Health Financi	al Systems	GOOD SAMARITAN H			U OF FOLIN CHIS-5335-TO
This report is	s required by law (42 USC 1395	ig; 42 CFR 413.20(b)). Fail	ire to report can re	esult in all interim	FORM APPROVED
payments made	since the beginning of the co	st reporting period being o	leemed overpayments	(42 USC 1395g).	омв но. 0938-0050
	HOSPITAL HEALTH CARE COMPLEX (Provider CCN: 15004	42 Period: From 01/01/2015	Worksheet S Parts I-III Date/Time Prepared: 5/25/2016 11:59 am
PART I - COST	REPORT STATUS				
Provider	1.[X]Electronically filed			Date: 5/25/20)16 Time: 11:59 am
use only	2. [] Manually submitted c	ost report			
·	3.[0] If this is an amended 4.[F] Medicare Utilization	d report enter the number o . Enter "F" for full or "L"	f times the provider for low.	r resubmitted this c	ost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. [N] Initial Report for 9. [N] Final Report for t	this Provider CCN 1 his Provider CCN	number of th	olumn 1 is 4: Enter mes reopened = 0-9.
		A STATE OF THE STA	and the second s	t tage announce, and trage a factor of the entire to the college of the efficients.	The state of the contract of the state of the state of

PART II - CERTIFIC

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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARITAN HOSPITAL (150042) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

(Signed)

off (cor or Administrator of Provider(s)

Title

5725/4/(

Version of			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	application to
		1.00	2.00	3.00	4.00	5.00	ACCOUNT OF THE
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	172,797	92,884	-3,957	0	1.00
2.00	Subprovider - IPF	0	10,727	418		0	2.00
	Subprovider - IRF	0	32,463	161		0	3.00
	Swing bed - SNF	0	0	0		0	5.00
	Swing bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00		0	215,987	93,463	-3,957	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.

From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/25/2016 9:57 am 3.00 4. 00 Hospital and Hospital Health Care Complex Address: Street: 520 SOUTH 7TH STREET 1.00 PO Box: 1.00 2.00 City: VINCENNES State: IN Zip Code: 47591 County: KNOX 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 GOOD SAMARITAN HOSPITAL 150042 99915 07/01/1966 Ν 0 3.00 Hospi tal 1 Subprovider - IPF GOOD SAMARITAN HOSPITAL 99915 01/01/1984 Р 4.00 15S042 4 Ν 0 4.00 5.00 Subprovider - IRF GOOD SAMARITAN - REHAB 15T042 99915 5 01/01/2001 Ν Р 0 5 00 Subprovi der - (Other) 6.00 6.00 7 00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 Hospi tal -Based SNF 9.00 9.00 10.00 Hospital-Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 12.00 Hospital-Based HHA GOOD SAMARITAN HOME 157432 99915 06/27/1995 N Ρ Ν 12.00 CARE 13 00 Separately Certified ASC GOOD SAMARITAN LINCOLN Hospi tal -Based Hospi ce 99915 01/01/1984 14.00 151526 14.00 TRALL HOSPICE 15.00 Hospital-Based Health Clinic - RHC 15.00 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) 01/01/2015 12/31/2015 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ N 22 00 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 §412.06(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 cost reporting Ν Ν 22.01 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 payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 2 Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. Medi cai d Other In-State In-State Out-of Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 433 1, 178 61 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 157 25.00 67 36 61 52 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150042 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/25/2016 9:57 am Program Name Program Code Unweighted IME Unwei ghted Direct ĞME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ahted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider 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 (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of

unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 + column 4)). (see instructions)

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE		TAN HOSPITAL	CCN: 150042	Peri od:		u of Form CMS- Worksheet S-2	
NOSPITAL AND NOSPITAL REALIN CARE COMPLE	A IDENTIFICATION DATA	Provider	CCN. 150042	From O	1/01/2015 2/31/2015	Part I Date/Time Pro 5/25/2016 9:	epared:
					1. 00	2.00	-
All Providers							
140.00 Are there any related organization chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the	N" for no in column 1. home office chain numb	If yes, and home er. (see instruc	office cos	ts	N		140. 00
1.00		2. 00			3.00	-6 -1	
If this facility is part of a chai home office and enter the home off				name and	a address	or the	
41. 00 Name:	Contractor's Name:			ctor's Nu	mber:		141. 00
42. 00 Street:	PO Box:		7: - 0	1-			142. 0
43.00 Ci ty:	State:		Zi p Coo	ie:			143. 0
						1.00	
44.00 Are provider based physicians' cos	sts included in Workshee	t A?				Y	144. 0
					1. 00	2.00	-
45.00 If costs for renal services are cl	aimed on Wkst. A, line	74, are the costs	s for		N N	2.00	145. 00
<pre>inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"</pre>	for yes or "N" for no lude Medicare utilization for no in column 2.	in column 1. If on for this cost	column 1 is reporting				
46.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/o	column 1. (See CMS Pub			f	N		146. 0
						1.00	+
47.00 Was there a change in the statisti	cal basis? Enter "Y" fo	r yes or "N" for	no.			N N	147. 0
48.00 Was there a change in the order of						N	148. 0
49.00 Was there a change to the simplifi	ed cost finding method?	Enter "Y" for ye	es or "N" fo		itle V	N Title XIX	149. 0
		1.00	2.00		3.00	4.00	+
Does this facility contain a provi		an exemption fro	m the appli		f the lowe	er of costs	
or charges? Enter "Y" for yes or '55.00 Hospi tal	'N" for no for each comp	onent for Part A N	and Part B	. (See 42	2 CFR §413 N	8. 13) N	 155. 0
56. 00 Subprovi der – TPF		N N	N N		N	N N	156. 0
57.00 Subprovi der - I RF		N	N		N	N	157. 0
58. 00 SUBPROVI DER		N.			N	N.	158. 0
59. 00 SNF 60. 00 HOME HEALTH AGENCY		N N	N N		N N	N N	159. 0 160. 0
61. 00 CMHC			N		N	N	161. 0
						1.00	4
Multicampus						1.00	
65.00 Is this hospital part of a Multica	mpus hospital that has	one or more camp	uses in dif	ferent CB	BSAs?	N	165. 0
Enter "Y" for yes or "N" for no.	Nama	County	Ctata	7: n Cada	CBSA	FTE/Campus	_
	Name O	County 1.00	2. 00	Zip Code 3.00	4. 00	5. 00	1
66.00 If line 165 is yes, for each campus enter the name in column		· · · · ·		<u> </u>	,,,,,,		0 166. 0
0, county in column 1, state in							
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
						1.00	
Health Information Technology (HI	() incentive in the Amer	ican Recovery an	d Reinvestm	ent Act		1.00	
67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the H	under §1886(n)? Enter O5 is "Y") and is a mean	"Y" for yes or 'ingful user (line	'N" for no.		the	Y	167. 0 0168. 0
68.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)?					lshi p		168. 0
69.00 If this provider is a meaningful utransition factor. (see instruction	iser (line 167 is "Y") a				enter the	0. 2	5169. 0
					gi nni ng	Endi ng	
70.00 Enter in columns 1 and 2 the EHR b	pedinning date and ending	n date for the r	enorti na		1. 00 /01/2015	2.00 12/31/2015	170. 0
period respectively (mm/dd/yyyy)	cyrninng date and ending	y date for the R	spor tring	017	01/2010	12/31/2015	170.0

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu						2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provi der CCN:	150042	From 01/01/2015		
				To 12/31/2015	Date/Time Pro 5/25/2016 9:	
		1			0, 20, 2010 71	, <u>u</u>
					1.00	
171.00 If line 167 is "Y", does this provide	N	171. 00				
Medicare cost plans reported on Wkst.						
(see instructions)						

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150042 Period: Worksheet S-2
From 01/01/2015 Part II

Date/Time Prepared: 12/31/2015 5/25/2016 9:57 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Υ 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 33.00 33.00 no, see instructions. Provi der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Υ 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 N 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position RENEE **ESSLINGER** 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report BKD, LLP 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 3173833768 RESSLI NGER@BKD. COM 43.00

report preparer in columns 1 and 2, respectively.

				From 01/01/2015 To 12/31/2015		
		Part B			7 20, 20, 20, 10	, <u> </u>
		<u>Date</u> 4.00				
	PS&R Data	1.00				
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	03/22/2016				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)					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 cost report? If yes, see instructions.					18. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.					19. 00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:					20. 00
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.					21. 00
			3. 00			
	Cost Report Preparer Contact Information		3.00	-		
	Enter the first name, last name and the title held by the cost report preparer in columns respectively.		SENIOR MANAGING CONSULTANT	-		41. 00
42. 00	Enter the employer/company name of the cost r preparer.	report				42. 00
43. 00	1					43. 00

Health Financial Systems GOOD SA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

					To 12/31/2015	Date/Time Pre 5/25/2016 9:5	
						I/P Days / 0/P	/ cilli
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	16	61, 49	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4. 00	HMO IRF Subprovider						4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		16	61, 49	0.00	0	7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	31. 00	3	30 8, 59	0.00	0	8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY)	43. 00				0	12. 00 13. 00
14. 00	NURSERY Total (see instructions)	43.00		70, 08	0.00	1	14. 00
15. 00	CAH visits		1.3	70,00	0.00	0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00		22 8, 03	0	0	16.00
17. 00	SUBPROVI DER - I RF	41. 00		25 9, 12		Ō	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	101. 00				0	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	11/ 00			0		23. 00
24. 00 24. 10	HOSPICE HOSPICE (non-distinct part)	116. 00 30. 00		0	U		24. 00 24. 10
25. 00	CMHC - CMHC	30.00					25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)		23	39			27. 00
28.00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)			0	0		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
33 00	outpatient days (see instructions) LTCH non-covered days						33. 00
33.00	LIGHT HOH-COVELED Days		I	I	I	I	1 33.00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 150042

				1	0 12/31/2015	5/25/2016 9:5	
		I/P Days	/ O/P Visits	/ Trips	Full Time E		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	·			Pati ents	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2	10, 646	537	16, 248			1.00
2 00	for the portion of LDP room available beds)	1 247	2 (22				2 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider	1, 247	2, 622				2. 00 3. 00
4. 00	HMO IRF Subprovider	47 92	306				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	92	300	0			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	10, 646	537	16, 248			7. 00
7.00	beds) (see instructions)	10, 040	337	10, 240			7.00
8. 00	INTENSIVE CARE UNIT	3, 158	223	6, 762			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		35	1, 051			13. 00
14.00	Total (see instructions)	13, 804	795	24, 061	0.00	1, 481. 63	14. 00
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF	1, 868	0	4, 219			
17. 00	SUBPROVI DER - I RF	6, 500	67	8, 049	0. 00	55. 43	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			•	0.00	0.00	21. 00
22. 00	HOME HEALTH AGENCY	0	0	0	0. 00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0	0	0	0.00	11 0/	23. 00
24. 00 24. 10	HOSPICE (non-distinct part)	0	0	0	0.00	11. 96	24. 00 24. 10
25. 00	CMHC - CMHC	٥	U	U			25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	1, 578. 41	27. 00
28. 00	Observation Bed Days		0	1, 859	0.00	1,0,0	28. 00
29. 00	Ambul ance Tri ps	o	٦	.,			29. 00
30. 00	Employee discount days (see instruction)			0			30.00
31. 00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	О	61	114			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00

Health Financial Systems GOOD SA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

				To	12/31/2015	Date/Time Prep 5/25/2016 9:5	
		Full Time Equivalents	Di scharges		arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	44.00	Pati ents	
1 00	Harrital Adulta 0 Dada (asluma 5 / 7 and	11. 00	12.00	13.00	14.00	15. 00	1 00
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and		(3, 126	1, 002	6, 276	1. 00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			236	0		2. 00
3.00	HMO I PF Subprovi der				0		3. 00
4.00	HMO I RF Subprovi der				0		4. 00
5. 00 6. 00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF						5. 00 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 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY						12. 00 13. 00
14. 00	Total (see instructions)	0. 00	(3, 126	1, 002	6, 276	
15. 00	CAH visits	0.00	`	0, 120	1, 002	0, 270	15. 00
16. 00	SUBPROVI DER - I PF	0. 00	(236	304	830	
17. 00	SUBPROVI DER - I RF	0. 00	(550	26	655	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00 21. 00
21. 00 22. 00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0. 00					21.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25 27. 00	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25 27. 00
28. 00	Total (sum of lines 14-26) Observation Bed Days	0.00					28.00
29. 00	Ambulance Trips						29. 00
30. 00	Employee discount days (see instruction)				ļ		30. 00
31.00	Employee discount days - IRF						31. 00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22 00	outpatient days (see instructions)						22.00
33. UU	LTCH non-covered days			1	I		33. 00

Provi der CCN: 150042

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared:

Contract						To	12/31/2015	Date/Time Pre	pared:
Line Number Reported Decision Social rise Social rise Contract Social rise Social rise Contract Social rise Contract Social rise Social rise Contract Social rise			Worksheet A	Amount	RecLassi fi cati	Adi usted	Paid Hours		
PARTICID						Sal ari es		Wage (col. 4 ÷	
DRET II - 9AGE DATA						`		col . 5)	
Mart 1 Water Patra SMAME SMA			1 00	2 00				6.00	
1.00 1.01 1.02		PART II - WAGE DATA	1.00	2.00	0.00	1. 00	0.00	0.00	
Instructions					.11				
Non-physic claim anestherist Purt	1.00		200.00	97, 782, 467		97, 782, 467	3, 380, 819. 00	28. 92	1.00
## April 1 Strative ## A	2.00			C	o	0	0.00	0.00	2. 00
## April 1 Strative ## A	0.00	A					0.00	0.00	0.00
Administrative ()	3.00	B and an anesthetist Parti		C		0	0.00	0.00	3.00
Hysysician = Part A - Teaching	4.00	Physician-Part A -		276, 911	0	276, 911	2, 523. 00	109. 75	4. 00
5.00 Physician-Part B	4 01						0.00	0.00	4 01
Non-physician-Part B 0 0 0 0 0 0.00 0.00 0.00 0.00 0.00				5. 071. 734	1	5. 071. 734		l e	
approved program		Non-physician-Part B		C	o	0		i e	
Contracted interns and residents (in an approved programs)	7.00		21. 00	C	0	0	0. 00	0. 00	7. 00
Residents (in an approved programs)	7 01			C		0	0.00	0.00	7 01
Home office personnel	,	residents (in an approved					0.00	0.00	
9.00 SNF	0.00						0.00	0.00	0.00
10.00			44. 00	C		0		l	
OTHER WACES & RELATED COSTS 11.00 Contract I abor: 1 pi rect Pati ent Care 0 0 0 0 0 0 0 0 0		Excluded area salaries (see		30, 962, 418	2, 210, 723	33, 173, 141		l .	
11.00 Contract labor: Direct Patient Care 6,863 0 6,863 578.00 11.87 11.00 Care									-
Care Contract labor: Top level	11. 00			6, 863	ol	6, 863	578. 00	11. 87	11.00
management and other management management and other management ma		Care		,		.,			
management and administrative	12. 00			C	0	0	0.00	0. 00	12. 00
Services									
A - Admin istrative		servi ces							
14. 00 Home office salaries & 0 0 0 0 0 0 0 0 0	13. 00			293, 164	. 0	293, 164	3, 018. 00	97. 14	13. 00
15.00 Home office: Physician Part A 0 0 0 0 0 0 0 0 0	14. 00			C	o	0	0.00	0.00	14. 00
- Admin is traitive when office and Contract Physician Part A - Teaching Wase-related costs (core) (see instructions)	45.00								45.00
16. 00 Home office and Contract Physicians Part A - Teaching	15.00			C		O	0.00	0.00	15.00
WAGE_RELATED_COSTS Wage_rel ated costs (core) (see instructions) 16,611,112 0 16,611,112 17,00 18.00 Wage_rel ated costs (other) 0 0 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0	16.00			C	o	0	0.00	0.00	16. 00
17. 00 Wage-related costs (core) (see 16. 611, 112 0 16. 611, 112 17. 00 18. 00 19. 00									ļ
Instructions	17. 00			16, 611, 112	.l ol	16, 611, 112			17. 00
Sec Instructions Excl uded areas 6,800,395 0 6,800,395 20.00 2		instructions)							
19.00 Excluded areas	18. 00			C	0	0			18. 00
21.00 Non-physician anesthetist Part B	19. 00			6, 800, 395	o	6, 800, 395			19. 00
B	20. 00	Non-physician anesthetist Part		C	0	0			20. 00
B	21 00	A Non-physician anesthetist Part		C		0			21 00
Administrative 22. 01 Physician Part A - Teaching 23. 00 Physician Part B	21.00	B				J			21.00
22. 01 Physician Part A - Teaching 200,846 0 200,846 0 220,00 23.00	22. 00			16, 540	0	16, 540			22. 00
23.00 Physician Part B 0 0 0 0 0 24.00 25.00 24.00 25.00 1nterns & residents (in an approved program) 0 0 0 0 0 0 25.00	22. 01	1		200. 846		200, 846			22. 01
25.00		Physician Part B		C	o	0			23. 00
Approved program OVERHEAD COSTS - DIRECT SALARIES					1				
26. 00 Empl oyee Benefits Department	25.00			C	0	U			25.00
27. 00 Administrative & General 28. 00 Administrative & General under contract (see inst.) 29. 00 Maintenance & Repairs 30. 00 Operation of Plant 31. 00 Laundry & Linen Service 32. 00 Housekeeping 33. 00 Housekeeping under contract (see instructions) 34. 00 Di etary 35. 00 Di etary 36. 00 Cafeteria 37. 00 Maintenance of Personnel 37. 00 Di washing administration 38. 00 Nursing Administration 39. 00 Central Services and Supply 20. 7, 511, 272									
28.00 Administrative & General under contract (see inst.) 29.00 Maintenance & Repairs 30.00 Operation of Plant 31.00 Laundry & Linen Service 32.00 Housekeeping 30.00 Dietary 31.00 Dietary under contract (see instructions) 34.00 Dietary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursing Administration 39.00 Central Services and Supply 29.00 Administrative & General under contract (see inst.) 516, 773					1				
Contract (see inst.) Contract (see instructions) Contract (se			3. 00						
30. 00 Operation of Plant 7. 00 2, 231, 407 141, 110 2, 372, 517 118, 317. 00 20. 05 30. 00 197, 882 17, 139. 00 11. 55 31. 00 197, 882 17, 139. 00 11. 55 31. 00 197, 882 17, 139. 00 11. 55 31. 00 1		1 ' ' '		_	_	_			
31.00 Laundry & Linen Service 8.00 197, 882 0 197, 882 17, 139.00 11.55 31.00 32.00 Housekeeping 9.00 1,928,989 0 1,928,989 146,973.00 13.12 32.00 33.00 Housekeeping under contract (see instructions)				2 231 407	141 110			l e	
33.00 Housekeeping under contract (see instructions) 34.00 Dietary 35.00 Dietary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursing Administration 37.00 Central Services and Supply 38.00 Central Services and Supply 38.00 Nursing Administration 38.00 Central Services and Supply					1	197, 882			
(see instructions) 34.00 Di etary 35.00 Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursing Administration 39.00 Central Services and Supply 34.00 10.00 1,326,576 -1,013,386 313,190 21,916.00 14.29 34.00 0 0 0 0.00 0.00 35.00 1,013,386 70,913.00 14.29 36.00 0 0 0 0 0.00 0.00 37.00 0 0 0 0 0.00 37.00 0 0 0 0.00 37.00 0 0 0 0 0.00 37.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			9. 00	1, 928, 989	o	1, 928, 989		l e	1
34.00 Di etary under contract (see instructions) 36.00 Cafeteria 37.00 Maintenance of Personnel 38.00 Nursi ng Administrati on 39.00 Central Services and Supply 10.00 1,326,576 -1,013,386 313,190 21,916.00 14.29 34.00 0 0 0 0 0 0.00 35.00 11.00 0 1,013,386 1,013,386 70,913.00 14.29 36.00 0 0 0 0 0 0 0 0.00 37.00 37.00 13.00 1,549,512 47,037 1,596,549 42,373.00 37.68 38.00	33. 00			C	9	0	0. 00	0.00	33.00
35. 00 Di etary under contract (see i nstructions) 36. 00 Cafeteria 11. 00 0 1,013,386 1,013,386 70,913.00 14. 29 36. 00 37. 00 Maintenance of Personnel 12. 00 0 0 0 0 0.00 37. 00 38. 00 Nursi ng Administration 13. 00 1,549,512 47,037 1,596,549 42,373. 00 37. 68 38. 00 39. 00 Central Services and Supply 14. 00 356,396 0 356,396 25,947. 00 13. 74 39. 00	34. 00	1 '	10. 00	1, 326, 576	-1, 013, 386	313, 190	21, 916. 00	14. 29	34.00
36. 00 Cafeteria 11. 00 0 1, 013, 386 70, 913. 00 14. 29 36. 00 37. 00 Maintenance of Personnel 12. 00 0 0 0 0 0 0 0 0 37. 00 38. 00 Nursi ng Administrati on 13. 00 1, 549, 512 47, 037 1, 596, 549 42, 373. 00 37. 68 38. 00 Central Services and Supply 14. 00 356, 396 0 356, 396 25, 947. 00 13. 74 39. 00		Di etary under contract (see		C	0	0		l	
37. 00 Maintenance of Personnel 12. 00 0 0 0 0. 00 0. 00 37. 00 38. 00 Nursing Administration 13. 00 1, 549, 512 47, 037 1, 596, 549 42, 373. 00 37. 68 38. 00 39. 00 Central Services and Supply 14. 00 356, 396 0 356, 396 25, 947. 00 13. 74 39. 00	36 00	1	11 00		1 012 294	1 012 294	70 913 00	1/1 20	36 00
38.00 Nursing Administration 13.00 1,549,512 47,037 1,596,549 42,373.00 37.68 38.00 39.00 Central Services and Supply 14.00 356,396 0 356,396 25,947.00 13.74 39.00				C	0	1, 013, 380			
	38. 00	Nursing Administration	13. 00					37. 68	38. 00
10. 00 3, 200, 170 -510, 000 2, 111, 707 11, 077, 00 57, 91 40. 00					1				
	-0.00	i nai macy	15.00	3, 233, 190	-515,000	2, / 1 / , 70 /	71,077.00	37.91	

Health Financial Systems		GOOD SAMARIT	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 01/01/2015 To 12/31/2015		oorod.
					To 12/31/2015	Date/Time Prep 5/25/2016 9:5	
	Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	2, 440, 400	0	2, 440, 40	0 124, 459. 00	19. 61	41.00
Records Library							
42.00 Social Service	17. 00	4, 703, 666	-3, 104, 420	1, 599, 24	6 84, 272. 00	18. 98	42.00
43.00 Other General Service	18. 00	0	0		0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Provider CCN: 150042 Peri od: Worksheet S-3 From 01/01/2015 To 12/31/2015 Part III Date/Time Prepared: 5/25/2016 9:57 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . col. 5) Salaries in (from Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 93, 227, 506 93, 227, 506 3, 354, 927. 00 27. 79 1.00 instructions) 2.00 30, 962, 418 2, 210, 723 33, 173, 141 973, 097. 00 2.00 Excluded area salaries (see 34.09 instructions) 3.00 Subtotal salaries (line 1 62, 265, 088 -2, 210, 723 60, 054, 365 2, 381, 830. 00 25. 21 3.00 minus line 2) 4.00 Subtotal other wages & related 300, 027 300, 027 3, 596. 00 83. 43 4.00 costs (see inst.) Subtotal wage-related costs 27. 69 5.00 16, 627, 652 Ω 16, 627, 652 0.00 5.00 (see inst.)

-2, 210, 723

-2, 726, 611

79, 192, 767

30, 335, 129

76, 982, 044

27, 608, 518

2, 385, 426. 00

1, 256, 522.00

6.00

7.00

32 27

21.97

Total (sum of lines 3 thru 5)

Total overhead cost (see

instructions)

6.00

7.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150042	
		From 01/01/2015 Part IV
		To 10/21/2015 Doto/Time December

	To 12/31/2015	Date/Time Pre 5/25/2016 9:5	pared: 7 am
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	5, 213, 735	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	12, 217, 200	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	461, 649	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	201, 207	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	228, 729	13. 00
14. 00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		41, 519	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumul ative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	3, 856, 723	17. 00
18. 00	Medicare Taxes - Employers Portion Only	1, 090, 334	18. 00
19. 00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	37, 136	22. 00
23.00	Tuition Reimbursement	418, 191	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	23, 766, 423	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Heal th	Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150042	Peri od: From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/25/2016 9:5	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Id	lenti fi cati on:			
1.00	Total facility's contract labor and bene	efit cost	0	0	1. 00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - IPF		0	0	3. 00
4.00	Subprovi der - IRF		0	0	4. 00
5.00	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9.00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11.00	Hospi tal -Based HHA		0	0	11. 00
10 00	6 1 1 0 1 6 1 460		1	I .	40 00

12.00 13.00 14. 00 15.00 16. 00 17. 00 0 18. 00

11.00 Hospital-Based HHA
12.00 Separately Certified ASC
13.00 Hospital-Based Hospice
14.00 Hospital-Based Health Clinic RHC
15.00 Hospital-Based Health Clinic FQHC
16.00 Hospital-Based-CMHC
17.00 Renal Dialysis
18.00 Other

	Financial Systems GOOD SAMARITAN HOS				u of Form CMS-2	
HOSPI 1	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CC		Peri od:	Worksheet S-10	0
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/25/2016 9:5	
			1		1. 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line	202 column	8)	0. 287343	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				18, 397, 368	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		om Medicaid	?	N	4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from N	Medi cai d			2, 801, 927	5. 00
6.00	Medi cai d charges				64, 906, 814	6. 00
7.00	Medicaid cost (line 1 times line 6)		6.11	0 15 10	18, 650, 519	
8. 00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)			es 2 and 5; if	0	8. 00
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for eac	h line)			
9.00	Net revenue from stand-alone SCHIP				0	
10.00	3				0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)	lina 11 min	ua lina O	if . zono thon	0	
12. 00	Difference between net revenue and costs for stand-alone SCHIP (I enter zero)			r < zero tnen	0	12. 00
	Other state or local government indigent care program (see instru			<u></u>		
13.00	Net revenue from state or local indigent care program (Not included)			,		13.00
14. 00	Charges for patients covered under state or local indigent care μ 10)	orogram (No	T Included	in lines 6 or	0	
15. 00	State or local indigent care program cost (line 1 times line 14)				0	
16. 00	Difference between net revenue and costs for state or local indig 13; if < zero then enter zero)	gent care p	rogram (lin	e 15 minus line	0	16. 00
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fund					17. 00
18.00	Government grants, appropriations or transfers for support of hos				0	
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	indigent c	are program	s (sum of lines	0	19. 00
			Uni nsured	Insured	Total (col. 1	
			patients	pati ents	+ col . 2)	
00.00	T	. 6	1.00	2.00	3. 00	00.00
20. 00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire 1	facility	4, 398, 93		11, 242, 860	
21. 00	Cost of initial obligation of patients approved for charity care times line 20)	(line 1	1, 264, 00	1, 966, 554	3, 230, 557	21. 00
22. 00	Partial payment by patients approved for charity care		64, 44		91, 930	22. 00
23. 00	Cost of charity care (line 21 minus line 22)		1, 199, 55	9 1, 939, 068	3, 138, 627	23. 00
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient of imposed on patients covered by Medicaid or other indigent care processes.		a Length o	f stay limit	N	24. 00
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		ram's Lengt	h of stay limit	0	25. 00
26. 00			3 -	,	21, 766, 056	
27. 00	Medicare bad debts for the entire hospital complex (see instructi				581, 829	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line	e 26 minus	line 27)		21, 184, 227	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exper	nse (line 1	times line	28)	6, 087, 139	29. 00
	10+				9, 225, 766	30.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line				9, 225, 766	

	n Financiai Systems Scilication and adjustments of thial balance o	F EVDENCES		CCN, 150042 F		Warksheet A	2332-10
RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period: From 01/01/2015	Worksheet A	
					Γο 12/31/2015	Date/Time Pre	
	0 1 0 1 0 1	0.1.	011	T 1 1 (1 1	D 1 . C. 1.	5/25/2016 9:5	7 am
	Cost Center Description	Sal ari es	0ther		Reclassificati	Reclassified	
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col . 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		0		21, 290, 407	21, 290, 407	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		7, 065, 481	7, 065, 481		-11, 483	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	624, 767	2, 488, 786	3, 113, 553	21, 140, 107	24, 253, 660	4. 00
4. 01	00401 COMMUNI CATI ONS	249, 016	99, 209	348, 225	-82, 333	265, 892	4. 01
4.02	00402 PURCHASING & RECEIVING	664, 965	311, 013			732, 848	4. 02
4.03	00403 REGI STRATI ON	806, 174	451, 476			914, 402	4. 03
4.04	00404 PATIENT ACCOUNTS	1, 993, 539	2, 896, 339			4, 185, 038	4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	7, 511, 272	22, 445, 019			24, 378, 638	5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	2, 231, 407 197, 882	4, 430, 826 368, 435			6, 107, 511 358, 583	7. 00 8. 00
9.00	00900 HOUSEKEEPING	1, 928, 989	1, 140, 322			2, 286, 261	9.00
10.00	1	1, 326, 576	1, 936, 284			677, 159	1
11. 00	1	1, 320, 370	1, 750, 204) 3, 202, 000		2, 108, 675	
13. 00	1	1, 549, 512	903, 922	1		1, 953, 654	
14. 00	l i	356, 396	391, 397			548, 443	
15. 00		3, 233, 795	15, 309, 462			3, 081, 298	
16. 00		2, 440, 400	1, 741, 072	4, 181, 472		3, 424, 556	1
17. 00	01700 SOCIAL SERVICE	0	0) (o	0	17. 00
17. 01	01701 MENTAL HEALTH OVERHEAD	4, 703, 666	3, 706, 130	8, 409, 796	-6, 028, 753	2, 381, 043	17. 01
23. 00	02300 PARAMED ED PGRM-(SPECIFY)	190, 647	82, 354	273, 001	-48, 432	224, 569	23. 00
23. 01	02302 PARAMED ED PGRM-(SPECIFY)	12, 081	6, 362	18, 443	-3, 841	14, 602	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		5, 676, 255	4, 746, 140			7, 602, 098	
31. 00		3, 466, 323	1, 802, 646			4, 002, 114	
40.00		0	0	1	, , , , , , ,	755, 757	40.00
41. 00		2, 709, 373	1, 712, 600			3, 734, 350	
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	331, 566	167, 963	499, 529	-114, 490	385, 039	43. 00
50. 00		3, 637, 832	5, 649, 185	9, 287, 017	-3, 761, 212	5, 525, 805	50.00
51. 00	1	0,037,032	0,049,100			0, 323, 603	51.00
51. 00	05101 ENDOSCOPY	954, 383	1, 252, 615	1	-	1, 309, 284	
52. 00	1 1	438, 612	232, 629			502, 978	
54. 00	1 1	3, 809, 996	6, 053, 804			6, 221, 515	
54. 01	05401 RADI OLOGY-NON-CAMPUS	797, 370	944, 322			1, 177, 646	
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	268, 525	138, 776		-65, 754	341, 547	54. 08
60.00		2, 438, 766	5, 080, 167	7, 518, 933	-3, 232, 831	4, 286, 102	60.00
63. 00		0	0) (834, 139	
65. 00		1, 913, 972	949, 819			2, 199, 148	1
66. 00		2, 492, 400	1, 017, 816			2, 848, 359	1
69. 00		4, 316, 569	2, 811, 973			5, 101, 441	1
70. 00 70. 01		0 318, 220	105 070	1	0 124 540	0 386, 730	70. 00 70. 01
70.01		316, 220	195, 079	513, 299	9 -126, 569 8, 884, 046	8, 884, 046	
71.00		0	0			2, 152, 971	
73. 00		17, 326	1, 743			14, 566, 274	73. 00
75. 00		957, 020	3, 197, 741			2, 064, 589	
76. 00		0	0) .,,		0	76. 00
76. 01	03950 INPATIENT DIALYSIS	0	756, 830	756, 830	-83, 048	673, 782	1
	OUTPATIENT SERVICE COST CENTERS		·		<u> </u>		
90.00		1, 589, 990	1, 239, 955	2, 829, 945	-766, 345	2, 063, 600	90.00
91. 00	09100 EMERGENCY	3, 512, 751	6, 883, 298	10, 396, 049	-1, 046, 192	9, 349, 857	91. 00
92. 00							92. 00
	OTHER REIMBURSABLE COST CENTERS				1		
96. 00		63, 817	115, 360			121, 934	
101. 0	0 10100 HOME HEALTH AGENCY	0	0) (0	0	101. 00
440.0	SPECIAL PURPOSE COST CENTERS		0.005.740	0.005 (46	2 205 (40		110 00
	0 11300 I NTEREST EXPENSE	(24 217	3, 095, 649			1, 175, 359	113.00
118.0	0 11600 HOSPICE 0 SUBTOTALS (SUM OF LINES 1-117)	634, 217 70, 366, 367	696, 336 114, 516, 335			187, 442, 220	
110.0	NONREI MBURSABLE COST CENTERS	70, 300, 307	114, 510, 555	104, 002, 702	2, 557, 510	107, 442, 220	1116.00
190 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0			0	190. 00
	0 19200 PHYSI CI ANS' PRI VATE OFFI CES	26, 366, 442	12, 219, 109	1		33, 892, 642	
	007950 COMMUNITY HEALTH SERVICES	150, 830	158, 475			240, 616	
	2 07952 MARKETING AND PUBLIC RELATIONS	169, 306	971, 147			1, 087, 044	
	3 07953 MH RESIDENTIAL	384, 948	216, 087			463, 741	
194.0	4 07954 UNUSED SPACE	0	0		o o	0	194. 04
	5 07955 MOB	209, 629	111, 644			260, 721	
	6 07956 FOUNDATI ON	117, 171	1, 110, 887	1, 228, 058	-19, 668	1, 208, 390	
	7 07957 KNOX COUNTY HEALTH DEPT	0	0		이		194. 07
	8 07958 I NDUSTRI AL HEALTH	17, 774	3, 369				194. 08
194. 0	9 07959 NRCC	0	0) (2, 473, 389	2, 473, 389	194. 09
		<u> </u>					

Heal th Financ	ial Systems		GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CMS-2552-10			
RECLASSI FI CA	TON AND ADJUSTMENTS OF TRIAL BALA	NCE OF	EXPENSES	Provi der		Peri od: From 01/01/2015	Worksheet A		
						To 12/31/2015	Date/Time Pre 5/25/2016 9:5		
	Cost Center Description		Sal ari es	Other	Total (col.	1 Reclassi ficati	Recl assi fi ed		
					+ col . 2)	ons (See A-6)	Trial Balance		
							(col. 3 +-		
							col. 4)		
			1. 00	2. 00	3. 00	4. 00	5. 00		
200.00	OTAL (SUM OF LINES 118-199)		97, 782, 467	129, 307, 053	227, 089, 52	0 0	227, 089, 520	200.00	

