, 733	2.00
3. 00	Total allowable cost excluding injections/infusions (line 1 m	inus line 2)		623, 509	
4. 00	Total Visits (from Wkst. M-2, column 5, line 8)			2, 031	
5.00	Physicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0	
6. 00 7. 00	Total adjusted visits (line 4 plus line 5) Adjusted cost per visit (line 3 divided by line 6)			2, 031 307. 00	l l
7.00	Adjusted cost per visit (illie 3 divided by illie 0)		Cal cul ati on		7.00
			Car car a troii	01 [[1111] [(1)	
			Rate Period 1	Rate Period 2	
			(01/01/2021	(04/01/2021	
			through	through	
			03/31/2021)	12/31/2021) 2. 00	
8. 00	Per visit payment limit (from CMS Pub. 100-04, chapter 9, §20	.6 or your contractor)	87. 52	233. 71	8.00
9. 00	Rate for Program covered visits (see instructions)	. o o. you. cont. doto. y	307. 00		9.00
	CALCULATION OF SETTLEMENT				Ī
10. 00	Program covered visits excluding mental health services (from	contractor records)	78	256	10.00
11. 00	Program cost excluding costs for mental health services (line	•	23, 946	59, 830	
12.00	Program covered visits for mental health services (from contr	•	0	0	
13. 00 14. 00	Program covered cost from mental health services (line 9 x li Limit adjustment for mental health services (see instructions		0	0	13.00 14.00
15. 00	Graduate Medical Education Pass Through Cost (see instructions	,	U U	U	15.00
16. 00	Total Program cost (sum of lines 11, 14, and 15, columns 1, 2	,	0	83, 776	
16. 01	Total program charges (see instructions)(from contractor's re			67, 151	16. 01
16. 02	Total program preventive charges (see instructions)(from prov	•		993	
16. 03	Total program preventive costs ((line 16.02/line 16.01) times	•		1, 239	1
16. 04	Total Program non-preventive costs ((line 16 minus lines 16.0	3 and 18) times .80)		59, 304	16. 04
16. 05	(Titles V and XIX see instructions.) Total program cost (see instructions)		0	60, 543	16. 05
17. 00	Primary payer amounts			00, 549	1
18. 00	Less: Beneficiary deductible for RHC only (see instructions)	(from contractor		8, 407	
	records)				
19. 00	Beneficiary coinsurance for RHC/FQHC services (see instruction	ns) (from contractor		11, 550	19.00
20.00	records)			40 F42	20.00
20. 00 21. 00	Net Medicare cost excluding vaccines (see instructions) Program cost of vaccines and their administration (from Wkst.	M-4 line 16)		60, 543 17, 379	
22.00	Total reimbursable Program cost (line 20 plus line 21)	W-4, 1111e 10)		77, 922	
23. 00	Allowable bad debts (see instructions)			0	1
23. 01	Adjusted reimbursable bad debts (see instructions)			0	1
	Allowable bad debts for dual eligible beneficiaries (see inst	ructi ons)		0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instruction	S)		0	l
25. 99	Demonstration payment adjustment amount before sequestration Net reimbursable amount (see instructions)			0 77, 922	
26. 00	Sequestration adjustment (see instructions)			77, 922	1
26. 02	, ,			0	1
27. 00	Interim payments			59, 655	
28. 00	Tentative settlement (for contractor use only)			0	28.00
29. 00	Balance due component/program (line 26 minus lines 26.01, 26. Protested amounts (nonallowable cost report items) in accorda			18, 267	
30.00		nce with CMS Dub 15-11		0	30.00