2 00 002000CAP REL COSTS-WRILE EQUIP 1-11,489 2.00 4.01 002000CAP REL COSTS-WRILE EQUIP 4.00 4.01 00200CAP REL COSTS-WRILE EQUIP 4.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00		Financial Systems	GOOD SAMARIT	AN HOSPITAL		In Lie	u of Form CMS-	-2552-10
Cost Center Description	RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der	CCN: 150042		Worksheet A	
SPREAM SERVICE DIST CHITES						To 12/31/2015		
1.00		Cost Center Description					372372010 4.3	77 2111
Company Comp					1			
2.00 00000 DOZDO LAP REL DOSIS - MARLE EDUIP 0 -11, 889 4.00 0.00		GENERAL SERVICE COST CENTERS	0.00	7.00	1			
4.00 DOMIC DATIONAID REPRETATIS DEPARTMENT - 570, 700 22, 882, 969 4.00 4.01 DOMIC DATIONAID REPRETATIVE & CENERAL -5, 462, 444 8, 915, 194 5.00 5.00 DOSDO DATIONAID REPRETATIVE & CENERAL -5, 462, 444 8, 915, 194 7.00 5.00 DOSDO DATIONAID REPRETATIVE & CENERAL -5, 462, 444 8, 915, 194 7.00 5.00 DOSDO DATIONAID REPRETATIVE & CENERAL -5, 462, 444 8, 915, 194 7.00 5.00 DOSDO DATIONAID REPRETATIVE & CENERAL -5, 462, 444 8, 915, 194 7.00 5.00 DOSDO DATIONAID REPRETATIVE & CENERAL -5, 462, 444 8, 915, 194 7.00 5.00 DOSDO DATIONAID REPRETATIVE & CENERAL -5, 462, 444 8, 915, 194 7.00 5.00 DOSDO DATIONAID REPRETATIVE & CENERAL -5, 462, 444 8, 915, 194 7.00 5.00 DOSDO DATIONAID REPRETATIVE & CENERAL -5, 462, 444 8, 915, 194 7.00 5.00 DOSDO DATIONAID REPRETATIVE & CENERAL -7, 462, 444 7.00 7.00 0.00			1					1. 00
4.01 DOGOD COMMANICATIONS 4.02 DOGOD COMMANICATIONS 4.02 DOGOD COMMANICATIONS 4.03 DOGOD COMMANICATIONS 4.03 DOGOD COMMANICATIONS 4.04 DOGOD COMMANICATIONS 4.05 DOGOD COMMANICATIONS 4.06 DOGOD COMMANICATIONS 4.07 DOGOD COMMANICATIONS 4.07 DOGOD COMMANICATIONS 4.07 DOGOD COMMANICATIONS 4.07 DOGOD COMMANICATIONS 4.08 DOGOD COMMANICATIONS 4.08 DOGOD COMMANICATIONS 4.00 DOGOD COMMANICAT			·					
4.02 00402 PURCHASTOR & BECEL VING								
4.03 ODIOS) RICK STRATION 0 914, 400 404 6040 405 40		i i	1					
5.00 05000 ADMINISTRATIVE & CEMERAL			1	1				4. 03
7.00 007000 [CREATION OF PLANT			-231, 088	3, 953, 950				4. 04
8.00 000000 LAUMORY & LINEN SERVICE 0 338, 583 8.00 7.00		1 1						5. 00
9.00 00000 INJECTIFE PING 0 2, 266, 261 9.000 10.000 10.000 INTERPEN NO.		1 1			1			
10.00 01000 DIFTARY -3.3, 886		1 1			1			
11.00 01.100 CAFETERIA 983.783 1, 124, 892 11.00 1			1	_, _,	1			
14.00 01400 CENTRAL SERVICES & SUPPLY 1-1 5-84, 432 15-00 10100 PHARMACY -2, 801 3, 421, 705 16-00 10100 PHARMACY -2, 801 3, 421, 705 16-00 17-70		1 1			1			11. 00
15.00 101500 PHARMACY	13.00	01300 NURSING ADMINISTRATION	C	1, 953, 654	·			13. 00
16.00 16-00 MEDICAL RECORDS & LIBRARY -2, 851 3, 421, 705 17.00 1710 017			1		1			14. 00
17.00 10700 SOCI AL SERVICE 0 0 17.00 17			•	1				1
17.01 10/701 MENTAL HEALTH OVERHEAD -0.55, 186 1,746, 857 23.0					1			
23.00		1 1	1		1			17. 01
IMPATIENT ROUTH IN SERVICE COST CENTERS 30.00 03000 (AUTES A PEDIATRIC S 182 7,601,916 31.00 31.00 03100 INTENSIVE CARE UNIT -13.125 3,986,989 31.00 41.00 04000 SURPROVIDER - 1 PF -2 3,734,348 41.00 43.00 4300 MINESERY -1,291 383,748 43.00 40.00 MINESERY -1,291 383,748 43.00 40.00 MINESERY MINESERY -1,291 383,748 43.00 40.00 MINESERY MINESERY -1,291 383,748 43.00 40.00 MINESERY MINESERY -1,291 40.00 40.00 MINESERY MINESERY -1,293 40.00 55.00 MINESERY MINESERY -2,20,805 60.00 60.00 MINESERY MINESERY -1,293 60.00 60.00 MINESERY MINESERY -1,293 60.00 MINESERY -			1					23. 00
30.00 30.00 ADULTS & PEDIATRICS -182 7, 601,916 30.00 31.00 30.10 10	23. 01		C	14, 602	2			23. 01
31.00 03100 INTERSIVE CARE UNIT			1	7 (04 04)				4
40.00 0.0000 SUBPROVIDER - IPF 0 755,757 40.00 41.00 0.4100		1 1	1	1	1			
41.00 04100 NURSERY -1.291 38.3,748 43.00 04300 NURSERY -1.291 38.3,748 43.00 04300 NURSERY -1.291 38.3,748 43.00 04300 NURSERY -1.291 38.3,748 43.00 05.00 05.00 05.00 05.00 05.00 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.10 05.00 05.00 05.10 05.10 05.10 05.10 05.10 05.10 05.00 05.1					1			
43.00 0.300 NURSERY -1, 291 333, 748 43.00			•		1			41. 00
50.00	43.00		-1, 291		1			43. 00
51.00								4
51.01								
52.00 05200 DELI VERY ROOM & LABOUR ROOM -56 502, 922 52.00 54.01 54.00 54.00 63.00 RADIOLOGY - 10 IAGNOSTI C -220, 805 6, 000, 710 54.00			· ·	1				1
54. 00 05400 RADI LLOGY-DI AGNOSTI C -220, 805 6, 000, 710 54, 00 54, 01 05401 RADI LLOGY-ONN-CAMPUS 0 1, 177, 646 54, 01 05401 RADI LLOGY-ONN-CAMPUS 0 1, 177, 646 54, 01 05401 RADI LLOGY-OSH BREAST CENTER -142, 754 198, 793 60, 00 6000 LABORATORY -61, 369 834, 139 66, 00 66, 00 66500 RESPI RATORY THERAPY -15, 995 2, 183, 153 65, 00 66, 00 66600 PHYSI CAL THERAPY -13, 350 2, 847, 009 66, 00 66600 PHYSI CAL THERAPY -13, 350 2, 847, 009 66, 00 66600 CILCETRORCHEPHAL GORAPHY 0 0 70, 00 70			1					1
54. 08 05408 RADIOLOGY-GSH BREAST CENTER				1				54. 00
60. 00 6000 LABORATORY 6.00 0600 LABORATORY PROCESSING & TRANS. 0 834, 139 63. 00 630 0 6500 BLODD STORING, PROCESSING & TRANS. 0 847, 009 65. 00 6500 RESPIRATORY THERAPY -1, 509 5 2, 183, 153 65. 00 66. 00 06600 PHYSICAL THERAPY -1, 509 2, 847, 009 66. 00 06600 PHYSICAL THERAPY -1, 509 2, 847, 009 66. 00 070		1 1	C					54. 01
63.00 06300 BLOOD STORI NO, PROCESSI NG & TRANS. 0 834, 139 65.00 06500 06500 RESPIRATORY THERAPY -1, 350 2, 847, 009 66.00 069.00 06600 RESPIRATORY THERAPY -1, 350 2, 847, 009 66.00 069.00 06900 ELECTROCARDI OLLOGY -2, 133, 502 2, 967, 939 0.0 070.01 07000 RELICITADE CRAPHY 0 0 0 0.0 070.01 07001 NEURODI AGNOSTI CS -13, 354 373, 376 77.0 070.01 07001 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 8, 884, 046 71.00 070.00 07000 DEDI CAL SUPPLIES CHARGED TO PATI ENT 0 2, 152, 971 72.00 072.00 072.00 IMPL. DEV. CHARGED TO PATI ENTS 0 2, 152, 971 72.00 075.00 075.00 ORUGO SCHARGED TO PATI ENTS 0 2, 152, 971 72.00 075.00 075.00 ORUGO SCHARGED TO PATI ENTS 0 2, 152, 971 72.00 075.00 075.00 ORUGO SCHARGED TO PATI ENTS 0 2, 152, 971 72.00 075.00 075.00 ORUGO SCHARGED TO PATI ENTS 0 2, 152, 971 72.00 075.00 075.00 ORUGO SCHARGED TO PATI ENTS 0 0, 0 0 0 075.00 075.00 ORUGO SCHARGED TO PATI ENT 0 0 0 0 075.00 075.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 075.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 O75.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 O75.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 O75.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 O75.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 O75.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 O75.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 ORUGO SCHARGED TO PATI ENT 0 0 0 075.00 ORUGO CLIN INC CRUTERS 0 0 0 0 075.00 ORUGO CLIN INC CRUTERS 0 0 0		1 1			1			54. 08
65. 00		1 1	-61, 369					
66.00 06600 PHYSI CAL THERAPY			_15 995	1	1			1
69. 00 06900 ELECTROCARDI OLOGY -2,133,502 2,967,939 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0 0		1 1			1			
70. 01 07001 NEURODI AGNOSTI CS -13, 354 373, 376 70. 01 71. 00 710.0 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 8, 884, 046 71. 00 72.00 1MPL. DEV. CHARGED TO PATI ENTS 0 2, 152, 971 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS -459, 939 14, 106, 335 73. 00 73.00 07300 ASC (NON-DI STINCT PART) -475 2, 064, 114 75. 00 70.00 30.00 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 0 0 0		1 1	1		1			69. 00
71. 00			1	1	1			70. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 2, 152, 971 72. 00 07300 DRUGS CHARGED TO PATIENTS -459, 939 14, 106, 335 73. 00 07500 JASC (NON-DISTINCT PART) -475 2, 064, 114 75. 00 7500 JASC (NON-DISTINCT PART) 76. 00 03020 MH ANCILLARY OUTPATIENT 0 0 0 0 76. 01 76. 01 00 07000 JURATIENT DIALYSIS -213, 351 460, 431 76. 01 00 07000 JURATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC -810, 461 1, 253, 139 91. 00 09000 JURATIENT SERVICE COST CENTERS 91. 00 00 00000 JURATIENT SERVICE COST CENTERS 91. 00 00 0000 JURATIENT JURATIENT SERVICE COST CENTERS 91. 00 00 0000 JURABLE MEDICAL EQUIP-RENTED 0 0 121, 934 92. 00 1000 JURABLE MEDICAL EQUIP-RENTED 0 0 121, 934 96. 00 101.00 JURATIENT SERVICE COST CENTERS 91. 00 0000 JURABLE MEDICAL EQUIP-RENTED 0 0 121, 934 96. 00 11300 JURATIENT SERVICE COST CENTERS 91. 00 11300 JURATIENT SERVICE COST CENTERS 91. 00 0 0 11300 JURATIENT JURATIE					1			70. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS	71.00	07700 MEDICAL SUPPLIES CHARGED TO PATIENT	1 _		1			1
75. 00 07500 ASC (NON-DISTINCT PART)			1					
76. 01 03950 INPATI ENT DI ALYSI S 0-213, 351 460, 431 90. 00 000 CUITRATI ENT SERVICE COST CENTERS 90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY 90. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 00140 ODBERVATI ON BEDS (NON-DI STI NCT ODBERVATI ON BORDS (NON-DI STI NCT ODBERVATI ON BORDS (NON-DI STI NCT ODBERVATI ON BORDS (N				1	1			75. 00
OUTPATIENT SERVICE COST CENTERS 90.00	76.00	03020 MH ANCILLARY OUTPATIENT	C) c				76.00
90. 00 09000 CLINIC -810, 461 1, 253, 139 90. 00 9100 EMERGENCY -5, 193, 432 4, 156, 425 91. 00 9200 OBSERVATION BEDS (NON-DISTINCT PART 07000 071ER REI MBURSABLE COST CENTERS 92. 00 071ER REI MBURSABLE COST CENTERS 96. 00 07000 DURABLE MEDICAL EQUI P-RENTED 0 121, 934 96. 00 101. 00 07000 DURABLE MEDICAL EQUI P-RENTED 0 0 0 121, 934 96. 00 101. 00 07000 DURABLE MEDICAL EQUI P-RENTED 0 0 0 121, 934 96. 00 101. 00 070000 07000 07000 07000 07000 07000 07000 07000 070000 07000 07000 07000 07000 07000 07000 07000 070000 07	76. 01		-213, 351	460, 431				76. 01
91. 00 09100 BMERGENCY -5, 193, 432 4, 156, 425 91. 00 92. 00 DSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 121, 934 96. 00 00 SPECI AL PURPOSE COST CENTERS 0 0 0 11.00	90 00		_810_461	1 252 130				90 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART THEN BURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 121, 934 96. 00 10100 HOME HEALTH AGENCY 0 0 0 101100 HOME HEALTH AGENCY 0 0 0 101100 HOME HEALTH AGENCY 0 0 0 10110 HOME HEALTH AGENCY 0 0 0 113. 00 11300 INTEREST EXPENSE 0 0 0 113. 00 11300 INTEREST EXPENSE 0 0 0 116. 00				1	1			91.00
96. 00 101. 00			1	1, 122, 122				92. 00
101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE O O O 116. 00 11600 HOSPI CE SUBTOTALS (SUM OF LINES 1-117) -19, 299, 521 168, 142, 699 O 118. 00 NONRE MBURSABLE COST CENTERS 190. 00 19200 PHYSI CI ANS* PRI VATE OFFI CES O 33, 892, 642 O 194. 00 07950 MARKETI NG AND PUBLIC RELATI ONS O 1, 087, 044 O 194. 03 07953 MH RESI DENTI AL CELATI O CELATI O CELATI O 194. 04 07954 UNUSED SPACE O CELATI O CELATI O 194. 05 07955 MOB O 260, 721 O 194. 06 07956 FOUNDATI ON O 194. 07 07957 KNOX COUNTY HEALTH DEPT O O 194. 08 07958 INDUSTRI AL HEALTH DEPT O O 194. 09 07959 NRCC O 2, 473, 389 194. 09 194. 09 07959 NRCC O 2, 473, 389 194. 09 194. 09 07959 NRCC O CELATI O CELATI O 194. 09 07959 NRCC O CELATI O CELATI O 194. 09 07959 NRCC O CELATI O CELATI O 194. 09 07959 NRCC O CELATI O CELATI O 194. 09 07959 NRCC O CELATI O 194. 09 O O O 195. 00 O O 195. 00 O O 1								
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113. 00	101.00		C) <u> </u>)			101. 00
116. 00	112 00							112 00
118. 00			1		1			
190. 00					1			118. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 33, 892, 642 194. 00 07950 COMMUNI TY HEALTH SERVI CES 0 240, 616 194. 02 07952 MARKETI NG AND PUBLI C RELATI ONS 0 1, 087, 044 194. 03 07953 MH RESI DENTI AL 0 463, 741 194. 04 07954 UNUSED SPACE 0 0 194. 05 07955 MOB 0 260, 721 194. 06 07956 FOUNDATI ON 0 1, 208, 390 194. 07 07957 KNOX COUNTY HEALTH DEPT 0 0 194. 08 07958 I NDUSTRI AL HEALTH DEPT 0 20, 757 194. 08 07959 NRCC 0 2, 473, 389 194. 09 07959 NRCC								
194. 00 07950 COMMUNITY HEALTH SERVICES 0 240, 616 194. 02 194. 02 07952 MARKETING AND PUBLIC RELATIONS 0 1, 087, 044 194. 02 194. 03 07953 MH RESIDENTIAL 0 463, 741 194. 03 194. 04 07954 UNUSED SPACE 0 0 194. 04 194. 05 07955 MOB 0 260, 721 194. 05 194. 06 07956 FOUNDATION 0 1, 208, 390 194. 05 194. 07 07957 KNOX COUNTY HEALTH DEPT 0 0 194. 07 194. 08 07958 I NDUSTRIAL HEALTH 0 20, 757 194. 08 194. 09 07959 NRCC 0 2, 473, 389 194. 09				1	1			190. 00
194. 02 07952 MARKETING AND PUBLIC RELATIONS 0 1,087,044 194. 02 194. 03 07953 MH RESIDENTIAL 0 463,741 194. 03 194. 04 07954 UNUSED SPACE 0 0 194. 04 194. 05 07955 MOB 0 260,721 194. 05 194. 06 07956 FOUNDATION 0 1,208,390 194. 07 194. 07 07957 KNOX COUNTY HEALTH DEPT 0 0 194. 07 194. 08 07958 INDUSTRIAL HEALTH 0 20,757 194. 08 194. 09 07959 NRCC 0 2,473,389 194. 09			-		1			
194. 03 07953 MH RESIDENTIAL 0 463, 741 194. 03 194. 04 07954 UNUSED SPACE 0 0 194. 04 194. 05 07955 MOB 0 260, 721 194. 05 194. 06 07956 FOUNDATION 0 1, 208, 390 194. 07 194. 07 07957 KNOX COUNTY HEALTH DEPT 0 0 194. 07 194. 08 07958 I NDUSTRI AL HEALTH 0 20, 757 194. 08 194. 09 07959 NRCC 0 2, 473, 389 194. 09			-	1	1			
194. 04 07954 UNUSED SPACE 0 0 194. 04 194. 05 07955 MOB 0 260, 721 194. 05 194. 06 07956 FOUNDATI ON 0 1, 208, 390 194. 06 194. 07 07957 KNOX COUNTY HEALTH DEPT 0 0 194. 07 194. 08 07958 I NDUSTRI AL HEALTH 0 20, 757 194. 08 194. 09 07959 NRCC 0 2, 473, 389 194. 09					1			
194. 05 07955 MOB 0 260, 721 194. 05 194. 06 07956 FOUNDATI ON 0 1, 208, 390 194. 06 194. 07 07957 KNOX COUNTY HEALTH DEPT 0 0 0 194. 07 194. 08 07958 I NDUSTRI AL HEALTH 0 20, 757 194. 08 194. 09 07959 NRCC 0 2, 473, 389 194. 09					1			194. 04
194. 07 07957 KNOX COUNTY HEALTH DEPT 0 0 194. 07 194. 08 07958 I NDUSTRI AL HEALTH 0 20, 757 194. 08 194. 09 07959 NRCC 0 2, 473, 389 194. 09				260, 721				194. 05
194. 08 07958 NDUSTRI AL HEALTH 0 20, 757 194. 09 07959 NRCC 0 2, 473, 389 194. 09			C		1			194. 06
194. 09 07959 NRCC 0 2, 473, 389 194. 09			C	1	1			194. 07
		1 1			1			
		1 1	-19, 299, 521					
	30		, 11, 22		•			

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/25/2016 9:57 am Provider CCN: 150042

					5/25/2016 9:5	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3.00	4. 00	5. 00		
1 00	A - DRUGS CHARGED TO PATIENTS		٥	12 702 725		1 00
1. 00	DRUGS CHARGED TO PATIENTS	73.00	0	13, 782, 735 13, 782, 735		1. 00
	B - MEDICAL SUPPLIES CHARGED	TO DATIENTS	U _I	13, 702, 733		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	8, 884, 046		1. 00
1.00	PATI ENT	71.00	Ĭ	0,001,010		1.00
2.00	BLOOD STORING, PROCESSING &	63.00	o	834, 139		2. 00
	TRANS.					
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0		7. 00 8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	Ö	Ö		11. 00
12. 00		0.00	Ö	Ö		12. 00
13.00		0.00	О	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0. 00 0. 00	0	0		19.00
20. 00 21. 00		0.00	0	0		20. 00 21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	Ö	o		23. 00
24.00		0.00	o	0		24. 00
25.00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00 31. 00	1	0. 00 0. 00	0	0		30. 00 31. 00
32. 00		0.00	0	0		32.00
33. 00		0.00	0	ő		33. 00
34. 00		0.00	Ö	Ö		34. 00
35. 00		0.00	o	0		35. 00
	0 — — — — — —			9, 718, 185		
	C - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	21, 222, 303		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4. 00 E. 00		0. 00 0. 00	0	0		4. 00 5. 00
5. 00 6. 00	+	0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8.00		0.00	Ö	o		8. 00
9. 00		0.00	O	0		9. 00
10.00		0.00	0	0		10. 00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15. 00		0.00	0	0		15.00
16. 00 17. 00	1	0. 00 0. 00	0	0		16. 00 17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	ő		19. 00
20. 00		0.00	Ö	o		20. 00
21. 00		0.00	O	Ō		21. 00
22. 00		0.00	О	0		22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0. 00 0. 00	0	0		27. 00
28. 00 29. 00		0.00	0	0		28. 00 29. 00
30. 00		0.00	0	0		30.00
31. 00		0.00	0	0		31. 00
	T. Control of the Con		-1	-1		<u> </u>

	Financial Systems		GOOD SAMARIT	AN HO					u of Form CMS-	
RECLASS	SI FI CATI ONS				Provi der	CCN: 1	150042	Peri od: From 01/01/2015	Worksheet A-6	
								To 12/31/2015	Date/Time Pre 5/25/2016 9:5	epared: 57 am
	Cost Center	Increases Line #	Salary	(Other					
32. 00	2. 00	3.00	4.00		5.00					32. 00
33.00		0.00	0		0					33. 00
34. 00 35. 00		0. 00 0. 00	0		0					34. 00 35. 00
36.00		0.00	0		0					36. 00
37. 00 38. 00		0. 00 0. 00	0		0					37. 00 38. 00
39. 00		0.00	O		0					39. 00
40. 00 41. 00		0. 00 0. 00	0		0					40. 00 41. 00
42. 00		0.00	0		0					42. 00
43. 00 44. 00		0. 00 0. 00	0		0					43. 00 44. 00
45. 00 46. 00		0. 00 0. 00	0		0					45. 00 46. 00
47.00		0.00	О		0					47. 00
48. 00 49. 00		0. 00 0. 00	0		0					48. 00 49. 00
	0 INTEREST EVENCE				21, 222, 303					
1.00	D - INTEREST EXPENSE CAP REL COSTS-BLDG & FIXT	1.00	0		3, 090, 599					1. 00
2.00	ADMI NI STRATI VE & GENERAL		0		5, 050 3, 095, 649					2. 00
	E - DEPRECIATION EXPENSE									
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	1. 00 0. 00	0	1	0, 564, 243 0					1. 00 2. 00
3.00		0.00	o		0					3. 00
4. 00 5. 00		0. 00 0. 00	0		0					4. 00 5. 00
6. 00 7. 00		0. 00 0. 00	0		0					6. 00 7. 00
8.00		0.00	o		0					8. 00
9. 00 10. 00		0. 00 0. 00	0		0					9. 00 10. 00
11.00		0.00	0		0					11. 00
12. 00 13. 00		0. 00 0. 00	0		0 0					12. 00 13. 00
14. 00 15. 00		0. 00 0. 00	0		0					14. 00 15. 00
16.00		0.00	O		0					16. 00
17. 00 18. 00		0. 00 0. 00	0		0					17. 00 18. 00
19.00		0.00	0		0					19. 00
20. 00 21. 00		0. 00 0. 00	0		0					20. 00 21. 00
22.00		0.00	o		0					22. 00
23. 00 24. 00		0. 00 0. 00	0		0 0					23. 00 24. 00
25. 00 26. 00		0. 00 0. 00	0		0					25. 00 26. 00
27. 00		0.00	o		0					27. 00
28. 00 29. 00		0. 00 0. 00	0		0					28. 00 29. 00
30.00		0.00	0		0					30.00
31. 00 32. 00		0. 00 0. 00	0		0					31. 00 32. 00
33.00		0.00	o		0					33. 00
34. 00 35. 00		0. 00 0. 00	0		0 0					34. 00 35. 00
36. 00 37. 00		0. 00 0. 00	0		0					36. 00 37. 00
38. 00		0.00	O		0					38. 00
39. 00 40. 00		0. 00 0. 00	0		0					39. 00 40. 00
41.00		0.00	O		0					41. 00
42. 00 43. 00		0. 00 0. 00	0		0 0					42. 00 43. 00
44. 00 45. 00		0. 00 0. 00	O		0					44. 00 45. 00
45. UU	0 — — — —		0	1	0, 564, 243					45.00
1. 00	G - INSURANCE EXPENSE CAP REL COSTS-BLDG & FIXT	1.00	0		558, 601					1. 00
12. 00	L		0		0					12. 00
	0		0		558, 601					

| Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

						10 12/31/2013	5/25/2016 9:57 am
		Increases			'		
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4.00	5. 00			
	H - MENTAL HEALTH OVERHEAD						
1.00	ADMINISTRATIVE & GENERAL	5.00	705, 550	325, 029			1.00
2.00	OPERATION OF PLANT	7.00	141, 110	65, 006			2. 00
3.00	NURSING ADMINISTRATION	13. 00	47, 037	21, 669			3. 00
4.00	SUBPROVI DER - I PF	40.00	517, 403	238, 354			4. 00
5.00	NRCC	194.09	1, 693, 320	780, 069			5. 00
	0		3, 104, 420	1, 430, 127			
	I - IMPL. DEV. CHARGED TO PAT	TI ENT					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	2, 152, 971			1.00
	PATI ENTS						
2.00		0.00	0	0			2. 00
3.00		0.00	0	0			3. 00
4.00		0.00	0	0			4. 00
5.00		0.00	0	0			5. 00
6.00		0.00	0	0			6. 00
7.00		0.00	0	0			7. 00
	0		0	2, 152, 971			
	J - ONCOLOGY						
1.00	DRUGS CHARGED TO PATIENTS	73.00	51 <u>5, 8</u> 88	25 <u>0, 2</u> 68			1.00
	0		515, 888	250, 268			
	K - DIETARY						
1. 00	CAFETERI A	1100	1, 013, 386	<u>1, 095, 2</u> 89			1.00
	0		1, 013, 386	1, 095, 289			
	L - DEPRECIATION EXPENSE		al	4 44 007			1.00
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 411, 907			1.00
2.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 659, 426			2.00
3.00	CAP REL COSTS-BLDG & FIXT	1.00	0	521, 185			3.00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	0	714, 669			4.00
5.00	CAP REL COSTS-BLDG & FLXT	1.00	0	2, 182, 354			5. 00
6.00	CAP REL COSTS-BLDG & FLXT	1.00	0	1, 743			6.00
7.00	CAP REL COSTS-BLDG & FIXT	1.00	0	585, 680			7. 00
8. 00		0.00		0			8. 00
F00 00	U Consideration of the second		4 (22 (04	7, 076, 964			F00 00
500.00) Grand Total: Increases		4, 633, 694	70, 947, 335			500.00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/25/2016 9:57 am Provider CCN: 150042

						5/25/2016	9: 57 am
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1 00	A - DRUGS CHARGED TO PATIENTS			12 702 725			1.00
1. 00	PHARMACY	15.00	<u></u>				1. 00
	B - MEDICAL SUPPLIES CHARGED	TO PATIENTS		15, 702, 733			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	59, 584	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	O		o		2. 00
3.00	OPERATION OF PLANT	7.00	0	59	o		3. 00
4.00	NURSING ADMINISTRATION	13.00	0	6			4. 00
5. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	_, -,	1		5. 00
6.00	PHARMACY	15. 00	0	1,			6.00
7. 00 8. 00	MENTAL HEALTH OVERHEAD ADULTS & PEDIATRICS	17. 01 30. 00	0	1, 400 1, 082, 749			7. 00 8. 00
9. 00	INTENSIVE CARE UNIT	31.00	0		0		9. 00
10.00	SUBPROVI DER - I RF	41.00	0	1			10.00
11. 00	NURSERY	43.00	0	1			11. 00
12.00	OPERATING ROOM	50.00	0	826, 101	o		12. 00
13.00	ENDOSCOPY	51. 01	0	315, 130			13. 00
14. 00	DELIVERY ROOM & LABOR ROOM	52. 00	0	,			14. 00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	0	887, 535			15.00
16. 00 17. 00	RADI OLOGY-NON-CAMPUS RADI OLOGY-NON-CAMPUS	54. 01 54. 01	0	1			16. 00 17. 00
18. 00	RADI OLOGY-NON-CAMPOS RADI OLOGY-GSH BREAST CENTER	54.01	0	36, 367 6, 403			18. 00
19. 00	LABORATORY	60.00	0				19. 00
20. 00	RESPIRATORY THERAPY	65.00	0		0		20.00
21. 00	PHYSI CAL THERAPY	66.00	O	1			21. 00
22.00	ELECTROCARDI OLOGY	69. 00	0	1, 041, 774	o		22. 00
23. 00	NEURODI AGNOSTI CS	70. 01	0	254	0		23. 00
24. 00	INPATIENT DIALYSIS	76. 01	0	3, 478			24. 00
25. 00	ASC (NON-DISTINCT PART)	75. 00	0	1,	1		25. 00
26. 00 27. 00	CLI NI C EMERGENCY	90. 00 91. 00	0	425, 030 34, 460			26. 00 27. 00
28. 00	DURABLE MEDICAL EQUIP-RENTED	91.00	0	1			28. 00
29. 00	HOSPI CE	116.00	0	1	_		29. 00
30. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0	1, 064, 819			30.00
31.00	COMMUNITY HEALTH SERVICES	194.00	0	18, 984	1		31.00
32.00	MH RESIDENTIAL	194. 03	0	390	0		32. 00
33. 00	MOB	194. 05	0	6, 934			33. 00
34.00	I NDUSTRI AL HEALTH	194. 08	0	1	0		34.00
35. 00	HOUSEKEEPI NG	9.00	— — — <u> </u>	9, 718, 185			35. 00
	C - EMPLOYEE BENEFITS			7,710,105			
1.00	COMMUNICATIONS	4. 01	C	81, 254	0		1.00
2.00	PURCHASING & RECEIVING	4. 02	0	225, 202	o		2. 00
3.00	REGI STRATI ON	4. 03	0	334, 039			3. 00
4.00	PATIENT ACCOUNTS	4. 04	0	1,			4. 00
5.00	ADMINISTRATIVE & GENERAL	5. 00	0	1,0,,,000			5. 00
6.00	OPERATION OF PLANT	7.00	0				6. 00
7. 00 8. 00	LAUNDRY & LINEN SERVICE HOUSEKEEPING	8. 00 9. 00	0	70,000			7. 00 8. 00
9. 00	DI ETARY	10.00	0				9. 00
10. 00	NURSING ADMINISTRATION	13. 00	0	1	1		10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	1	1		11. 00
12.00	PHARMACY	15. 00	0	697, 046			12. 00
13.00	MEDICAL RECORDS & LIBRARY	16. 00	0		1		13. 00
14. 00	MENTAL HEALTH OVERHEAD	17. 01	0	1,,	1		14. 00
15.00	PARAMED ED PGRM-(SPECIFY)	23. 00 23. 01	0	1			15.00
16. 00 17. 00	PARAMED ED PGRM-(SPECIFY) ADULTS & PEDIATRICS	30.00	0	1	1		16. 00 17. 00
18. 00	INTENSIVE CARE UNIT	31.00	0	1			18. 00
19. 00	SUBPROVI DER - I RF	41.00	0	1			19. 00
20.00	NURSERY	43.00	O	1	1		20. 00
21.00	OPERATING ROOM	50.00	0	415, 948			21. 00
22. 00	ENDOSCOPY	51. 01	0				22. 00
23. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	1			23. 00
24. 00	OPERATING ROOM	50. 00 54. 00	0				24. 00
25. 00 26. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-NON-CAMPUS	54. 00 54. 01	0	850, 451 13, 568			25. 00 26. 00
27. 00	RADI OLOGY-NON-CAMPUS	54. 01	0				27. 00
28. 00	RADI OLOGY-NON-CAMPUS	54. 01	0	105, 670			28. 00
29. 00	RADI OLOGY-NON-CAMPUS	54. 01	0				29. 00
30.00	RADI OLOGY-NON-CAMPUS	54. 01	0	20, 558			30. 00
31. 00	RADI OLOGY-GSH BREAST CENTER	54. 08	0				31. 00
32.00	LABORATORY	60.00	0				32.00
33. 00	RESPI RATORY THERAPY	65. 00	0	435, 809	0		33. 00

	Financial Systems		GOOD SAMARIT			0011 450040		u of Form CMS	
RECLAS	SIFI CATIONS			F	'rovi der	CCN: 150042	Peri od: From 01/01/2015	Worksheet A-	
							To 12/31/2015	Date/Time Pr 5/25/2016 9:	
	Cost Center	Decreases Li ne #	Sal ary	Oth	ner	Wkst. A-7 Ref	1		
	6. 00	7. 00	8. 00	9.		10.00	7		
34. 00	PHYSI CAL THERAPY	66.00	0		598, 271		0		34.00
35. 00	ELECTROCARDI OLOGY	69. 00	0		627, 324		0		35. 00
36.00	NEURODI AGNOSTI CS	70. 01	0		77, 730		0		36. 00
37. 00	ASC (NON-DISTINCT PART)	75. 00 90. 00	0		306, 479		0		37. 00 38. 00
38. 00 39. 00	CLINIC EMERGENCY	90.00	0		338, 802 906, 558		0		39.00
40. 00	DURABLE MEDICAL EQUIP-RENTED	96.00	0		20, 891		0		40.00
41. 00	HOSPI CE	116.00	0		138, 488		o O		41. 00
42.00	PHYSICIANS' PRIVATE OFFICES	192.00	0		615, 846		0		42. 00
43.00	COMMUNITY HEALTH SERVICES	194. 00	0		49, 353		0		43. 00
44. 00	MARKETING AND PUBLIC	194. 02	0		45, 432		0		44. 00
4E 00	RELATIONS MH RESIDENTIAL	194. 03	0		125 252		0		45. 00
45. 00 46. 00	MOB	194. 03	0		135, 253 53, 618		0		46. 00
47. 00	FOUNDATI ON	194.06	0		19, 668		0		47. 00
48. 00	I NDUSTRI AL HEALTH	194. 08	0		235		o		48. 00
49.00	DRUGS CHARGED TO PATIENTS	73.00	0		<u>1, 6</u> 86		o		49. 00
	0		0	21,	222, 303				
1 00	D - INTEREST EXPENSE	112.00	0	2	005 (40	1	1		1 00
1. 00 2. 00	I NTEREST EXPENSE	113. 00 0. 00	0		095, 649 0		0		1.00
2.00		0.00	0		<u>_</u> 095, 649		9		2.00
	E - DEPRECIATION EXPENSE			- 0,	070,017				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0		22, 612		9		1. 00
2.00	COMMUNI CATI ONS	4. 01	0		1, 079		9		2. 00
3.00	PURCHASING & RECEIVING	4. 02	0		17, 928		9		3. 00
4.00	REGI STRATI ON	4. 03	0		9, 209		9		4. 00
5. 00 6. 00	PATIENT ACCOUNTS ADMINISTRATIVE & GENERAL	4. 04 5. 00	0	4	53, 260 456, 324		9		5. 00 6. 00
7. 00	OPERATION OF PLANT	7.00	0		430, 324 238, 707		9		7. 00
8. 00	LAUNDRY & LINEN SERVICE	8.00	0		109, 078		9		8. 00
9. 00	HOUSEKEEPI NG	9. 00	0		41, 044		9		9. 00
10.00	DI ETARY	10.00	0		50, 326		9		10.00
11. 00	NURSING ADMINISTRATION	13. 00	0		250, 701		9		11. 00
12. 00	CENTRAL SERVICES & SUPPLY	14. 00	0		52, 871		9		12. 00
13. 00	PHARMACY	15. 00	0		163, 296		9		13. 00
14. 00 15. 00	MEDICAL RECORDS & LIBRARY MENTAL HEALTH OVERHEAD	16.00	0		16, 432		9		14. 00 15. 00
16. 00	PARAMED ED PGRM-(SPECIFY)	17. 01 23. 00	0		72, 156 2, 052		9		16. 00
17. 00	PARAMED ED PGRM-(SPECIFY)	23. 01	0		2, 432		9		17. 00
18. 00	ADULTS & PEDIATRICS	30.00	0		226, 222		9		18. 00
19.00	INTENSIVE CARE UNIT	31.00	0		296, 268		9		19. 00
20.00	SUBPROVI DER - I RF	41.00	0		39, 228		9		20. 00
21. 00	NURSERY	43.00	0		21, 002		9		21. 00
22. 00	OPERATING ROOM	50.00	0		538, 672		9		22. 00
23. 00 24. 00	ENDOSCOPY DELIVERY ROOM & LABOR ROOM	51. 01 52. 00	0		341, 581 33, 688		9		23. 00 24. 00
25. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	1	33, 666 882, 509		9		25. 00
26. 00	RADI OLOGY-NON-CAMPUS	54. 01	0	.,	240		9		26. 00
27. 00	RADI OLOGY-NON-CAMPUS	54. 01	0		2, 878		9		27. 00
28. 00	RADI OLOGY-NON-CAMPUS	54. 01	0		221, 223		9		28. 00
29. 00	RADI OLOGY-NON-CAMPUS	54. 01	0		83, 745		9		29. 00
30.00	LABORATORY	60.00	0		94, 312		9		30.00
31. 00 32. 00	RESPIRATORY THERAPY	65.00	0		49, 053		9		31.00
32. 00 33. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0		17, 988 355, 608		0		32. 00 33. 00
34. 00	NEURODI AGNOSTI CS	70. 01	0		48, 585		9		34. 00
35. 00	INPATIENT DIALYSIS	76. 01	0		79, 570		9		35. 00
36. 00	ASC (NON-DISTINCT PART)	75. 00	0		534, 631		9		36. 00
37. 00	CLINIC	90.00	0		2, 513		9		37. 00
38. 00	EMERGENCY	91.00	0		99, 133		9		38. 00
39. 00	DURABLE MEDICAL EQUIP-RENTED	96.00	0		748		9		39. 00
40.00	HOSPICE	116.00	0		9, 263		9		40.00
41. 00 42. 00	PHYSICIANS' PRIVATE OFFICES COMMUNITY HEALTH SERVICES	192. 00 194. 00	0		12, 199 352		9		41. 00 42. 00
43.00	MARKETING AND PUBLIC	194.00	0		332 7, 977		9		43. 00
. 5. 50	RELATIONS	.,52	J		., ,,,				.5. 55
44.00	MH RESIDENTIAL	194. 03	0		1, 651		9		44. 00
45. 00	RADI OLOGY-NON-CAMPUS	<u>54.</u> 01	0		3, 897		9		45. 00
	O LINCHDANCE EVDENCE		0	10,	564, 243				
1. 00	G - INSURANCE EXPENSE ADMINISTRATIVE & GENERAL	5.00	0		558, 601	1:	2		1.00
1.00	A SEMENT STRAIL VE & SENERAL	0.00	0		0 0				12.00
00	0 — — — — —	<u> </u>			558, 601	··	7		
	•						*		·

					1	o 12/31/2015 [Date/Time Prepared: 5/25/2016 9:57 am
		Decreases					37 20 10 71 07 dill
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	H - MENTAL HEALTH OVERHEAD						
1.00	MENTAL HEALTH OVERHEAD	17. 01	3, 104, 420	1, 430, 127	0		1. 00
2.00		0.00	0	0	0		2. 00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4. 00
5.00		0. 00	0_	0	0		5. 00
	0		3, 104, 420	1, 430, 127			
	I - IMPL. DEV. CHARGED TO PAT						
1. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	397			1. 00
2.00	EMERGENCY	91.00	0	6, 041			2. 00
3.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	45			3. 00
4. 00	OPERATING ROOM	50.00	0	1, 836, 689			4. 00
5.00	ELECTROCARDI OLOGY	69. 00	0	2, 395			5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	21, 790	0		6. 00
7. 00	ASC (NON-DISTINCT PART)	<u>75.</u> 00	0_	28 <u>5, 6</u> 14			7. 00
	0		0	2, 152, 971			
	J - ONCOLOGY						
1.00	PHARMACY	1500	51 <u>5,</u> 888	25 <u>0, 2</u> 68			1. 00
	0		515, 888	250, 268			
	K - DIETARY						
1. 00	DI ETARY	10.00	1, 013, 386	1, 095, 289			1. 00
	0		1, 013, 386	1, 095, 289			
	L - DEPRECIATION EXPENSE	0.00		7 07/ 0//			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7, 076, 964	9		1.00
2.00		0.00	0	0	9		2. 00
3.00		0.00	0	0	9		3. 00
4.00		0.00	0	0	9		4. 00
5.00		0.00	0	0	9		5. 00
6.00		0.00	0	0	9		6. 00
7.00		0.00	0	0	9		7. 00
8. 00		0.00		0	<u> </u>		8. 00
F00 00	U Consideration Decision		4 (22 (24	7, 076, 964			F00 00
500.00	Grand Total: Decreases	I	4, 633, 694	70, 947, 335	1		500.00

					rom 01/01/2015 o 12/31/2015		nared·
				'	0 12/01/2010	5/25/2016 9:5	
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
	<u></u>	1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET					T	
1.00	Land	8, 487, 647	290, 338		290, 338		
2.00	Land Improvements	6, 102, 833	3, 125, 685	C	3, 125, 685	37, 157	2. 00
3.00	Buildings and Fixtures	0	0	0	0	0	3. 00
4.00	Building Improvements	88, 343, 615	34, 676, 819	0	34, 676, 819	61, 624	4. 00
5.00	Fi xed Equipment	0	0	0	0	0	5. 00
6.00	Movable Equipment	243, 795, 414	96, 389, 486	0	96, 389, 486	93, 874, 242	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	346, 729, 509	134, 482, 328	0	134, 482, 328	95, 548, 023	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10. 00	Total (line 8 minus line 9)	346, 729, 509	134, 482, 328	C	134, 482, 328	95, 548, 023	10. 00
		Ending Balance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	7, 202, 985	0				1. 00
2.00	Land Improvements	9, 191, 361	0				2. 00
3.00	Buildings and Fixtures	0	0				3. 00
4.00	Building Improvements	122, 958, 810	0				4. 00
5.00	Fixed Equipment	0	0				5. 00
6.00	Movable Equipment	246, 310, 658	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	385, 663, 814	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	385, 663, 814	0				10. 00

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150042	Peri od: From 01/01/2015	Worksheet A-7 Part II		
						Date/Time Pre	pared:	
						5/25/2016 9:5	7 am	
			Sl	JMMARY OF CAP	'I IAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see		
					instructions)			
		9. 00	10. 00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	ind 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0)	0	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	7, 065, 481	0		o o	0	2.00	
3.00	Total (sum of lines 1-2)	7, 065, 481	0	ol .	o o	0	3. 00	
SUMMARY OF CAPITAL								
	Cost Center Description	Other	Total (1) (sum	1				
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)	,					
		14.00	15. 00	1				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	ind 2				
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	1 0	7, 065, 481				2.00	
3.00	Total (sum of lines 1-2)	0	7, 065, 481	1			3. 00	
2.00	1	1	.,000,101	1				

Heal th	n Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7		
					From 01/01/2015 To 12/31/2015		oorod:	
					10 12/31/2013	5/25/2016 9:5		
		COMI	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAR					
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
			Leases	for Ratio	instructions)			
				(col . 1 - col 2)	•			
		1. 00	2.00	3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	0.00		0.00		
1.00	CAP REL COSTS-BLDG & FLXT	139, 353, 156	0	139, 353, 15	0. 361333	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	246, 310, 658	0	246, 310, 65	0. 638667	0	2.00	
3.00	Total (sum of lines 1-2)	385, 663, 814		385, 663, 81			3. 00	
		ALLOCA	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease		
	oust deliter bescription		Capi tal -Relate		bepreer a troit	Lease		
			d Costs	through 7)				
		6.00	7. 00	8. 00	9. 00	10.00		
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 17, 156, 564		1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 -11, 483		2. 00	
3. 00	Total (sum of lines 1-2)	0	0	 MMARY OF CAPI	0 17, 145, 081	0	3. 00	
			St	JIMIMARY OF CAPI	IAL			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
			instructions)	instructions)) Capi tal -Relate			
					d Costs (see	through 14)		
		11.00	10.00	10.00	instructions)	45.00		
	PART III - RECONCILIATION OF CAPITAL COSTS CI	11.00	12.00	13. 00	14.00	15. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	3, 090, 599	558, 601		0 0	20, 805, 764	1. 00	
2.00	CAP REL COSTS-BEDG & TTXT	3, 090, 399 ∩) 550,001 0		0 0	-11, 483	2. 00	
3.00	Total (sum of lines 1-2)	3, 090, 599	558, 601		0 0		3. 00	
0.00	1.5.5. (56 61 111165 1 2)	0,070,077	1 555, 661	ı	J ₁	20,771,201	0.00	

Health Financial Systems
ADJUSTMENTS TO EXPENSES GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150042 Peri od: From 01/01/2015 To 12/31/2015 Worksheet A-8 Date/Time Prepared: 5/25/2016 9:57 am Expense Classification on Worksheet A

				Expense Classification on To/From Which the Amount is 1			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FLXT	4. 00 1. 00	5. 00	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00		3. 00
	(chapter 2)		0				
4. 00	Trade, quantity, and time discounts (chapter 8)	В	-247, 028	PURCHASING & RECEIVING	4. 02	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6.00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
8. 00	21) Tel evi si on and radio service (chapter 21)	В	-217, 944	ADMINISTRATIVE & GENERAL	5.00	О	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -10, 626, 563		0.00	0	9. 00 10. 00
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00		
12. 00	Related organization transactions (chapter 10)	A-8-1	0			0	12. 00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	B B	-983. 783	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0.00		15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than	В	-459, 939	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-61, 625	ADMINISTRATIVE & GENERAL	5. 00	О	18. 00
19. 00	abstracts Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20.00	Vending machines		0		0.00		20.00
21. 00	Income from imposition of interest, finance or penalty		U		0. 00	0	21. 00
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	О	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	1 .		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	*** Cost Center Deleted ***	0. 00 67. 00		29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	0	*** Cost Center Deleted ***	68.00		31. 00
32. 00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest		0		0. 00	O	32. 00
	OTHER MISC FEES	В		PURCHASI NG & RECEI VI NG	4. 02		
33. 01	OTHER MISC FEES	В	-38, 963	PATIENT ACCOUNTS	4. 04	0	33. 01