CALCULATI	nancial Systems GREENE COUNTY GENER ION OF REIMBURSEMENT SETTLEMENT FOR HOSPITAL-BASED RHC/FQHC		Peri od:	u of Form CMS-2 Worksheet M-3	
SERVI CES		Component CCN, 1E 0E20	From 01/01/2021	Doto/Time Dro	no no d
		Component CCN: 15-8538	To 12/31/2021	Date/Time Pre 5/27/2022 11:	
		Title XVIII	RHC IV		
				4 00	
DE	TERMINATION OF RATE FOR HOSPITAL-BASED RHC/FQHC SERVICES			1. 00	
	otal Allowable Cost of hospital-based RHC/FQHC Services (fro	om Wkst. M-2. Line 20)		514, 229	1.0
1	ost of injections/infusions and their administration (from W			182, 041	2. 0
	otal allowable cost excluding injections/infusions (line 1 m	ninus line 2)		332, 188	3.00
	otal Visits (from Wkst. M-2, column 5, line 8)			2, 655	1
	nysicians visits under agreement (from Wkst. M-2, column 5,	line 9)		0 2, 655	5. 0 6. 0
	otal adjusted visits (line 4 plus line 5) djusted cost per visit (line 3 divided by line 6)			125. 12	1
7.00 AC	gusted cost per visit (iiiie s divided by iiiie o)		Cal cul ati on		7.0
			Rate Period 1		
			(01/01/2021	(04/01/2021	
			through 03/31/2021)	through 12/31/2021)	
			1.00	2. 00	
8. 00 Pe	er visit payment limit (from CMS Pub. 100-04, chapter 9, §20	0.6 or your contractor)	87. 52	139. 91	8.00
	ate for Program covered visits (see instructions)		125. 12	125. 12	9.00
	ALCULATION OF SETTLEMENT		122	425	10.0
1	rogram covered visits excluding mental health services (from rogram cost excluding costs for mental health services (line		132 16, 516	425 53, 176	1
4	rogram covered visits for mental health services (from contr	*	0,510	0 0	1
1	rogram covered cost from mental health services (line 9 x li	•	0	0	13.0
	mit adjustment for mental health services (see instructions		0	0	14.00
4	raduate Medical Education Pass Through Cost (see instruction	*			15.00
	otal Program cost (sum of lines 11, 14, and 15, columns 1, 2		0	69, 692	
1	otal program charges (see instructions)(from contractor's re otal program preventive charges (see instructions)(from prov	•		106, 839 1, 976	
4	otal program preventive costs ((line 16.02/line 16.01) times	•		1, 289	
1	otal Program non-preventive costs ((line 16 minus lines 16.0	•		39, 650	1
	Titles V and XIX see instructions.)				
1	otal program cost (see instructions)		0	40, 939	16. 0! 17. 0
	rimary payer amounts ess: Beneficiary deductible for RHC only (see instructions)	(from contractor		18, 840	
	ecords)	(110m contractor		10, 010	10.00
19. 00 Be	eneficiary coinsurance for RHC/FQHC services (see instructio	ons) (from contractor		17, 205	19.00
1	ecords)				
1	et Medicare cost excluding vaccines (see instructions)	M 4 line 14)		40, 939	
	rogram cost of vaccines and their administration (from Wkst. ptal reimbursable Program cost (line 20 plus line 21)	W-4, TITIE 10)		38, 782 79, 721	
	lowable bad debts (see instructions)			140	
1	djusted reimbursablè bad debts (see instructions)			91	23.0
N I	lowable bad debts for dual eligible beneficiaries (see inst	ructions)		95	1
	THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	>		0	
	oneer ACO demonstration payment adjustment (see instruction emonstration payment adjustment amount before sequestration	is)		0	
1	et reimbursable amount (see instructions)			79, 812	
	equestration adjustment (see instructions)			0	1
26. 02 De	emonstration payment adjustment amount after sequestration			0	26. 0
1	nterim payments			48, 773	
1	entative settlement (for contractor use only)	02 27 and 20)		0	28.00
	alance due component/program (line 26 minus lines 26.01, 26. rotested amounts (nonallowable cost report items) in accorda			31, 039 0	
JU. UU PI	napter I, §115.2	INCC WITH OWN FUD. 10-11	'	U] 50.0

Health Financial Systems	GREENE COUNTY GENE	RAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	VACCINE COST	Provider CCN: 15-1317	Peri od: From 01/01/2021	Worksheet M-4
		Component CCN: 15-8535	To 12/31/2021	Date/Time Prepared: 5/27/2022 11:27 am
		Title XVIII	RHC I	