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Provi der CCN: 150042

Pagement Cress Cast Fraction on NoverSeers A Pagement Pa					To	12/31/2015	Date/Time Prep 5/25/2016 9:57	
Cost Center Description Basis/Code (2)					Expense Classification on	Worksheet A	372372010 7.3	aiii
1.00 2.00 3.00								
1.00 2.00 3.00								
1.00 2.00 3.00								
1.00 2.00 3.00								
1.00 2.00 3.00		Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
13.13 18 18 18 18 18 18 18			1. 00			4. 00	5. 00	
13.1.0 DITTLE M. N.C. ITELS 1					1		-	
31.05 SHYLAT I NOON							_	
33.00 GTHER MISC FEES 8 -11/ENTRAL SERVICES & SUPPLY 14.00 0.33.06 33.07 GTHER MISC SEES 8 -772/SPTRAILING ROOM 50.00 0.33.08 33.07 GTHERM INSCRIPTLY, AMD TIME 8 -772/SPTRAILING ROOM 50.00 0.33.09 33.09 TRAILING COMMITTY, AMD TIME 8 -772/SPTRAILING ROOM 50.00 0.33.09 33.09 TRAILING COMMITTY, AMD TIME 8 -10/ENTRAILING ROOM 50.00 0.33.09 33.09 TRAILING COMMITTY, AMD TIME 8 -10/ENTRAILING ROOM 50.00 0.33.10 33.10							-	
33.07 DITTLE MISC FIETS 8 -3-								
01 SCOUNTS 03 3.0 FIRED COUNTITY, AND TIME B -200 LABORATORY 6.0 0 0 33.0 0 7 7 7 7 7 7 7 7							-	
TRADE QUANTITY, AND TIME B	33.08	TRADE, QUANTITY, AND TIME	В	-772	OPERATING ROOM	50.00	0	33. 08
10 SCOUNTS		1						
33.10 PAYSICLORY HINDER B	33. 09		В	-200	LABORATORY	60.00	0	33. 09
DISCOUNTS	22 10		D	16	DUVSICAL THEDADV	66 00	0	22 10
33.11 AMESTHESIOLOGY BENEFITS B -344_380EMPLOYEE BENEFITS DEPARTIENT	33. 10		В	-10	ITITST CAL TITERALT	00.00	Ĭ	33. 10
33.13 7 MUSSAGE THERAPY B -3,157 RESPIRATION THERAPY 65.00 0.33,13 33.13 33.14 FORD SERVICE B -3,157 RESPIRATION THERAPY 23.00 0.33,15 33.15 ROUNDEY -1 STUDENT TUITION B -56,787 PARAMED ED PRAM. (SPECIFY) 23.00 0.33,15 33.17 ROUNDEY -1,100 PART 1.00 PA	33. 11	1	В	-344, 280	EMPLOYEE BENEFITS DEPARTMENT	4.00	О	33. 11
1.000 SERVICE B -33, 886 DIETARY 10, 00 0 33, 14	33. 12	RADIOLOGY - SILVER ETC		-46	RADI OLOGY-DI AGNOSTI C	54.00	O	33. 12
33.15 ABIOLOGY - STUDENT TUITION B -50,787 PARAMED ED PORNIC (SPECIFY) 23.00 33.15							0	
33.16 RENTAL INCOME B							Ĭ	
33.17 RINTAL INCOME B -5,750 ADD ILLOCY -DI ARMOSTIC C 0 0 33.19				·	` '		-	
No. Section								
COMPENSAT 10 PHYSICIAN ON-CALL TIME A -148, 017 ADMIN ISTRATIVE & GENERAL 5.00 33. 19 AIA USEFUL LIVES CARRYFORWARD A -95 CAP REL COSTS-BLDG & FIXT 1.00 9. 33. 20 33. 21 HALTH PAYLLION AIA CARRYFORWARD 33. 22 OTHER MISC FEES B -13, 125 INTENSIVE CARE UNIT 31. 00 33. 22 33. 23 ADVANCE EMIT TRAINING A -12, 750 PLESPH RATORY THERAPY 65. 00 33. 23 33. 24 1990 ASSETS - AIA LIVES A -2. 110 CAPP REL COSTS-BLDG & FIXT 1.00 9. 33. 20 33. 22 33. 23 ADVANCE EMIT TRAINING A -12, 750 PLESPH RATORY THERAPY 65. 00 33. 25 33. 26 33. 26 34. 27 35. 25 35. 25 36. 27 37. 27 38. 28 38. 28 ASSETS - AIA LIVES A -2. 110 CAPP REL COSTS-BLDG & FIXT 1.00 9. 33. 26 33. 27 34. 29 35. 25 35. 26 36. 27 37. 27 38. 28 38. 27 38. 28 38. 28 38. 28 38. 29 39. 20 3								
33. 20 MAL USEFUL LIVES CARRYFORWARD A -95CAP REL COSTS-BLDG & FIXT 1.00 9 33. 20 32. 21 ALAIT PAVILION AL	00. 10			20, 120	20122 32.12.1.10 32.7.1.1	00		00. 10
	33. 19	PHYSICIAN ON-CALL TIME	A	-148, 017	ADMINISTRATIVE & GENERAL	5. 00	0	33. 19
CARRYFORMARD 33. 22 OTHER MISC FEES 33. 23 ADVANCE EMI TRAINING A -12, 750 RESPIRATORY THERAPY 65. 00 93. 22 33. 24 1990 ASSETS - AINA LIVES CARRYFORMARD 35. 25 ALC OF MEDICAL RECORDS & B -2, 1150 AP REL COSTS-BLDG & FIXT 1. 00 93. 24 32. 26 OTHER MISC FEES B -6, 840 OPERATION OF PLANT 7. 00 33. 25 33. 27 OTHER MISC FEES B -31, 106 MEDITAL HEALTH OVERHEAD 7. 01 93. 22 33. 26 OTHER MISC FEES B -31, 106 MEDITAL HEALTH OVERHEAD 7. 00 33. 27 OTHER MISC FEES B -31, 106 MEDITAL HEALTH OVERHEAD 7. 01 93. 32 93. 29 OTHER MISC FEES B -4, 840 OPERATION OF PLANT 7. 00 33. 27 OTHER MISC FEES B -3, 116 MEDITAL HEALTH OVERHEAD 7. 01 93. 32 91 OTHER MISC FEES B -2, 343 RADI OLOGY-DI AGNOSTIC 54. 00 93. 32 91 PHYSICIAN BILLING COSTS A -192, 125 PATIENT ACCOUNTS A -193, 125 PATIENT ACCOUNTS A -194, 125 PATI		1	1		l .		9	
33. 22 OTHER MI SC FEES B -13. 129 INTENSIVE CARE UNIT 31. 00 0 33. 22 33. 24 1990 ASSETS - ANA LIVES A -2.119 CAP REL COSTS-BLDG & FIXT 1. 00 9 33. 24 CARRYFORMARD B -13.0MEDICAL RECORDS & LIBRARY 1. 00 0 33. 25 33. 26 OTHER MI SC FEES B -3.11, 100 MENTAL HEALTH OVERHEAD 17. 01 0 33. 25 33. 26 OTHER MI SC FEES B -3.11, 100 MENTAL HEALTH OVERHEAD 17. 01 0 33. 26 33. 27 OTHER MI SC FEES B -3.11, 100 MENTAL HEALTH OVERHEAD 17. 01 0 33. 28 33. 29 OTHER MI SC FEES B -3.11, 100 MENTAL HEALTH OVERHEAD 17. 01 0 33. 28 33. 30 MEPHROLOCY RENTAL I NOOME B -199, 165 IMPATI ENT DI ALYSIS 76. 01 0 33. 30 33. 31 PHYSICIAN BILLING COSTS A -192, 125 PATI ENT ACCOUNTS 4. 00 0 0 33. 32 33. 32 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 01 0 33. 30 33. 34 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 01 0 33. 30 33. 34 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 01 0 33. 30 33. 34 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 01 0 33. 32 33. 34 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 01 0 33. 32 35. 35 ONTHIS MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 33. 32 36. 36 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 33. 32 37. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 33. 32 38. 34 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 33. 32 39. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 33. 34 30. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 33. 34 30. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 0 33. 34 30. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 0 33. 34 30. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 0 33. 34 30. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 0 33. 34 30. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 0 33. 36 30. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 0 33. 36 30. 30 OTHER MI SC FEES B -199, 165 IMPATI ENT DI ALYSIS 76. 00 0 0 33. 36 30. 30 OTHER MI	33. 21		A	-26, 044	CAP REL COSTS-BLDG & FIXT	1. 00	9	33. 21
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ABSTRACTS				,				
33. 20 OTHER MISC FEES B -6, B40 PERATION OF PLANT 7, 00 0 33, 26	33. 25		В	-130	MEDICAL RECORDS & LIBRARY	16. 00	0	33. 25
33.27 OTHER MISC FEES B	22.27	1	В	/ 040	ODEDATION OF DIANT	7.00		22.27
13.2 INTEREST INCOME		1						
33. 29 OTHER MISC FEES B -2, 343 RADI OLDGY - DI AGNOSTI C 54, 00 0 33, 29		1						
33.30 NEPHROLOCY RENTAL INCOME B		1						
33. 32 OTHER MI SC FEES B -75LABORATORY 60. 00 0 33. 32 33. 33 OTHER MI SC FEES B -182/ADULTS & PEDIATRICS 30. 00 0 33. 33 33. 34 OTHER MI SC FEES B -88/RESPIRATORY THERAPY 65. 00 0 33. 34 33. 35 DONATI ONS EXPENSE A -50, 085/ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 35 33. 37 2004 SURETY BOND EXPENSE A -20, 525/ADMIN ISTRATI VE & GENERAL 5. 00 0 33. 37 33. 39 OTHER MI SC FEES B -4, 522 ELECTROCARDI OLOGY 69. 00 0 33. 39 33. 40 OTHER MI SC FEES B -1, 291 NURSERY 43. 00 0 33. 39 33. 40 OTHER MI SC FEES B -1, 291 NURSERY 43. 00 0 33. 34 33. 40 OTHER MI SC FEES B -1, 291 NURSERY 43. 00 0 33. 40 33. 40 OTHER MI SC FEES B -1, 522 PELECTROCARDI OLOGY 51. 01 0 33. 42 <td>33. 30</td> <td>NEPHROLOGY RENTAL INCOME</td> <td>В</td> <td></td> <td></td> <td></td> <td>o</td> <td>33. 30</td>	33. 30	NEPHROLOGY RENTAL INCOME	В				o	33. 30
33. 33 OTHER MISC FEES B -182/ADULTS & PEDIATRICS 30. 00 0 33. 34 33. 34 OTHER MISC FEES B -88/ESPIRATORY THERAPY 65. 00 0 33. 34 33. 35 DONATI ONS EXPENSE A -50. 085/ADMI IN STRATI VE & GENERAL 5. 00 0 33. 35 33. 36 OTHER MISC FEES B -1. 189/PHYSI CAL THERAPY 66. 00 0 33. 35 33. 37 2004 SURETY BOND EXPENSE A -20. 525/ADMI IN STRATI VE & GENERAL 5. 00 0 33. 39 33. 39 OTHER MISC FEES B -4. 522/ELECTROCARDI OLOGY 69. 00 0 33. 39 33. 40 OTHER MISC FEES B -1. 291 NURSERY 43. 00 0 33. 39 33. 41 OTHER MISC FEES B -1. 291 NURSERY 43. 00 0 33. 49 33. 40 OTHER MISC FEES B -1. 291 NURSERY 43. 00 0 33. 49 33. 41 HAL REM MISC FEES B -1. 291 NURSERY 43. 00 0 33. 49						4. 04	0	
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33.35 ODNATI ONS EXPENSE A -50, 085 ADMI NI STRATI VE & GENERAL 5.00 0 33.35 33.36 OTHER MISC FEES B -1, 189 PHYSI CAL THERAPY 66.00 0 33.35 33.37 2004 SURETY BOND EXPENSE A -20, 255 ADMI NI STRATI VE & GENERAL 5.00 0 33.35 33.38 OTHER MISC FEES B -4, 522 ELECTROCARDI OLOGY 69.00 0 33.38 33.39 OTHER MISC FEES B -1, 291 NURSERY 43.00 0 33.39 33.40 OTHER MISC FEES B -1, 291 NURSERY 43.00 0 33.40 33.41 OTHER MISC FEES B -1, 291 NURSERY 43.00 0 33.41 33.42 OTHER MISC FEES B -1, 291 NURSERY 51.01 0 33.41 33.43 2012 BOND I SSUE COSTS B 45, 855 ADMI NI STRATI VE & GENERAL 5.00 0 33.42 33.43 2012 BOND I SSUE COSTS B 45, 855 ADMI NI STRATI VE & GENERAL 5.00 0 33.43 33.44 IHA LOBBYI NG OFFSET B -3, 158 ADMI NI STRATI VE & GENERAL 5.00 0 33.45 33.46 INDI ANA CHAMBER LOBBYI NG OFFSET B -150 ADMI NI STRATI VE & GENERAL 5.00 0 33.45 33.47 TRADE, OUANTI TY, AND TI ME B -1, 057 OPERATI ON OF PLANT 7.00 0 33.45 33.49 TRADE, OUANTI TY, AND TI ME B -1, 057 OPERATI ON OF PLANT 7.00 0 33.45 33.51 TRADE, OUANTI TY, AND TI ME B -1, 790 CLI NI C 90.00 0 33.55 33.53 ADVERTI SI NG A -1, 28 PENGVI DER - I RF 41.00 0 33.55 33.54 ADVERTI SI NG A -1, 85 EMERGENCY 91.00 0 33.55 33.55 ADVERTI SI NG A -1, 45 PENGVI DER - I RF 41.00 0 33.55 33.56 ADVERTI SI NG A -1, 45 PENGVI DER - I RF 41.00 0 33.55 33.56 ADVERTIS ING A -1, 28 PENGVI DER - I RF 41.00 0 33.55 33.56 ADVERTIS ING A -1, 28 PENGVI DER - I RF 41.00 0 33.55 33.56 ADVERTIS ING A -1, 28 PENGVI DER - I RF 41.00 0 33.55 33.56 ADVERTIS ING A -1, 28 PENGVI DER - I RF 41.00 0 33.55 33.56 ADVERTIS ING A -1, 28 PENGVI DER - I RF 41.00 0 33.55 33.57 BEAUTY SHOP EXPENSE A -1, 039 ADMINI STRATI VE & GENERAL 5								
33. 36 OTHER MISC FEES		1	1				-	
33. 37 2004 SURETY BOND EXPENSE A -20,525 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 37 33. 38		1						
33. 38 OTHER MISC FEES B			•					
33. 40 OTHER MISC FEES B -6, 478 OPERATI NG ROOM 50. 00 0 33. 40 33. 41 OTHER MISC FEES B -21 ENDOSCOPY 51. 01 0 33. 41 33. 42 OTHER MISC FEES B -56 OELI VERY ROOM & LABOR ROOM 52. 00 0 33. 42 33. 43 2012 BOND I SSUE COSTS B 45, 855 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 43 33. 44 IHA LOBBYING OFFSET B -3, 158 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 43 33. 45 ITHER MISC FEES B -537 ASC (NON-DISTINCT PART) 75. 00 0 33. 45 33. 46 INDI ANA CHAMBER LOBBYING B -150 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 46 0FFSET 0 0 0 0 0 33. 47 TRADE, QUANTI TY, AND TIME B -22, 279 ADMIN IN STRATI VE & GENERAL 5. 00 0 33. 47 0 1 1 1 1 1 1 1 0 1 1 1 1 1 1 0 1 1 1 1 1 1 0 1 1 1 1 1 0 33. 49 TRADE, QUANTI TY, AND TIME B -16 MENTAL HEALTH OVERHEAD 17. 01 0 33. 49 0 1 1 1 1 1 1 1 0 1 1 1 1 1 1 0 1 1 1 1 1 0 1 1 1 1 1 0 1 1 1 1 1 0		l .	В				O	
33. 41 OTHER MISC FEES B -21 ENDOSCOPY 51. 01 0 33. 41 33. 42 OTHER MISC FEES B -56 DELI VERY ROOM & LABOR ROOM 52. 00 0 33. 43 33. 43 2012 BOND I SSUE COSTS B 45,855 ADWERTIS ING A -56 DELI VERY ROOM & LABOR ROOM 52. 00 0 33. 43 33. 44 IHA LOBBYING OFFSET B -56 DELI VERY ROOM & LABOR ROOM 52. 00 0 33. 43 33. 45 OTHER MISC FEES B -3,158 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 44 33. 45 OTHER MISC FEES B -537 ASC (NON-DI STI NCT PART) 75. 00 0 33. 45 33. 46 INDI ANA CHAMBER LOBBYING B -150 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 46 07FSET 07 OTHER MISC FEES 0 0 0 0 33. 47 TRADE, QUANTI TY, AND TI ME B -1,057 OPERATION OF PLANT 7. 00 0 33. 48 07 DI SCOUNTS DI SCOUNTS 0 0 0 0 33. 49 TRADE, QUANTI TY, AND TI ME B -1,057 OPERATION OF PLANT 7. 00 0 33. 49 07 DI SCOUNTS 0 0 0 0 0 0 33. 50 OTHER MISC FEES B -1,790 CLI NI C 90. 00 0 33. 50 33. 51 TRADE, QUANTI TY, AND TI ME B -2 SUBPROVI DER - I RF 0 0 0 0 33. 52 OTHER MISC FEES B -7,875 EMERGENCY 91. 00 0 33. 51 33. 53 ADVERTI SI NG A -4,082 ADMIR NI STRATI VE & GENERAL 5. 00 0 33. 53 33. 55 ADVERTI SI NG A -4,082 ADMIR NI STRATI VE & GENERAL 5. 00 0 33. 55 33. 56 ADVERTI SI NG A -125 HOSPI CE 116. 00 0 33. 56 33. 57 BEAUTY SHOP EXPENSE A -840 ADMIN NI STRATI VE & GENERAL 5. 00 0 33. 56 33. 58 ALCOHOLI C BEVERAGES A -1,039 ADMIN NI STRATI VE & GENERAL 5. 00 0 33. 58 33. 58 ALCOHOLI C BEVERAGES A -840 ADMIN NI STRATI VE & GENERAL 5. 00 0 33. 58 33. 58 ALCOHOLI C BEVERAGES A -1,039 ADMIN NI STRATI VE & GENERAL 5. 00 0 33. 58 33. 58 ALCOHOLI C BEVERAGES A -1,039 ADMIN NI STRATI VE & GENERAL 5. 00 0 33. 58 33. 58 ALCOHOLI C BEVERAGES A -1,039 ADMIN NI STR	33. 39	OTHER MISC FEES	В	-1, 291	NURSERY	43.00	0	33. 39
33. 42 OTHER MISC FEES B 45,855 ADMINISTRATIVE & GENERAL 5.00 0.33. 42							_	
33. 43 33. 44 1HA LOBBYI NG OFFSET								
33. 44							_	
33. 45 OTHER MISC FEES B -537 ASC (NON-DISTINCT PART) 75. 00 0 33. 45 1 NDI ANA CHAMBER LOBBYING OFFSET 5.00 0 33. 46 OFFSET								
33. 46 INDI ANA CHAMBER LOBBYING OFFSET S							_	
33. 47 TRADE, QUANTITY, AND TIME B -22, 279 ADMINISTRATIVE & GENERAL 5.00 0 33. 47 DI SCOUNTS 33. 48 TRADE, QUANTITY, AND TIME B -1, 057 OPERATION OF PLANT 7.00 0 33. 48 DI SCOUNTS 33. 49 TRADE, QUANTITY, AND TIME B -16 MENTAL HEALTH OVERHEAD 17. 01 0 33. 49 DI SCOUNTS 33. 50 OTHER MISC FEES B -1, 790 CLINIC 90.00 0 33. 50 TRADE, QUANTITY, AND TIME B -2 SUBPROVIDER - IRF 41.00 0 33. 51 DI SCOUNTS 33. 52 OTHER MISC FEES B -7, 875 EMERGENCY 91.00 0 33. 52 33. 53 ADVERTISING A -4, 082 ADMINISTRATIVE & GENERAL 5.00 0 33. 53 33. 54 ADVERTISING A -592 RADIOLOGY-DI AGNOSTIC 54.00 0 33. 54 33. 55 ADVERTISING A -145 PHYSICAL THERAPY 66.00 0 33. 55 33. 56 ADVERTISING A -125 HOSPICE 116.00 0 33. 56 33. 57 BEAUTY SHOP EXPENSE A -840 ADMINISTRATIVE & GENERAL 5.00 0 33. 57 33. 58 ALCOHOLIC BEVERAGES A -1, 039 ADMINISTRATIVE & GENERAL 5.00 0 33. 57 33. 58 ALCOHOLIC BEVERAGES					1		0	
DI SCOUNTS TRADE, QUANTITY, AND TIME B		OFFSET						
33. 48 TRADE, QUANTITY, AND TIME DISCOUNTS 33. 49 TRADE, QUANTITY, AND TIME B -16 MENTAL HEALTH OVERHEAD 17. 01 0 33. 49 DISCOUNTS 33. 50 OTHER MISC FEES B -1,790 CLINIC 90. 00 0 33. 50 33. 51 TRADE, QUANTITY, AND TIME B -2 SUBPROVIDER - IRF 41. 00 0 33. 51 DISCOUNTS B -7,875 EMERGENCY 91. 00 0 33. 51 33. 52 OTHER MISC FEES B -7,875 EMERGENCY 91. 00 0 33. 52 33. 53 ADVERTISING A -4,082 ADMINISTRATIVE & GENERAL 5. 00 0 33. 53 33. 54 ADVERTISING A -145 PHYSICAL THERAPY 66. 00 0 33. 54 33. 55 ADVERTISING A -125 HOSPICE 116. 00 0 33. 56 33. 57 BEAUTY SHOP EXPENSE A -840 ADMINISTRATIVE & GENERAL 5. 00 0 33. 57 33. 58 ALCOHOLIC BEVERAGES A -1,039 ADMINISTRATIVE & GENERAL 5. 00 0 33. 57	33. 47		В	-22, 279	ADMINISTRATIVE & GENERAL	5. 00	0	33. 47
DI SCOUNTS TRADE, QUANTITY, AND TIME B	22 40		D	1 057	ODEDATION OF DIANT	7 00		22 40
33. 49 TRADE, QUANTITY, AND TIME DISCOUNTS 33. 50 OTHER MISC FEES 33. 51 TRADE, QUANTITY, AND TIME DISCOUNTS 33. 52 OTHER MISC FEES 33. 52 OTHER MISC FEES 33. 53 ADVERTISING 33. 54 ADVERTISING 33. 55 ADVERTISING 33. 55 ADVERTISING 33. 56 ADVERTISING 33. 56 ADVERTISING 33. 57 BEAUTY SHOP EXPENSE 34. 00 33. 57 BEAUTY SHOP EXPENSE 35. 00 0 33. 56 ADVERTISI WE ADMINISTRATIVE & GENERAL 36. 00 0 33. 56 ADVERTISING 37. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33. 40		Ь	-1,037	OPERATION OF PLANT	7.00	٩	33. 40
DI SCOUNTS B	33. 49		В	-16	MENTAL HEALTH OVERHEAD	17. 01	o	33. 49
33. 51 TRADE, QUANTITY, AND TIME DISCOUNTS 33. 52 OTHER MISC FEES B -7, 875 EMERGENCY 91. 00 0 33. 52 33. 53 ADVERTISING A -4, 082 ADMINISTRATIVE & GENERAL 5. 00 0 33. 53 33. 54 ADVERTISING A -592 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 54 33. 55 ADVERTISING A -145 PHYSICAL THERAPY 66. 00 0 33. 55 33. 56 ADVERTISING A -125 HOSPICE 116. 00 0 33. 56 33. 57 BEAUTY SHOP EXPENSE A -840 ADMINISTRATIVE & GENERAL 5. 00 0 33. 57 33. 58 ALCOHOLIC BEVERAGES A -1, 039 ADMINISTRATIVE & GENERAL 5. 00 0 33. 58		DI SCOUNTS						
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33. 52 OTHER MISC FEES B -7, 875 EMERGENCY 91. 00 0 33. 52 33. 53 ADVERTI SI NG A -4, 082 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 53 33. 54 ADVERTI SI NG A -592 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 54 33. 55 ADVERTI SI NG A -145 PHYSI CAL THERAPY 66. 00 0 33. 55 33. 56 ADVERTI SI NG A -125 HOSPI CE 116. 00 0 33. 56 33. 57 BEAUTY SHOP EXPENSE A -840 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 57 33. 58 ALCOHOLI C BEVERAGES A -1, 039 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 58	33. 51		В	-2	SUBPROVI DER - I RF	41. 00	0	33. 51
33. 53 ADVERTI SI NG A -4,082 ADMI NI STRATI VE & GENERAL 5.00 0 33. 53 33. 54 ADVERTI SI NG A -592 RADI OLOGY-DI AGNOSTI C 54.00 0 33. 54 33. 55 ADVERTI SI NG A -145 PHYSI CAL THERAPY 66.00 0 33. 55 33. 56 ADVERTI SI NG A -125 HOSPI CE 116.00 0 33. 56 33. 57 BEAUTY SHOP EXPENSE A -840 ADMI NI STRATI VE & GENERAL 5.00 0 33. 57 33. 58 ALCOHOLI C BEVERAGES A -1,039 ADMI NI STRATI VE & GENERAL 5.00 0 33. 58	33 E3		D D	7 075	EMERGENCY	01 00		33 E3
33. 54 ADVERTI SI NG A -592 RADI OLOGY-DI AGNOSTI C 54. 00 0 33. 54 33. 55 ADVERTI SI NG A -145 PHYSI CAL THERAPY 66. 00 0 33. 55 33. 56 ADVERTI SI NG A -125 HOSPI CE 116. 00 0 33. 56 33. 57 BEAUTY SHOP EXPENSE A -840 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 57 33. 58 ALCOHOLI C BEVERAGES A -1, 039 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 58			1					
33. 55 ADVERTI SI NG A -145 PHYSI CAL THERAPY 66. 00 0 33. 55 33. 56 ADVERTI SI NG A -125 HOSPI CE 116. 00 0 33. 56 33. 57 BEAUTY SHOP EXPENSE A -840 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 57 33. 58 ALCOHOLI C BEVERAGES A -1, 039 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 58			1				_	
33. 56 ADVERTISING A -125 HOSPICE 116. 00 0 33. 56 33. 57 BEAUTY SHOP EXPENSE A -840 ADMINISTRATIVE & GENERAL 5. 00 0 33. 57 33. 58 ALCOHOLIC BEVERAGES A -1, 039 ADMINISTRATIVE & GENERAL 5. 00 0 33. 58							_	
33. 58 ALCOHOLI C BEVERAGES A -1, 039 ADMI NI STRATI VE & GENERAL 5. 00 0 33. 58	33. 56	ADVERTI SI NG		-125	HOSPI CE	116.00	o	33. 56
			1				_	
33. 59 HAF AUJUSIMENT A -4, 312, 793 AUMINISTRATIVE & GENERAL 5.00 0 33.59			1					
	33. 59	HAF ADJUSIMENI	I A	-4, 312, 793	JADMINISTRATIVE & GENERAL	5. 00	0	33. 59

Health Financial Systems	GOOD SAMARITAN HOSPITAL				In Lieu of Form CMS-2552-10			
ADJUSTMENTS TO EXPENSES			Provider CCN: 150042		eriod: rom 01/01/2015	Worksheet A-8		
					To			
			E>	kpense Classification	n on '	Worksheet A		
			To/F	rom Which the Amount	is t	to be Adjusted		
Cost Center Description	Basis/Code (2)	Amount		Cost Center		Li ne #	Wkst. A-7 Ref.	
	1.00	2.00		3. 00		4. 00	5. 00	
50.00 TOTAL (sum of lines 1 thru 49)		-19, 299, 521						50.00
(Transfer to Worksheet A,								
column 6, line 200.)								

- (1) Description all chapter references in this column pertain to CMS Pub. 15-1.(2) Basis for adjustment (see instructions).
- A. Costs if cost, including applicable overhead, can be determined.

 B. Amount Received if cost cannot be determined.

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

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

Provi der CCN: 150042

					-	Го 12/31/2015	Date/Time Pro 5/25/2016 9:5	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component	1102 711104111	ider Component	
							Hours	
	1. 00	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	
1.00		MENTAL HEALTH OVERHEAD	724, 995			159, 800	1, 828	
2.00		OPERATING ROOM	1, 476, 100				0	
3.00		DR. O	253, 224				1, 580	
4.00		DR. G	197, 154				520	1
5. 00		DR. Q	124, 608				1, 337	1
6.00		DR. R	18, 000		18, 000		300	
7.00		ELECTROCARDI OLOGY	2, 130, 662				31	7. 00
8.00		NEURODI AGNOSTI CS	19, 500		19, 500		80	
9.00		DR. S	40, 000	·	0 40,000		336	1
10.00		ASC (NON-DISTINCT PART) DR. L	11, 001	-1, 00	· ·	159, 800	144 144	
11. 00 12. 00		EMERGENCY	819, 734 5, 216, 595			159, 800 159, 800	404	
200.00	91.00	EWERGENCT	11, 031, 573				6, 704	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Provi der	Physician Cost	
	WKSt. A LITTO #	I denti fi er	Li mi t		E Memberships &	Component	of Malpractice	
		1 45.111 11 51	2	Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14.00	
1.00		MENTAL HEALTH OVERHEAD	140, 440				0	
2. 00		OPERATING ROOM	0	1	0		0	
3. 00		DR. O	121, 386			1	0	
4.00		DR. G	54, 400			1	0	
5.00		DR. Q DR. R	102, 718			1	0	
6. 00 7. 00		ELECTROCARDI OLOGY	23, 048 2, 382					0.00
8. 00		NEURODI AGNOSTI CS	6, 146			1	0	
9. 00		DR. S	25, 814			0	0	
10. 00		ASC (NON-DISTINCT PART)	11, 063				0	7.00
11. 00		DR. L	11, 063				0	
12. 00		EMERGENCY	31, 038				Ö	
200.00			529, 498				Ö	1
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1 00	2.00	14	1/ 00	17.00	10.00		
1. 00	1. 00	MENTAL HEALTH OVERHEAD	15. 00	16. 00 140, 44	17. 00 0 44, 120	18. 00 584, 555		1. 00
2. 00		OPERATING ROOM			0 44, 120	1, 476, 100		2.00
3. 00		DR. O			٥			3. 00
4. 00		DR. G	l o			,		4. 00
5. 00		DR. Q	0					5. 00
6.00		DR. R	0			0		6. 00
7. 00	69. 00	ELECTROCARDI OLOGY	0			2, 128, 280		7. 00
8.00	70. 01	NEURODI AGNOSTI CS	0	6, 14	6 13, 354	13, 354		8. 00
9.00		DR. S	0	25, 81	4 14, 186	l		9. 00
10.00		ASC (NON-DISTINCT PART)	0		938			10.00
11. 00		DR. L	0					11. 00
12.00	91. 00	EMERGENCY	0					12. 00
200.00			0	529, 49	133, 429	10, 626, 563		200. 00

	Financial Systems	GOOD SAMARITA		001 450040 5		eu of Form CMS-:	2552-10
COST	NLLOCATION - GENERAL SERVICE COSTS		Provi der	F	Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
			CAPI TAL REI	LATED COSTS		5/25/2016 9:5	/ am
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP		COMMUNI CATI ONS	
		for Cost Allocation			BENEFITS DEPARTMENT		
		(from Wkst A			DEPARTMENT		
		col. 7)					
		0	1. 00	2. 00	4. 00	4. 01	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	20, 805, 764	20, 805, 764				1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	-11, 483 23, 882, 960	105, 865	-11, 483			2. 00 4. 00
4. 01	00401 COMMUNI CATI ONS	265, 892	105, 005				
4. 02	00402 PURCHASING & RECEIVING	467, 547	363, 732	d	164, 184		1
4.03	00403 REGI STRATI ON	914, 402	0	C	199, 049	3, 170	
4.04	00404 PATIENT ACCOUNTS	3, 953, 950	0	C			
5.00	00500 ADMINISTRATIVE & GENERAL	18, 916, 194	1, 108, 083		_, -,,		
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	6, 099, 614 358, 583	3, 384, 050 126, 672				7. 00 8. 00
9. 00	00900 HOUSEKEEPING	2, 286, 261	185, 727				
10. 00	01000 DI ETARY	643, 273	0		•		
11. 00	01100 CAFETERI A	1, 124, 892	300, 973	(11. 00
13.00	01300 NURSING ADMINISTRATION	1, 953, 654	250, 867	•			
14.00	01400 CENTRAL SERVICES & SUPPLY	548, 432	6, 182				1
15. 00 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY	3, 081, 293	148, 875				1
17. 00	01700 SOCIAL SERVICE	3, 421, 705	117, 339 0				
17. 00	01701 MENTAL HEALTH OVERHEAD	1, 745, 857	82, 797				
23. 00	02300 PARAMED ED PGRM-(SPECIFY)	167, 782	0				
23. 01	02302 PARAMED ED PGRM-(SPECIFY)	14, 602	0	C			1
	INPATIENT ROUTINE SERVICE COST CENTERS	_					
30.00	03000 ADULTS & PEDI ATRI CS	7, 601, 916	1, 821, 788				1
31. 00 40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	3, 988, 989	643, 152				1
41. 00	04100 SUBPROVI DER – TPF	755, 757 3, 734, 348	318, 798 533, 511				
43. 00	1	383, 748	0		· ·		1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 042, 455	454, 755		•	10, 951	
51.00	05100 RECOVERY ROOM	0	0	C		0	
51. 01	05101 ENDOSCOPY	1, 309, 263	294, 358	(· ·		
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	502, 922 6, 000, 710	562, 376		· ·		
54. 01	05401 RADI OLOGY -NON-CAMPUS	1, 177, 646	115, 872				1
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	198, 793	0	1			1
60.00	06000 LABORATORY	4, 224, 733	199, 847	(602, 146	6, 772	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	834, 139	0	C	0	0	63. 00
	06500 RESPI RATORY THERAPY	2, 183, 153	133, 672				65.00
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	2, 847, 009 2, 967, 939	199, 390 387, 570				66. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	2, 707, 737	307, 370			0, 340	1
70. 01	07001 NEURODI AGNOSTI CS	373, 376	183, 899			3, 314	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	8, 884, 046	0	C	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 152, 971	0	C	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	14, 106, 335	0		131, 654		
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03020 MH ANCILLARY OUTPATIENT	2, 064, 114	0			9, 222	1
76. 00	03950 I NPATIENT DIALYSIS	460, 431	206, 438				1
70.01	OUTPATIENT SERVICE COST CENTERS	100, 101	200, 100		,		70.01
90.00	09000 CLI NI C	1, 253, 139	64, 178	C	392, 578	0	90. 00
91. 00	09100 EMERGENCY	4, 156, 425	397, 361		867, 319	6, 916	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
07.00	OTHER REIMBURSABLE COST CENTERS	121 024	0.470		15 757		0, 00
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	121, 934	9, 478 0				96. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			,		1101.00
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	1, 175, 234	116, 930	C	156, 592		116. 00
118.00	, ,	168, 142, 699	12, 824, 535	(16, 801, 529	252, 881	118. 00
100.00	NONREI MBURSABLE COST CENTERS						100.00
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1920 PHYSICIANS' PRIVATE OFFICES	0 33, 892, 642	0 3 271 810	1			190. 00 192. 00
	07950 COMMUNITY HEALTH SERVICES	240, 616	3, 271, 810 61, 003				194. 00
	207952 MARKETING AND PUBLIC RELATIONS	1, 087, 044	21, 048				194. 00
	07953 MH RESIDENTIAL	463, 741	487, 350		95, 046	0	194. 03
194. 04	07954 UNUSED SPACE	0	2, 634, 719		0	0	194. 04
	07955 MOB	260, 721	586, 287				194. 05
194.06	07956 FOUNDATI ON	1, 208, 390	15, 828	(28, 930	0	194. 06

Health Financial Systems	GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150042	Period: From 01/01/2015 To 12/31/2015		pared: 7 am	
		CAPI TAL REL	ATED COSTS				
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS		
	0	1.00	2.00	4. 00	4. 01		
194.07 07957 KNOX COUNTY HEALTH DEPT	0	113, 346		0 0	2, 594	194. 07	
194. 08 07958 I NDUSTRI AL HEALTH	20, 757	0		0 4, 389	0	194. 08	
194. 09 07959 NRCC	2, 473, 389	789, 838		0 418, 091	0	194. 09	
200.00 Cross Foot Adjustments						200. 00	
201.00 Negative Cost Centers		0	-11, 48	0	0	201. 00	
202.00 TOTAL (sum lines 118-201)	207, 789, 999	20, 805, 764	-11, 48	23, 988, 825	327, 376	202. 00	

Provider CCN: 150042

					12/31/2013	5/25/2016 9:5	
	Cost Center Description	PURCHASING &	REGI STRATI ON	PATI ENT	Subtotal	ADMI NI STRATI VE	
		RECEI VI NG		ACCOUNTS		& GENERAL	
	OFNEDAL CEDIU OF OCCT OFNEDO	4. 02	4. 03	4. 04	4A. 04	5. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1.00	00100 CAP REL COSTS BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
4. 00	00400 EMPLOTEE BENEFITS DEPARTMENT						4. 00
4. 01	00401 COMMON CATTONS 00402 PURCHASING & RECEIVING	998, 921					4. 01
4. 02	00402 PORCHASTING & RECEIVING	639	1 117 260				4. 02
4. 03	00404 PATIENT ACCOUNTS	2, 269	1, 117, 260 0	4, 463, 133			4. 03
5. 00	00500 ADMINISTRATIVE & GENERAL	7, 260	0	4, 403, 133	22, 092, 885	22, 092, 885	5. 00
7. 00	00700 OPERATION OF PLANT	8, 871	0	0	10, 078, 324	1, 198, 968	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 363	0	0	536, 476	63, 822	8. 00
9. 00	00900 HOUSEKEEPING		0	0		351, 840	9. 00
	01000 DI ETARY	6, 500	0	0	2, 957, 505		9. 00 10. 00
10. 00 11. 00	01100 CAFETERI A	36, 308 0	0	0	759, 503	90, 354	
13. 00	01300 NURSI NG ADMI NI STRATI ON	681	0	0	1, 676, 220 2, 604, 731	199, 412 309, 872	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 897	0	0	646, 660	76, 930	14. 00
15. 00	01500 PHARMACY		0	0			15. 00
	01600 MEDICAL RECORDS & LIBRARY	427, 593	0	٦	4, 334, 881	515, 699	
16.00		431	0	0	4, 153, 695	494, 144 0	16.00
17. 00 17. 01	01700 SOCIAL SERVICE		0	0	2 247 504		17. 00 17. 01
23. 00	01701 MENTAL HEALTH OVERHEAD 02300 PARAMED ED PGRM-(SPECIFY)	5, 543	0	0	2, 247, 504 214, 861	267, 374	23. 00
23. 00	02302 PARAMED ED PGRM-(SPECIFY)	42	0	0	.,	25, 561 2, 097	
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	42	Ų	U	17, 627	2,097	23. 01
30. 00	03000 ADULTS & PEDIATRICS	47, 131	67, 868	271, 150	11, 278, 070	1, 341, 696	30. 00
31. 00	03100 INTENSIVE CARE UNIT	8, 768	34, 805	139, 055	5, 676, 100	675, 257	31. 00
40. 00	04000 SUBPROVI DER – I PF	0, 700	11, 711	46, 787	1, 261, 668	150, 094	40. 00
41. 00	04100 SUBPROVI DER - TPF	-	17, 735	70, 855	5, 039, 490		41. 00
43.00	04300 NURSERY	3, 130 1, 044	2, 578	10, 300	5, 039, 490 479, 536	57, 048	43.00
43.00	ANCI LLARY SERVICE COST CENTERS	1,044	2, 370	10, 300	479, 330	37,046	43.00
50. 00	05000 OPERATING ROOM	45, 436	63, 089	252, 055	5, 766, 944	686, 064	50. 00
51. 00	05100 RECOVERY ROOM	45, 430	03, 009	252, 055	5, 700, 74 4	080,004	51. 00
51. 00	05100 RECOVERT ROOM	13, 919	29, 369	117, 337	2, 003, 203	238, 311	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 919	9, 236	36, 902	659, 275	78, 431	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	32, 077	182, 102	726, 949	8, 459, 766		54. 00
54. 00	05401 RADI OLOGY - NON - CAMPUS	3, 987	40, 875	163, 307	1, 698, 562	202, 069	54. 00
54. 01	05408 RADI OLOGY-NON-CAMPOS 05408 RADI OLOGY-GSH BREAST CENTER	3, 967			270, 608	32, 193	54. 01
	06000 LABORATORY		1, 026	4, 101		675, 648	
60. 00 63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	82, 296 0	112, 826	450, 767	5, 679, 387 875, 530		60. 00 63. 00
65.00	06500 RESPIRATORY THERAPY	7, 875	8, 286 29, 303	33, 105 117, 072	2, 947, 681	350, 671	65. 00
66. 00	06600 PHYSI CAL THERAPY						66. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 427 33, 180	67, 148	268, 272 305, 444	4, 000, 355	475, 902 574, 113	
70.00	07000 ELECTROCARDI OLOGY	33, 180	76, 452 0	305, 444	4, 842, 712	576, 113 0	69. 00 70. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	813	13, 391	53, 500	706, 863	84, 092	70.00
70.01	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	013	21, 013	83, 953	8, 989, 012	1, 069, 378	70.01
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	65, 859	27, 238	108, 821	2, 354, 889	280, 149	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	00, 009	138, 352	552, 751	14, 929, 092	1, 776, 039	73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	43, 608	53, 552	213, 952	2, 620, 742	311, 777	75. 00 75. 00
76. 00	03020 MH ANCI LLARY OUTPATIENT	43,000	03, 332	213, 432	2, 020, 742	311,777	76.00
76. 00	03950 INPATIENT DIALYSIS	180	- 1	12, 048	682, 113		76. 00 76. 01
70.01	OUTPATIENT SERVICE COST CENTERS	100	3,010	12, 040	002, 113	01, 140	70.01
90. 00	09000 CLINIC	13, 808	9, 786	39, 096	1, 772, 585	210, 876	90. 00
91.00	09100 EMERGENCY	8, 997	88, 048	351, 774	5, 876, 840	699, 138	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 997	00, 040	331, 774	5, 670, 640 O	077, 130	92.00
72. UU	OTHER REIMBURSABLE COST CENTERS				U		7Z. UU
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	2, 780	1, 463	5, 844	157, 256	18, 708	96. 00
	10100 HOME HEALTH AGENCY	2,780	1, 403	5, 844	157, 250		101. 00
101.00	SPECIAL PURPOSE COST CENTERS	U	U _I	U	U	U	101.00
113 00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	737	6, 992	27, 936	1, 484, 853	176, 646	
118. 00		921, 763	1, 117, 260	4, 463, 133	152, 834, 004	15, 553, 617	
110.00	NONREI MBURSABLE COST CENTERS	721, 703	1, 117, 200	4, 403, 133	132, 634, 604	15, 555, 617	116.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19000 BIFT, FLOWER, COFFEE SHOP & CANTEEN	51, 306	0	0	43, 791, 933	5, 209, 770	
	07950 COMMUNITY HEALTH SERVICES		0	0			
	207952 MARKETING AND PUBLIC RELATIONS	914 20, 052		0	345, 105 1, 169, 947	41, 055 139, 183	
	07952 MARKETING AND PUBLIC RELATIONS			0		139, 183	
		1, 430		0	1, 047, 567 2, 634, 719		
	107954 UNUSED SPACE		O O	٦	2, 634, 719	313, 439	
	507955 MOB	263	O O	0	899, 462 1 256 226	107, 004	
	07956 FOUNDATION	3, 188	o o	0	1, 256, 336	149, 460	
	707957 KNOX COUNTY HEALTH DEPT		O	0	115, 940	13, 793	
	3 07958 I NDUSTRI AL HEALTH	5		0	25, 151		194. 08
	07959 NRCC	0	이	0	3, 681, 318	437, 948	
200.00					11 400	^	200. 00
201.00	Negative Cost Centers	0	0	0	-11, 483	0	201. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2015	Part I	
				To 12/31/2015	Date/Time Pre	pared:
					5/25/2016 9:5	7 am
Cost Center Description	PURCHASING &	REGI STRATI ON	PATI ENT	Subtotal	ADMI NI STRATI VE	
	RECEI VI NG		ACCOUNTS		& GENERAL	
	4. 02	4. 03	4. 04	4A. 04	5. 00	
202.00 TOTAL (sum lines 118-201)	998, 921	1, 117, 260	4, 463, 13	3 207, 789, 999	22, 092, 885	202. 00