		Component	0014. 10 0000	7270172021	5/27/2022 11:	
		Title	XVIII	RHC I		
		PNEUMOCOCCAL	I NFLUENZA	COVI D-19	MONOCLONAL	
		VACCI NES	VACCI NES	VACCI NES	ANTI BODY	
					PRODUCTS	
		1. 00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	2, 266, 631		2, 266, 631	2, 266, 631	1.00
2.00	Ratio of injection/infusion staff time to total health	0. 001331	0. 006325	0. 000000	0. 000000	2. 00
2 00	care staff time	2 017	14 22/	0	0	2 00
3. 00	Injection/infusion health care staff cost (line 1 x line	3, 017	14, 336	U	0	3. 00
4. 00	Injections/infusions and related medical supplies costs	72, 279	52, 140	0	0	4. 00
4.00	(from your records)	12, 217	52, 140	U	U	4.00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	75, 296	66, 476	0	0	5. 00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from	3, 367, 406		3, 367, 406	3, 367, 406	6. 00
0.00	Worksheet M-1, col. 7, line 22)	0,007,100	0,007,100	0,007,100	0,007,100	0.00
7.00	Total overhead (from Wkst. M-2, line 19)	1, 951, 111	1, 951, 111	1, 951, 111	1, 951, 111	7. 00
8.00	Ratio of injection/infusion direct cost to total direct	0. 022360		0. 000000	0.000000	8. 00
	cost (line 5 divided by line 6)					
9.00	Overhead cost - injection/infusion (line 7 x line 8)	43, 627	38, 517	0	0	9.00
10.00	Total injection/infusion costs and their administration	118, 923	104, 993	0	0	10.00
	costs (sum of lines 5 and 9)					
11. 00	Total number of injections/infusions (from your records)	399	, , , , ,	0	0	
12.00	Cost per injection/infusion (line 10/line 11)	298. 05		0. 00	0. 00	12.00
13.00	Number of injection/infusion administered to Program	86	772	0	0	13.00
	benefi ci ari es			_	_	
13. 01	Number of COVID-19 vaccine injections/infusions			0	0	13. 01
14 00	administered to MA enrollees	25 (22	40.750	0	0	14 00
14. 00	Program cost of injections/infusions and their	25, 632	42, 753	U	U	14. 00
	administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)					
15. 00	Total cost of injections/infusions and their		223, 916			15. 00
13.00	administration costs (sum of columns 1, 2, 2.01, and 2.02,		223, 910			13.00
	line 10) (transfer this amount to Wkst. M-3, line 2)					
16. 00	Total Program cost of injections/infusions and their		68, 385			16. 00
	administration costs (sum of columns 1, 2, 2.01, and 2.02,					
	line 14) (transfer this amount to Wkst. M-3, line 21)					

Health Financial Systems	GREENE COUNTY GENER	AL HOSPITAL	In Lieu	ı of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FOHC VAC	CCINE COST	Provider CCN: 15-1317	Peri od: From 01/01/2021	Worksheet M-4

Component CCN: 15-8533 To 12/31/2021 Date/Time Prepared: 5/27/2022 11:27 am Title XVIII RHC II PNEUMOCOCCAL INFLUENZA COVI D-19 MONOCLONAL **VACCINES VACCINES** VACCI NES ANTI BODY **PRODUCTS** 1.00 2.00 2.01 2.02 686, 787 1.00 Health care staff cost (from Wkst. M-1, col. 7, line 10) 686, 787 686, 787 686, 787 1.00 Ratio of injection/infusion staff time to total health 2.00 0.005705 0.016112 0.000000 0.000000 2.00 care staff time 3.00 Injection/infusion health care staff cost (line 1 x line 3.918 11,066 0 0 3.00 Injections/infusions and related medical supplies costs 4.00 78,001 53, 304 0 4.00 (from your records) 5.00 Direct cost of injections/infusions (line 3 plus line 4) 81, 919 64, 370 5 00 0 6.00 Total direct cost of the hospital-based RHC/FQHC (from 922, 772 922, 772 922, 772 922, 772 6.00 Worksheet M-1, col. 7, line 22) 7.00 Total overhead (from Wkst. M-2, line 19) 660, 116 660, 116 660, 116 660, 116 7.00 Ratio of injection/infusion direct cost to total direct 0.000000 0.088775 0.069757 0.000000 8.00 8.00 cost (line 5 divided by line 6) 9.00 Overhead cost - injection/infusion (line 7 x line 8) 58,602 46,048 9.00 10.00 Total injection/infusion costs and their administration 140, 521 110, 418 0 0 10.00 costs (sum of lines 5 and 9) 11 00 Total number of injections/infusions (from your records) 416 1 302 11 00 0 0 0.00 12.00 Cost per injection/infusion (line 10/line 11) 337.79 84.81 0.00 12.00 13.00 Number of injection/infusion administered to Program 484 0 13.00 116 benefi ci ari es Number of COVID-19 vaccine injections/infusions 13.01 0 0 13.01 administered to MA enrollees Program cost of injections/infusions and their 14.00 39, 184 41,048 0 14.00 administration costs (line 12 times the sum of lines 13 and 13.01, as applicable) 15.00 Total cost of injections/infusions and their 250, 939 15.00 administration costs (sum of columns 1, 2, 2.01, and 2.02, line 10) (transfer this amount to Wkst. M-3, line 2) 16.00 Total Program cost of injections/infusions and their 80, 232 16.00 administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC VA	ACCINE COST	Provider CCN: 15-1317	Peri od:	Worksheet M-4
			From 01/01/2021	