Provi der CCN: 150042

					10		5/25/2016 9: 5	
		Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
			7. 00	8. 00	9. 00	10.00	11. 00	
		AL SERVICE COST CENTERS						
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01		COMMUNI CATI ONS						4. 01
4.02		PURCHASING & RECEIVING						4. 02
4.03		REGI STRATI ON						4. 03
4.04	1	PATIENT ACCOUNTS						4. 04
5.00	1	ADMINISTRATIVE & GENERAL	11 277 202					5.00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	11, 277, 292 90, 161	690, 459				7. 00 8. 00
9. 00		HOUSEKEEPI NG	132, 195	37, 729				9. 00
10.00		DI ETARY	0	10, 189		966, 428		10.00
11.00		CAFETERI A	214, 223	0	22, 542	0	2, 112, 397	11. 00
13.00		NURSING ADMINISTRATION	178, 559	0	-	0	34, 003	
14. 00		CENTRAL SERVICES & SUPPLY	4, 400	1, 652		0	22, 126	
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	105, 965 83, 518	0		0	77, 416 106, 130	
17. 00		SOCIAL SERVICE	03, 510	0	17, 404	0	100, 130	17. 00
17. 01	1	MENTAL HEALTH OVERHEAD	58, 932	11, 492		Ö	148, 597	
23. 00	02300	PARAMED ED PGRM-(SPECIFY)	0	0	0	0	5, 335	23. 00
23. 01		PARAMED ED PGRM-(SPECIFY)	0	0	0	0	0	23. 01
00.00		I ENT ROUTINE SERVICE COST CENTERS	1 00/ /00	00/ 4/4	007.000	400.000	00/ 470	00.00
30. 00 31. 00	1	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	1, 296, 692 457, 776	226, 161 91, 331		433, 902 179, 321	226, 473 117, 096	
40. 00		SUBPROVI DER - I PF	226, 910	91, 331		111, 883	52, 246	
41. 00	1	SUBPROVI DER - I RF	379, 736	46, 976		213, 451	109, 182	41. 00
43.00		NURSERY	0	5, 996		27, 871	10, 073	43. 00
		LARY SERVICE COST CENTERS						
50.00		OPERATI NG ROOM	323, 681	28, 213		0	49, 881	50.00
51. 00 51. 01		RECOVERY ROOM ENDOSCOPY	209, 515	0 17, 681		O O	0 28, 664	51. 00 51. 01
52. 00		DELIVERY ROOM & LABOR ROOM	207, 313	5, 924		0	12, 961	52. 00
54.00		RADI OLOGY-DI AGNOSTI C	400, 282	56, 411		Ö	116, 963	
54. 01		RADI OLOGY-NON-CAMPUS	82, 474	0	0	0	22, 356	54. 01
54. 08		RADI OLOGY-GSH BREAST CENTER	0	0		0	0	54. 08
60.00	1	LABORATORY	142, 245	0	,	0	98, 226	
63. 00 65. 00	1	BLOOD STORING, PROCESSING & TRANS. RESPIRATORY THERAPY	95, 144	0 102	-	0	0 58, 718	63. 00 65. 00
66. 00		PHYSICAL THERAPY	141, 920	24, 569		0	64, 330	
69. 00		ELECTROCARDI OLOGY	275, 861	11, 857		o	73, 439	69. 00
70.00		ELECTROENCEPHALOGRAPHY	0	0	1	0	0	70. 00
70. 01		NEURODI AGNOSTI CS	130, 893	11, 423	65, 325	0	12, 349	
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
75. 00		ASC (NON-DISTINCT PART)	0	25, 893	167, 418	0	0	
76. 00	1	MH ANCILLARY OUTPATIENT	0	0	0	o	0	
		INPATIENT DIALYSIS	146, 936	0	0	0	0	
		TIENT SERVICE COST CENTERS	_					
90.00		CLINIC	45, 680			0	27, 285	90.00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	282, 829	58, 472	163, 286	0	119, 220	91. 00 92. 00
72.00		REIMBURSABLE COST CENTERS						72.00
96.00		DURABLE MEDICAL EQUIP-RENTED	6, 746	0	0	0	2, 761	96. 00
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101. 00
		AL PURPOSE COST CENTERS						
		I NTEREST EXPENSE	02 227		(0.007		21 172	113.00
118.00		HOSPICE SUBTOTALS (SUM OF LINES 1-117)	83, 227 5, 596, 500	0 672, 088		966, 428	21, 172 1, 617, 002	116.00
110.00		IMBURSABLE COST CENTERS	3, 370, 300	072,000	2, 707, 147	700, 420	1, 017, 002	1110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	2, 328, 775	18, 371	447, 964	0	444, 864	192. 00
		COMMUNITY HEALTH SERVICES	43, 420	0		0		194. 00
		MARKETING AND PUBLIC RELATIONS	14, 981	0	6, 329	0		194. 02
		MH RESIDENTIAL UNUSED SPACE	346, 880 1, 875, 311	0	0	O O		194. 03 194. 04
	07954		417, 301	0	0	0		194. 04
		FOUNDATI ON	11, 266	o	Ö	ol		194. 06
		KNOX COUNTY HEALTH DEPT	80, 676	0	21, 078	ō		194. 07
		I NDUSTRI AL HEALTH	0	0	0	o		194. 08
	07959		562, 182	0	0	0	0	194. 09
200. 00 201. 00		Cross Foot Adjustments Negative Cost Centers	0	0	o	o	0	200. 00 201. 00
201.00	1	Inegative oust centers	1 0	0	ı o	Ч	0	1201.00

Health Financial Systems GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150042		Worksheet B	
				From 01/01/2015	Part I	
				To 12/31/2015	Date/Time Pre	pared:
					5/25/2016 9:5	7 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9.00	10.00	11.00	
202.00 TOTAL (sum lines 118-201)	11, 277, 292	690, 459	3, 479, 26	966, 428	2, 112, 397	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2015 Part I
To 12/31/2015 Date/Time Prepared: 5/25/2016 9:57 am Provider CCN: 150042

				12/31/2015	5/25/2016 9:5	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
	13.00	14. 00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01 00401 COMMUNI CATI ONS 4. 02 00402 PURCHASI NG & RECEI VI NG						4. 01
4. 03 00403 REGI STRATI ON						4. 02 4. 03
4. 04 O0404 PATIENT ACCOUNTS						4. 04
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					•	8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	3, 127, 165	705 004				13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	795, 231	E 422 44E			14.00
15. 00 01500 PHARMACY 16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	365, 188	5, 432, 465 0	4 0E7 2E0		15. 00 16. 00
17. 00 01700 SOCIAL SERVICE		368	0	4, 857, 259	0	17. 00
17. 01 01700 SOCIAL SERVICE	0	4, 734	556	0	0	17. 00
23. 00 02300 PARAMED ED PGRM-(SPECIFY)	0	1, 731	0	0	Ö	23. 00
23. 01 02302 PARAMED ED PGRM-(SPECIFY)	o	36	0	0	Ō	23. 01
I NPATIENT ROUTINE SERVICE COST CENTERS	, -		· · · · · · · · · · · · · · · · · · ·			
30. 00 03000 ADULTS & PEDIATRICS	985, 961	40, 251	5, 190	2, 225, 397	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	509, 780	7, 488	3, 719	951, 806	0	31. 00
40. 00 04000 SUBPROVI DER - 1 PF	227, 454	0	0	172, 748	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	475, 330	2, 673	2, 669	203, 233	0	41.00
43. 00 04300 NURSERY	43, 854	891	146	37, 259	0	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	217, 159	38, 804	22, 043	169, 360	0	50.00
51. 00 05100 RECOVERY ROOM	217, 139	30, 604 0	22, 043	109, 300	0	51.00
51. 01 05101 ENDOSCOPY	0	11, 887	869	142, 263	0	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	56, 428	1, 639	247	0	ő	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	27, 395	41, 927	0	0	54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS	0	3, 405	11, 667	0	0	54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0	332	0	0	0	54. 08
60. 00 06000 LABORATORY	0	70, 284	1, 144	0	0	60. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0	6, 726	1, 265	13, 549	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	2, 073	6, 512	111 770	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	28, 337	479	111, 778	0	69. 00 70. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 70. 01 07001 NEURODI AGNOSTI CS		695	0	47, 421	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	075	0	47, 421	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	56, 246	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	0	4, 805, 908	0	Ö	73. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	37, 243		210, 007		75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76. 00
76.01 03950 INPATIENT DIALYSIS	0	154	962	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	11, 792	4, 103	0		90. 00
91. 00 09100 EMERGENCY	519, 028	7, 684	3, 877	572, 438	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	2, 375	0	0	0	96. 00
101. 00 10100 HOME HEALTH AGENCY	0	2, 375	0	0		101.00
SPECIAL PURPOSE COST CENTERS		<u> </u>	0			101.00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	92, 171	629	8	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 127, 165	729, 335	4, 946, 574	4, 857, 259	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	43, 817	479, 272	0		192. 00
194. 00 07950 COMMUNITY HEALTH SERVICES	0	781	6, 619	0		194. 00
194. 02 07952 MARKETING AND PUBLIC RELATIONS	0	17, 125	0	0		194. 02
194. 03 07953 MH RESIDENTIAL	0	1, 221	0	0		194. 03 194. 04
194. 04 07954 UNUSED_SPACE 194. 05 07955 MOB		0 225	0	0		194. 04 194. 05
194. 06 07956 FOUNDATION		2, 723	0	0		194. 05
194.07 07957 KNOX COUNTY HEALTH DEPT		2, 723 N	0	0		194. 00
194. 08 07958 I NDUSTRI AL HEALTH		4	o	0		194. 08
194. 09 07959 NRCC	0	o	0	0		194. 09
200.00 Cross Foot Adjustments						200. 00
	'					

Н	ealth Finar	ncial Systems	GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10			
C	COST ALLOCATION - GENERAL SERVICE COSTS			Provi der	Provider CCN: 150042		Worksheet B		
						From 01/01/2015			
						To 12/31/2015			
_							5/25/2016 9:5	7 am	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
			ADMI NI STRATI ON	SERVICES &		RECORDS &			
				SUPPLY		LI BRARY			
			13. 00	14.00	15. 00	16. 00	17. 00		
2	201.00	Negative Cost Centers	0	0		0	0	201.00	
2	202.00	TOTAL (sum lines 118-201)	3, 127, 165	795, 231	5, 432, 46	5 4, 857, 259	0	202. 00	

Provi der CCN: 150042

			To	12/31/2015	Date/Time Pre 5/25/2016 9:5	
Cost Center Description	MENTAL HEALTH	PARAMED ED	PARAMED ED	Subtotal	Intern &	7 (311)
	OVERHEAD	PGRM	PGRM		Residents Cost	
					& Post Stepdown	
					Adjustments	
	17. 01	23. 00	23. 01	24. 00	25. 00	
GENERAL SERVICE COST CENTERS						1 00
1.00 O0100 CAP REL COSTS-BLDG & FIXT 2.00 O0200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01 00401 COMMUNI CATI ONS						4. 01
4. 02 OO402 PURCHASING & RECEIVING						4. 02
4. 03 00403 REGISTRATION						4. 03
4. 04 00404 PATIENT ACCOUNTS 5. 00 00500 ADMINISTRATIVE & GENERAL						4. 04 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 11. 00 01100 CAFETERI A						10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY						15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY						16.00
17. 00 01700 SOCI AL SERVI CE 17. 01 01701 MENTAL HEALTH OVERHEAD	2, 835, 738					17. 00 17. 01
23. 00 02300 PARAMED ED PGRM-(SPECIFY)	2,033,730	245, 763				23. 00
23. 01 02302 PARAMED ED PGRM-(SPECIFY)	0		19, 760			23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	1	_1				
30. 00 03000 ADULTS & PEDI ATRI CS	1, 002, 443	0	0	19, 999, 536	0	30. 00 31. 00
31. 00 03100 INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF	277, 804	0	0	8, 965, 597 2, 480, 807	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	o	0	7, 249, 409	0	41.00
43. 00 04300 NURSERY	0	0	0	673, 291	0	43. 00
ANCILLARY SERVICE COST CENTERS		ما		7 5/0 701		F0 00
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	0	0	0	7, 560, 781	0	50. 00 51. 00
51. 01 05101 ENDOSCOPY	0	o	0	2, 706, 368	0	51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	O	0	827, 562	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	245, 763	0	10, 525, 374	0	54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS 54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0	0	0	2, 020, 533 303, 133	0	54. 01 54. 08
60. 00 06000 LABORATORY		0	19, 760	6, 740, 617	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	Ö	Ō	0	979, 687	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	3, 513, 344	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	4, 789, 616	0	66.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	6, 023, 924	0	69. 00 70. 00
70. 01 07001 NEURODI AGNOSTI CS		ő	0	1, 059, 070	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10, 058, 390	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2, 691, 284	0	, 00
73.00 07300 DRUGS CHARGED TO PATIENTS 75.00 07500 ASC (NON-DISTINCT PART)	1, 270, 403	0	0	21, 511, 039 4, 676, 757	0	73. 00 75. 00
76. 00 03020 MH ANCILLARY OUTPATIENT	1, 270, 403	o	0	4, 070, 737	0	1
76. 01 03950 INPATIENT DIALYSIS	0	0	0	911, 313	0	
OUTPATIENT SERVICE COST CENTERS	1	al		0.005.5(0		
90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY	0	0	0	2, 095, 560 8, 302, 812	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		ď	0	0, 302, 012	0	
OTHER REIMBURSABLE COST CENTERS	,					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	187, 846		96. 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	0	О	0	1, 919, 533		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 550, 650	245, 763	19, 760	138, 773, 183	0	118. 00
NONREI MBURSABLE COST CENTERS		ما	0	ما	0	190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	285, 088	0	0	53, 049, 854		190.00
194. 00 07950 COMMUNITY HEALTH SERVICES	0	Ö	0	458, 095		194. 00
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	o	0	1, 354, 673		194. 02
194. 03 07953 MH RESIDENTIAL	0	0	0	1, 546, 302		194. 03
194. 04 07954 UNUSED_SPACE 194. 05 07955 MOB		0	0	4, 823, 469 1, 431, 544		194. 04 194. 05
194. 06 07956 FOUNDATION		ol	0	1, 423, 280		194. 05
194.07 07957 KNOX COUNTY HEALTH DEPT	0	o	0	231, 487	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	28, 147	0	194. 08

Health Financial Systems	GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B		
				From 01/01/2015			
				To 12/31/2015	Date/Time Pre 5/25/2016 9:5		
Cost Center Description	MENTAL HEALTH	PARAMED ED	PARAMED ED	Subtotal	Intern &		
	OVERHEAD	PGRM	PGRM		Residents Cost		
					& Post		
					Stepdown		
					Adjustments		
	17. 01	23. 00	23. 01	24.00	25. 00		
194. 09 07959 NRCC	0	0		0 4, 681, 448	0	194. 09	
200.00 Cross Foot Adjustments		0		0	0	200. 00	
201.00 Negative Cost Centers	0	0		0 -11, 483	0	201. 00	
202.00 TOTAL (sum lines 118-201)	2, 835, 738	245, 763	19, 76	0 207, 789, 999	0	202. 00	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150042

			5/25/2016 9:5	<u>7 am </u>
	Cost Center Description	Total		
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
4. 01	00401 COMMUNI CATI ONS			4. 01
4. 02	00402 PURCHASING & RECEIVING			4. 02
4. 03	00403 REGI STRATI ON			4. 03
4. 04	00404 PATIENT ACCOUNTS			4. 04
5. 00	00500 ADMINISTRATIVE & GENERAL			5. 00
7. 00	00700 OPERATION OF PLANT	1		7. 00
	1			
8. 00	00800 LAUNDRY & LINEN SERVICE			8.00
9.00	00900 HOUSEKEEPI NG			9.00
10.00	01000 DI ETARY			10.00
	01100 CAFETERI A			11.00
	01300 NURSI NG ADMI NI STRATI ON			13.00
	01400 CENTRAL SERVICES & SUPPLY			14. 00
	01500 PHARMACY			15. 00
	01600 MEDICAL RECORDS & LIBRARY			16. 00
	01700 SOCI AL SERVI CE			17. 00
	01701 MENTAL HEALTH OVERHEAD			17. 01
	02300 PARAMED ED PGRM-(SPECIFY)			23. 00
23. 01	02302 PARAMED ED PGRM-(SPECIFY)			23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDIATRICS	19, 999, 536		30.00
31. 00	03100 INTENSIVE CARE UNIT	8, 965, 597		31. 00
	04000 SUBPROVI DER - I PF	2, 480, 807		40.00
	04100 SUBPROVI DER - I RF	7, 249, 409		41.00
43.00	04300 NURSERY	673, 291		43.00
	ANCI LLARY SERVI CE COST CENTERS	,		1
50. 00	05000 OPERATING ROOM	7, 560, 781		50.00
51. 00	05100 RECOVERY ROOM	0		51.00
	05101 ENDOSCOPY	2, 706, 368		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	827, 562		52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 525, 374		54.00
	05401 RADI OLOGY-DI AGNOSTI C	2, 020, 533		54. 00
	1	1 1		54.01
	O5408 RADI OLOGY-GSH BREAST CENTER	303, 133		1
	06000 LABORATORY	6, 740, 617		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	979, 687		63.00
65. 00	06500 RESPIRATORY THERAPY	3, 513, 344		65. 00
66.00	06600 PHYSI CAL THERAPY	4, 789, 616		66.00
69. 00	06900 ELECTROCARDI OLOGY	6, 023, 924		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0		70.00
	07001 NEURODI AGNOSTI CS	1, 059, 070		70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 058, 390		71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 691, 284		72. 00
	07300 DRUGS CHARGED TO PATIENTS	21, 511, 039		73. 00
	07500 ASC (NON-DISTINCT PART)	4, 676, 757		75. 00
76. 00	03020 MH ANCI LLARY OUTPATI ENT	0		76. 00
76. 01	03950 INPATIENT DIALYSIS	911, 313		76. 01
	OUTPATIENT SERVICE COST CENTERS			
90. 00	09000 CLI NI C	2, 095, 560		90.00
91. 00	09100 EMERGENCY	8, 302, 812		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	<u> </u>		92. 00
	OTHER REIMBURSABLE COST CENTERS]
	09600 DURABLE MEDICAL EQUIP-RENTED	187, 846		96. 00
	10100 HOME HEALTH AGENCY	0		101.00
	SPECIAL PURPOSE COST CENTERS			1
113.00	11300 I NTEREST EXPENSE			113. 00
	11600 HOSPI CE	1, 919, 533		116. 00
118. 00		138, 773, 183		118. 00
	NONREI MBURSABLE COST CENTERS	100, 770, 100		1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	53, 049, 854		190.00
	07950 COMMUNITY HEALTH SERVICES	458, 095		194. 00
	07950 COMMUNITY HEALTH SERVICES	1		194. 00
		1, 354, 673		
	07953 MH RESI DENTI AL	1, 546, 302		194. 03
	07954 UNUSED SPACE	4, 823, 469		194. 04
	07955 MOB	1, 431, 544		194. 05
	07956 FOUNDATION	1, 423, 280		194. 06
	07957 KNOX COUNTY HEALTH DEPT	231, 487		194. 07
	07958 INDUSTRIAL HEALTH	28, 147		194. 08
	07959 NRCC	4, 681, 448		194. 09
200.00	Cross Foot Adjustments	0		200. 00
_00.00,		1 11 400		201. 00
201.00	Negative Cost Centers	-11, 483		1201.00
		207, 789, 999		202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150042

				To	12/31/2015	Date/Time Pre 5/25/2016 9:5	
			CAPI TAL REI	LATED COSTS		372372010 7.3	7 cili
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	cost center bescription	Assigned New	DEDO & TIXI	WVDEE EQUIT	Subtotal	BENEFITS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	105, 865	0	105, 865	105, 865	4. 00
4. 01	00401 COMMUNI CATI ONS	0	0	0	0	271	4. 01
4. 02 4. 03	00402 PURCHASING & RECEIVING 00403 REGISTRATION	0	363, 732 0		363, 732 0	725 879	4. 02 4. 03
4.04	00404 PATIENT ACCOUNTS	0	0	0	0	2, 173	4. 04
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	0	1, 108, 083		1, 108, 083	8, 956	5. 00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	0	3, 384, 050 126, 672		3, 384, 050 126, 672	2, 586 216	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	0	185, 727	0	185, 727	2, 103	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	200 073	_	0 300, 973	341	10. 00 11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	300, 973 250, 867		250, 867	1, 105 1, 740	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	6, 182	0	6, 182	388	14. 00
15. 00 16. 00	O1500 PHARMACY O1600 MEDI CAL RECORDS & LI BRARY	0	148, 875		148, 875 117, 220	2, 963 2, 660	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	117, 339 0	0	117, 339 0	2,000	17. 00
17. 01	01701 MENTAL HEALTH OVERHEAD	0	82, 797	0	82, 797	1, 743	17. 01
23. 00 23. 01	02300 PARAMED ED PGRM-(SPECIFY) 02302 PARAMED ED PGRM-(SPECIFY)	0	0	-	0	208	23. 00 23. 01
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	U	13	23.01
30. 00	03000 ADULTS & PEDIATRICS	0	., 02., , 00		1, 821, 788		30. 00
31. 00 40. 00	03100 NTENSI VE CARE UNI T 04000 SUBPROVI DER - PF	0	643, 152 318, 798		643, 152 318, 798	3, 778 564	31. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0	533, 511		533, 511	2, 953	41. 00
43.00	04300 NURSERY	0	0		0	361	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 0	454, 755	O	454, 755	3, 965	50. 00
51. 00	05100 RECOVERY ROOM	0	0		454, 755	0	51. 00
51. 01	05101 ENDOSCOPY	0	294, 358		294, 358	1, 040	51. 01
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	0 562, 376	0	0 562, 376	478 4, 153	52. 00 54. 00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0	115, 872		115, 872	869	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0	0	0	0	293	54. 08
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0	199, 847	0	199, 847 0	2, 658 0	60. 00 63. 00
65. 00	06500 RESPIRATORY THERAPY	0	133, 672	_	133, 672	2, 086	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	199, 390		199, 390	2, 717	66. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	387, 570 0	1	387, 570	4, 705 0	69. 00 70. 00
70. 01	07001 NEURODI AGNOSTI CS	0	183, 899		183, 899	347	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 581	
75. 00	07500 ASC (NON-DISTINCT PART)	0	ő	Ö	0	1, 043	
76. 00	03020 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76. 00
76. 01	03950 I NPATI ENT DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	206, 438	0	206, 438	0	76. 01
90.00	09000 CLI NI C	0	64, 178	0	64, 178	1, 733	90. 00
91.00	09100 EMERGENCY	0	397, 361	0	397, 361	3, 829	
92.00	09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS				0		92. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	9, 478	0	9, 478	70	96. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	0	116, 930	0	116, 930		116. 00
118.00		0	12, 824, 535	0	12, 824, 535	74, 171	118. 00
190 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	O	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES		3, 271, 810		3, 271, 810	28, 704	
	07950 COMMUNITY HEALTH SERVICES	0	61, 003		61, 003		194. 00
	07952 MARKETING AND PUBLIC RELATIONS 07953 MH RESIDENTIAL	0	21, 048 487, 350		21, 048 487, 350		194. 02 194. 03
	07954 UNUSED SPACE	0	2, 634, 719		2, 634, 719		194. 03
194.05	07955 MOB	0	586, 287	0	586, 287		194. 05
	07956 FOUNDATION 07957 KNOX COUNTY HEALTH DEPT	0	15, 828 113, 346		15, 828 113, 346		194. 06 194. 07
174. 07	107737 KNOX COUNTY HEALTH DEPT	1 0	1 113, 340	ı U	113, 340	0	1174.07

Health Financial Systems GOOD SAMARITAN HOSPITAL				In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2015	Part II	
				To 12/31/2015	Date/Time Pre 5/25/2016 9:5	
		CAPI TAL REL	ATED COSTS		372372010 9.3	7 (3111
		OALLIAE KEE	LATED COSTS			
Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
2222 23 2322 p 3	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Rel ated Costs					
	0	1.00	2.00	2A	4. 00	
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	19	194. 08
194. 09 07959 NRCC	o	789, 838		0 789, 838	1, 846	194. 09
200.00 Cross Foot Adjustments				o		200. 00
201.00 Negative Cost Centers		0	-11, 48	3 -11, 483	0	201. 00
202.00 TOTAL (sum lines 118-201)	0	20, 805, 764	-11, 48	3 20, 794, 281	105, 865	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150042

					12/31/2015	5/25/2016 9:5	
	Cost Center Description	COMMUNI CATI ONS		REGI STRATI ON	PATI ENT	ADMI NI STRATI VE	
		4 01	RECEI VI NG 4. 02	4. 03	ACCOUNTS 4. 04	& GENERAL	
	GENERAL SERVICE COST CENTERS	4. 01	4. 02	4.03	4. 04	5. 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						4. 00
4.01	00401 COMMUNI CATI ONS	271					4. 01
4.02	00402 PURCHASING & RECEIVING	3	364, 460				4. 02
4.03	00403 REGI STRATI ON	3	233				4. 03
4. 04	00404 PATI ENT ACCOUNTS	12	828		3, 013	1	4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	27	2, 649		C	1, 119, 715	5. 00
7.00	00700 OPERATION OF PLANT	0	3, 236		C	60, 762	7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	862		C	3, 234	8.00
10.00	01000 DI ETARY	2	2, 372 13, 247	1		17, 831 4, 579	9. 00 10. 00
11. 00	01100 CAFETERI A	0	13, 247	1	0	10, 106	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	4	249	_	C	15, 704	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	1	1, 057		C	3, 899	14.00
15.00	01500 PHARMACY	5	156, 004	0	C	26, 135	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	10	157	0	C	25, 043	16. 00
17. 00		0	0		C	0	17. 00
17. 01	01701 MENTAL HEALTH OVERHEAD	15	2, 022	1	C	13, 550	17. 01
23. 00	02300 PARAMED ED PGRM-(SPECIFY)	0	3	0	C	1 .,	23. 00
23. 01	02302 PARAMED ED PGRM-(SPECIFY)	0	15	0	C) 106	23. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		17 104	59	176	67, 995	30.00
31. 00	1 1	55	17, 196 3, 199	1	90	1	31.00
40. 00	1 1	1	3, 177	1	30		40.00
41. 00	04100 SUBPROVI DER – I RF	9	1, 142	1	46	1	41. 00
43. 00	04300 NURSERY	0	381	2	7	2, 891	43. 00
	ANCILLARY SERVICE COST CENTERS	'		'			
50.00	05000 OPERATING ROOM	9	16, 578	55	164	34, 769	50. 00
51. 00	05100 RECOVERY ROOM	0	0		C	0	51.00
51. 01	05101 ENDOSCOPY	3	5, 078	1	76		51. 01
52. 00	1	0	700	l .	24		52. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	12	11, 704	1	587	1	54.00
54. 01	05401 RADI OLOGY -NON-CAMPUS	0	1, 455		106		
54. 08 60. 00	05408 RADI OLOGY-GSH BREAST CENTER 06000 LABORATORY	0	142	l .	ა ეტი	1, 631	54. 08
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	30, 027 0	1	293 21	1	60. 00 63. 00
65. 00	06500 RESPIRATORY THERAPY	3	2, 873		76		65.00
66. 00	06600 PHYSI CAL THERAPY	1	886	1	174	1	66.00
69. 00	06900 ELECTROCARDI OLOGY	5	12, 106	1	198		69.00
70.00	1 1	0	0	1	C		70.00
70. 01	07001 NEURODI AGNOSTI CS	3	297	12	35	4, 262	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	18	55	54, 195	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	24, 029	1	71		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	120	359		73. 00
75. 00		8	15, 911	46	139		75. 00
	03020 MH ANCI LLARY OUTPATI ENT	0	0	0	C	1	
76.01	03950 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	66	3	8	4, 112	76. 01
90. 00		0	5, 038	8	25	10, 687	90.00
91.00	I I	6	3, 283	1	228		
92. 00			0, 200	, ,	220	00, 101	92.00
	OTHER REIMBURSABLE COST CENTERS			l I			
96.00		0	1, 014	1	4	948	96. 00
101.00	0 10100 HOME HEALTH AGENCY	0	0	0	C	0	101. 00
	SPECIAL PURPOSE COST CENTERS	,					
	D 11300 INTEREST EXPENSE						113. 00
	D 11600 HOSPI CE	0	269		18		116. 00
118. 00		210	336, 308	1, 115	3, 013	788, 237	118. 00
400.0	NONREI MBURSABLE COST CENTERS						400 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	0	10 710	0	C	264, 099	190.00
	007950 COMMUNITY HEALTH SERVICES	55	18, 719 334				194. 00
	2 07952 MARKETING AND PUBLIC RELATIONS	0	7, 316				194. 00
	3 07953 MH RESIDENTIAL	0	522		Č		194. 03
	4 07954 UNUSED SPACE		0	1	0	15, 885	
	5 07955 MOB		96	- 1	C		194. 05
	6 07956 FOUNDATI ON		1, 163	1	C		194. 06
	7 07957 KNOX COUNTY HEALTH DEPT	2	0	O	C		194. 07
	B 07958 INDUSTRIAL HEALTH	o	2	0	C		194. 08
	9 07959 NRCC	0	0	0	C	22, 195	
200.00							200. 00
201.00	Negative Cost Centers	0	0	0	C	0	201. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150042	Peri od:	Worksheet B	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre	
					5/25/2016 9:5	<u>7 am</u>
Cost Center Description	COMMUNI CATI ONS	PURCHASING &	REGISTRATION	N PATIENT	ADMI NI STRATI VE	
		RECEI VI NG		ACCOUNTS	& GENERAL	
	4. 01	4. 02	4. 03	4. 04	5. 00	
202.00 TOTAL (sum lines 118-201)	271	364, 460	1, 11	3, 013	1, 119, 715	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150042 | Period: From 01/01/2015

	005047101105	I ALINDRY &	LIQUOFI/FFDI NO	51.5745)/	5/25/2016 9:5	7 am
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	7.00	8.00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P						2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01 00401 COMMUNI CATI ONS 4. 02 00402 PURCHASI NG & RECEI VI NG						4. 01 4. 02
4. 03 00403 REGISTRATION	•					4. 02
4. 04 00404 PATI ENT ACCOUNTS						4. 04
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT	3, 450, 634					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	27, 588	158, 572				8.00
9. 00 00900 HOUSEKEEPI NG	40, 449	8, 665	257, 149			9. 00
10. 00 01000 DI ETARY	0	2, 340	7, 863	28, 372		10.00
11. 00 01100 CAFETERI A	65, 548	0	1, 666	0	379, 398	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	54, 636	0	0	0	6, 107	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	1, 346	379	3, 212	O O	3, 974	14. 00 15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	32, 423 25, 555	0	2, 462 1, 434	0	13, 904 19, 062	16. 00
17. 00 01700 SOCIAL SERVICE	25, 555	0	1, 434	0	17,002	17. 00
17. 01 01701 MENTAL HEALTH OVERHEAD	18, 032	2, 639	7, 136	0	26, 689	17. 00
23. 00 02300 PARAMED ED PGRM-(SPECIFY)	0	1	0	o	958	23. 00
23. 01 02302 PARAMED ED PGRM-(SPECIFY)	0	o	0	O	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS	•					
30. 00 03000 ADULTS & PEDIATRICS	396, 763	51, 943	69, 275	12, 739	40, 676	30.00
31.00 03100 INTENSIVE CARE UNIT	140, 071	20, 975	21, 871	5, 264	21, 031	31. 00
40. 00 04000 SUBPROVI DER - I PF	69, 430	1	0	3, 285	9, 384	40. 00
41. 00 04100 SUBPROVI DER - RF	116, 192		13, 093	6, 266	19, 610	41.00
43. 00 04300 NURSERY	0	1, 377	785	818	1, 809	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	99, 040	6, 480	19, 115	ol	8, 959	50. 00
51. 00 05100 RECOVERY ROOM	99, 040	0, 460	19, 113	0	0, 939	51. 00
51. 01 05101 ENDOSCOPY	64, 108	4, 061	3, 989	0	5, 148	51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0 1, 100	1, 360	935	o	2, 328	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	122, 479		12, 598	o	21, 007	54. 00
54. 01 05401 RADI OLOGY-NON-CAMPUS	25, 235		0	0	4, 015	54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0	0	0	0	0	54.08
60. 00 06000 LABORATORY	43, 524	0	3, 985	0	17, 642	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	29, 112	23	2, 919	0	10, 546	65. 00
66. 00 06600 PHYSI CAL THERAPY	43, 425		5, 466	0	11, 554	66.00
69. 00 06900 ELECTROCARDI OLOGY	84, 408	2, 723	7, 638	0	13, 190	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 70. 01 07001 NEURODI AGNOSTI CS	40.051	2 422	4 929	O O	0 2, 218	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40, 051	2, 623	4, 828	0	2, 218	70. 01 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	5, 947	12, 374	o	0	75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0		0	O	0	76.00
76.01 03950 INPATIENT DIALYSIS	44, 960	О	0	o	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	13, 977		1, 716	0	4, 901	90.00
91. 00 09100 EMERGENCY	86, 540	13, 429	12, 068	0	21, 413	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	2, 064	O	0	o	404	04 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 101. 00 10100 HOME HEALTH AGENCY	2,064		0	ol		96. 00 101. 00
SPECIAL PURPOSE COST CENTERS	0	<u> </u>	0	<u> </u>	0	101.00
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 H0SPI CE	25, 466	o	4, 496	o	3, 803	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 712, 422		220, 924	28, 372	290, 424	
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	712, 559		33, 109	0	79, 898	
194.00 07950 COMMUNITY HEALTH SERVICES	13, 286	0	1, 090	0		194. 00
194. 02 07952 MARKETING AND PUBLIC RELATIONS	4, 584	0	468	0		194. 02
194. 03 07953 MH RESI DENTI AL	106, 139	1	0	0		194. 03
194. 04 07954 UNUSED SPACE	573, 809	1	0	0		194. 04 194. 05
194. 05 07955 MOB 194. 06 07956 FOUNDATI ON	127, 686 3, 447	1	0	o o		194. 05 194. 06
194.07 07950 FOUNDATTON 194.07 07957 KNOX COUNTY HEALTH DEPT	24, 685	1	1, 558	0		194. 06
194. 08 07958 NDUSTRIAL HEALTH	24,083	1	1, 558	0		194. 07
194. 09 07959 NRCC	172, 017	l ol	0	0		194. 00
200.00 Cross Foot Adjustments	1,2,317		١	٩		200.00
201.00 Negative Cost Centers	0	o	0	o		201. 00
			<u> </u>			

Health Financial Systems	GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150042		Worksheet B	
				From 01/01/2015	Part II	
				To 12/31/2015	Date/Time Pre	pared:
					5/25/2016 9:5	7 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	G DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7. 00	8. 00	9. 00	10.00	11.00	
202.00 TOTAL (sum lines 118-201)	3, 450, 634	158, 572	257, 14	19 28, 372	379, 398	202. 00

Provi der CCN: 150042

| Period: | Worksheet B | From 01/01/2015 | Part II | To | 12/31/2015 | Date/Time Prepared: | 5/25/2016 9:57 am

					12/31/2013	5/25/2016 9:5	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	SOCIAL SERVICE	
			SUPPLY		LI BRARY		
	OFNEDAL CEDIU OF COCT OFNITEDO	13. 00	14. 00	15. 00	16. 00	17. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 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
4. 01	00401 COMMUNI CATI ONS						4. 01
4. 02	00402 PURCHASING & RECEIVING						4. 02
4.03	00403 REGI STRATI ON						4. 03
4.04	00404 PATIENT ACCOUNTS						4. 04
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 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
13. 00	01300 NURSING ADMINISTRATION	329, 307					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	327, 307	20, 438				14. 00
15. 00	01500 PHARMACY		9, 392	392, 163			15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	o	9	0	191, 269		16. 00
17. 00	01700 SOCIAL SERVICE	o	o	0	0	0	17. 00
17. 01	01701 MENTAL HEALTH OVERHEAD	O	122	40	o	0	17. 01
23. 00	02300 PARAMED ED PGRM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01	02302 PARAMED ED PGRM-(SPECIFY)	0	1	0	0	0	23. 01
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	100 007	4 004	075	07.400		
30.00	03000 ADULTS & PEDIATRICS	103, 827	1, 034	375	87, 632	0	30.00
31. 00 40. 00	03100 INTENSIVE CARE UNIT 04000 SUBPROVI DER - I PF	53, 683 23, 952	192 0	268 0	37, 480	0	31.00
41. 00	04100 SUBPROVIDER - I PF	50, 055	69	193	6, 802 8, 003	0	40. 00 41. 00
43. 00	04300 NURSERY	4, 618	23	11	1, 467	0	43.00
43.00	ANCI LLARY SERVI CE COST CENTERS	4,010	23		1, 407		43.00
50. 00	05000 OPERATING ROOM	22, 868	997	1, 591	6, 669	0	50. 00
51.00	05100 RECOVERY ROOM	0	О	0	0	0	51. 00
51.01	05101 ENDOSCOPY	0	305	63	5, 602	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	5, 942	42	18	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	704	3, 027	0	0	54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0	87	842	0	0	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0	4 005	0	0	0	54. 08
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.		1, 805	83 0	U	0	60. 00 63. 00
65. 00	06500 RESPIRATORY THERAPY		173	91	534	0	65. 00
66. 00	06600 PHYSI CAL THERAPY		53	470	034	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY		728	35	4, 402	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	o	18	1	1, 867	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	o	0	o	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 445	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	346, 931	0	0	73. 00
	07500 ASC (NON-DISTINCT PART)	0	957	2, 402	8, 270	0	75. 00
	03020 MH ANCI LLARY OUTPATI ENT	0	0	0	0		76. 00
76. 01	03950 I NPATI ENT DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	4]	69	U	0	76. 01
90. 00	09000 CLINIC	l ol	303	296	٥	0	90. 00
91. 00	09100 EMERGENCY	54, 656	197	280	22, 541	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	01,000	'''	200	22,011	· ·	92. 00
	OTHER REIMBURSABLE COST CENTERS						
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	61	0	0	0	96. 00
	10100 HOME HEALTH AGENCY	o	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	9, 706	16	1	0		116. 00
118.00		329, 307	18, 746	357, 087	191, 269	0	118. 00
100.00	NONREI MBURSABLE COST CENTERS		ما	0	ام	0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 0	1 125	24 509	0		190. 00 192. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 COMMUNITY HEALTH SERVICES		1, 125 20	34, 598 478	0		192. 00 194. 00
194.00	07952 MARKETING AND PUBLIC RELATIONS		440	0	0		194. 00
	07953 MH RESIDENTIAL		31	0	0		194. 02
	07954 UNUSED SPACE		o	0	Ö		194. 04
	07955 MOB		6	Ö	ol		194. 05
	07956 FOUNDATION	0	70	0	o		194. 06
	07957 KNOX COUNTY HEALTH DEPT	0	o	0	o		194. 07
	07958 I NDUSTRI AL HEALTH	0	o	0	o		194. 08
	07959 NRCC	0	0	0	0		194. 09
200.00	Cross Foot Adjustments						200. 00

Health Fin	ancial Systems	GOOD SAMARITA	GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552-10			
ALLOCATI ON	OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2015	Worksheet B			
						Date/Time Pre 5/25/2016 9:5			
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE			
		ADMI NI STRATI ON	SERVICES &		RECORDS &				
			SUPPLY		LI BRARY				
		13. 00	14. 00	15. 00	16. 00	17. 00			
201.00	Negative Cost Centers	0	0	(0 0	0	201. 00		
202.00	TOTAL (sum lines 118-201)	329, 307	20, 438	392, 163	191, 269	0	202. 00		

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150042

				T ₁	o 12/31/2015	Date/Time Pre 5/25/2016 9:5	
	Cost Center Description	MENTAL HEALTH	PARAMED ED	PARAMED ED	Subtotal	Intern &	, <u> </u>
		OVERHEAD	PGRM	PGRM		Residents Cost	
						& Post Stepdown	
						Adjustments	
		17. 01	23. 00	23. 01	24. 00	25. 00	
	GENERAL SERVICE COST CENTERS			T			4.00
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
4. 00	00400 EMPLOTEE BENEFITTS DEPARTMENT						4. 00
4. 02	00402 PURCHASING & RECEIVING						4. 02
4. 03	00403 REGI STRATI ON						4. 03
4.04	00404 PATIENT ACCOUNTS						4. 04
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE						8. 00 9. 00
10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15. 00
	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCI AL SERVI CE	154 705					17. 00
17. 01 23. 00	01701 MENTAL HEALTH OVERHEAD 02300 PARAMED ED PGRM-(SPECIFY)	154, 785 0	2, 464				17. 01 23. 00
23. 00	02302 PARAMED ED PGRM-(SPECIFY)	0	2, 404	135			23. 00
20.01	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		100			20.01
30.00	03000 ADULTS & PEDIATRICS	54, 717			2, 732, 437	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	0			985, 310	0	31. 00
40.00	04000 SUBPROVI DER - I PF	15, 164			455, 027	0	40. 00
41. 00	04100 SUBPROVI DER – I RF	0			792, 328	0	41.00
43. 00	04300 NURSERY	0			14, 550	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0			676, 014	0	50. 00
51. 00	05100 RECOVERY ROOM	l o			070,014	0	51. 00
51. 01	05101 ENDOSCOPY	0			395, 933	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0			15, 810	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			802, 913	0	54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0			158, 757	0	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0			2, 079	0	54. 08
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	0			334, 209 5, 307	0	60. 00 63. 00
65. 00	06500 RESPIRATORY THERAPY	0			199, 905	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	o			293, 954	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0			546, 971	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	0			240, 461	0	70. 01
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0			54, 268	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0			39, 767 437, 998	0	72. 00 73. 00
	07500 ASC (NON-DISTINCT PART)	69, 343			132, 240	0	75. 00 75. 00
	03020 MH ANCI LLARY OUTPATIENT	0,,510			0	Ö	76. 00
	03950 INPATIENT DIALYSIS	0			255, 660	0	76. 01
	OUTPATIENT SERVICE COST CENTERS			,			
	09000 CLI NI C	0			102, 866	0	90. 00
	09100 EMERGENCY	0			651, 338	0	91.00
92.00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					0	92. 00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	0			14, 136	0	96. 00
	10100 HOME HEALTH AGENCY	l o			0		101. 00
	SPECIAL PURPOSE COST CENTERS	-,					
	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0			170, 354		116. 00
118. 00		139, 224	0	0	10, 510, 592	0	118. 00
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN			I	0	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	15, 561			4, 464, 456		190.00
	07950 COMMUNITY HEALTH SERVICES	0			79, 603		194. 00
	07952 MARKETING AND PUBLIC RELATIONS	0			42, 372		194. 02
	07953 MH RESIDENTIAL	0			605, 450		194. 03
	07954 UNUSED SPACE	0			3, 224, 413		194. 04
	07955 MOB	0			721, 082		194. 05
	07956 FOUNDATION 07957 KNOX COUNTY HEALTH DEPT	0			28, 838 140, 290		194. 06 194. 07
	07957 KNOX COUNTY HEALTH DEPT	0			140, 290 173		194. 07 194. 08
50		, 9		1	. , 9	·	

Health Financial Systems	Financial Systems GOOD SAMARITAN HOSPITAL				In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B			
				From 01/01/2015 To 12/31/2015		narod:		
				10 12/31/2013	5/25/2016 9:5	7 am		
Cost Center Description	MENTAL HEALTH	PARAMED ED	PARAMED ED	Subtotal	Intern &			
	OVERHEAD	PGRM	PGRM		Residents Cost			
					& Post			
					Stepdown			
					Adjustments			
	17. 01	23.00	23. 01	24.00	25. 00			
194. 09 07959 NRCC	0			985, 896	0	194. 09		
200.00 Cross Foot Adjustments		2, 464	13	2, 599	0	200. 00		
201.00 Negative Cost Centers	0	0)	0 -11, 483	0	201. 00		
202.00 TOTAL (sum lines 118-201)	154, 785	2, 464	13	20, 794, 281	0	202. 00		

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150042

				25/2016 9:57 am
	Cost Center Description	Total	, , , , , , , , , , , , , , , , , , , ,	20, 2010 7107 4
		26. 00		
	GENERAL SERVICE COST CENTERS			
1.00	00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT			4. 00
4. 01	00401 COMMUNI CATI ONS			4. 01
4. 02	00402 PURCHASING & RECEIVING			4. 02
4. 03	00403 REGI STRATI ON			4. 03
4.04	00404 PATI ENT ACCOUNTS			4. 04
5.00	00500 ADMI NI STRATI VE & GENERAL			5. 00
7. 00	00700 OPERATION OF PLANT			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE			8. 00
9.00	00900 HOUSEKEEPI NG			9. 00
10. 00	01000 DI ETARY			10.00
11. 00	01100 CAFETERI A			11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON			13.00
	01400 CENTRAL SERVICES & SUPPLY			14.00
	01500 PHARMACY			15. 00
	01600 MEDI CAL RECORDS & LI BRARY			16.00
	01700 SOCIAL SERVICE			17. 00
17. 01	01701 MENTAL HEALTH OVERHEAD			17. 01
23. 00	02300 PARAMED ED PGRM-(SPECIFY)			23. 00
23. 01	02302 PARAMED ED PGRM-(SPECIFY)			23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000 ADULTS & PEDI ATRI CS	2, 732, 437		30.00
31. 00	03100 I NTENSI VE CARE UNI T	985, 310		31.00
40. 00	04000 SUBPROVI DER - I PF	455, 027		40.00
41. 00	04100 SUBPROVI DER - I RF	792, 328		41.00
43. 00	04300 NURSERY	14, 550		43.00
	ANCI LLARY SERVI CE COST CENTERS			
50. 00	O5000 OPERATI NG ROOM	676, 014		50. 00
51. 00	05100 RECOVERY ROOM	0		51.00
51. 01	05101 ENDOSCOPY	395, 933		51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	15, 810		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	802, 913		54. 00
54. 01	05401 RADI OLOGY-NON-CAMPUS	158, 757		54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	2, 079		54. 08
60.00	06000 LABORATORY	334, 209		60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	5, 307		63. 00
65. 00	06500 RESPI RATORY THERAPY	199, 905		65. 00
66. 00	06600 PHYSI CAL THERAPY	293, 954		66. 00
69. 00	06900 ELECTROCARDI OLOGY	546, 971		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		70. 00
	07001 NEURODI AGNOSTI CS	240, 461		70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	54, 268		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	39, 767		72.00
	07300 DRUGS CHARGED TO PATIENTS	437, 998		73.00
75. 00	07500 ASC (NON-DISTINCT PART)	132, 240		75. 00
76. 00	03020 MH ANCILLARY OUTPATIENT	0		76. 00
76. 01	03950 INPATIENT DIALYSIS	255, 660		76. 01
	OUTPATIENT SERVICE COST CENTERS			
90. 00	09000 CLI NI C	102, 866		90.00
91. 00	09100 EMERGENCY	651, 338		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART			92. 00
	OTHER REIMBURSABLE COST CENTERS			
	09600 DURABLE MEDI CAL EQUI P-RENTED	14, 136		96. 00
101.00	10100 HOME HEALTH AGENCY	0		101. 00
	SPECIAL PURPOSE COST CENTERS			
	11300 INTEREST EXPENSE			113. 00
	11600 H0SPI CE	170, 354		116. 00
118.00		10, 510, 592		118. 00
	NONREI MBURSABLE COST CENTERS			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	4, 464, 456		192. 00
	07950 COMMUNITY HEALTH SERVICES	79, 603		194. 00
	07952 MARKETING AND PUBLIC RELATIONS	42, 372		194. 02
	07953 MH RESIDENTIAL	605, 450		194. 03
194. 04	07954 UNUSED SPACE	3, 224, 413		194. 04
194.05	07955 MOB	721, 082		194. 05
	07956 FOUNDATI ON	28, 838		194. 06
194. 07	07957 KNOX COUNTY HEALTH DEPT	140, 290		194. 07
194.08	07958 I NDUSTRI AL HEALTH	173		194. 08
	07959 NRCC	985, 896		194. 09
200.00		2, 599		200. 00
201.00	1 1	-11, 483		201.00
202.00		20, 794, 281		202. 00

	Financial Systems	GOOD SAMARITA				u of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2015	Worksheet B-1	
					o 12/31/2015	Date/Time Pre	pared:
						5/25/2016 9:5	<u>7 am</u>
		CAPITAL REI	LATED COSTS				
	Coot Conton Decemintion	DIDC 0 FLVT	MANDLE FOLLID	EMDLOVEE	COMMUNICATIONS	DIDCHACING 0	
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	COMMUNI CATI ONS	PURCHASI NG & RECEI VI NG	
		(SQUARE TELT)	(SQUARE TELT)	DEPARTMENT	(NUMBER OF	(SUPPLIES C	
				(GROSS	PHONES)	0ST)	
				SALARI ES)	11.0.120)	33.7	
		1.00	2.00	4.00	4. 01	4. 02	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	864, 933					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		846, 308	1			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 401					4. 00
4. 01	00401 COMMUNI CATI ONS	0	0	217,010		00 /55 500	4. 01
4. 02 4. 03	OO4O2 PURCHASI NG & RECEI VI NG OO4O3 REGI STRATI ON	15, 121	15, 121	1		32, 655, 530 20, 896	1
4. 03	00404 PATIENT ACCOUNTS	0		806, 174 1, 993, 539		74, 179	1
5. 00	00500 ADMI NI STRATI VE & GENERAL	46, 065	45, 660			237, 324	1
7. 00	00700 OPERATION OF PLANT	140, 681				289, 981	1
8.00	00800 LAUNDRY & LINEN SERVICE	5, 266				77, 238	1
9.00	00900 HOUSEKEEPI NG	7, 721		1		212, 494	1
10.00	01000 DI ETARY	0	0	313, 190	18	1, 186, 913	10.00
11. 00	01100 CAFETERI A	12, 512	12, 512	1, 013, 386	1	0	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	10, 429		1		22, 274	1
14. 00	01400 CENTRAL SERVICES & SUPPLY	257	l .	l .		94, 688	1
15. 00	01500 PHARMACY	6, 189				13, 978, 618	1
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 878	977	1	1	14, 081	
17. 00	01700 SOCIAL SERVICE	2 442	2 443	1 500 244	-	101 100	
17. 01 23. 00	01701 MENTAL HEALTH OVERHEAD 02300 PARAMED ED PGRM-(SPECIFY)	3, 442		1, 599, 246 190, 647		181, 190 236	•
23. 00	02302 PARAMED ED PGRM-(SPECIFY)		_	1	1		•
23.01	INPATIENT ROUTINE SERVICE COST CENTERS			12,001	<u> </u>	1, 377	23.01
30. 00	03000 ADULTS & PEDI ATRI CS	75, 735	75, 613	5, 676, 255	463	1, 540, 717	30.00
31. 00	03100 I NTENSI VE CARE UNI T	26, 737				286, 621	•
40.00	04000 SUBPROVI DER - I PF	13, 253				0	1
41.00	04100 SUBPROVI DER - I RF	22, 179	22, 179	2, 709, 373	76	102, 316	41.00
43.00	04300 NURSERY	0	0	331, 566	0	34, 116	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	18, 905		1	1	1, 485, 324	1
51.00	05100 RECOVERY ROOM	12 227	_	054 202		0	
51. 01 52. 00	O5101 ENDOSCOPY O5200 DELIVERY ROOM & LABOR ROOM	12, 237	12, 237			455, 011 62, 720	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	23, 379	1			1, 048, 624	1
54. 01	05401 RADI OLOGY-NON-CAMPUS	4, 817				130, 330	1
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0	,, ,,,			12, 689	1
60.00	06000 LABORATORY	8, 308	8, 308	1		2, 690, 306	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	5, 557	5, 679	1, 913, 972	28	257, 450	65. 00
66.00	06600 PHYSI CAL THERAPY	8, 289		1			66. 00
	06900 ELECTROCARDI OLOGY	16, 112	16, 112	4, 316, 569	1	1, 084, 661	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	010.000	0	0	
70. 01	07001 NEURODI AGNOSTI CS	7, 645	7, 645	318, 220		26, 585	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS	0	0		0	2, 152, 971	71. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		533, 214		2, 132, 9/1 0	73.00
75. 00	07500 ASC (NON-DISTINCT PART)			957, 020		1, 425, 568	•
76. 00	03020 MH ANCI LLARY OUTPATIENT	0	_	707,020		0 1, 120, 000	76. 00
76. 01	03950 INPATIENT DIALYSIS	8, 582	8, 582		1	5, 888	1
	OUTPATIENT SERVICE COST CENTERS			•	'		1
90.00	09000 CLI NI C	2, 668	2, 668	1, 589, 990	0	451, 380	90.00
91.00	09100 EMERGENCY	16, 519	16, 519	3, 512, 751	48	294, 123	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	1	1	1			
	09600 DURABLE MEDI CAL EQUI P-RENTED	394					96.00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	<u> </u>	0	0	101. 00
113 00	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	4, 861	4, 861	634, 217	3	24 077	116. 00
118.00		533, 139					
	NONREI MBURSABLE COST CENTERS		y==7=		.,	227	1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	136, 015			459	1, 677, 208	192. 00
	07950 COMMUNITY HEALTH SERVICES	2, 536					194. 00
	07952 MARKETING AND PUBLIC RELATIONS	875	l .			655, 514	
	07953 MH RESIDENTIAL	20, 260		l .	1		194. 03
	07954 UNUSED SPACE	109, 530			T .		194. 04
	07955 MOB 07956 FOUNDATION	24, 373 658					194. 05
174.00	PIOT 330 I CONDATTON	1 008	008	117, 171	١	104, 221	1174. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2015		
				Γο 12/31/2015	Date/Time Pre 5/25/2016 9:5	
	CAPITAL REL	ATED COSTS			372372010 9.3	/ alli
	CAFITAL KLL	LATED COSTS				
Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS	PURCHASING &	
cost center bescription	(SQUARE FEET)		BENEFITS	COMMUNICATIONS	RECEI VI NG	
	(SQUARE TEET)	(SQUARE TEET)	DEPARTMENT	(NUMBER OF	(SUPPLIES C	
			(GROSS	PHONES)	0ST)	
			SALARI ES)	THORES	031)	
	1.00	2.00	4.00	4. 01	4. 02	
194. 07 07957 KNOX COUNTY HEALTH DEPT	4, 712	4, 712		18		194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	17, 77	1 0		194. 08
194. 09 07959 NRCC	32, 835	32. 835	· ·		1	194. 09
200.00 Cross Foot Adjustments	02,000	02,000	., 0,0,02			200.00
201.00 Negative Cost Centers					1	201. 00
202.00 Cost to be allocated (per Wkst. B,	20, 805, 764	-11, 483	23, 988, 82!	327, 376	1	
Part I)	20,000,701	11, 100	20, 700, 02	327, 373	7,70, 721	202.00
	04 05 4770	0 000000	0 04/00	444 004540	0 000500	000

24. 054770

0. 000000

0. 246906

105, 865

0.001090

144. 091549

0. 119278

271

0. 030590 203. 00 364, 460 204. 00

0. 011161 205. 00

Unit cost multiplier (Wkst. B, Part I)
Cost to be allocated (per Wkst. B,
Part II)
Unit cost multiplier (Wkst. B, Part
II)

203.00

204.00

205.00

	FINANCIAI SYSTEMS	GOOD SAMARITA		0011 450040 0		u or form CMS	
COST	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Worksheet B-1 Date/Time Pre 5/25/2016 9:5	pared:
	Cost Center Description	REGISTRATION (GROSS CHAR GES)	PATIENT ACCOUNTS (GROSS CHAR	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		4. 03	GES) 4. 04	5A	5. 00	7. 00	
	GENERAL SERVICE COST CENTERS	4.03	4.04	J JA	3.00	7.00	
1.00 2.00 4.00 4.01 4.02 4.03 4.04	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS 00402 PURCHASING & RECEIVING 00403 REGISTRATION 00404 PATIENT ACCOUNTS	482, 952, 627 0	482, 952, 627				1. 00 2. 00 4. 00 4. 01 4. 02 4. 03 4. 04
5. 00 7. 00 8. 00	OO5OO ADMINISTRATIVE & GENERAL OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	0 0	C C C) -22, 092, 885) 0) 0	10, 078, 324		
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	C	0 0	2, 957, 505 759, 503	7, 721 0	9. 00 10. 00
11. 00 13. 00 14. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 0	C C	0 0	2, 604, 731	10, 429	13. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	C	0 0		6, 189 4, 878	15. 00 16. 00
17. 00 17. 01 23. 00	01700 SOCI AL SERVI CE 01701 MENTAL HEALTH OVERHEAD 02300 PARAMED ED PGRM-(SPECI FY)	0 0	C C			0 3, 442 0	17. 01
23. 01	02302 PARAMED ED PGRM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0 00 040 070	00.040.070	,			
30. 00 31. 00 40. 00	03000 ADULTS & PEDI ATRI CS 03100 INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	29, 342, 072 15, 047, 597 5, 062, 954	29, 342, 072 15, 047, 597 5, 062, 954	7 0	5, 676, 100	26, 737	31. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	7, 667, 454 1, 114, 602	7, 667, 454 1, 114, 602				1
50. 00 51. 00	O5000 OPERATING ROOM O5100 RECOVERY ROOM	27, 275, 695 0	27, 275, 695 C	1		18, 905 0	1
51. 01 52. 00 54. 00	O5101 ENDOSCOPY O5200 DELI VERY ROOM & LABOR ROOM O5400 RADI OLOGY-DI AGNOSTI C	12, 697, 442 3, 993, 278 78, 647, 688	12, 697, 442 3, 993, 278 78, 647, 688	0	659, 275	0	52. 00
54. 00 54. 01 54. 08	05401 RADI OLOGY-NON-CAMPUS 05408 RADI OLOGY-GSH BREAST CENTER	17, 672, 034 443, 767	17, 672, 034 443, 767	• O	1, 698, 562	4, 817	54. 01
60. 00 63. 00 65. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	48, 779, 038 3, 582, 356 12, 668, 806	48, 779, 038 3, 582, 356 12, 668, 806	0	875, 530	8, 308 0 5, 557	63. 00
66. 00 69. 00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	29, 030, 640 33, 053, 093	29, 030, 640 33, 053, 093	0 0	4, 000, 355 4, 842, 712	8, 289 16, 112	66. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0 5, 789, 411 9, 084, 814	5, 789, 411 9, 084, 814		706, 863	0 7, 645 0	70. 01
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	11, 775, 860 59, 815, 030	11, 775, 860 59, 815, 030	0 0	2, 354, 889 14, 929, 092	0 0	72. 00 73. 00
76. 00 76. 01	07500 ASC (NON-DISTINCT PART) 03020 MH ANCILLARY OUTPATIENT 03950 INPATIENT DIALYSIS	23, 152, 477 0 1, 303, 786	23, 152, 477 C 1, 303, 786	0	0	0 0 8, 582	76. 00
90.00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	4, 230, 665	4, 230, 665		1, 772, 585	2, 668	90.00
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	38, 066, 649	38, 066, 649	0	5, 876, 840	16, 519	91. 00 92. 00
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	632, 423 0	632, 423 0	1			96. 00 101. 00
	11300 I NTEREST EXPENSE 11600 HOSPI CE	3, 022, 996 482, 952, 627	3, 022, 996 482, 952, 627				113. 00 116. 00 118. 00
192. 00 194. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 007950 COMMUNITY HEALTH SERVICES	0 0	0	0 0	43, 791, 933 345, 105	136, 015 2, 536	194. 00
194. 03 194. 04	07952 MARKETING AND PUBLIC RELATIONS 07953 MH RESIDENTIAL 07954 UNUSED SPACE	0 0	C C		.,	20, 260	194. 02 194. 03 194. 04
194. 05 194. 06	07955 MOB 07956 FOUNDATION 07957 KNOX COUNTY HEALTH DEPT	0	0		899, 462 1, 256, 336 115, 940	658	194. 05 194. 06 194. 07
194.08	O7957 KNOX COUNTY HEALTH DEPT O7958 INDUSTRI AL HEALTH O7959 NRCC	0	0	0	25, 151	0	194. 07 194. 08 194. 09

Heal th Fi	nancial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/25/2016 9:5	
	Cost Center Description	REGI STRATI ON	PATI ENT	Reconciliatio	n ADMI NI STRATI VE	OPERATION OF	
		(GROSS CHAR	ACCOUNTS		& GENERAL	PLANT	
		GES)	(GROSS CHAR		(ACCUM. COST)	(SQUARE FEET)	
			GES)				
		4. 03	4. 04	5A	5. 00	7. 00	
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	1, 117, 260	4, 463, 133		22, 092, 885	11, 277, 292	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 002313	0. 009241		0. 118965	17. 121438	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	1, 115	3, 013		1, 119, 715	3, 450, 634	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000002	0. 000006		0. 006029	5. 238830	205. 00

In Lieu of Form CMS-2552-10 Health Financial Systems GOOD SAMARITAN HOSPITAL Provi der CCN: 150042 COST ALLOCATION - STATISTICAL BASIS Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/25/2016 9:57 am Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG LINEN SERVICE (PATIENT DA ADMI NI STRATI ON (TIME SPENT) (MAN HOURS) (LBS OF LAU YS) (DIRECT NUR NDRY) SING) 9.00 8.00 10.00 11.00 13.00 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 00401 COMMUNI CATI ONS 4.01 4.01 00402 PURCHASING & RECEIVING 4.02 4.02 00403 REGI STRATI ON 4.03 4.03 4.04 00404 PATIENT ACCOUNTS 4.04 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7 00 00800 LAUNDRY & LINEN SERVICE 8.00 1, 164, 512 8.00 9.00 00900 HOUSEKEEPI NG 63, 633 66, 523 9.00 10.00 01000 DI ETARY 17, 185 2,034 36, 443 10.00 01100 CAFETERI A 2. 477. 223 11 00 11 00 0 431 0 01300 NURSING ADMINISTRATION 13.00 0 0 39, 876 842, 361 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 2,786 831 0 25, 947 0 14.00 01500 PHARMACY 90. 786 15 00 637 0 15 00 0 0 16.00 01600 MEDICAL RECORDS & LIBRARY 0 371 0 124, 459 0 16.00 01700 SOCIAL SERVICE 0 0 17.00 17.00 0 0 17.01 01701 MENTAL HEALTH OVERHEAD 19, 382 1,846 174, 261 17.01 0 02300 PARAMED ED PGRM-(SPECIFY) 0 23 00 23 00 0 C 6, 256 0 02302 PARAMED ED PGRM-(SPECIFY) 23.01 C 0 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 381, 441 17, 921 16, 362 265, 587 265, 587 30.00 03100 INTENSIVE CARE UNIT 6,762 137, 319 137, 319 31 00 31.00 154,036 5, 658 40.00 04000 SUBPROVI DER - I PF 4, 219 61, 269 61, 269 40.00 04100 SUBPROVIDER - IRF 79, 228 41.00 3, 387 8.049 128.039 128, 039 41.00 04300 NURSERY <u>10</u>, 112 1, 051 43.00 203 11.813 11, 813 43.00 ANCILLARY SERVICE COST CENTERS 4, 945 50.00 05000 OPERATING ROOM 47, 584 58, 496 58, 496 50.00 C 05100 RECOVERY ROOM 51.00 0 0 51.00 51.01 05101 ENDOSCOPY 29, 821 1, 032 0 33.615 51.01 0 0 05200 DELIVERY ROOM & LABOR ROOM 52 00 9, 991 242 15, 200 15, 200 52 00 05400 RADI OLOGY-DI AGNOSTI C 137, 163 54.00 54.00 95, 141 3, 259 05401 RADI OLOGY-NON-CAMPUS 0 54.01 0 26, 217 0 54.01 05408 RADI OLOGY-GSH BREAST CENTER 0 54.08 54.08 0 0 60.00 06000 LABORATORY 0 1,031 115, 190 0 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06500 RESPIRATORY THERAPY 172 755 0 68, 859 65.00 65.00 0 06600 PHYSI CAL THERAPY 75. 440 66.00 41 437 1, 414 Λ 66,00 1, 976 69.00 06900 ELECTROCARDI OLOGY 19, 997 86, 122 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07001 NEURODI AGNOSTI CS 19, 266 0 70.01 1, 249 14, 482 0 70.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 C 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 43,670 3, 201 0 75.00 76.00 03020 MH ANCILLARY OUTPATIENT 0 0 76.00 03950 INPATIENT DIALYSIS 76.01 0 0 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 28 444 0 31.997 Λ 90.00 91.00 09100 EMERGENCY 98, 618 3, 122 0 139, 810 139, 810 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 3, 238 Ol 96.00

101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113 00 24, 828 116. 00 116. 00 11600 HOSPI CE 1, 163 24, 828 SUBTOTALS (SUM OF LINES 1-117) 1, 133, 528 1, 896, 269 842, 361 118. 00 118.00 57, 152 36, 443 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 30, 984 8, 565 0 521, 695 0 192.00 194. 00 07950 COMMUNITY HEALTH SERVICES 0 0 194.00 0 282 7, 466 194. 02 07952 MARKETING AND PUBLIC RELATIONS 0 0 8.336 0 194. 02 121 194.03 07953 MH RESIDENTIAL 0 C 0 30, 502 0 194, 03 194.04 07954 UNUSED SPACE 0 0 0 194. 04 0 194. 05 07955 MOB 0 0 8, 856 0 194. 05 194. 06 07956 FOUNDATION 0 0 194, 06 C 4,099 194.07 07957 KNOX COUNTY HEALTH DEPT 403 0 194. 07 194. 08 07958 I NDUSTRI AL HEALTH 0 0 194. 08

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 150042	Peri od: Worksheet B-1

0031 AL	ECONTION STATISTIONE BASIS		Trovider		From 01/01/2015	WOLKSHEEL D. I	
					To 12/31/2015		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(TIME SPENT)	(PATIENT DA	(MAN HOURS)	ADMI NI STRATI ON	
		(LBS OF LAU		YS)			
		NDRY)				(DI RECT NUR	
						SI NG)	
		8. 00	9. 00	10.00	11.00	13.00	
194. 09	07959 NRCC	0	0)	0	0	194. 09
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	690, 459	3, 479, 269	966, 42	8 2, 112, 397	3, 127, 165	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 592917	52. 301745	26. 51889	3 0. 852728	3. 712381	203. 00
204.00	Cost to be allocated (per Wkst. B,	158, 572	257, 149	28, 37	2 379, 398	329, 307	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 136170	3. 865565	0. 77853	1 0. 153155	0. 390933	205. 00
	11)						
	·	,		•	,	•	-

	Financial Systems	GUUD SAMARITA		001 450040 0		U OT FORM CMS-	
COST A	ILLOCATION - STATISTICAL BASIS		Provi der	F	eriod: from 01/01/2015 fo 12/31/2015	Worksheet B-1 Date/Time Pre 5/25/2016 9:5	pared:
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (SUPPLI ES C OST)	PHARMACY (COSTED REC QUIS)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)		7 dili
		14.00	15. 00	16. 00	17. 00	17. 01	
4 00	GENERAL SERVI CE COST CENTERS	T			1		1 00
1. 00 2. 00 4. 00 4. 00 4. 01 4. 02 4. 03 4. 04 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 17. 01 23. 00 23. 01	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATIONS 00402 PURCHASING & RECEIVING 00403 REGISTRATION 00404 PATIENT ACCOUNTS 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 MENTAL HEALTH OVERHEAD 02300 PARAMED ED PGRM-(SPECIFY) 01001 CENTER DEVILEE SERVICE COST CENTERS	30, 439, 543 13, 978, 618 14, 081 0 181, 190 236 1, 377	15, 580, 018 0 0 1, 595 0 0	1, 434 0 0 0 0	0 0	51, 680, 566 0 0	23. 00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1, 540, 717	14, 884	457	O	10 240 427	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	286, 621	14, 884 10, 666	657 281		18, 269, 427 0	30.00
40. 00	04000 SUBPROVI DER - I PF	200, 021	10, 000	51		5, 062, 954	
41.00	04100 SUBPROVI DER - I RF	102, 316	7, 655	60		0	1
43.00	04300 NURSERY	34, 116	420	11	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
70. 01 71. 00 72. 00 73. 00 75. 00 76. 00	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05101 ENDOSCOPY 05200 DELI VERY ROOM & LABOR ROOM 05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-NON-CAMPUS 05408 RADI OLOGY-GSH BREAST CENTER 06000 LABORATORY 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07500 ASC (NON-DI STINCT PART) 03020 MH ANCI LLARY OUTPATI ENT	1, 485, 324 0 455, 011 62, 720 1, 048, 624 130, 330 12, 689 2, 690, 306 0 257, 450 79, 340 1, 084, 661 0 26, 585 0 2, 152, 971 0 1, 425, 568 0 5, 888	63, 219 0 2, 493 707 120, 243 33, 459 0 3, 281 0 3, 627 18, 675 1, 375 0 26 0 0 13, 783, 091 95, 427 0 2, 759	33 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 51. 01 52. 00 54. 00 54. 01 54. 08 60. 00 63. 00 66. 00 69. 00 70. 01 71. 00 72. 00 73. 00 75. 00 76. 00
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	451, 380	11, 766			0	
91.00	09100 EMERGENCY	294, 123	11, 118	169	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	90, 891	0	0	0	0	96. 00
101.00	10100 HOME HEALTH AGENCY	0	0			0	101.00
	SPECIAL PURPOSE COST CENTERS	,					
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	24, 077	22	0	0		116. 00
118.00		27, 917, 210	14, 186, 508	1, 434	0	46, 484, 858	118. 00
100.00	NONREI MBURSABLE COST CENTERS	O	0			0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 677, 208	1, 374, 526	0		5, 195, 708	
	07950 COMMUNITY HEALTH SERVICES	29, 886	18, 984		1		194. 00
	07952 MARKETING AND PUBLIC RELATIONS	655, 514	10, 704		1		194. 02
194. 03	07953 MH RESIDENTIAL	46, 750	0	0	ol		194. 03
194. 04	07954 UNUSED SPACE	0	0	0	ol	0	194. 04
194. 05	07955 MOB	8, 603	0	0	ıl ol		194. 05
	07956 FOUNDATI ON	104, 221	0	0	0		194. 06
	07957 KNOX COUNTY HEALTH DEPT	0	0	0	1		194. 07
194.08	07958 I NDUSTRI AL HEALTH	151	0	0	0	0	194. 08

Heal th Fi	nancial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLO	CATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					From 01/01/2015 To 12/31/2015		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(COSTED REC	RECORDS &		OVERHEAD	
		SUPPLY	QUIS)	LI BRARY	(TIME SPENT)	(CHARGES)	
		(SUPPLI ES C		(TIME SPENT)			
		OST)					
		14.00	15.00	16.00	17. 00	17. 01	
194. 09 07	959 NRCC	0	0		0 0	0	194. 09
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	795, 231	5, 432, 465	4, 857, 25	9 0	2, 835, 738	202. 00
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 026125	0. 348682	3, 387. 20990.	0. 000000	0. 054870	203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	20, 438	392, 163	191, 26	9 0	154, 785	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000671	0. 025171	133. 38145	0. 000000	0. 002995	205. 00

GOOD SAMARITAN HOSPITAL

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provi der CCN: 150042

				5/25/2016 9:5	
	Cost Center Description	PARAMED ED	PARAMED ED		
		PGRM	PGRM		
		(ASSIGNED TIME)	(ASSIGNED TIME)		
		23. 00	23. 01		
	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
4. 01	00401 COMMUNI CATI ONS				4. 01
4. 02 4. 03	OO4O2 PURCHASI NG & RECEI VI NG OO4O3 REGI STRATI ON				4. 02 4. 03
4. 04	00404 PATIENT ACCOUNTS				4. 04
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
10. 00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14.00	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY				14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00	01700 SOCIAL SERVICE				17. 00
17. 01	01701 MENTAL HEALTH OVERHEAD				17. 01
23. 00	02300 PARAMED ED PGRM-(SPECIFY)	100			23. 00
23. 01	02302 PARAMED ED PGRM-(SPECIFY)		100		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	0	0		30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0		31. 00
40. 00	04000 SUBPROVI DER - I PF	0	0		40.00
41. 00	04100 SUBPROVI DER - I RF	0	0		41.00
43. 00	04300 NURSERY	0	0		43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	0		50.00
51. 00	05100 RECOVERY ROOM	0	0		51.00
51. 01	05101 ENDOSCOPY	l o	o		51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	O		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	100	O		54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0	0		54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0	0		54. 08
60.00	06000 LABORATORY	0	100		60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		65. 00
66. 00 69. 00	O6600 PHYSI CAL THERAPY O6900 ELECTROCARDI OLOGY	0	0		66. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
70. 01	07001 NEURODI AGNOSTI CS	o o	o		70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	O		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		73. 00
	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 00	03020 MH ANCILLARY OUTPATIENT	0	0		76. 00
76. 01	03950 I NPATI ENT DI ALYSI S	0	0		76. 01
00 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	O	0		90.00
	09100 EMERGENCY	0	0		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		O ₁		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		96. 00
101.00	10100 HOME HEALTH AGENCY	0	O		101. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 I NTEREST EXPENSE				113. 00
	11600 H0SPI CE	0	0		116. 00
118.00		100	100		118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		190. 00
	19000 GIFT, PLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
	07950 COMMUNITY HEALTH SERVICES		0		194. 00
	07952 MARKETING AND PUBLIC RELATIONS		n		194. 02
	07953 MH RESIDENTIAL	l ől	o		194. 03
	07954 UNUSED SPACE	ol	ol		194. 04
194.05	07955 MOB	o	o		194. 05
	07956 FOUNDATI ON	0	o		194. 06
	07957 KNOX COUNTY HEALTH DEPT	0	0		194. 07
	07958 I NDUSTRI AL HEALTH	0	0		194. 08
194. 09	07959 NRCC	0	0		194. 09

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 150042	Peri od: Worksheet B-1 From 01/01/2015
		To 12/31/2015 Date/Time Prepared:

				5/25/2016 9: 5	7 am
	Cost Center Description	PARAMED ED	PARAMED ED		
		PGRM	PGRM		
		(ASSI GNED	(ASSI GNED		
		TIME)	TIME)		
		23. 00	23. 01		
200.00	Cross Foot Adjustments				200. 00
201.00	Negative Cost Centers				201. 00
202.00	Cost to be allocated (per Wkst. B,	245, 763	19, 760		202. 00
	Part I)				
203.00	Unit cost multiplier (Wkst. B, Part I)	2, 457. 630000	197. 600000		203. 00
204.00	Cost to be allocated (per Wkst. B,	2, 464	135		204. 00
	Part II)				
205. 00	Unit cost multiplier (Wkst. B, Part	24. 640000	1. 350000		205. 00
	11)				
	•			· · · · · · · · · · · · · · · · · · ·	

						5/25/2016 9:5	7 am
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
20.00	03000 ADULTS & PEDIATRICS	19, 999, 536		19, 999, 536	ol	10,000 534	20.00
30.00						19, 999, 536	
31.00	03100 NTENSI VE CARE UNI T	8, 965, 597		8, 965, 597		8, 965, 597	
40. 00	04000 SUBPROVI DER - I PF	2, 480, 807		2, 480, 807		2, 480, 807	40. 00
41. 00	04100 SUBPROVI DER - I RF	7, 249, 409		7, 249, 409		7, 249, 409	41. 00
43.00	04300 NURSERY	673, 291		673, 291	0	673, 291	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 560, 781		7, 560, 781	0	7, 560, 781	50.00
51.00	05100 RECOVERY ROOM	0		l c	o	0	51.00
51. 01	05101 ENDOSCOPY	2, 706, 368		2, 706, 368	0	2, 706, 368	51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	827, 562	l e	827, 562		827, 562	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 525, 374		10, 525, 374		10, 525, 374	ł
54. 01	05401 RADI OLOGY-NON-CAMPUS	2, 020, 533		2, 020, 533		2, 020, 533	
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	303, 133		303, 133		303, 733	
60.00	06000 LABORATORY	6, 740, 617		6, 740, 617		6, 740, 617	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	979, 687		979, 687		979, 687	1
65.00	06500 RESPI RATORY THERAPY	3, 513, 344	l .			3, 513, 344	
66.00	06600 PHYSI CAL THERAPY	4, 789, 616	0	4, 789, 616	0	4, 789, 616	66. 00
69.00	06900 ELECTROCARDI OLOGY	6, 023, 924		6, 023, 924	7, 348	6, 031, 272	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		C	0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	1, 059, 070		1, 059, 070	13, 354	1, 072, 424	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 058, 390		10, 058, 390		10, 058, 390	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	2, 691, 284		2, 691, 284		2, 691, 284	
73. 00	07300 DRUGS CHARGED TO PATIENTS	21, 511, 039		21, 511, 039		21, 511, 039	
75. 00	07500 ASC (NON-DISTINCT PART)	4, 676, 757		4, 676, 757	I	4, 677, 695	1
76. 00	03020 MH ANCILLARY OUTPATIENT	4,070,737		4, 070, 737		4, 077, 075	76.00
		_	l		- 1	-	
76. 01	03950 I NPATI ENT DI ALYSI S	911, 313		911, 313	14, 186	925, 499	76. 01
	OUTPATIENT SERVICE COST CENTERS		l				
90.00	09000 CLI NI C	2, 095, 560		2, 095, 560		2, 112, 118	
91. 00	09100 EMERGENCY	8, 302, 812	l e	8, 302, 812	•	8, 339, 137	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 053, 303		2, 053, 303		2, 053, 303	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	187, 846		187, 846	0	187, 846	96. 00
101.00	10100 HOME HEALTH AGENCY	0		l c		0	101.00
	SPECIAL PURPOSE COST CENTERS		•	•	'		İ
113 00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	1, 919, 533		1, 919, 533		1, 919, 533	
200.00		140, 826, 486	l e		I	140, 915, 795	ł
200.00	,	2, 053, 303	l e	2, 053, 303		2, 053, 303	
201.00		138, 773, 183					
202.00	Total (see mistructions)	138, 773, 183	l 0	138,773,183	89, 309	138, 862, 492	J2U2. UU