			CCN: 15-8534 T	o 12/31/2021	Date/Time Pre 5/27/2022 11:	
			XVIII	RHC III		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1.00	2. 00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	227, 616	227, 616	227, 616	227, 616	
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 001800	0. 009073	0. 000000	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	410	2, 065	0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	6, 937	10, 976	0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	7, 347	13, 041	0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	304, 562	304, 562	304, 562	304, 562	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	363, 680	363, 680	363, 680	363, 680	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 024123	0. 042819	0. 000000	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	8, 773	15, 572	0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	16, 120	28, 613	0	0	10. 00
11.00	Total number of injections/infusions (from your records)	51	257	0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	316. 08	111. 33	0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	18	105	0	0	13. 00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	5, 689	11, 690	0	0	14. 00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		44, 733			15. 00
16. 00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		17, 379			16. 00

Health Financial Systems	GREENE COUNTY GENER	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF HOSPITAL-BASED RHC/FQHC	VACCINE COST	Provider CCN: 15-1317		Worksheet M-4
		Component CCN: 15-8538	From 01/01/2021	

		Component		To 12/31/2021	Date/Time Pre 5/27/2022 11:	
		Title	: XVIII	RHC IV		
		PNEUMOCOCCAL VACCI NES	I NFLUENZA VACCI NES	COVI D-19 VACCI NES	MONOCLONAL ANTI BODY PRODUCTS	
		1. 00	2.00	2. 01	2. 02	
1.00	Health care staff cost (from Wkst. M-1, col. 7, line 10)	130, 056	130, 05	6 130, 056	130, 056	1.00
2. 00	Ratio of injection/infusion staff time to total health care staff time	0. 005656	0. 03052	9 0.000000	0. 000000	2.00
3. 00	Injection/infusion health care staff cost (line 1 x line 2)	736	3, 97	0 0	0	3. 00
4. 00	Injections/infusions and related medical supplies costs (from your records)	32, 745	38, 64	6 0	0	4. 00
5.00	Direct cost of injections/infusions (line 3 plus line 4)	33, 481	42, 61	6 0	0	5.00
6. 00	Total direct cost of the hospital-based RHC/FQHC (from Worksheet M-1, col. 7, line 22)	214, 958	214, 95	8 214, 958	214, 958	6. 00
7.00	Total overhead (from Wkst. M-2, line 19)	299, 271	299, 27	1 299, 271	299, 271	7.00
8. 00	Ratio of injection/infusion direct cost to total direct cost (line 5 divided by line 6)	0. 155756	0. 19825	3 0.000000	0. 000000	8. 00
9.00	Overhead cost - injection/infusion (line 7 x line 8)	46, 613	59, 33	1 0	0	9.00
10. 00	Total injection/infusion costs and their administration costs (sum of lines 5 and 9)	80, 094	101, 94	7 0	0	10.00
11.00	Total number of injections/infusions (from your records)	171	92	3 0	0	11.00
12.00	Cost per injection/infusion (line 10/line 11)	468. 39	110. 4	5 0.00	0.00	12.00
13. 00	Number of injection/infusion administered to Program beneficiaries	67	6	7 0	0	13.00
13. 01	Number of COVID-19 vaccine injections/infusions administered to MA enrollees			0	0	13. 01
14. 00	Program cost of injections/infusions and their administration costs (line 12 times the sum of lines 13 and 13.01, as applicable)	31, 382	7, 40	0 0	0	14.00
15. 00	Total cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02,		182, 04	1		15.00
16. 00	line 10) (transfer this amount to Wkst. M-3, line 2) Total Program cost of injections/infusions and their administration costs (sum of columns 1, 2, 2.01, and 2.02, line 14) (transfer this amount to Wkst. M-3, line 21)		38, 78	2		16. 00