Hospi tal Title XVIII

			litl	e XVIII	Hospital	PPS	
			Charges				
	Cost Center Description	Inpati ent	Outpati ent	Total (col 6	Cost or Other	TEFRA	
	oost center bescription	i inpati cirt	outputient	+ col . 7)	Ratio	Inpatient	
				+ (01. 7)	Ratio		
			7.00	0.00	0.00	Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	18, 269, 427		18, 269, 427			30.00
31.00	03100 INTENSIVE CARE UNIT	15, 047, 597		15, 047, 597			31. 00
40.00	04000 SUBPROVI DER - I PF	5, 062, 954		5, 062, 954			40. 00
41. 00	04100 SUBPROVI DER - I RF	7, 667, 454		7, 667, 454			41. 00
43. 00	04300 NURSERY	1, 114, 602		1, 114, 602			43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS	1, 114, 002		1, 114, 002			43.00
F0 00		40.054.007	47 004 000	07.075.405	0.077400	0.00000	F0 00
50. 00	05000 OPERATING ROOM	10, 054, 297	17, 221, 398		0. 277198	0. 000000	
51. 00	05100 RECOVERY ROOM	0	0		0. 000000	0.000000	
51. 01	05101 ENDOSCOPY	1, 897, 380	10, 800, 062			0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 617, 140	376, 138		0. 207239	0.000000	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 933, 675	66, 714, 013	78, 647, 688	0. 133829	0.000000	54.00
54.01	05401 RADI OLOGY-NON-CAMPUS	2, 302, 043	15, 369, 991		0. 114335	0.000000	54. 01
54.08	05408 RADI OLOGY-GSH BREAST CENTER	3, 271	440, 496	443, 767	0. 683090	0.000000	54. 08
60.00	06000 LABORATORY	14, 226, 856	34, 552, 182			0.000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 907, 923	1, 674, 433		0. 273476	0. 000000	
65. 00	06500 RESPIRATORY THERAPY	9, 925, 571	2, 743, 235		0. 277322	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	12, 835, 842	16, 194, 798		0. 277322	0.000000	66.00
	06900 ELECTROCARDI OLOGY						
69. 00		8, 454, 654	24, 598, 439			0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	
70. 01	07001 NEURODI AGNOSTI CS	212, 713	5, 576, 698		0. 182932	0.000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 820, 547	2, 264, 267			0.000000	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 949, 357	1, 826, 503	11, 775, 860	0. 228542	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	16, 591, 598	43, 223, 432	59, 815, 030	0. 359626	0.000000	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	90, 476	23, 062, 001	23, 152, 477	0. 201998	0.000000	75. 00
76.00	03020 MH ANCILLARY OUTPATIENT	ol	0		0.000000	0.000000	76. 00
76. 01	03950 INPATIENT DIALYSIS	1, 223, 245	80, 541	1, 303, 786	0. 698974	0.000000	76. 01
70.0.	OUTPATIENT SERVICE COST CENTERS	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	00/011	1,000,700	0.070771	0.00000	70.0.
90.00	09000 CLINI C	0	4, 230, 665	4, 230, 665	0. 495326	0. 000000	90.00
91. 00	09100 EMERGENCY	7, 362, 061	30, 704, 588			0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 354, 233	7, 718, 412	11, 072, 645	0. 185439	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	80, 026	552, 397	632, 423	0. 297026	0.000000	
101.00	10100 HOME HEALTH AGENCY	0	0	0			101. 00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	513, 627	2, 509, 369	3, 022, 996			116. 00
200.00		170, 518, 569	312, 434, 058				200. 00
201.00		1,0,010,007	312, 101, 000	102, 702, 027			201.00
202.00		170, 518, 569	312, 434, 058	482, 952, 627			202.00
202.00	p protein (see mistructions)	170, 510, 509	312, 434, 030	1 402, 702, 021	ı I		1202.00

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150042
From 01/01/2015
To 12/31/2015
Vorksheet C
From 01/01/2015
To 12/31/2015
Fore CMS-2552-10
Vorksheet C
From 01/01/2015
To 12/31/2015
Fore CMS-2552-10
Vorksheet C
From 01/01/2015
To 12/31/2015
Fore CMS-2552-10
Vorksheet C
From 01/01/2015
Fore CMS-2552-10
Vorksheet C
Fore CMS-2552-10
Vork

				5/25/2016 9:57 am
		Title XVIII	Hospi tal	PPS
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
40. 00 04000 SUBPROVI DER - I PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				41.00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 277198			50.00
51.00 O5100 RECOVERY ROOM	0. 000000			51.00
51. 01 05101 ENDOSCOPY	0. 213143			51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 207239			52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 133829			54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS	0. 114335			54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0. 684443			54. 08
60. 00 06000 LABORATORY	0. 138187			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 273476			63.00
65. 00 06500 RESPIRATORY THERAPY	0. 277322			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 164985			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 182472			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 185239			70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 107165			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 228542			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 359626			73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 202039			75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0. 000000			76. 00
76.01 03950 INPATIENT DIALYSIS	0. 709855			76. 01
OUTPATIENT SERVICE COST CENTERS	·			
90. 00 09000 CLI NI C	0. 499240			90.00
91. 00 09100 EMERGENCY	0. 219067			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 185439			92.00
OTHER REIMBURSABLE COST CENTERS				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 297026			96. 00
101.00 10100 HOME HEALTH AGENCY	1			101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>			
113. 00 11300 NTEREST EXPENSE				113. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
	. '			•

					10 12/31/2013	5/25/2016 9:5	
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	19, 999, 536		19, 999, 53		19, 999, 536	
31.00	03100 I NTENSI VE CARE UNIT	8, 965, 597		8, 965, 59	7 0	8, 965, 597	31.00
40.00	04000 SUBPROVI DER - I PF	2, 480, 807		2, 480, 80	7 0	2, 480, 807	40.00
41.00	04100 SUBPROVI DER - I RF	7, 249, 409		7, 249, 40	9 0	7, 249, 409	41.00
43.00	04300 NURSERY	673, 291		673, 29	1 0	673, 291	43. 00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 560, 781		7, 560, 78	1 0	7, 560, 781	50.00
51.00	05100 RECOVERY ROOM	0			0 0	0	51.00
51. 01	05101 ENDOSCOPY	2, 706, 368		2, 706, 36	8 0	2, 706, 368	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	827, 562		827, 56	2 0	827, 562	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 525, 374		10, 525, 37	4 0	10, 525, 374	54.00
54.01	05401 RADI OLOGY-NON-CAMPUS	2, 020, 533		2, 020, 53	3 0	2, 020, 533	54. 01
54.08	05408 RADI OLOGY-GSH BREAST CENTER	303, 133		303, 13	3 600	303, 733	54. 08
60.00	06000 LABORATORY	6, 740, 617		6, 740, 61	7 0	6, 740, 617	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	979, 687		979, 68	7 0	979, 687	63. 00
65.00	06500 RESPIRATORY THERAPY	3, 513, 344	0	3, 513, 34	4 0	3, 513, 344	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 789, 616	0	4, 789, 61	6 0	4, 789, 616	66. 00
69.00	06900 ELECTROCARDI OLOGY	6, 023, 924		6, 023, 92	4 7, 348	6, 031, 272	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	1, 059, 070		1, 059, 07	0 13, 354	1, 072, 424	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	10, 058, 390		10, 058, 39	0 0	10, 058, 390	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	2, 691, 284		2, 691, 28		2, 691, 284	
73.00	07300 DRUGS CHARGED TO PATIENTS	21, 511, 039		21, 511, 03	9 0	21, 511, 039	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	4, 676, 757		4, 676, 75	7 938	4, 677, 695	
76.00	03020 MH ANCI LLARY OUTPATI ENT	0			0 0	0	1
76. 01	03950 INPATIENT DIALYSIS	911, 313		911, 31	3 14, 186	925, 499	76. 01
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	2, 095, 560		2, 095, 56	0 16, 558	2, 112, 118	90.00
91.00	09100 EMERGENCY	8, 302, 812		8, 302, 81	2 36, 325		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 053, 303		2, 053, 30	3	2, 053, 303	92. 00
	OTHER REIMBURSABLE COST CENTERS						1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	187, 846		187, 84	6 0	187, 846	96. 00
101.00	10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS							1
							113. 00
	11600 H0SPI CE	1, 919, 533		1, 919, 53	3	1, 919, 533	116. 00
200.00	1	140, 826, 486					
201.00	,	2, 053, 303		2, 053, 30		2, 053, 303	
202.00		138, 773, 183					
			'				•

			'	0 12/31/2013	5/25/2016 9:5	
		Ti t	le XIX	Hospi tal	Cost	
		Charges	<u> </u>			
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	+ col. 7)	Rati o	Inpati ent	
					Rati o	
	6.00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	18, 269, 427		18, 269, 427			30. 00
31.00 03100 INTENSIVE CARE UNIT	15, 047, 597		15, 047, 597			31.00
40. 00 04000 SUBPROVI DER - 1 PF	5, 062, 954		5, 062, 954			40. 00
41. 00 04100 SUBPROVI DER - I RF	7, 667, 454		7, 667, 454			41.00
43. 00 04300 NURSERY	1, 114, 602		1, 114, 602			43.00
ANCILLARY SERVICE COST CENTERS	•					
50. 00 05000 OPERATING ROOM	10, 054, 297	17, 221, 398	27, 275, 695	0. 277198	0.000000	50. 00
51.00 05100 RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
51. 01 05101 ENDOSCOPY	1, 897, 380	10, 800, 062	12, 697, 442	0. 213143	0.000000	51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 617, 140	376, 138		0. 207239	0.000000	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	11, 933, 675	66, 714, 013	78, 647, 688	0. 133829	0.000000	54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS	2, 302, 043	15, 369, 991			0.000000	54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	3, 271	440, 496			0.000000	54. 08
60. 00 06000 LABORATORY	14, 226, 856	34, 552, 182			0.000000	•
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 907, 923	1, 674, 433			0.000000	63.00
65. 00 06500 RESPIRATORY THERAPY	9, 925, 571	2, 743, 235			0.000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	12, 835, 842	16, 194, 798			0.000000	66, 00
69. 00 06900 ELECTROCARDI OLOGY	8, 454, 654	24, 598, 439			0.000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0. 000000	0.000000	70. 00
70. 01 07001 NEURODI AGNOSTI CS	212, 713	5, 576, 698	5, 789, 411	0. 182932	0.000000	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 820, 547	2, 264, 267			0.000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 949, 357	1, 826, 503			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	16, 591, 598	43, 223, 432			0.000000	
75. 00 07500 ASC (NON-DISTINCT PART)	90, 476	23, 062, 001			0.000000	75. 00
76. 00 03020 MH ANCILLARY OUTPATIENT	0	0			0.000000	76. 00
76. 01 03950 I NPATI ENT DI ALYSI S	1, 223, 245	80, 541	1, 303, 786		0.000000	76. 01
OUTPATIENT SERVICE COST CENTERS	, , , , , ,		, , , , , , , , , , , , , , , , , , , ,			
90. 00 09000 CLINIC	0	4, 230, 665	4, 230, 665	0. 495326	0. 000000	90. 00
91. 00 09100 EMERGENCY	7, 362, 061	30, 704, 588			0. 000000	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 354, 233	7, 718, 412			0. 000000	
OTHER REIMBURSABLE COST CENTERS	2,00.,200	.,,	,			
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	80, 026	552, 397	632, 423	0. 297026	0.000000	96. 00
101.00 10100 HOME HEALTH AGENCY	0	0			0.00000	101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>					
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	513, 627	2, 509, 369	3, 022, 996			116. 00
200.00 Subtotal (see instructions)	170, 518, 569	312, 434, 058				200. 00
201.00 Less Observation Beds	1.2,0.0,007	, , 500	, , , , , , , , , ,			201. 00
202.00 Total (see instructions)	170, 518, 569	312, 434, 058	482, 952, 627			202. 00
		5.2, .5., 000	1 .02, ,02, 02,	1		

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 150042
From 01/01/2015
To 12/31/2015
Date/Time Prepared:

Cost Center Description				10 12/31/2013	5/25/2016 9:57 am
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30000 ADULTS & PEDIATRICS 30.00 31.00 305000 ADULTS & PEDIATRICS 31.00 3			Title XIX	Hospi tal	
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30000 ADULTS & PEDI ATRIC S 31.00 30000 ADULTS & PEDI ATRIC S 31.00 30000 ADULTS & PEDI ATRIC S 31.00 31.00 31.00 31.00 1 MITENIS VE CARE UNIT 40.00 40.00 40.00 40.00 5 MIRPORVIDER - 1 PF 41.00	Cost Center Description	PPS Inpatient			
INPATI ENT ROUTINE SERVICE COST CENTERS 30.00 30.00 30.00 ADULTS & PEDIATRIC SS 31.00 31		Ratio			
30.00 0.0000 0.0000 ADULTS & PEDI ATRI CS 31.00 40.00 0.0000 SUBPROVI DER - I PF 40.00 40.00 40.00 0.0000 SUBPROVI DER - I PF 41.00 40.00 40.00 40.00 0.0000 0.0000 41.00 40		11. 00			
31.00 0.0100 INTENSIVE CARE UNIT 31.00 40.00 40.00 0.0000 SUBPROVI DER - I RF 41.00 41.00 41.00 0.0100 SUBPROVI DER - I RF 41.00 43.00	INPATIENT ROUTINE SERVICE COST CENTERS				
40.00 04000 SUBPROVI DER - I PF 41.00 43.00 04300 NURSERY 43.00 04300 NURSERY 43.00 04300 NURSERY 43.00 04300 NURSERY 43.00 05000 OPERATI NO ROOM 50.000 50.00 51.00 051000 OPERATI NO ROOM 50.00000 51.00 05100 RECOVERY ROOM 50.000000 51.00 51.00 51.00 051.00 051.00 051.00 05000 050.00000 52.00 052.00	30. 00 03000 ADULTS & PEDI ATRI CS				30.00
41. 00	31.00 03100 INTENSIVE CARE UNIT				31.00
43. 00	40. 00 04000 SUBPROVI DER - 1 PF				40.00
ANCILLARY SERVICE COST CENTERS	41. 00 04100 SUBPROVI DER - RF				41.00
50.00 05000 05000 05000 05000 05000 0510	43. 00 04300 NURSERY				43.00
51.00 05100 RECOVERY ROOM 0.000000 51.01 05101 ENDOSCOPY 0.000000 51.01 05101 ENDOSCOPY 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 54.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 54.00 05200 DELI VERY ROOM & LABORSTIC 0.000000 54.00 05401 RADI OLOGY-MON-CAMPUS 0.000000 54.00 05401 RADI OLOGY-MON-CAMPUS 0.000000 54.00 05401 RADI OLOGY-MON-CAMPUS 0.000000 54.00 05408 RADI OLOGY-GSH BREAST CENTER 0.000000 54.08 0.000000 54.08 0.000000 54.08 0.000000 54.08 0.000000 0.000000 54.08 0.000000 65.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	ANCILLARY SERVICE COST CENTERS				
51.01 05101 ENDOSCOPY 0.000000 51.01 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 05400 RADI IOLOGY-DI AGNOSTIC 0.000000 54.00 54.01 05401 RADI IOLOGY-DI AGNOSTIC 0.000000 54.00 54.01 05401 RADI IOLOGY-DI AGNOSTIC 0.000000 54.00 54.08 05408 RADI IOLOGY-GSH BREAST CENTER 0.000000 54.08 60.00 06000 LABORATORY 0.000000 65.00 63.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06500 RESPI RATORY THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 0.000000 65.00 67.00 06900 ELECTROCARDI IOLOGY 0.000000 69.00 70.00 07000 ELECTROCARDI IOLOGY 0.000000 70.00 70.01 07000 NEURODI AGNOSTIC S 0.000000 70.00 70.01 07000 NEURODI AGNOSTIC S 0.000000 71.00 70.10 07010 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.000000 72.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 73.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 73.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 IMPL. DEV. CHARGED TO PATI ENT 0.000000 75.00 70.00 07020 07020 07020 070200 070200 070200 070200 070200 070200 070200 070200 070200 070200 070200 070200 070200 070200 070200	50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.000000 54.00 054.00 05400 RADI OLOGY-DI AGNOSTIC 0.000000 54.01 05401 RADI OLOGY-NON-CAMPUS 0.000000 54.01 05401 RADI OLOGY-SH BREAST CENTER 0.000000 554.01 05408 RADI OLOGY-SH BREAST CENTER 0.000000 65.00 06000 LABORATORY 0.000000 65.00 06000 LABORATORY 0.000000 65.00 06500 RESPI RATORY THERAPY 0.000000 65.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 RESPI RATORY THERAPY 0.000000 66.00 06500 RESPI RATORY THERAPY 0.000000 070.	51.00 05100 RECOVERY ROOM	0. 000000			51.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54. 01 54. 01 05401 RADI OLOGY-NON-CAMPUS 0.000000 54. 01 54. 08 05408 RADII OLOGY-SSH BREAST CENTER 0.000000 54. 08 60. 00 06000 LABORATORY 0.000000 65. 00 65. 00 06500 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 65. 00 65. 00 06500 RESPI RATORY THERAPY 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 65. 00 66. 00 06600 PHYSI CAL THERAPY 0.000000 69. 00 67. 00 06900 ELECTROCARDI OLOGY 0.000000 69. 00 67. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70. 01 67. 00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70. 01 67. 00 07001 NEURODI AGNOSTI CS 0.000000 71. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.000000 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0.000000 73. 00 73. 00 07300 SRUGS CHARGED TO PATI ENTS 0.000000 75. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0.000000 75. 00 76. 00 03950 INPATI ENT DI ALYSIS 0.000000 76. 01 001761 03950 INPATI ENT DI ALYSIS 0.000000 76. 01 001761 0700 MEDI CAL EDUI PATI ENTS 0.000000 76. 01 001761 0700 MEDICAL EDUI PATI ENT 0.000000 76. 01 001761 0700 MEDICAL EDUI PATI ENT 0.000000 76. 01 001761 0700 MEDICAL EDUI PATI ENT 0.000000 91. 00 001761 0700 MEDICAL EDUI PATI ENT 0.000000 91. 00 001761 0700 MEDICAL EDUI PATI ENT 0.000000 92. 00 001761 0700 MEDICAL EDUI PATI ENT 0.000000 92. 00 001761 0700 MEDICAL EDUI PATI ENT 0.000000 93. 00 001761 0700 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.00000000	51. 01 05101 ENDOSCOPY	0. 000000			51. 01
54. 01 05401 RADI OLOGY-NON-CAMPUS 0.000000 54. 08	52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
54. 08	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY 0. 000000 63. 00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0. 000000 65. 00 06500 RESPI RATORY THERAPY 0. 000000 065. 00 06500 RESPI RATORY THERAPY 0. 000000 066. 00 06600 PHYSI CAL THERAPY 0. 000000 069. 00 06900 ELECTROCARDI OLOGY 0. 000000 70. 00 70.	54. 01 05401 RADI OLOGY-NON-CAMPUS	0. 000000			54. 01
63. 00 66300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000000	54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0. 000000			54. 08
65. 00	60. 00 06000 LABORATORY	0. 000000			60.00
66. 00 06600 PHYSI CAL THERAPY 0.000000 69. 00	63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63.00
69. 00 06900 ELECTROCARDIOLOGY 0.000000 69.00 70. 00 07000 ELECTROCARDIOLOGY 0.000000 70.00 70. 01 07001 NEURODIAGNOSTICS 0.000000 70.00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0.000000 75. 00 76. 00 03020 MH ANCILLARY OUTPATIENT 0.000000 75. 00 76. 00 03020 MH ANCILLARY OUTPATIENT 0.000000 76. 01 001PATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0.000000 91. 00 91. 00 09100 EMERGENCY 0.000000 91. 00 92. 00 09200 DISERVATION BEDS (NON-DISTINCT PART) 0.000000 92. 00 011CO 011000 HOME HEALTH AGENCY 0.000000 92. 00 0110. 00 01000 HOME HEALTH AGENCY 10.000000 10.000000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.00000 10.00000 10.00000 10.00000 10.00000 10.00000 10.000000 10.00000 10.00000 10.00000 10.000000 10.00000 10.000000 10.000000 10.00000 10.000000 10.000000 10.000000 10.000000 10.000000	65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 70. 01 70. 00 70. 01 707001 NEURODI JAGNOSTI CS 0. 000000 70. 01 70. 00 71. 00 71. 00 771.00 771	66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
70. 01 07001 NEURODI AGNOSTI CS 0. 000000 70. 01 71. 00 71. 00 71. 00 MEDI CAL SUPPLIES CHARGED TO PATIENT 0. 000000 71. 00 72. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 0. 000000 72. 00 73. 00 73. 00 73.00 75. 00 75	69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
72. 00	70. 01 07001 NEURODI AGNOSTI CS	0. 000000			70. 01
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 000000 75. 00 07500 ASC (NON-DISTINCT PART) 0. 000000 75. 00 03020 MH ANCI LLARY OUTPATIENT 0. 000000 76. 00 03020 MH ANCI LLARY OUTPATIENT 0. 000000 76. 00 03950 INPATIENT DIALYSIS 0. 000000 76. 01 0000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 0000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 000000 76. 01 0000000000000000000000000000000000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
75. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72. 00
76. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 01 03950 NPATI ENT DI ALYSI S	75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
OUTPATIENT SERVICE COST CENTERS O	76.00 03020 MH ANCILLARY OUTPATIENT	0. 000000			76.00
90. 00 09000 CLINI C 0.000000 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0.000000 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0.000000 92. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 96. 00 000000 096. 00 000000 096. 00 000000 096. 00 000000 000000 000000 000000 000000	76. 01 03950 INPATIENT DIALYSIS	0. 000000			76. 01
91. 00 09100 EMERGENCY 0. 000000 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 0000000 0000000 00000000 00000000	OUTPATIENT SERVICE COST CENTERS				
92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0.000000 0THER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0.000000 101.00 HOME HEALTH AGENCY 101.00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	90. 00 09000 CLI NI C	0. 000000			90.00
OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 96. 00 101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	91. 00 09100 EMERGENCY	0. 000000			91.00
96. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
101. 00 10100 HOME HEALTH AGENCY 101. 00 SPECI AL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE 116. 00 200. 00 Subtotal (see instructions) 200. 00 201. 00 Less Observation Beds 201. 00	OTHER REIMBURSABLE COST CENTERS				
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 116.00 11600 11600 1000	96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
113. 00	101.00 10100 HOME HEALTH AGENCY				101.00
116. 00 11600 200. 00 Subtotal (see instructions) 201. 00 Less Observation Beds 116. 00 200. 00 201. 00	SPECIAL PURPOSE COST CENTERS				
116. 00 11600 200. 00 Subtotal (see instructions) 201. 00 Less Observation Beds 116. 00 200. 00 201. 00	113. 00 11300 NTEREST EXPENSE				113. 00
201.00 Less Observation Beds 201.00					116. 00
201.00 Less Observation Beds 201.00	200.00 Subtotal (see instructions)				200. 00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds				201.00
	202.00 Total (see instructions)				202. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS			Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/25/2016 9:5	pared: 7 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	2, 732, 437	0	2, 732, 43	18, 107	150. 91	30. 00
31.00 INTENSIVE CARE UNIT	985, 310		985, 31	0 6, 762	145. 71	31.00
40. 00 SUBPROVI DER - I PF	455, 027	0	455, 02	4, 219	107. 85	40.00
41. 00 SUBPROVI DER - I RF	792, 328	0	792, 32	8, 049	98. 44	41.00
43. 00 NURSERY	14, 550		14, 55	1, 051	13. 84	43.00
200.00 Total (lines 30-199)	4, 979, 652		4, 979, 65	38, 188		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	10, 646	1, 606, 588				30.00
31.00 INTENSIVE CARE UNIT	3, 158	460, 152				31.00
40. 00 SUBPROVI DER - I PF	1, 868	201, 464				40.00
41. 00 SUBPROVI DER - I RF	6, 500	639, 860)			41.00
43. 00 NURSERY	0		1			43.00
200.00 Total (lines 30-199)	22, 172	2, 908, 064				200. 00

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITA	AL		In Lie	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Prov			Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/25/2016 9:5	
					e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal			Ratio of Cos	t Inpatient	Capital Costs	
			(from Wks	st. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I,	col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)		2)			
		26)						
		1.00	2.00)	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	676, 014	27, 27	75, 695	0. 02478	4 8, 611, 269	213, 422	50.00
51.00	05100 RECOVERY ROOM	0		0	0.00000	0 0	0	51.00
51. 01	05101 ENDOSCOPY	395, 933	12, 69	7, 442	0. 03118	2 1, 058, 326	33, 001	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 810	3, 99	3, 278	0. 00395	9 0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	802, 913	78, 64	17, 688	0. 01020	9 7, 176, 027	73, 260	54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS	158, 757	17, 67	72, 034	0. 00898	4 1, 172, 774	10, 536	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	2, 079	44	13, 767	0. 00468	5 0	0	54. 08

334, 209

199, 905

293, 954

546, 971

240, 461

54, 268

39, 767

437, 998

132, 240

255, 660

102, 866

651, 338

280, 533

14, 136

5, 641, 119

5, 307

48, 779, 038

3, 582, 356

12, 668, 806

29, 030, 640

33, 053, 093

5, 789, 411

9, 084, 814

11, 775, 860

59, 815, 030

23, 152, 477

1, 303, 786

4, 230, 665

38, 066, 649

11, 072, 645

632, 423 432, 767, 597 0.006851

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9, 171, 017

1, 223, 641

5, 497, 527

3, 807, 636

6, 163, 907

2, 657, 565

3, 998, 701

9, 476, 840

961, 918

3, 198, 012

1, 100, 496

65, 396, 673

121, 017

62, 831

1, 812

86, 745

38, 556

102,000

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15,874

13, 504

69, 399

188, 623

54, 718

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75.00

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76.01

91.00

0 96.00

60. 00 06000 LABORATORY

63.00

66.00

69 00

70.00

70. 01

71 00

72.00

73.00

75.00

76.00

76.01

90.00

91.00

92.00

96.00

200.00

06300 BLOOD STORING, PROCESSING & TRANS.

07100 MEDICAL SUPPLIES CHARGED TO PATIENT

09200 OBSERVATION BEDS (NON-DISTINCT PART

07200 I MPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

09600 DURABLE MEDICAL EQUIP-RENTED

07500 ASC (NON-DISTINCT PART)

03020 MH ANCILLARY OUTPATIENT

03950 INPATIENT DIALYSIS

09000 CLI NI C

09100 EMERGENCY

06500 RESPIRATORY THERAPY

07000 ELECTROENCEPHALOGRAPHY

06600 PHYSI CAL THERAPY

06900 ELECTROCARDI OLOGY

07001 NEURODI AGNOSTI CS

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Period: From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	0	0		0	0	30. 00 31. 00
40. 00 04000 SUBPROVI DER - PF	0	0		0 0	ő	40.00
41. 00 04100 SUBPROVI DER - RF	0	Ö		0 0	ō	41.00
43. 00 04300 NURSERY	0	0		0	0	43. 00
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	I npati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
		7.00	0.00	col . 8)		
INDATIONE DOUTING CODYLOG COCT CONTEDC	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	10 107	0.00	10 (4	(20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	18, 107					30. 00 31. 00
40. 00 04000 SUBPROVI DER - 1 PF	6, 762 4, 219		·			40.00
41. 00 04100 SUBPROVI DER - 1 PF	8, 049					41. 00
43. 00 04300 NURSERY	1, 051			0 0		43.00
200.00 Total (lines 30-199)	38, 188		22, 17	٥		200. 00
200.00 Total (Titles 30-144)	30, 100	I	22, 17	۷ ا	I	1200.00

Health Financial Systems	GOOD SAMARITAN HO	GOOD SAMARITAN HOSPITAL In Lie			
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150042	From 01/01/2015	Worksheet D Part IV Date/Time Prepared: 5/25/2016 9:57 am	
		Ti +Lo VVIII	Hospi tal	DDC	

				1	0 12/31/2015	5/25/2016 9:5	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician N	lursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0	0	0	0	50.00
	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
	05101 ENDOSCOPY	0	0	0	0	0	51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	245, 763	0	245, 763	1
	05401 RADI OLOGY-NON-CAMPUS	0	0	0	0	0	54. 01
	05408 RADI OLOGY-GSH BREAST CENTER	0	0	0	0	0	54. 08
	06000 LABORATORY	0	0	19, 760	0	19, 760	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
	07001 NEURODI AGNOSTI CS	0	0	0	0	0	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
	03020 MH ANCI LLARY OUTPATI ENT	0	0	0	0	0	76. 00
76. 01	03950 I NPATIENT DIALYSIS	0	0	0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	0	0	0	0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
200.00	Total (lines 50-199)	0	0	265, 523	0	265, 523	200. 00

Heal th	Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10								
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS			er CCN: 150042	Peri od: Worksheet From 01/01/2015 Part IV To 12/31/2015 Date/Time 5/25/2016		pared:		
				itle XVIII	Hospi tal	PPS			
	Cost Center Description	Total		es Ratio of Co		Inpati ent			
			(from Wkst.						
		Cost (sum of		. (col. 5 ÷ co		Charges			
		col. 2, 3 and	8)	7)	(col. 6 ÷ col.				
		4)			7)				
		6.00	7. 00	8. 00	9. 00	10.00			
	ANCILLARY SERVICE COST CENTERS	T							
50.00	05000 OPERATING ROOM	0	27, 275,				1		
51. 00	05100 RECOVERY ROOM	0		0.0000		l .			
51. 01	05101 ENDOSCOPY	0	12, 697,				1		
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 993,						
54. 00	05400 RADI OLOGY-DI AGNOSTI C	245, 763					54. 00		
54. 01	05401 RADI OLOGY-NON-CAMPUS	0	17, 672,						
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0	443,			l .	54. 08		
60.00	06000 LABORATORY	19, 760					1		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	3, 582,	356 0. 0000	0. 000000	1, 223, 641	63.00		
65.00	06500 RESPI RATORY THERAPY	0	12, 668,				65. 00		
66.00	06600 PHYSI CAL THERAPY	0	29, 030,				66. 00		
69. 00	06900 ELECTROCARDI OLOGY	0	33, 053,	0.0000	0. 000000	6, 163, 907	69. 00		
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0.0000	0. 000000	0	70.00		
70. 01	07001 NEURODI AGNOSTI CS	0	5, 789,	411 0. 0000	0. 000000	121, 017	70. 01		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9, 084,	314 0. 0000	0. 000000	2, 657, 565	71. 00		
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 775,	360 0.0000	0. 000000	3, 998, 701	72. 00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	59, 815,	0. 0000	0. 000000	9, 476, 840	73. 00		
75.00	07500 ASC (NON-DISTINCT PART)	0	23, 152,	477 0. 0000	0. 000000	0	75. 00		
76.00	03020 MH ANCILLARY OUTPATIENT	0		0.0000	0. 000000	0	76. 00		
76. 01	03950 INPATIENT DIALYSIS	0	1, 303,	786 0. 0000	0. 000000	961, 918	76. 01		
	OUTPATIENT SERVICE COST CENTERS			•	.	•	1		
00 00	00000 CLINIC		4 220	((E) 0 000(0 000000	J 0	1 00 00		

0

0 265, 523 4, 230, 665 38, 066, 649

11, 072, 645

632, 423 432, 767, 597 0.000000

0. 000000 0. 000000

0.000000

0.000000

0. 000000 0. 000000

0.000000

90.00

91.00

3, 198, 012

1, 100, 496 92. 00

0 96. 00 65, 396, 673 200. 00

90. 00 09000 CLI NI C 91. 00 09100 EMERGENCY

92. 00 | 09200 | 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS | 09600 | DURABLE MEDICAL EQUIP-RENTED | 200. 00 | Total (lines 50-199)

Health Financial Systems	ancial Systems GOOD SAMARITAN HOSPITAL			u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150042		Worksheet D
THROUGH COSTS			From 01/01/2015	Part IV

					10	12/31/2015	5/25/2016 9:5	
			Ti tl	e XVIII		Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent				
		Program	Program	Program				
		Pass-Through	Charges	Pass-Through				
		Costs (col. 8		Costs (col.	9			
		x col. 10)		x col. 12)				
	T	11.00	12.00	13. 00				
	ANCILLARY SERVICE COST CENTERS							
	05000 OPERATING ROOM	0	15, 410, 940		0			50.00
	05100 RECOVERY ROOM	0	0)	0			51.00
51. 01	05101 ENDOSCOPY	0	4, 773, 451		0			51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0			52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	22, 425	25, 357, 151	79, 24	41			54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0	4, 378, 942		0			54. 01
54.08	05408 RADI OLOGY-GSH BREAST CENTER	0	0)	0			54. 08
60.00	06000 LABORATORY	3, 714	5, 751, 152	2, 32	29			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	776, 376	,	0			63. 00
65.00	06500 RESPI RATORY THERAPY	0	2, 313, 822		0			65. 00
66.00	06600 PHYSI CAL THERAPY	0	7, 179	1	0			66. 00
69.00	06900 ELECTROCARDI OLOGY	0	7, 530, 545		0			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0			70. 00
70. 01	07001 NEURODI AGNOSTI CS	o	1, 976, 175		0			70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	1, 877, 877		0			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	1, 502, 465		0			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	23, 579, 043		0			73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0)	0			75. 00
76. 00	03020 MH ANCI LLARY OUTPATI ENT	0	0)	0			76. 00
76. 01	03950 INPATIENT DIALYSIS	0	59, 109		0			76. 01
	OUTPATIENT SERVICE COST CENTERS	·	·		-			
90.00	09000 CLI NI C	0	0		0			90.00
91.00	09100 EMERGENCY	o	7, 535, 001		0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	O	2, 063, 246	,	0			92. 00
	OTHER REIMBURSABLE COST CENTERS			•				1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0			96. 00
200.00	Total (lines 50-199)	26, 139	104, 892, 474	81, 57	70			200. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 150042 Peri od: Worksheet D From 01/01/2015 Part V Date/Time Prepared: 12/31/2015 5/25/2016 9:57 am Title XVIII Hospi tal Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 277198 15, 410, 940 4, 271, 882 50.00 62 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 0 05101 ENDOSCOPY 0 0 51 01 0 213143 4, 773, 451 1, 017, 428 51 01 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.207239 0 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 133829 25, 357, 151 48 3, 393, 522 54.00 0 500, 666 54. 01 05401 RADI OLOGY-NON-CAMPUS 4, 378, 942 0 114335 143 54 01 05408 RADIOLOGY-GSH BREAST CENTER 54.08 0.683090 0 Λ 54.08 60.00 06000 LABORATORY 0. 138187 5, 751, 152 19, 916 0 794, 734 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0. 273476 776, 376 0 0 212, 320 63.00 06500 RESPIRATORY THERAPY 65 00 0 277322 2, 313, 822 0 641, 674 65 00 66.00 06600 PHYSI CAL THERAPY 0.164985 7, 179 0 1, 184 66.00 69.00 06900 ELECTROCARDI OLOGY 0. 182250 7, 530, 545 0 1, 372, 442 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 0 0 70.00 1, 976, 175 70.01 07001 NEURODI AGNOSTI CS 0.182932 0 361, 506 70 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1. 107165 1, 877, 877 307 0 2, 079, 120 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 228542 1, 502, 465 343, 376 72.00 C 72.00 157, 156 07300 DRUGS CHARGED TO PATIENTS 0. 359626 23, 579, 043 8, 479, 637 73.00 486 73.00 07500 ASC (NON-DISTINCT PART) 75 00 0. 201998 0 0 0 75 00 76.00 03020 MH ANCILLARY OUTPATIENT 0.000000 0 0 76.00 0 03950 INPATIENT DIALYSIS 76.01 0.698974 59, 109 0 0 41, 316 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 0.495326 0 0 09100 EMERGENCY 0. 218113 7, 535, 001 0 0 1, 643, 482 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0. 185439 2,063,246 0 382, 606 92.00 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0. 297026 C 0 96.00 157, 156 200.00 Subtotal (see instructions) 104, 892, 474 20, 962 25, 536, 895 200. 00 201.00 Less PBP Clinic Lab. Services-Program 201.00

104, 892, 474

20, 962

157, 156

25, 536, 895 202. 00

Only Charges

202.00

Net Charges (line 200 +/- line 201)

| Peri od: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared:

				10 12/31/2015	5/25/2016 9:57	
		Title	e XVIII	Hospi tal	PPS	
	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						
50. 00 05000 OPERATING ROOM	17	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
51. 01 05101 ENDOSCOPY	0	0				51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	6	0				54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS	16	o				54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0	o				54.08
60. 00 06000 LABORATORY	2, 752	o				60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	o				63.00
65. 00 06500 RESPIRATORY THERAPY	0	o				65.00
66. 00 06600 PHYSI CAL THERAPY	0	o				66.00
69. 00 06900 ELECTROCARDI OLOGY	0	l ol				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	o				70.00
70. 01 07001 NEURODI AGNOSTI CS	0	o				70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	340	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	175	56, 517				73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76. 00 03020 MH ANCI LLARY OUTPATIENT	0					76. 00
76. 01 03950 NPATI ENT DI ALYSI S	0					76. 01
OUTPATIENT SERVICE COST CENTERS		<u> </u>				, 0. 0.
90. 00 09000 CLINIC	0	0				90.00
91. 00 09100 EMERGENCY	0					91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
OTHER REIMBURSABLE COST CENTERS		<u> </u>				72.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	1	O				96. 00
200.00 Subtotal (see instructions)	3, 306				.	200.00
201.00 Less PBP Clinic Lab. Services-Program	3,300	30, 317				200.00
Only Charges					[*	201.00
202.00 Net Charges (line 200 +/- line 201)	3, 306	56, 517			.	202. 00
202.00	3,300] 30, 317			l·	202.00

Heal th Financial Systems GOOD SANARITAN HOSPITAL In Lieu of Form CMS-2552-10								
Component CN: 155042 From 01/1/2015 Date/Time Prepared: 5/25/2016 9: 57. am					0011 450040			2552-10
Component CCN: 15SO42 To 12/31/2015 Date/Time Prepared: 5/25/2016 9: 57 am	APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150042			
Title XVIII Subprovider PPS				Component	CCN: 15S042			nared·
Cost Center Description				ooporrorr				
Capital Related Cost (From Wkst. B, Part II, col. Charges (Col. II + col. Charges (Col. II + col. Program (Column 3 x Column 4)				Ti tl	e XVIII		PPS	
Related Cost			T.					
ANCI LLARY SERVICE COST CENTERS Part I, col. (col. 1 + col. 2) Charges Column 4)		Cost Center Description						
Part II, col. 8) 2) 3.00 4.00 5.00								
ANCILLARY SERVICE COST CENTERS						. Charges	column 4)	
NOTE ANCILLARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00				8)	2)			
ANCILLARY SERVICE COST CENTERS 50.00								
50. 00			1. 00	2.00	3.00	4. 00	5. 00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0								
51.01 05101 ENDOSCOPY 395, 933 12, 697, 442 0.031182 112 3 51.01						·		
52. 00 05200 DELI VERY ROOM & LABOR ROOM 15, 810 3, 993, 278 0. 003959 0 0 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 802, 913 78, 647, 688 0. 010209 61, 869 632 54. 00 54. 01 05401 RADI OLOGY-NOR-CAMPUS 158, 757 17, 672, 034 0. 008984 8, 182 74 54. 01 54. 08 05408 RADI OLOGY-GSH BREAST CENTER 2, 079 443, 767 0. 004685 0 0 54. 08 60. 00 06000 LABORATORY 334, 209 448, 779, 038 0. 006851 151, 947 1., 041 60. 00 63. 00 06500 BODD STORI NG, PROCESSI NG & TRANS. 5, 307 3, 582, 356 0. 001481 0 0 0 63. 00 65. 00 06500 RESPI RATORY THERAPY 199, 905 12, 668, 806 0. 015779 128, 788 2, 032 65. 00 66. 00 06600 PHYSI CAL THERAPY 293, 954 29, 030, 640 0. 010126 67, 932 688 66. 00 66. 00 06600 PHYSI CAL THERAPY 293, 954 29, 030, 640 0. 010126 67, 932 688 66. 00 67. 00 07000 ELECTROCARDI OLOGY 546, 971 33, 053, 093 0. 016548 16, 423 272 69. 00 67. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0 0. 70. 01 67. 00 07001 NEURODI AGNOSTI CS 240, 461 5, 789, 411 0. 041535 0 0 70. 01 67. 00 07200 IMPL. DEV. CHARGED TO PATI ENT 54, 268 9, 084, 814 0. 005973 4, 041 24 71. 00 75. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 39, 767 11, 775, 860 0. 003377 0 0 72. 00 67. 00 03020 MAROL LLARY OUTPATI ENT 32, 240 23, 152, 477 0. 005712 0 0 75. 00 67. 01 03950 INPATI ENT DI ALYSIS 255, 660 1, 303, 786 0. 196090 7, 831 1, 536 76. 01 67. 00 03950 INPATI ENT DI ALYSIS 255, 660 1, 303, 786 0. 196090 7, 831 1, 536 76. 01 67. 00 03020 MERGENCY 651, 338 38, 066, 649 0. 017110 152, 363 2, 607 91. 00 67. 00 09000 DURBAE E MEDI CAL EQUI P-RENTED 14, 136 632, 423 0. 02352 0 0 96. 00 67. 00 09000 DURBAE E MEDI CAL EQUI P-RENTED 14, 136 632, 423 0. 022352 0 0 96. 00 67. 00 09000 00000 0000000000000			-	-				
54. 00 05400 RADI OLOGY-DI AGNOSTI C 802, 913 78, 647, 688 0.010209 61, 869 632 54. 00 54. 01 54. 01 78. 010 63. 00 54. 01 63. 010 63. 00 65. 00 05401 RADI OLOGY-RON-CAMPUS 158, 757 17, 672, 034 0.008984 8, 182 74 54. 01 54. 01 54. 01 54. 08 05408 RADI OLOGY-GSH BREAST CENTER 2, 0.79 443, 767 0.004685 0.006085 151, 947 1.041 60. 00 66. 00 06000 LABORATORY 0.00685 0.00685 151, 947 1.041 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 5, 307 3, 582, 356 0.001481 0 0.01579 128, 788 2.032 65. 00 66. 00 06500 RESPI RATORY THERAPY 199, 905 12, 668, 806 0.01579 128, 788 2.032 65. 00 66. 00 06600 PHYSI CAL THERAPY 293, 954 29, 303, 640 0.010126 67, 932 688 66. 00 66. 00 06900 ELECTROCARDI OLOGY 546, 971 33, 053, 093 0.016548 16, 423 272 69. 00 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 0.0000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.00000								
54. 01 05401 RADI OLOGY-NON-CAMPUS 158, 757 17, 672, 034 0.008984 8, 182 74 54. 01 54. 08 05408 RADI OLOGY-GSH BREAST CENTER 2, 079 443, 767 0.004685 0 0 0 54. 08 60. 00 06000 LABORATORY 334, 209 48, 779, 038 0.006851 151, 947 1, 041 60. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 5, 307 3, 582, 356 0.001481 0 0 63. 00 65. 00 06500 RESPI RATORY THERAPY 199, 905 12, 668, 806 0.015779 128, 788 2, 032 65. 00 66. 00 06600 PHYSI CAL THERAPY 293, 954 29, 030, 640 0.010126 67, 932 688 66. 00 69. 00 06900 ELECTROCARDI OLOGY 546, 971 33, 053, 093 0.016548 16, 423 272 69. 00 70. 01 07001 NEURODI AGNOSTI CS 240, 461 5, 789, 411 0.041535 0 0 70. 01 71. 00 07100 MEDICAL SUPPLI ES CHARGED TO PATI ENT 54, 268 9, 084, 814 0.005973 4, 041 24 71. 00 72. 00 07300 DRUGS CHARGED TO PATI ENTS 33, 767 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>_</td> <td></td>							_	
54. 08								
60. 00 06000 LABORATORY								
63. 00							-	
65. 00 06500 RESPIRATORY THERAPY 199, 905 12, 668, 806 0. 015779 128, 788 2, 032 65. 00 66. 00 06600 PHYSI CAL THERAPY 293, 954 29, 030, 640 0. 010126 67, 932 688 66. 00 69. 00 6900 ELECTROCARDI OLOGY 546, 971 33, 053, 093 0. 016548 16, 423 272 69. 00 70. 00 7000 ELECTROCARDI OLOGY 0 0 0. 000000 0 0 70. 00 70. 01 07001 NEURODI AGNOSTI CS 240, 461 5, 789, 411 0. 041535 0 0 70. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 54, 268 9, 084, 814 0. 005973 4, 041 24 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 39, 767 11, 775, 860 0. 003377 0 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 437, 998 59, 815, 030 0.007323 167, 858 1, 229 73. 00 75. 00 07500 ASC (NON-DISTINCT PART) 132, 240 23, 152, 477 0. 005712 0 0 75. 00 76. 01 03950 INPATI ENT DI ALYSI S 255, 660 1, 303, 786 0. 196090 7, 831 1, 536 76. 01 000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0							1, 041	
66. 00							-	
69. 00	65.00		199, 905	12, 668, 806			2, 032	
70. 00								
70. 01 07001 NEURODI AGNOSTI CS 240, 461 5, 789, 411 0. 041535 0 0 70. 01 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 54, 268 9, 084, 814 0. 005973 4, 041 24 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 39, 767 11, 775, 860 0. 003377 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 437, 998 59, 815, 030 0. 007323 167, 858 1, 229 73. 00 07500 ASC (NON-DI STI NCT PART) 132, 240 23, 152, 477 0. 005712 0 0 75. 00 76. 00 0. 000000 0 0 0 76. 00 0. 000000 0 0 0. 000000 0	69. 00		546, 971	33, 053, 093			272	
71. 00			0	_			0	
72. 00	70. 01						0	
73. 00							24	
75. 00	72.00		39, 767	11, 775, 860	0.0033			
76. 00	73.00		437, 998	59, 815, 030	0. 00732	167, 858	1, 229	73. 00
76. 01 03950 INPATIENT DIALYSIS 255, 660 1, 303, 786 0. 196090 7, 831 1, 536 76. 01 00TPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 102, 866 4, 230, 665 0. 024314 0 0 0 0 90. 00 9100 EMERGENCY 651, 338 38, 066, 649 0. 017110 152, 363 2, 607 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 11, 072, 645 0. 000000 10, 210 0 92. 00 0THER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 14, 136 632, 423 0. 022352 0 0 96. 00	75.00		132, 240	23, 152, 477	0.0057	12 0	0	75. 00
OUTPATIENT SERVICE COST CENTERS 90.00 O9000 CLI NI C 102, 866 4, 230, 665 0.024314 0 90.00 91.00 O9100 EMERGENCY 651, 338 38, 066, 649 0.017110 152, 363 2, 607 91.00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 11, 072, 645 0.000000 10, 210 0 92.00 OTHER REI MBURSABLE COST CENTERS 96.00 O9600 DURABLE MEDI CAL EQUI P-RENTED 14, 136 632, 423 0.022352 0 0 96.00 O96.00	76.00		0	0			0	76. 00
90. 00	76. 01	03950 I NPATIENT DIALYSIS	255, 660	1, 303, 786	0. 1960	7, 831	1, 536	76. 01
91. 00 09100 EMERGENCY 651, 338 38, 066, 649 0. 017110 152, 363 2, 607 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 11, 072, 645 0. 000000 10, 210 0 92. 00 0THER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 14, 136 632, 423 0. 022352 0 0 96. 00 0 96. 00 0 0 0 0 0 0 0 0 0								
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0 11, 072, 645 0.000000 10, 210 0 92. 00 0THER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 14, 136 632, 423 0.022352 0 0 96. 00 0 96. 00 0 0 0 0 0 0 0 0 0	90.00						_	
OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 14, 136 632, 423 0. 022352 0 0 96. 00	91. 00		651, 338					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 14, 136 632, 423 0.022352 0 96. 00	92. 00		0	11, 072, 645	0.00000	00 10, 210	0	92. 00
200. 00 Total (Lines 50-199) 5, 360, 586 432, 767, 597 785, 404 10, 333 200. 00							_	
	200.00	Total (lines 50-199)	5, 360, 586	432, 767, 597	1	785, 404	10, 333	200. 00

Health Financial Systems	GOOD SAMARITAN	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERV			CCN: 150042	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2015	Part IV	
		Component	CCN: 15S042	To 12/31/2015	Date/Time Pre	pared:
		T' 11	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	6.1	5/25/2016 9: 5 PPS	/ am
		11 11	e XVIII	Subprovi der – I PF	PPS	
Cost Center Description	Non Physician N	Jursina School	Allied Healt		Total Cost	
Social Social Person	Anesthetist	ar or rig contoor	7 1. 04 1.041 0	Medi cal	(sum of col 1	
	Cost			Education Cost		
	0001			Ludouti oii ooot	4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	0		0 0	0	50. 00
51. 00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
51. 01 05101 ENDOSCOPY	o	0		0 0	0	51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0		0 0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	0	245, 70	53 0	245, 763	54. 00
54. 01 05401 RADI OLOGY-NON-CAMPUS	o	0		0 0	0	54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	o	0		0 0	0	54. 08
60. 00 06000 LABORATORY	o	0	19, 70	50 0	19, 760	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	О	0		0 0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	o	0		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	o	0		0 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	o	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0		0 0	0	70. 00
70. 01 07001 NEURODI AGNOSTI CS	o	0		0 0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0		0 0	0	76. 00
76.01 03950 INPATIENT DIALYSIS	0	0		0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0	90. 00
91. 00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	
200.00 Total (lines 50-199)	ol	0	265, 52	23 0	265, 523	1200 00

Health Financial Systems G00	D SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE	OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2015		
		Componen	t CCN: 15S042	To 12/31/2015	Date/Time Pre 5/25/2016 9:5	pared:
		Ti +I	e XVIII	Subprovi der -	PPS	/ alli
		11 (1	e viii	IPF	FF3	
Cost Center Description	Total	Total Charges	Ratio of Cost		Inpati ent	
		(from Wkst. C,		Ratio of Cost		
	(sum of		(col. 5 ÷ col		Charges	
	2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	,	,	7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	27, 275, 695	II.			
51. 00 05100 RECOVERY ROOM	0	C				
51. 01 05101 ENDOSCOPY	0	12, 697, 442				51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 993, 278				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	245, 763	78, 647, 688				54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS	0					
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0					54. 08
60. 00 06000 LABORATORY	19, 760					60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0					
65. 00 06500 RESPI RATORY THERAPY	0					
66. 00 06600 PHYSI CAL THERAPY	0	29, 030, 640				
69. 00 06900 ELECTROCARDI OLOGY	0	33, 053, 093				
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	[C				
70. 01 07001 NEURODI AGNOSTI CS	0	5, 789, 411				
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9, 084, 814				
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	,,	l l			
75. 00 07500 ASC (NON-DISTINCT PART)	0	,,				
76. 00 03020 MH ANCILLARY OUTPATIENT	0		1 0.0000			76. 00
76. 01 03950 I NPATI ENT DI ALYSI S	0	1, 303, 786	0.00000	0. 000000	7, 831	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0					
91. 00 09100 EMERGENCY	0					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	11, 072, 645	0.00000	0. 000000	10, 210	92. 00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		l	0. 000000		
200.00 Total (lines 50-199)	265, 523	432, 767, 597	Ί		785, 404	200. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCII THROUGH COSTS	LARY SERVICE OTHER PASS	S Provi der	CCN: 150042	Period: From 01/01/2015	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15S042	To 12/31/2015	Date/Time Prep 5/25/2016 9:5	pared: 7 am
		Ti tl	e XVIII	Subprovi der – I PF	PPS	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. x col. 12) 13.00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM 51 00 05100 RECOVERY ROOM	0	1, 796		0		50. 00 51. 00

		Cost Center Description	Program	Program	Program	
			Pass-Through	Charges	Pass-Through	
			Costs (col. 8	char ges	Costs (col. 9	
			x col . 10)		x col . 12)	
			11.00	12.00	13.00	
-		ANCILLARY SERVICE COST CENTERS	111111		10.00	
ļ	50. 00	05000 OPERATING ROOM	0	1, 796	0	50. 00
ļ	51. 00	05100 RECOVERY ROOM	o	0	0	51. 00
į	51. 01	05101 ENDOSCOPY	o	0	0	51. 01
ļ	52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52. 00
ļ	54. 00	05400 RADI OLOGY-DI AGNOSTI C	193	0	0	54.00
ļ	54. 01	05401 RADI OLOGY-NON-CAMPUS	0	0	0	54. 01
ļ	54. 08	05408 RADIOLOGY-GSH BREAST CENTER	0	0	0	54. 08
(60. 00	06000 LABORATORY	62	0	0	60.00
(63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63. 00
(65. 00	06500 RESPI RATORY THERAPY	0	0	0	65. 00
(66. 00	06600 PHYSI CAL THERAPY	0	0	0	66. 00
(69. 00	06900 ELECTROCARDI OLOGY	0	0	0	69. 00
	70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70. 00
	70. 01	07001 NEURODI AGNOSTI CS	0	0	0	70. 01
		07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71. 00
		07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72. 00
	73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73. 00
	75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	75. 00
		03020 MH ANCILLARY OUTPATIENT	0	0	0	76. 00
	76. 01	03950 INPATIENT DIALYSIS	0	0	0	76. 01
		OUTPATIENT SERVICE COST CENTERS				
		09000 CLI NI C	0	0	0	90.00
		09100 EMERGENCY	0	0	0	91. 00
(92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92. 00
		OTHER REIMBURSABLE COST CENTERS				4
		09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	96. 00
	200. 00	Total (lines 50-199)	255	1, 796	0	200. 00

Health Financial Systems	GOOD SAMARITA				u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
		Component		From 01/01/2015 To 12/31/2015	Part V Date/Time Pre	narad.
		Component	. CCN. 133042	10 12/31/2013	5/25/2016 9:5	pareu. 7 am
		Titl	e XVIII	Subprovi der -	PPS	7 (3111
				IPF		
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 277198	1, 796		0	498	
51.00 05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
51. 01 05101 ENDOSCOPY	0. 213143	0		0	0	51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 207239	0		0	0	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 133829	0		0	0	54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS	0. 114335	0		0	0	54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0. 683090	0		0	0	54. 08
60. 00 06000 LABORATORY	0. 138187	0		0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 273476	0		0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	0. 277322	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 164985	0		0 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 182250	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
70. 01 07001 NEURODI AGNOSTI CS	0. 182932	0		0 0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 107165	0		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 228542	0		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 359626	0		0 2, 672	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 201998	0		0 0	0	75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0. 000000	0		0 0	0	76. 00
76.01 03950 INPATIENT DIALYSIS	0. 698974	0		0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS]
90. 00 09000 CLI NI C	0. 495326	0		0 0	0	90. 00
91. 00 09100 EMERGENCY	0. 218113	0		0	0	91.00
02 00 00200 ORSERVATION REDS (NON DISTINCT DART	0 105420		I		_	00 00

0. 185439

0. 297026

1, 796

1, 796

0 0

0 0

0

2, 672 0

2, 672

91. 00 92. 00

0 96.00 498 200.00 201.00

498 202. 00

92.00

200.00

201.00

202.00

09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 +/- line 201)

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Health Financial Systems	GOOD SAMARIT	AN HOSPI	TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES A	ENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provide		ovi der	CCN: 150042	Peri od: From 01/01/2015	Worksheet D Part V	
		Cor	mponent	CCN: 15S042	To 12/31/2015		
			Title	e XVIII	Subprovi der - I PF	PPS	
	Costs						
Cost Center Description	Cost	Cos	st				
	Rei mbursed	Rei mbu	ursed				
	Servi ces	Servi ce	es Not				
	Subject To	Subj ec	ct To				
	Ded. & Coins.	Ded. & (Coi ns.				

		Cos	STS	
	Cost Center Description	Cost	Cost	
		Rei mbursed	Reimbursed	
		Servi ces	Servi ces Not	
		Subject To	Subject To	
		Ded. & Coins.	Ded. & Coins.	
		(see inst.)	(see inst.)	
		6.00	7. 00	
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
51.01	05101 ENDOSCOPY	0	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	54. 00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0	0	54. 01
54.08	05408 RADI OLOGY-GSH BREAST CENTER	0	0	54. 08
60.00	06000 LABORATORY	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	961	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	75. 00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	76. 00
76. 01	03950 INPATIENT DIALYSIS	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS			
90.00	09000 CLI NI C	0	0	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96. 00
200.00	Subtotal (see instructions)	0	961	200.00
201.00	Less PBP Clinic Lab. Services-Program	0		201. 00
	Only Charges			
202.00	Net Charges (line 200 +/- line 201)	0	961	202. 00

						6.5	
	Financial Systems	GOOD SAMARITA		0011 450040		eu of Form CMS-2	2552-10
APPOR I	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	IL COSTS	Provi der	CCN: 150042	Peri od: From 01/01/2015	Worksheet D Part II	
			Component	t CCN: 15T042	To 12/31/2015		nared:
					10 12/01/2010	5/25/2016 9:5	
			Ti tl	e XVIII	Subprovi der -	PPS	
					I RF		
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
	T	1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	676, 014		1			
51. 00	05100 RECOVERY ROOM	0	_				
51. 01	05101 ENDOSCOPY	395, 933					
52.00	05200 DELIVERY ROOM & LABOR ROOM	15, 810					52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	802, 913					
54. 01	05401 RADI OLOGY-NON-CAMPUS	158, 757				639	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	2, 079					54. 08
60.00	06000 LABORATORY	334, 209		1			
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	5, 307					63.00
65.00	06500 RESPI RATORY THERAPY	199, 905					
66.00	06600 PHYSI CAL THERAPY	293, 954	29, 030, 640	0. 01012	26 5, 913, 748	59, 883	66. 00
69. 00	06900 ELECTROCARDI OLOGY	546, 971	33, 053, 093			1, 752	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	00	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	240, 461	5, 789, 411	0. 04153	35 22, 440		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	54, 268	9, 084, 814	0.00597	73 223, 766	1, 337	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	39, 767	11, 775, 860	0.00337			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	437, 998	59, 815, 030	0. 00732	907, 917	6, 649	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	132, 240	23, 152, 477	0.0057	12 0	0	75. 00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	0.00000	00	0	76.00
76. 01	03950 INPATIENT DIALYSIS	255, 660	1, 303, 786	0. 1960	90 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	102, 866	4, 230, 665	0. 0243	14 0	0	90.00
91.00	09100 EMERGENCY	651, 338	38, 066, 649		10 90, 291	1, 545	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	11, 072, 645	0.00000	202, 628	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	14, 136	632, 423	0. 0223	52 0		
200.00	Total (lines 50-199)	5, 360, 586	432, 767, 597		9, 677, 632	98, 657	200. 00

Health Financial Contant	COOD CAMADITA	N HOCDITAL		1 1:-	£ F CMC	2552 42
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	GOOD SAMARITAI		CCN 150042		u of Form CMS-: Worksheet D	2552-10
THROUGH COSTS	WICE UTHER PASS	Provider	CCN: 150042	Peri od: From 01/01/2015	Part IV	
THROUGH COSTS		Component	CCN: 15T042			pared:
		· ·			5/25/2016 9:5	
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Non Physician N	Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00	0.00	0.00	4.00	4)	
ANOLLI ADV. CEDIU OF COCT. OFNITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			I	0 0		F0 00
50. 00 05000 OPERATING ROOM	0	0		0 0	0	
51. 00 05100 RECOVERY ROOM	0	0		0 0	0	
51. 01 05101 ENDOSCOPY	0	0		0	0	51. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	0.45 7	0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	245, 7		245, 763	1
54. 01 05401 RADI OLOGY-NON-CAMPUS	0	0		0 0	0	1
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0	0	10.7	0 0	0	
60. 00 06000 LABORATORY	0	0	19, 7		19, 760	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	
70. 01 07001 NEURODI AGNOSTI CS	0	0		0	0	70. 01
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0		0	0	,
76. 00 03020 MH ANCI LLARY OUTPATI ENT	0	0		0 0	0	76. 00
76. 01 03950 I NPATI ENT DI ALYSI S	0	0		0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS			ı			
90. 00 09000 CLI NI C	0	0	1	0 0	0	
91. 00 09100 EMERGENCY	0	0		0 0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART	0	0		0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS			1			0, 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0		
200.00 Total (lines 50-199)	0	0	265, 5	23 0	265, 523	1200.00

Heal th Financial Systems GOOD SAMARITAN HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150042 Component CCN: 15T042 To 12/31/2015 To 12/31/2015 Date/Time Prepared: 5/25/2016 9: 57 am Title XVIII Cost Center Description Total Outpatient Cost (sum of Cost (sum of Cost (sum of Col. 2, 3 and Col. 3 and Col. 2, 3 and Col. 3 and Col. 2, 3 and Col. 3 an
THROUGH COSTS Component CCN: 15T042 Title XVIII Cost Center Description Total Outpatient Cost (sum of col. 2, 3 and col. 3, 3 and col. 2, 3 and col. 2, 3 and col. 3,
Component CCN: 15T042 To 12/31/2015 Date/Time Prepared: 5/25/2016 9: 57 am Title XVIII Subprovider - IRF Cost Center Description Total Outpatient Cost (sum of Cost (sum of Cost (sum of Col. 2, 3 and Col. 2, 3 and Col. 2, 3 and Component CCN: 15T042 To 12/31/2015 Date/Time Prepared: 5/25/2016 9: 57 am PPS Ratio of Cost (outpatient Cost (from Wkst. C, to Charges (col. 5 ÷ col. to Charges (col. 6 ÷ col. col. col. 6 + col. col. col. col. col. col. col. col.
Title XVIII Subprovider - PPS Cost Center Description Total Outpatient Cost (sum of Cost (sum of Col. 2, 3 and Col. 2, 3 and S) Outpatient Cost (sum of Col. 2, 3 and S) Outpatient Cost (sum of Col. 2, 3 and S) Subprovider - PPS IRF Outpatient (from Wkst. C, Part I, col. (col. 5 ÷ col. (col. 6 + col
Cost Center Description Total Outpatient (from Wkst. C, Cost (sum of Cost (sum of Col. 2, 3 and Col. 2, 3 and Col. 2, 3 and Cost (sum of Cost (sum of Col. 2, 3 and Cost (sum of Col. 2, 3 and Cost (sum of Cost (sum of Col. 3) (subprovider - IRF Total Charges Ratio of Cost (outpatient to Charges (col. 5 ÷ col. 5 + col. 5) (col. 6 ÷ col. 5) Subprovider - IRF Outpatient (from Wkst. C, Part I, col. 5) (col. 5 ÷ col. 5) (col. 6 ÷ col. 5)
Cost Center Description Total Total Charges Ratio of Cost Outpatient Outpatient Cost (sum of Co
Cost Center Description Total Total Charges Ratio of Cost Outpatient (from Wkst. C, Cost (sum of Cost (sum o
Outpatient (from Wkst. C, to Charges Cost (sum of cost (sum of col. 2, 3 and 8) Outpatient (from Wkst. C, to Charges (col. 5 ÷ col. to Charges (col. 6 ÷ col. col. col. col. col. col. col. col.
col . 2, 3 and 8) 7) (col . 6 ÷ col .
4) 7)
6.00 7.00 8.00 9.00 10.00
ANCILLARY SERVICE COST CENTERS
50. 00 05000 0PERATI NG ROOM 0 27, 275, 695 0.000000 0.000000 83, 661 50.00
51. 00 05100 RECOVERY ROOM 0 0.000000 0.000000 0 51. 00
51. 01 05101 ENDOSCOPY 0 12, 697, 442 0. 000000 0. 000000 58, 637 51. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 3, 993, 278 0.000000 0.000000 0 52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 245, 763 78, 647, 688 0. 003125 0. 003125 381, 565 54. 00
54. 01 05401 RADI OLOGY-NON-CAMPUS 0 17, 672, 034 0.000000 0.000000 71, 106 54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER 0 443, 767 0.000000 0.000000 0 54. 08
60. 00 06000 LABORATORY 19, 760 48, 779, 038 0. 000405 0. 000405 787, 117 60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 3, 582, 356 0.000000 0.000000 17, 445 63. 00
65. 00 06500 RESPI RATORY THERAPY 0 12, 668, 806 0. 000000 0. 000000 803, 449 65. 00
66. 00 06600 PHYSI CAL THERAPY 0 29, 030, 640 0. 000000 0. 000000 5, 913, 748 66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 33, 053, 093 0. 000000 0. 000000 105, 894 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0. 000000 0 70. 00
70. 01 07001 NEURODI AGNOSTI CS 0 5, 789, 411 0. 000000 0. 000000 22, 440 70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 9, 084, 814 0.000000 0.000000 223, 766 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 11, 775, 860 0.000000 0.000000 7, 968 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 59, 815, 030 0.000000 0.000000 907, 917 73. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 23, 152, 477 0. 000000 0. 000000 0 75. 00
76. 00 03020 MH ANCI LLARY OUTPATI ENT 0 0 0. 000000 0. 000000 0 76. 00
76. 01 03950 I NPATI ENT DI ALYSI S 0 1, 303, 786 0. 000000 0. 000000 0 76. 01
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC 0 4, 230, 665 0. 000000 0. 000000 0 90. 00
91. 00 09100 EMERGENCY 0 38, 066, 649 0. 000000 0. 000000 90, 291 91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0 11, 072, 645 0. 000000 0. 000000 202, 628 92. 00
OTHER REIMBURSABLE COST CENTERS
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 632, 423 0.000000 0.000000 0 96. 00
200. 00 Total (lines 50-199) 265, 523 432, 767, 597 9, 677, 632 200. 00

Hoal th	Financial Systems	GOOD SAMARITA	N HOSDITAI		In Lio	u of Form CMS-	2552 10
APPORT	TITMAINER AT SYSTEMS TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER THE COSTS		Provi der	CCN: 150042 t CCN: 15T042	Peri od: From 01/01/2015	Worksheet D Part IV Date/Time Pre 5/25/2016 9:5	pared:
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10) 11.00	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12) 13.00	h		
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00			
50.00	05000 OPERATI NG ROOM	0	1, 197		0		50.00
51.00	05100 RECOVERY ROOM	0	0	1	0		51.00
51. 01	05101 ENDOSCOPY	0	0)	0		51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 192	0)	0		54. 00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0	0)	0		54. 01
54.08	05408 RADI OLOGY-GSH BREAST CENTER	0	0		0		54. 08
60.00	06000 LABORATORY	319	0		0		60. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	0		63. 00
65.00	06500 RESPI RATORY THERAPY	0	0	1	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	1	0		66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0)	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0		70. 00
70. 01	07001 NEURODI AGNOSTI CS	0	0)	0		70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1	0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	1	0		73. 00
	07500 ASC (NON-DISTINCT PART)	0	0	1	0		75. 00
76.00	03020 MH ANCILLARY OUTPATIENT	0	0	·	0		76. 00
76. 01	03950 I NPATI ENT DI ALYSI S	0	0	1	0		76. 01

0

1, 511

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90.00

91. 00

92.00

96.00

200. 00

0

1, 197

OUTPATIENT SERVICE COST CENTERS

OTHER REI MBURSABLE COST CENTERS
96.00 OP600 DURABLE MEDI CAL EQUI P-RENTED
200.00 Total (Lines 50-199)

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

09000 CLI NI C

90.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 01/01/2015	Part V	
		Component	CCN: 15T042	To 12/31/2015	Date/Time Pre 5/25/2016 9:5	pared:
		T: +1	e XVIII	Subprovi der -	9: 5 PPS	/ am
		11 11	e xviii	I RF	PPS	
			Charges	IKF	Costs	
Cost Center Description	Cost to Charge	DDC Doimburged		Cost	PPS Services	
cost center bescription		Servi ces (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
	Part I, col. 9	HISt.)	Subject To	Subject To		
	Part 1, COI. 9		Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	0. 277198	1, 197		0	332	50.00
51. 00 05100 RECOVERY ROOM	0. 277198	1, 197		0 0	0	51.00
		0		0		
	0. 213143	0		0	0	51. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 207239	0		0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 133829	0		0	0	54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS	0. 114335	0		0	0	54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0. 683090	0		0	0	54. 08
60. 00 06000 LABORATORY	0. 138187	0		0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 273476	0		0	0	63. 00
65. 00 06500 RESPI RATORY THERAPY	0. 277322	0		0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 164985	0		0 0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 182250	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 182932	0		0 0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 107165	0		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 228542	0		0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 359626	0		0 4, 042	0	73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 201998	0		0 0	0	75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0. 000000	0		0	0	76. 00
76. 01 03950 I NPATIENT DIALYSIS	0. 698974	0		0	0	76. 01
OUTPATIENT SERVICE COST CENTERS	2. 2. 3,7,1					1
90. 00 09000 CLINIC	0. 495326	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 218113	0		0 0	o o	
02 00 00200 ORSEDVATION REDS (NON DISTINCT DART	0.105430	0		م م	0	

0. 185439 0. 297026 0 0

0 0

0

1, 197

1, 197

4, 042 0

4, 042

91. 00 92. 00

96.00 0

332 200. 00 201. 00

332 202. 00

200.00

201.00

202.00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 +/- line 201)

Health Financial Systems	GOOD SAMARIT	AN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST		Provi der	CCN: 150042	Peri od: From 01/01/2015	Worksheet D Part V	
			Component	CCN: 15T042	To 12/31/2015	Date/Time Pre 5/25/2016 9:5	pared: 7 am
			Ti tl	e XVIII	Subprovi der -	PPS	
					IRF		
	Co	sts					
Cost Center Description	Cost		Cost				
	Rei mbursed	Rei	mbursed				
	Servi ces	Serv	vices Not				
	Subject To	Sub	ject To				
	Ded. & Coins.	Ded.	& Coins.				
	(see inst.)	(se	e inst.)				

	Costs	
Cost Center Description	Cost Cost	
	Reimbursed Reimbursed	
	Services Services Not	
	Subject To Subject To	
	Ded. & Coins. Ded. & Coins	
	(see inst.) (see inst.)	
	6.00 7.00	
ANCILLARY SERVICE COST CENTERS		
50.00 05000 OPERATING ROOM	0	0 50.00
51.00 05100 RECOVERY ROOM	0	0 51.00
51. 01 05101 ENDOSCOPY	0	0 51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0 52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0 54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS	0	0 54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0	0 54.08
60. 00 06000 LABORATORY	0	0 60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	0 63.00
65. 00 06500 RESPIRATORY THERAPY	o	0 65.00
66. 00 06600 PHYSI CAL THERAPY	o	0 66.00
69. 00 06900 ELECTROCARDI OLOGY	o	0 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0 70.00
70. 01 07001 NEURODI AGNOSTI CS	o	0 70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	o	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0 1, 45	4 73.00
75.00 07500 ASC (NON-DISTINCT PART)	ol	0 75.00
76. 00 03020 MH ANCI LLARY OUTPATIENT	ol	0 76.00
76. 01 03950 INPATIENT DIALYSIS	ol	0 76. 01
OUTPATIENT SERVICE COST CENTERS		
90. 00 09000 CLI NI C	0	0 90.00
91. 00 09100 EMERGENCY	ol	0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	ol	0 92.00
OTHER REIMBURSABLE COST CENTERS		
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	96.00
200.00 Subtotal (see instructions)	0 1, 45	4 200.00
201.00 Less PBP Clinic Lab. Services-Program	ol	201.00
Only Charges		
202.00 Net Charges (line 200 +/- line 201)	0 1, 45	4 202.00
		•

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/25/2016 9:5	pared:
		Ti t	le XIX	Hospi tal	Cost	/ dill
		11.0	Charges	поэрт саг	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
555 C 5511 C 5555 T P C 511	Ratio From	Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(555 111511)	
	Part I, col. 9		Subject To	Subject To		
	·		Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 277198	0	1, 807, 40	0	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000)	0 0	0	51.00
51. 01 05101 ENDOSCOPY	0. 213143	0	1, 275, 66	9 0	0	51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 207239	0	44, 42	8 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 133829	0	7, 880, 04	.9	0	54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS	0. 114335	0	1, 815, 45	5 0	0	54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER	0. 683090	0	52, 03	0	0	54. 08
60. 00 06000 LABORATORY	0. 138187	0	4, 081, 19	5 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 273476	0	197, 77	9 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 277322	0	324, 02	2 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 164985		1, 912, 87	8 0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	0. 182250	0	2, 905, 49	0 0	0	07.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 182932	0	658, 70	0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 107165	0	267, 44		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 228542	0	215, 74		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 359626	0	5, 105, 41		0	73. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 201998	l e	2, 724, 01		0	75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0. 000000	0)	0	1	76. 00
76. 01 03950 I NPATI ENT DI ALYSI S	0. 698974	0	9, 51	3 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS		г	T	_1		4
90. 00 09000 CLI NI C	0. 495326	l e	499, 71		•	70.00
91. 00 09100 EMERGENCY	0. 218113		0,020,72			,
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0. 185439		911, 67	4 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	0.20702/		1 (5.24	7	0	1 00 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 297026	0	1,			
200.00 Subtotal (see instructions)			36, 380, 59	0	i	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges						201. 00
202.00 Net Charges (line 200 +/- line 201)		0	36, 380, 59	0	0	202. 00
202.00 Net charges (11116 200 +/ - 11116 201)	I	1	1 30, 300, 37	ارا	, 0	1202.00

Health Financial Systems	GOOD SAMARITAN HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 150042	Peri od:	Worksheet D

From 01/01/2015 Part V To 12/31/2015 Date/Time Prepared: 5/25/2016 9:57 am Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Reimbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 501, 008 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05101 ENDOSCOPY 271, 900 0 51 01 51.01 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 9, 207 52.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 054, 579 54.00 0 54. 01 05401 RADI OLOGY-NON-CAMPUS 207.570 54.01 05408 RADI OLOGY-GSH BREAST CENTER 0 54.08 35, 541 54.08 60.00 06000 LABORATORY 563, 968 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 54, 088 0 63.00 63.00 06500 RESPIRATORY THERAPY 89. 858 0 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 315, 596 0 66.00 69.00 06900 ELECTROCARDI OLOGY 529, 526 0 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 Ol 07001 NEURODI AGNOSTI CS 120, 498 70.01 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 296, 109 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 49, 306 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 836, 040 0 73.00 07500 ASC (NON-DISTINCT PART) 0 75.00 550, 245 75.00 76.00 03020 MH ANCILLARY OUTPATIENT 0 76.00 03950 INPATIENT DIALYSIS 6,649 0 76.01 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 247, 521 0 91.00 09100 EMERGENCY 791,037 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 169, 060 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 19, 380 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 200.00 Subtotal (see instructions) 7, 718, 686 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 201. 00 Only Charges

7, 718, 686

0

202.00

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems	GOOD SAMARITAN H	IOSPI TAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT	OPERATING COST	Provi der CCN: 150042	From 01/01/2015	Worksheet D-1 Date/Time Prepared: 5/25/2016 9:57 am
-		Title XVIII	Hospi tal	DDS

		Title XVIII	Hospi tal	5/25/2016 9:5 PPS	7 am
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days	vate room days,	18, 107 18, 107 0	1. 00 2. 00 3. 00	
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room reporting period		r 31 of the cost	16, 248 0	4. 00 5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)			0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)			10, 646	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only through December 31 of the cost reporting period (see instructions)	ons)	,	0	10.00
11. 00 12. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX	er O on this line)	, ,	0	11. 00 12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	3 .	,	0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program	r, enter O on this line	e)	0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	0	15. 00 16. 00		
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	0.00	17. 00		
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	0.00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0.00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost report	ng period (line	19, 999, 536 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		0 19, 999, 536	26. 00 27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges)			0	29. 00 30. 00
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	30.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line	31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	d private room cost di	fferential (line	19, 999, 536	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS'	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i		T	1, 104. 52	38. 00
39. 00	Program general inpatient routine service cost per drem (see 1	•		11, 758, 720	39. 00
40. 00	Medically necessary private room cost applicable to the Program	-		0	40. 00
	Total Program general inpatient routine service cost (line 39 +	,		11, 758, 720	

Heal th	Financial Systems	GOOD SAMARITAN	I HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST			CCN: 150042	Peri od:	Worksheet D-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
			T; +1	e XVIII	Hospi tal	5/25/2016 9: 5 ¹ PPS	7 am
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient Cost		Diem (col. 1		(col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	2.00				42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	8, 965, 597	6, 762	1, 325.	3, 158	4, 187, 129	43. 00 44. 00
45. 00							45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wks					17, 460, 776	
49. 00	Total Program inpatient costs (sum of lines 4	1 through 48)(s	ee instructio	ns)		33, 406, 625	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	itient routine s	ervices (from	ı Wkst. D. sur	n of Parts I and	2, 066, 740	50. 00
	[111)		·				
51. 00	Pass through costs applicable to Program inpa and IV)	itient ancillary	services (fr	om Wkst. D, s	sum of Parts II	1, 023, 328	51. 00
52. 00	Total Program excludable cost (sum of lines 5	0 and 51)				3, 090, 068	52. 00
53.00	Total Program inpatient operating cost exclud	9 1	ated, non-phy	sician anesth	netist, and	30, 316, 557	53. 00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	2)					
54. 00	Program discharges					0	54. 00
55.00	Target amount per discharge					0.00	55. 00
56. 00	Target amount (line 54 x line 55)			! F/!	1: 52)	0	56. 00
57. 00 58. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and tar	get amount (i	ine 56 minus	TINE 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	orting period e	ndi ng 1996, u	pdated and co	ompounded by the		59. 00
	market basket					0.00	
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of lines 53/54 is less than the lower of lines				the amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than						01.00
	amount (line 56), otherwise enter zero (see i	nstructions)					
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	62. 00 63. 00
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(555 77151745					00.00
64. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s through Decem	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	s after Decembe	r 31 of the c	ost reporting	period (See	o	65. 00
	instructions)(title XVIII only)			-> <			
66. 00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ie costs (line 6	4 plus line 6	5)(TITIE XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	costs through	December 31 o	of the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	costs after Do	combor 21 of	the cost rong	orting ported		68. 00
08.00	(line 13 x line 20)	costs after be	cember 31 or	the cost repo	of tring period		08.00
69. 00	Total title V or XIX swing-bed NF inpatient r					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				1		70. 00
71. 00	Adjusted general inpatient routine service co	,		• • • • • • • • • • • • • • • • • • • •			71. 00
72.00	Program routine service cost (line 9 x line 7		/II.	25)			72.00
73. 00 74. 00	Medically necessary private room cost applica Total Program general inpatient routine servi						73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient r				Part II, column		75. 00
	26, line 45)	>					
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79. 00	Aggregate charges to beneficiaries for excess			· .			79. 00
80. 00 81. 00	Total Program routine service costs for compa		st limitation	ı (line 78 mir	nus line 79)		80. 00 81. 00
82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li						82. 00
83. 00	Reasonable inpatient routine service costs (s	ee instructions)				83. 00
84.00	Program inpatient ancillary services (see ins		->				84. 00
85. 00 86. 00	Utilization review - physician compensation (Total Program inpatient operating costs (sum						85. 00 86. 00
55. 60	PART IV - COMPUTATION OF OBSERVATION BED PASS						55. 50
87. 00	Total observation bed days (see instructions)					1, 859	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per d Observation bed cost (line 87 x line 88) (see	•	iine 2)			1, 104. 52 2, 053, 303	
_ , . 00	(300 (300)	40 (7 0110)					50

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/25/2016 9:5	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	2, 732, 437	19, 999, 536	0. 13662	5 2, 053, 303	280, 533	90.00
91.00 Nursing School cost	0	19, 999, 536	0.00000	2, 053, 303	0	91.00
92.00 Allied health cost	0	19, 999, 536	0.00000	2, 053, 303	0	92.00
93.00 All other Medical Education	0	19, 999, 536	0.00000	2, 053, 303	0	93. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150042	Peri od: From 01/01/2015	Worksheet D-1
	Component CCN: 15SO42	To 12/31/2015	Date/Time Prepared: 5/25/2016 9:57 am
	Title XVIII	Subprovider -	PPS