Health Financial Systems	GREENE COUNTY GENER	RAL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RE	HC/FQHC PROVI DER FOR	Provider CCN: 15-1317	Peri od:	Worksheet M-5
SERVICES RENDERED TO PROGRAM BENEFICIARII	ES	Component CCN: 15-8535	From 01/01/2021 To 12/31/2021	Date/Time Prepared: 5/27/2022 11:27 am

		·		5/27/2022 11:2	27
			RHC I		
				rt B	
			mm/dd/yyyy	Amount	
	<u> </u>		1. 00	2. 00	
00	Total interim payments paid to hospital-based RHC/FQHC			577, 781	1
00	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	The state of the state of			_ ا
00	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				
)1	Program to Provider			0	3
2					3
3					3
)4					3
5					3
3	Provider to Program			U	
0	Provider to Program			0	1
1					
2					3
3					3
4					
9	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.	08)			3
00	Total interim payments (sum of lines 1, 2, and 3.99) (trans			577, 781	2
,0	27)	Tel to worksheet w 5, Title		377,701	
	TO BE COMPLETED BY CONTRACTOR				
00	List separately each tentative settlement payment after des	k review. Also show date o	f		1 5
	each payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				İ
)1				0	
2				0	- 5
3				0	5
	Provider to Program				
0				0	
1				0	5
2				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.			0	Ę
0	Determined net settlement amount (balance due) based on the cost report. (1)				6
1	SETTLEMENT TO PROVIDER			87, 701	1
)2	SETTLEMENT TO PROGRAM			0	6
00	Total Medicare program liability (see instructions)			665, 482	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
	N C O I I	0	1. 00	2. 00	
00	Name of Contractor			1	8

Health Financial Systems	GREENE COUNTY GENER	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RESERVICES RENDERED TO PROGRAM BENEFICIARIES		Provider CCN: 15-1317 Component CCN: 15-8533	From 01/01/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 11:27 am

			5/2//2022 11: 2	21
		RHC II		
			rt B	
		mm/dd/yyyy	Amount	
		1. 00	2. 00	
OO Total interim payments paid to hospital-based			109, 247	1
OO Interim payments payable on individual bills,			0	2
the contractor for services rendered in the contractor	ost reporting period. If none, write			
"NONE" or enter a zero				
DO List separately each retroactive lump sum adj	ustment amount based on subsequent			3
revision of the interim rate for the cost rep	orting period. Also show date of each			
payment. If none, write "NONE" or enter a zero	0. (1)			
Program to Provider				ĺ
01			0	1 3
2			l ol	1 3
03			0	3
04			o	3
05			0	3
Provider to Program				,
0			0	1 :
1			0	
2			0	
3			0	3
54				3
99 Subtotal (sum of lines 3.01-3.49 minus sum of	lines 3 50_3 08)			3
Total interim payments (sum of lines 1, 2, and			109, 247	2
27)	u 3. 77) (transfer to worksheet M-3, fille		107, 247	-
TO BE COMPLETED BY CONTRACTOR				
List separately each tentative settlement pays	ment after desk review. Also show date of	-		5
each payment. If none, write "NONE" or enter				`
Program to Provider	u 2010. (1)			
01			0	5
02			l ő	5
03			0	5
Provider to Program				,
0			0	5
1			0	E
2				
9 Subtotal (sum of lines 5.01-5.49 minus sum of	lines 5 50-5 98)			5
Determined net settlement amount (balance due) based on the cost report. (1)				è
1 SETTLEMENT TO PROVIDER			96, 469	
2 SETTLEMENT TO PROGRAM			70, 409	
Total Medicare program liability (see instruc	tions)		205, 716	
of Trotal medicale program transfitty (see Institut	ti viis)	Contractor	NPR Date	'
		Number		
	0	1. 00	(Mo/Day/Yr) 2.00	
Mama of Contractor	U	1.00	2.00	-
Name of Contractor	l l	1	1	8

Health Financial Systems	GREENE COUNTY GENER	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED RH SERVICES RENDERED TO PROGRAM BENEFICIARIE		Provider CCN: 15-1317 Component CCN: 15-8534	From 01/01/2021	Worksheet M-5 Date/Time Prepared: 5/27/2022 11:27 am

				5/27/2022 11: 2	27
			RHC III		
				t B	_
			mm/dd/yyyy	Amount	╄
_ 1			1. 00	2. 00	-
	nterim payments paid to hospital-based RHC/FQHC			59, 655	
	payments payable on individual bills, either submi			0	
	tractor for services rendered in the cost reporting	g period. If none, write	•		
	or enter a zero				1
	parately each retroactive lump sum adjustment amour				
revision	n of the interim rate for the cost reporting period	d. Also show date of each	•		
payment.	If none, write "NONE" or enter a zero. (1)				
	to Provi der				1
1				0	
2				0	
3			•	0	
4				0	
5				0	1
	to Program			_	1
0				0	
1				0	
2				0	
3				0	
4				0	
	(sum of lines 3.01-3.49 minus sum of lines 3.50-3			0	
	nterim payments (sum of lines 1, 2, and 3.99) (tran	nsfer to Worksheet M-3, line		59, 655	
27)	MADI ETED DV CONTRACTOR				-
	MPLETED BY CONTRACTOR				1
	parately each tentative settlement payment after de	esk review. Also show date of			
	yment. If none, write "NONE" or enter a zero. (1) to Provider				1
1	to Provider			0	1
2					
3					
	to Program			U	ł
) Provider	to Program			0	1
i					
2					
1	(sum of lines 5.01-5.49 minus sum of lines 5.50-5	5 00)		0	
	ned net settlement amount (balance due) based on th		1	ا	
	ENT TO PROVIDER	ie cost report. (1)	1	18, 267	1
	ENT TO PROVIDER		1	10, 207	
			1	77, 922	1
o jiutai Me	edicare program liability (see instructions)		Contractor	NPR Date	\vdash
			Number	(Mo/Day/Yr)	
		0	1. 00	2. 00	
0 Name of	Contractor	U	1.00	2.00	Н
o pivalile of	COILLI aC LOI	1		1	1

Health Financial Systems	GREENE COUNTY GENER	AL HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO HOSPITAL-BASED R SERVICES RENDERED TO PROGRAM BENEFICIARI		Provider CCN: 15-1317 Component CCN: 15-8538	From 01/01/2021	

				5/27/2022 11: 2	27 a
			RHC I V		
				rt B	
			mm/dd/yyyy	Amount	
			1.00	2.00	
00	Total interim payments paid to hospital-based RHC/FQHC			48, 773	1
	Interim payments payable on individual bills, either submitte			0	2
	the contractor for services rendered in the cost reporting pe	eriod. If none, write			
	"NONE" or enter a zero				
00	List separately each retroactive lump sum adjustment amount b	ased on subsequent			3
	revision of the interim rate for the cost reporting period. A	Iso show date of each			
	payment. If none, write "NONE" or enter a zero. (1)				
	Program to Provider				
)1				0	3
)2				0	3
)3				l ol	3
)4				l ol	1 3
)5					3
	Provider to Program		<u> </u>		
0	,			0	3
1				0	3
2				l ol	3
3				l ol	3
54				0	3
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98	3)		0	3
	Total interim payments (sum of lines 1, 2, and 3.99) (transfe			48, 773	4
	27)				
Ī	TO BE COMPLETED BY CONTRACTOR		•	•	
00	List separately each tentative settlement payment after desk	review. Also show date o	f		5
	each payment. If none, write "NONE" or enter a zero. (1)				
Ī	Program to Provider				
)1	-			0	5
)2				0	5
)3				0	5
	Provider to Program				
0				0	5
1				0	5
52				0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98	3)		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)				6
	SETTLEMENT TO PROVIDER			31, 039	6
	SETTLEMENT TO PROGRAM			0	ϵ
	Total Medicare program liability (see instructions)			79, 812	7
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
		0	1. 00	2.00	