PAPET A.L. REPOVED RECONDUCTION PAPET A.L. REPOVED RECONDUCTION PAPET A.L. REPOVED RECONDUCTION REPORT A.L. REPOVED RECONDUCTION A.L. REPOVED REPOVED RECONDUCTION A.L. REPOVED			TI LIE AVIII	I PF	FF3	
NAME		Cost Center Description			1.00	
INPATIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatient days (including private room days, excluding swing-bed and neberon days) 1.7 you have only private room days, (calluding swing-bed and observation bed days) 1.7 you have only private room days, (and only private room days, and only private room days) 4.219 4.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days 4,219 4,00						
do not complete finis line. 4. 05 Sele-privater room days (excluding saring-bed and observation bed days) through Becember 31 of the cost period (including private room days) after December 31 of the cost period reporting period (including private room days) after December 31 of the cost period reporting period (including private room days) after December 31 of the cost period reporting period (including private room days) after December 31 of the cost period reporting period (including private room days) after December 31 of the cost period reporting period (including private room days) after December 31 of the cost period reporting period (including private room days) after December 31 of the cost period reporting period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost period (including private room days) after December 31 of the cost reporting period (see instruction of the Cost period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days)						
Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SF type inpatient days (including private room days) after December 31 of the cost of control to the private room days after December 31 of the cost of control ting period (if calendar year, enter 0 on this 11 ne) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11 ne) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11 ne) 7.00 Total inpatient days including private room days after December 31 of the cost reporting period (if calendar year, enter 0 on this 11 ne) 7.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.00 Swing-bed NF type inpatient days applicable to the Program (excluding private room days) 7.01 Swing-bed NF type inpatient days applicable to the Program (excluding private room days) 7.01 Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this 11 ne) 7.00 Medically recessary private room days applicable to services through December 31 of the cost reporting period (including private room days) 7.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including private room days applicable to NF type servi	3.00		i. II you have only pri	vate room days,	U	3.00
report in period of the cost report in 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 of th	4.00		days)		4, 219	4. 00
1 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) 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 swing-bed NF type inpatient days (including private room days) after December 31 of the cost No. 00	5.00		days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed Ni type inpatient days (including private room days) after December 31 of the cost 8.00 Total swing-bed Ni type inpatient days (including private room days) after December 31 of the cost 9.00 Total swing-bed Ni type inpatient days (including private room days) after December 31 of the cost 9.00 Total swing-bed Ni type inpatient days (including private room days) after December 31 of the cost 9.00 Total swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and 9.00 Total swing-bed SNF type inpatient days applicable to the Program (excluding 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 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 Modically incessary 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 Modically incessary private room days applicable to services after December 31 of the cost 18.00 Modically incessary private room days applicable to services after December 31 of the cost 19.00 Modical rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Modical rate for swing-bed SNF services applicable to services after December 31 of the cost 19.00 Modical rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Modical rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x x line 10) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x x line 10) 23.00 Swing-bed cost applicable to SNF type services	6 00		days) after December 3	21 of the cost		6.00
Total swing-bed NF type inpatient days (including private room days) affer December 31 of the cost	0.00		uays) arter becember 3	or or the cost	o l	0.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days including private room days applicable to the program (excluding private room days) Total period (see instructions) Total nursery days (title V or XIX only) Medical rate for swing-bed NF services applicable to services through December 31 of the cost Total period (see instructions) Medical rate for swing-bed NF services applicable to services after December 31 of the cost Total general inpatient routine service cost (see instructions) Medical general inpatient routine service cost (see instructions) Medical general inpatient routine service sthrough December 31 of the cost reporting period (line S X IIne 17) Total general inpatient routine service cost (see instructions) Medical general inpatient routine service cost (see instructions) Medical general inpatient period (see instructions) Medical general inpatient routine service cost (see instructions) Medical general inpatient ro	7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 0.0 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 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 supplied SNF type inpatient days applicable to title XVIII only on this line) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only on this line) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after supplied SNF type inpatient days applicable to titles Y or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles Y or XIX only (including private room days) after supplied SNF type inpatient days applicable to titles Y or XIX only (including private room days) after supplied SNF type inpatient days applicable to the Program (excluding swing-bed days) 13.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 14.00 SNIN SNE SNE SNE SNE SNE SNE SNE SNE SNE SN	0.00	1 91	dava) after December 21	of the cost		0.00
1.00 North Impatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 0.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 0.10.00 1.00	6.00		lays) al tel Decellibel 31	of the cost	٥	8.00
10.00 Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after brown becember 31 of the cost reporting period (see instructions) swing-bed SMr type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (incle along very enter 0 on this line) 12.00 Swing-bed NR type inpatient days applicable to titles V or XIX only (including private room days) 12.00 through December 31 of the cost reporting period (incle along very enter 0 on this line) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 after December 31 of the cost reporting period (incleandar year, enter 0 on this line) 16.00 Nursery days (title V or XIX only) 10.01 Nursery days	9. 00		the Program (excluding	swing-bed and	1, 868	9. 00
through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after December 31 of the cost reporting period (lif calendar year, enter 0 on this line) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medical processory private room days applicable to the Program (excluding private room days) 15.00 Total nursery days (title V or XIX only) 16.00 No Nursery days (title V or XIX only) 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (lacer are to reswing-bed SNF services applicable to services after December 31 of the cost reporting period (lacer are for swing-bed SNF services applicable to services after December 31 of the cost reporting period (lacer are for swing-bed SNF services applicable to services through December 31 of the cost of the cost reporting period (lacer are for swing-bed SNF services applicable to services after December 31 of the cost of the cost reporting period (lacer are to reswing-bed SNF services applicable to services after December 31 of the cost of the cost reporting period (lacer are to reswing-bed SNF services applicable to services after December 31 of the cost of the cost reporting period (lacer are to reswing-bed SNF services applicable to services after December 31 of the cost of the cost reporting period (lacer are to reswing-bed SNF services applicable to services after December 31 of the cost of the cost reporting period (line size in lacer applicable to SNF type services through December 31 of the cost reporting period (line six in line 18) 20.00 Wedicad are are for swing-bed SNF services after December 31 of the cost reporting period (line six in line 18) 21.01 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line six in line 18) 22.02 Swing-bed cost applicable to SNF type services after Dec	10.00		. (: :!			10.00
11.00 Swing-bed SNF type Inpatient days applicable to title XVIII only (Including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) 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 titles V or XIX only (Including private room 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) 18.00 Nursery days (title V or XIX only) 19.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting r	10.00			oom days)	U	10.00
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37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 480, 807 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) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37. 00 2, 480, 807 37. 00 37. 00 37. 00 37. 00 480, 807 480, 80		9 ' '	31)			
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) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			d private room cost dif	ferential (line		
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 588.01 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		27 minus line 36)	,		=, .55, 557	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 588.01 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 588.01 38.00 1,098,403 39.00 40.00			MENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,098,403 39.00 40.00	38 00				5QQ 01	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 1,098,403 41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 098, 403	41. 00

Heal th	Financial Systems	GOOD SAMARITAN	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der CCN		iod: m 01/01/2015	Worksheet D-1	
			Component CCI		12/31/2015	Date/Time Pre 5/25/2016 9:5	
			Title XV	/III Su	ıbprovi der -	PPS	7 diii
	Cost Center Description	Total			IPF Program Days	Program Cost	
		Inpatient CostII	npatient DaysDier	n (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00	INTENSIVE CARE UNIT	0	0	0. 00	0	0	43. 00 44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wk					188, 002	1
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(S	ee instructions)			1, 286, 405	49. 00
50. 00	Pass through costs applicable to Program inp	atient routine s	ervices (from Wks	st. D, sum of	Parts I and	201, 464	50. 00
51. 00	Pass through costs applicable to Program inp	atient ancillary	services (from V	Vkst. D, sum	of Parts II	10, 588	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				212, 052	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-physici	an anestheti	st, and	1, 074, 353	53. 00
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION	<u></u>					F4 00
55.00	Program discharges Target amount per discharge					0 0. 00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and tar	get amount (line	56 minus lin	e 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	•			ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re market basket	porting period e	nding 1996, updat	ted and compo	unded by the	0.00	59. 00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year				amount by	0. 00 0	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	ber 31 of the cos	st reporting	period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the cost	reporting pe	riod (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6	4 plus line 65)(1	title XVIII o	nly). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 of th	ne cost repor	ting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after De	cember 31 of the	cost reporti	na period	0	68. 00
	(line 13 x line 20)			•	ng perrou		
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c			(line 37)			70. 00 71. 00
72.00	Program routine service cost (line 9 x line	71)	,) E)			72. 00
73. 00 74. 00	Medically necessary private room cost applic Total Program general inpatient routine serv			30)			73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (from Works	sheet B, Part	II, column		75. 00
76.00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu	s line 77)					77. 00 78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			ne 78 minus	line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on	•		//		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		s)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 thr					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		line 2)				88. 00 89. 00
200	(30)				ı	·	00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	COMPUTATION OF INPATIENT OPERATING COST			Peri od:	Worksheet D-1	
		Component	CCN: 15S042	From 01/01/2015 To 12/31/2015	Date/Time Prep 5/25/2016 9:5	
		Ti tl	e XVIII	Subprovi der -	PPS	
	0 1	D 11 0 1		I PF	01 11	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (OST					
90.00 Capital -related cost	455, 027	2, 480, 807	0. 18341	9 0	0	90.00
91.00 Nursing School cost	0	2, 480, 807	0.00000	0	0	91.00
92.00 Allied health cost	0	2, 480, 807	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 480, 807	0. 00000	0	0	93. 00
COMPUTATION OF OBSERVATION BED PASS THROUGH (90.00 Gapital-related cost Nursing School cost 92.00 Allied health cost	1. 00 COST	2.00 2,480,807 2,480,807 2,480,807 2,480,807	3. 00 0. 18341 0. 00000 0. 00000	Observation Bed Cost (from line 89) 4.00 9 0 0 0 0 0	Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	91. 00 92. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150042	Peri od: From 01/01/2015	Worksheet D-1
	Component CCN: 15TO42	To 12/31/2015	Date/Time Prepared: 5/25/2016 9:57 am
	Title XVIII	Subprovider -	PPS

ABAT ALL REWORDER COMPONENTS 1.00			TI LIE AVIII	I RF	FF3	
NAMELIE LOWS NAME		Cost Center Description			1.00	
MARTIENT DAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
1.00 Impatient days (including private room days, excluding saing-bed and nebsorn days) 1.00						
A private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this I line. 4.00 Semi-private room days (excluding swing-bed and observation bed days). 5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (I cell endar year, enter 0 on this I line). 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (I cell endar year, enter 0 on this I line). 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (I cell endar year, enter 0 on this I line). 8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (I cell endar year, enter 0 on this I line). 8.00 Swing-bed SNF type inpatient days applicable to the I tel XVIII and I) (including private room days). 8.01 Swing-bed SNF type inpatient days applicable to the I tel XVIII and I) (including private room days). 8.02 Swing-bed SNF type inpatient days applicable to the I tel XVIII and I) (including private room days). 8.03 Swing-bed SNF type inpatient days applicable to the I tel XVIII and I) (including private room days). 9.04 Swing-bed SNF type inpatient days applicable to the I tel XVIII and I) (including private room days). 9.05 Swing-bed NF type inpatient days applicable to the I tel XVIII and I) (including private room days). 9.06 Swing-bed NF type inpatient days applicable to the I swing I cell day in private room days). 9.07 Swing-bed NF type inpatient days applicable to the SNF type inpatient days applicable to the SNF type inpatient days applicable to the Program (excluding swing-bed days). 9.08 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days). 9.09 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days). 9.10 Swing-bed NF type inpatient days applicable to th					· ·	
do not complete this line. 4. 00 Sell-private room days (excluding swing-bed and observation bed days) through becember 31 of the cost 5.00 lotal swing-bed SNF type inpatient days. (Including private room days) after December 31 of the cost 7.00 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 7.00 reporting period (if calendar year, enter 0 on this line) 8.00 Total sing-bed NF type inpatient days (Including private room days) after December 31 of the cost 7.00 reporting period (if calendar year, enter 0 on this line) 9.00 Total sing-bed NF type inpatient days (Including private room days) after December 31 of the cost 7.00 reporting period (if calendar year, enter 0 on this line) 9.01 Total inpatient days sincluding private room days) after December 31 of the cost 7.00 reporting period (if calendar year, enter 0 on this line) 9.02 Sing-bed SNF type inpatient days applicable to title XVIII only (Including private room days) after 9.00 reporting the period (if calendar year, enter 0 on this line) 11.00 Sing-bed SNF type inpatient days applicable to title XVIII only (Including private room days) after 9.00 sing-bed NF type inpatient days applicable to title Vor IXX only (Including private room days) after 1.00 Sing-bed NF type inpatient days applicable to title Vor IXX only (Including private room days) after 1.00 Sing-bed NF type inpatient days applicable to titles Vor XIX only (Including private room days) after 1.00 Sing-bed NF type inpatient days applicable to titles Vor XIX only (Including private room days) after 1.00 Sing-bed NF type inpatient days applicable to Sing-bed NF type inpatient days applicable to Sing-bed NF type inpatient days applicable to Sing-bed Sing-bed Archives applicable to Sing-bed Sing-bed Sing-bed Sing-bed Sing-bed Sing-bed Sing-bed Sing-bed Sing-bed S						
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reporting period (if calendar year; enter 0 on this line) 7.00 7	4.00		days)		8, 049	4.00
10 10 10 10 10 10 10 10	5.00		days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Mir type inpatient days (including private room days) through becember 31 of the cost 8. 00 Total swing-bed Mir type inpatient days (including private room days) after December 31 of the cost 10. 00 Total swing-bed Mir type inpatient days (including private room days) after December 31 of the cost 10. 00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and newton days) 11. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 11. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 12. 00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 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) 14. 00 Medically in excessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Mirror days (title V or XIX only) 16. 00 Mirror days (title V or XIX only) 17. 00 Medicare rate for swing-bed SMF services applicable to services through December 31 of the cost 18. 00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost 18. 00 Medicare rate for swing-bed SMF services applicable to services after December 31 of the cost 18. 00 Medicard rate for swing-bed SMF services after December 31 of the cost reporting period (line 8 x line 13) 18. 00 Medicard rat	6 00		days) after December 3	21 of the cost	0	6 00
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10	7.00		days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 0.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 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 SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 13.00 Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) 13.00 Swing-bed SNF 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 unrespr days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 16.00 SNIN SEND SNIN SNIN SNIN SNIN SNIN SNIN SNIN SN	0.00	1 31	dava) aftan Dagamban 21	of the cost	0	0.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 0.00	8.00		lays) after becember 3	of the cost	U	8.00
10.00 Swing-bed SMT type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) and the cost reporting period (including private room days) after the cost reporting period (including private room days) after the cost reporting period (including private room days) after the cost reporting period (including private room days) after the cost reporting period (including private room days) after the cost reporting period (including private room days) after the cost reporting period (including private room days) after the cost reporting period (including private room days) after the cost after December 31 of the cost reporting period (including private room days) after the cost after December 31 of the cost reporting period (including private room days) after the cost after December 31 of the cost reporting period (including private room days) after the cost after December 31 of the cost reporting period (including private room days) after the cost after December 31 of the cost afte	9.00		the Program (excluding	swing-bed and	6, 500	9. 00
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11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 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) 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 Nursery days (title V or XIX only) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Total nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 19.00 Medical rear for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period excluding swing-bed cost applicable to services after December 31 of the cost period for period in the cost reporting period of the cost period for swing-bed NF services applicable to services after December 31 of the cost period for period for swing-bed NF services applicable to services after December 31 of the cost period for period for swing-bed NF services applicable to services after December 31 of the cost period for period for swing-bed NF services applicable to services after December 31 of the cost for period for swing-bed for swing-bed NF services after December 31 of the cost reporting period (line for swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line for SNF type services through December 31 of the cost reporting period (line for SNF type services through December 31 of the cost reporting period (line for SNF type services after December 31 of the cost reporting period (line for SNF type services through December 31 of the cost reporting period (line for SNF type services through December 31 of the cost reporti	10.00			oom days)	0	10.00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 12.00	11.00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11.00
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14.00	13. 00		only (including private	e room days)	0	13. 00
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16. 00 Nursery days (title V or XIX only) 0 0			(excluding swing-bed of	lays)	-	
SWING BED ADJUSTMENT						
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18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19. 00 Medicald rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 19. 00	17. 00		through December 31 of	the cost	0. 00	17. 00
reporting period	18 00	1 31	after December 31 of t	he cost	0.00	18 00
reporting period	10.00	9	arter becomber 51 or t	ine cost	0.00	10.00
20. 00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10tal general inpatient routine service cost (see instructions) 7, 249, 409 21. 00 22. 00 5 wing-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) 8	19. 00		through December 31 of	the cost	0.00	19. 00
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37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 7, 249, 409 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) 900.66 38.00 7.854,290 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		9	31)			
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40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 5,854,290 41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00
	41. 00	lotal Program general inpatient routine service cost (line 39 +	line 40)	I	5, 854, 290	41. 00

44.00 CORRINATY CARE UNIT	Heal th	Financial Systems	GOOD SAMARITAN H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description	COMPUT	ATION OF INPATIENT OPERATING COST			Fr	om 01/01/2015		
Total Program (ast Program (as							5/25/2016 9:5	
Input Imput Impu				Title XV	/III S		PPS	
1.00		Cost Center Description		atient Days Diem	n (col. 1 ÷	Program Days	(col. 3 x col.	
Intensive Care Type Inpatient Respital Builts				2. 00	3. 00		5. 00	
	42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42.00
45.00 SURPH INTERSIVE CARE UNIT		INTENSIVE CARE UNIT	0	0	0.00	0	0	
Cost Center Description	46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
1 00	47. 00	· · · · · · · · · · · · · · · · · · ·						47. 00
49.00 Program inpatient costs (sum of lines 41 through 48) (see instructions) 7,918,120 49.00 Pass through costs applicable to Program inpatient routine services (from Wkst. B. sum of Parts III 100,168 51.00 111 100				>				
PASS_THROUGH COST_ADJUSTNERNTS 10.00 PASS_THROUGH COST_ADJUSTNERNTS 11.10 PASS_THROUGH COST_ADJUSTNERNTS 11.10 PASS_THROUGH COST_ADJUSTNERNTS 11.10 PASS_THROUGH COST_ADJUSTNERNTS 11.10 PASS_THROUGH COST_ADJUSTNERNTS 10.00 PASS_THROUGH COST_ADJUSTNERNTS 10		, ,						1
1110 1110	F0 00	PASS THROUGH COST ADJUSTMENTS	y , ,	,				
and IV)	50.00		atient routine ser	/ices (Trom WKS	ST. D, SUM O	T Parts I and	639, 860	50.00
17.10 17.1	51. 00		atient ancillary s	ervices (from W	/kst. D, sum	of Parts II	100, 168	51.00
medical education costs (line 4º minus line 52)	52. 00		50 and 51)				740, 028	52. 00
TARSET MOUNT AND LIMIT COMPUTATION 54.00 FORT and discharge 0.54.00 55.00 Target amount per discharge 0.00 55.00 Target amount per discharge 0.00 55.00 56.00 Target amount per discharge 0.00 56.00 Target amount	53. 00			ed, non-physici	an anesthet	ist, and	7, 178, 092	53. 00
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75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ line 2) 77.00 Program capital-related costs (line 9 x line 76) 78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Reasonable inpatient routine service costs (see instructions) 82.00 Itilization review - physician compensation (see instructions) 85.00 Utilization review - physician compensation (see instructions) 75.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Oscillation routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Comparison for the cost of		,	,	ne 14 x line 3	35)			73.00
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77. 00 Program capital-related costs (line 9 x line 76) 78. 00 Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records) 79. 00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81. 00 Inpatient routine service cost per diem limitation Inpatient routine service cost limitation (line 9 x line 81) 82. 00 Reasonable inpatient routine service costs (see instructions) 83. 00 Program inpatient ancillary services (see instructions) 85. 00 Utilization review - physician compensation (see instructions) 86. 00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87. 00 Reasonable inpatient routine service costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 88. 00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88. 00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 89. 00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2) 80. 00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)		26, line 45)		sis (IIUII WULKS	ыссь в, Раг	t II, COLUMNI		
78.00 Inpatient routine service cost (line 74 minus line 77) 79.00 Aggregate charges to beneficiaries for excess costs (from provider records) 79.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)			,					76. 00 77. 00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) 81.00 Inpatient routine service cost per diem limitation 81.00 Inpatient routine service cost limitation (line 9 x line 81) 82.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 80.00 Reasonable inpatient 79 minus line 79 81.00 Reasonable inpatient routine service cost limitation (line 78 minus line 79) 81.00 Reasonable inpatient routine 81.00 82.00 Reasonable inpatient routine 82 in structions) 83.00 Reasonable inpatient routine cost per diem (line 27 ÷ line 2)	78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
81.00 Inpatient routine service cost per diem limitation 82.00 Inpatient routine service cost limitation (line 9 x line 81) 83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST Total observation bed days (see instructions) 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 87.00 Reasonable inpatient routine service cost limitation 88.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service cost (see instructions) 89.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service costs (see instructions) 89.00 Reasonable inpatient routine service cost limitation 89.00 Reasonable inpatient routine service cost (see instructions) 89.00			·		ne 78 minus	line 79)		79.00
83.00 Reasonable inpatient routine service costs (see instructions) 84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Reasonable inpatient routine service costs (see instructions) 86.00 PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 88.00 Reasonable inpatient routine service costs (see instructions) 84.00 86.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine service costs (see instructions) 88.00 Reasonable inpatient routine service costs (see instructions) 87.00 Reasonable inpatient routine services (see instructions) 88.00 Reasonable inpatient routine services (see i	81. 00	Inpatient routine service cost per diem limi	tation	141. 511 (11	oi iida			81.00
84.00 Program inpatient ancillary services (see instructions) 85.00 Utilization review - physician compensation (see instructions) 86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Representation of the control of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2) 88.00 Representation of the cost per diem (line 27 + line 2)		l ·						82. 00 83. 00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)	84. 00	Program inpatient ancillary services (see in	structions)					84. 00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST 87.00 Total observation bed days (see instructions) 88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2) 0.00 88.00				gh 85)				85. 00 86. 00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 0.00 88.00		PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST				_	
		,		ne 2)				
	89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component	CCN: 15T042	From 01/01/2015 To 12/31/2015	Date/Time Prep 5/25/2016 9:5	
		Ti tl	e XVIII	Subprovi der -	PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	col umn 1 ÷ col umn 2	IRF Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	OST					
90.00 Capital -related cost	792, 328	7, 249, 409	0. 10929	6 0	0	90. 00
91.00 Nursing School cost	0	7, 249, 409	0. 00000	0	0	91.00
92.00 Allied health cost	0	7, 249, 409			0	92.00
93.00 All other Medical Education	0	7, 249, 409	0.00000	0 0	0	93. 00

Health Financial Systems GOOD SAMARITAN H	_			u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od: From 01/01/2015	Worksheet D-3	
			To 12/31/2015	Date/Time Pre	pared:
				5/25/2016 9:5	7 am
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	13, 292, 698		30. 00
31. 00 03100 NTENSI VE CARE UNI T			6, 160, 875		31. 00
40. 00 04000 SUBPROVI DER - PF			0, 100, 070		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 27719	8, 611, 269	2, 387, 027	50.00
51. 00 05100 RECOVERY ROOM		0.00000	00	0	51.00
51. 01 05101 ENDOSCOPY		0. 21314	1, 058, 326	225, 575	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 20723	39 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13382		960, 361	54.00
54. 01 05401 RADI OLOGY-NON-CAMPUS		0. 11433	35 1, 172, 774	134, 089	54. 01
54. 08 05408 RADI OLOGY-GSH BREAST CENTER		0. 68444		0	54.08
60. 00 06000 LABORATORY		0. 13818		1, 267, 315	60.00
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.		0. 27347		334, 636	63.00
65. 00 06500 RESPI RATORY THERAPY		0. 27732		1, 524, 585	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 16498		·	
69. 00 06900 ELECTROCARDI OLOGY		0. 18247		1, 124, 740	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70. 00
70. 01 07001 NEURODI AGNOSTI CS		0. 18523		22, 417	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 10716		2, 942, 363	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 22854		913, 871	72. 00
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 35962			73. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0. 20203		0	75. 00
76. 00 03020 MH ANCI LLARY OUTPATI ENT		0.00000		0	76. 00
76. 01 03950 I NPATI ENT DI ALYSI S		0. 70985	961, 918	682, 822	76. 01
OUTPATIENT SERVICE COST CENTERS		0.4002	10 0	0	00 00

0. 499240

0.219067

0. 185439

0. 297026

3, 198, 012

1, 100, 496

65, 396, 673

65, 396, 673

0 90.00

91.00

92.00

0 96.00

201. 00 202. 00

700, 579

204, 075

17, 460, 776 200. 00

90.00

91.00

92.00

96.00

200.00

201.00

202.00

09000 CLI NI C

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

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

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

09600 DURABLE MEDICAL EQUIP-RENTED

+ -	coop camap	I TAN JIOCOJ TAJ		111-	£ E OMC	2552 40
	nancial Systems GOOD SAMARI T ANCILLARY SERVICE COST APPORTIONMENT	ITAN HOSPITAL	CCN: 150042	Period:	eu of Form CMS- Worksheet D-3	
INIAILIN	ANGIELANI SERVICE GOST ALTONITONMENT		t CCN: 15S042	From 01/01/2015		pared:
		Ti tl	e XVIII	Subprovi der - I PF	PPS	7 alli
	Cost Center Description		Ratio of Cos To Charges	Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
LN	PATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
	1000 ADULTS & PEDIATRICS		I	0		30.00
31. 00 03 40. 00 04 41. 00 04	ADDET SEPTIMES THOO INTENSIVE CARE UNIT THOO SUBPROVIDER - IPF THOO SUBPROVIDER - IRF THOO SUBPROVIDER - IRF THOO SUBPROVIDER - IRF			2, 248, 108 0		31. 00 40. 00 41. 00 43. 00
	CILLARY SERVICE COST CENTERS					
50. 00 05	1000 OPERATI NG ROOM 1000 RECOVERY ROOM		0. 2771 0. 0000			1
1	101 ENDOSCOPY		0. 2131		24	
	200 DELIVERY ROOM & LABOR ROOM		0. 2072		0	
	400 RADI OLOGY-DI AGNOSTI C		0. 1338		8, 280	1
54. 01 05	401 RADI OLOGY-NON-CAMPUS		0. 1143			54. 01
54. 08 05	408 RADI OLOGY-GSH BREAST CENTER		0. 6844	43 0	0	54. 08
60. 00 06	000 LABORATORY		0. 1381	87 151, 947	20, 997	60.00
63. 00 06	300 BLOOD STORING, PROCESSING & TRANS.		0. 2734	76 0	0	63.00
65. 00 06	500 RESPI RATORY THERAPY		0. 2773	22 128, 788	35, 716	65.00
66. 00 06	600 PHYSI CAL THERAPY		0. 1649	85 67, 932	11, 208	66. 00
69. 00 06	900 ELECTROCARDI OLOGY		0. 1824	72 16, 423	2, 997	69. 00
70. 00 07	OOO ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	70.00
70. 01 07	OO1 NEURODI AGNOSTI CS		0. 1852	39 0	0	70. 01
71. 00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 1071	65 4, 041	4, 474	71. 00
72. 00 07	200 IMPL. DEV. CHARGED TO PATIENTS		0. 2285	42 0	0	72. 00
73. 00 07	300 DRUGS CHARGED TO PATIENTS		0. 3596	26 167, 858	60, 366	73. 00
75. 00 07	500 ASC (NON-DISTINCT PART)		0. 2020	39 0	0	75. 00
76. 00 03	020 MH ANCILLARY OUTPATIENT		0.0000	00	0	76. 00
76. 01 03	950 INPATIENT DIALYSIS		0. 7098	7, 831	5, 559	76. 01
OU.	TPATIENT SERVICE COST CENTERS					
90.00 09	000 CLI NI C		0. 4992	40 0	0	90. 00
91.00 09	100 EMERGENCY		0. 2190	67 152, 363	33, 378	91. 00
92.00 09	200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1854	39 10, 210	1, 893	92. 00
OT	HER REIMBURSABLE COST CENTERS					
96. 00 09	600 DURABLE MEDICAL EQUIP-RENTED		0. 2970	26 0	0	96. 00
200.00	Total (sum of lines 50-94 and 96-98)			785, 404	188, 002	200.00
201.00	Less PBP Clinic Laboratory Services-Program only ch	arges (line 61)		0		201. 00
202. 00	Net Charges (line 200 minus line 201)	•	1	785, 404		202. 00

	Financial Systems GOOD SAMARITAN HC ENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150042	Period:	u of Form CMS-2 Worksheet D-3	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider	CCN: 150042	From 01/01/2015	worksneet D-3	
		•		To 12/31/2015	5/25/2016 9:5	
		Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30.00	03000 ADULTS & PEDI ATRI CS			0		30.00
31. 00	03100 NTENSI VE CARE UNIT			0		31.00
40.00	04000 SUBPROVI DER - I PF			0		40.00
	04100 SUBPROVI DER – I RF			6, 187, 740		41.00
	04300 NURSERY			0, 107, 710		43.00
.0.00	ANCI LLARY SERVI CE COST CENTERS					10.00
50.00	05000 OPERATI NG ROOM		0. 27719	98 83, 661	23, 191	50.00
51. 00	05100 RECOVERY ROOM		0. 00000		0	1
51. 01	05101 ENDOSCOPY		0. 21314		12, 498	51.01
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 20723	·	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 13382	381, 565	51, 064	54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS		0. 11433		8, 130	
54. 08	05408 RADI OLOGY-GSH BREAST CENTER		0. 68444	13 0	0	54.08
60.00	06000 LABORATORY		0. 13818	787, 117	108, 769	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0. 27347	76 17, 445	4, 771	63.00
65.00	06500 RESPI RATORY THERAPY		0. 27732	22 803, 449	222, 814	65.00
66.00	06600 PHYSI CAL THERAPY		0. 16498	5, 913, 748	975, 680	66. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 18247	72 105, 894	19, 323	
70.00	07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.00
	07001 NEURODI AGNOSTI CS		0. 18523			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 10716			
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 22854		1, 821	72.00
	07300 DRUGS CHARGED TO PATIENTS		0. 35962		326, 511	
	07500 ASC (NON-DISTINCT PART)		0. 20203		0	
	03020 MH ANCI LLARY OUTPATI ENT		0. 00000		0	
76. 01	03950 I NPATI ENT DI ALYSI S		0. 70985	55 0	0	76. 01
00 00	OUTPATIENT SERVICE COST CENTERS		0.4000	10		00.00
	09000 CLINIC		0. 49924		10.700	
91. 00 92. 00	O9100		0. 21906	·	19, 780	
72. UU	OTHER REIMBURSABLE COST CENTERS		0. 18543	39 202, 628	37, 575	∮ 9∠. UU
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0. 29702	26 0	0	96. 00
200.00			0. 27/02	9, 677, 632	-	1
200.00		line 61)		7,011,032	2,003,630	200.00
201. UU		1110 017		i U	1	1201.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL			u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150042	Peri od:	Worksheet D-3	
			From 01/01/2015 To 12/31/2015	Date/Time Pre	narod:
			10 12/31/2013	5/25/2016 9:5	
	Ti t	le XIX	Hospi tal	Cost	, <u>u</u>
Cost Center Description		Ratio of Cos	t Inpatient	Inpati 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 & PEDIATRICS			1, 280, 009		30. 00
31.00 03100 INTENSIVE CARE UNIT			1, 054, 279		31. 00
40. 00 04000 SUBPROVI DER - I PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY			78, 092		43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 27719	•	232, 548	
51.00 05100 RECOVERY ROOM		0.00000		0	51.00
51. 01 05101 ENDOSCOPY		0. 21314	•	28, 334	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 20723		52, 520	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 13382	•		
54. 01 05401 RADI OLOGY-NON-CAMPUS		0. 11433	•		
54. 08 05408 RADI OLOGY-GSH BREAST CENTER		0. 68309		156	
60. 00 06000 LABORATORY		0. 13818	•	137, 741	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 27347		36, 557	
65. 00 06500 RESPI RATORY THERAPY		0. 27732			
66. 00 06600 PHYSI CAL THERAPY		0. 16498	•		
69. 00 06900 ELECTROCARDI OLOGY		0. 18225	•	107, 957	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	70. 00
70. 01 07001 NEURODI AGNOSTI CS		0. 18293		2, 726	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 10716	•	529, 078	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 22854	•	159, 312	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 35962			
75.00 07500 ASC (NON-DISTINCT PART)		0. 20199	•	1, 280	
76. 00 03020 MH ANCILLARY OUTPATIENT		0. 00000		0	76. 00
76. 01 03950 I NPATI ENT DI ALYSI S		0. 69897	74 85, 704	59, 905	76. 01
OUTPATIENT SERVICE COST CENTERS					
		0 40533	06	Λ .	

0.495326

0. 218113

0. 185439

0. 297026

515, 808

235, 007

5, 607

8, 741, 224

8, 741, 224

90.00

91.00

92.00

96.00

201. 00 202. 00

112, 504

43, 579

1, 665

2, 395, 475 200. 00

09000 CLI NI C

09100 EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

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

Net Charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

09600 DURABLE MEDICAL EQUIP-RENTED

90.00

91.00

92.00

96.00

200.00

201.00

202.00

ealth Financial Systems GOOD SA NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	AMARITAN HOSPITAL Provider	CCN: 150042	Peri od:	u of Form CMS-3 Worksheet D-3	
		t CCN: 15SO42	From 01/01/2015	Date/Time Pre	
	•			5/25/2016 9:5	
	Ti t	le XIX	Subprovi der - I PF	Cost	
Cost Center Description	<u> </u>	Ratio of Cos	t Inpatient	Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
D. 00 03000 ADULTS & PEDIATRICS			0		30.
1.00 03100 INTENSIVE CARE UNIT			0		31.
0. 00 04000 SUBPROVI DER - 1 PF			291, 712		40.
I. 00 04100 SUBPROVI DER - I RF			0		41.
3. 00 04300 NURSERY			0		43.
ANCILLARY SERVICE COST CENTERS					
D. 00 05000 OPERATING ROOM		0. 2771	98 0	0	50.
.00 05100 RECOVERY ROOM		0.0000		0	1
I. 01 05101 ENDOSCOPY		0. 2131		23	
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2072		0	
I. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1338	· ·	1, 082	1
4. 01 05401 RADI OLOGY-NON-CAMPUS		0. 1143		54	
I. 08 05408 RADI OLOGY-GSH BREAST CENTER		0. 6830		0	
0. 00 06000 LABORATORY		0. 1381	· ·	2, 664	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 2734		0	
5. 00 06500 RESPI RATORY THERAPY 5. 00 06600 PHYSI CAL THERAPY		0. 2773	· ·	1, 496	
2. 00 06900 ELECTROCARDI OLOGY		0. 1649 0. 1822	· ·	779 259	
0. 00 07000 ELECTROCARDI OLOGI D. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1822	· ·	259	
0. 01 07000 ELECTROLINGEFFIALOGRAFITI		0. 1829		76	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 1071		1, 094	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2285		0	1
00 07300 DRUGS CHARGED TO PATIENTS		0. 3596		7, 820	
0. 00 07500 ASC (NON-DISTINCT PART)		0. 2019	· ·	0	1
0. 00 03020 MH ANCI LLARY OUTPATI ENT		0.0000		Ō	
o. 01 03950 NPATIENT DIALYSIS		0. 6989		268	76
OUTPATIENT SERVICE COST CENTERS		•			
. 00 09000 CLI NI C		0. 4953	26 0	0	90
. 00 09100 EMERGENCY		0. 2181	13 0	0	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 1854	39 0	0	92
OTHER REIMBURSABLE COST CENTERS					
0. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 2970		0	
00.00 Total (sum of lines 50-94 and 96-98)			63, 013	15, 615	200
D1.00 Less PBP Clinic Laboratory Services-Program only	y charges (line 61)		0		201
D2.00 Net Charges (line 200 minus line 201)			63, 013		202

	inancial Systems GON T ANCILLARY SERVICE COST APPORTIONMENT	OD SAMARITAN HOSPITAL	CCN: 150042	Peri od:	u of Form CMS-2 Worksheet D-3	
INFAILL	VI ANCIELARI SERVICE COSI AFFORTIONMENT			From 01/01/2015		
		Component	CCN: 15T042		Date/Time Pre 5/25/2016 9:5	pared 7 am
		Ti t	le XIX	Subprovi der - I RF	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
	NOATH ENT. DOUTLINE OFFICE OF COOT OFFITEDO		1. 00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS		ı			
	3000 ADULTS & PEDI ATRI CS			0		30.0
	3100 I NTENSI VE CARE UNI T			0		31.0
	4000 SUBPROVI DER - I PF 4100 SUBPROVI DER - I RF			239, 797		40. C
- 1	4300 NURSERY			239, 797		43.0
	NCI LLARY SERVI CE COST CENTERS			U		43.0
	5000 OPERATING ROOM		0. 2771	98 743	206	50.0
	5100 RECOVERY ROOM		0.0000		0	1
	5101 ENDOSCOPY		0. 21314		410	
	5200 DELIVERY ROOM & LABOR ROOM		0. 2072		0	
	5400 RADI OLOGY-DI AGNOSTI C		0. 1338		2, 035	1
	5401 RADI OLOGY-NON-CAMPUS		0. 1143		405	1
	5408 RADI OLOGY-GSH BREAST CENTER		0. 6830		0	1
0.00	6000 LABORATORY		0. 1381	37 27, 041	3, 737	60.
3.00 0	6300 BLOOD STORING, PROCESSING & TRANS.		0. 2734	76 625	171	
5.00 0	6500 RESPI RATORY THERAPY		0. 2773	22 8, 504	2, 358	65.
	6600 PHYSI CAL THERAPY		0. 16498	196, 863	32, 479	66.
	6900 ELECTROCARDI OLOGY		0. 1822		651	
	7000 ELECTROENCEPHALOGRAPHY		0.00000		0	70.
	7001 NEURODI AGNOSTI CS		0. 1829:		83	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 1071		7, 892	1
1	7200 IMPL. DEV. CHARGED TO PATIENTS		0. 2285		63	1
- 1	7300 DRUGS CHARGED TO PATIENTS		0. 3596		10, 240	1
	7500 ASC (NON-DISTINCT PART)		0. 2019		0	1
	3020 MH ANCI LLARY OUTPATI ENT		0.0000		0	
	3950 INPATIENT DIALYSIS		0. 6989	74 0	0	76.
	UTPATIENT SERVICE COST CENTERS 9000 CLINIC		0.4053	24	0	00
	9000 CLINIC 9100 EMERGENCY		0. 4953 0. 2181		669	
	9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2181	•	0 0	
	THER REIMBURSABLE COST CENTERS		U. 1854.	J7 U		¹ 9∠.
	9600 DURABLE MEDICAL EQUIP-RENTED		0, 2970;	26	0	96.
00.00	Total (sum of lines 50-94 and 96-98)		0. 27/0.	297, 409	61, 399	
01.00	Less PBP Clinic Laboratory Services-Program	only charges (line 61)		271, 409	01, 399	200.
201.00	Net Charges (line 200 minus line 201)	only charges (Title 01)		297, 409		201.

PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS 0 1.00 2.00		ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150042	Peri od: From 01/01/2015		
MMI A. Mobilish IDSPINAL SURPICES DRIBER JPPS 0 1.00 2.00					To 12/31/2015	5/25/2016 9:5	pared: 7 am
Mark A - IMPAILED HIGH HIGHSPITAL SEMPLES MIDRE 1979			li tl	e XVIII	Hospi tal	PPS	
1.00 Dick mounts other than outil per payments for discharges occurring prior		DADT A INDATIENT HOSDITAL SERVICES LINDED LDDS		0	1. 00	2. 00	
1. 02 006 constructions of the than out lier payments for discharges occurring on or 21,575,300 1.02 006 constructions of the than out lier payments for discharges occurring proper of the constructions of the constructi	1.00	DRG Amounts Other than Outlier Payments			0		1.00
1.02 DRG amounts other than outlier payments for discharges occurring on or 21,975,303 1.02	1. 01		g prior		0		1. 01
1.03 1.05	1 02	To October 1 (see instructions) DRG amounts other than outlier payments for discharges occurring	a on or		21 575 303		1 02
discharges occurring prior to October 1 (see instructions)	1.02		9 011 01		21, 070, 000		1.02
1.04 Disc For Tederal special fic operating payment for Model 4 BRCI for discharges occurring on an after October 1 (see instructions) 733,734 2.00 0.11 repayments for discharges (see instructions) 733,734 2.00 0.11 repayments for discharges for Woodel 4 BRCI (see instructions) 0 2.00 0.10 0.00	1. 03				0		1. 03
discharges occurring on or after October 1 (see Instructions) 733,734 2.00 2.0	1.04				0		1. 04
2.01 Outlier reconcilitation anount 0 2.01							
2.00					/33, /34		
Bed days available of vided by number of days in the cost reporting 186.91 4.00 186.71 186.72 186.7			ns)		o		
period (see Instructions)			·		10/ 01		3.00
Indirect Medical Education Adjustment 5.00 5.	4.00		ı ng		186. 91		4.00
Cost reporting period ending on or before 12/31/1996, (see instructions) 6.00 6.		Indirect Medical Education Adjustment					
File count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 criteria for an add-on to the cap for new programs in accordance with 42 criteria for an add-on to the cap for new programs in accordance with 42 criteria for an add-on to the cap for new programs in accordance with 42 criteria for an add-on the following for the following following for the following	5. 00				0.00		5. 00
CFR 413.79(e)	6.00				0.00		6. 00
7.00 MAX Section 422 reduction amount to the IME cap as specified under 42 0.00 7.00			e with 42				
CRR \$412.105(f)(1)(1)(8)(1) CRR \$412.105(f)(1)(1)(8)(8)(2) If the cost report straddles July 1, 2011 then see Instructions.	7. 00		der 42		0.00		7. 00
CFR \$412.105(f)(1)(1)(8)(2) If the cost report straddles July 1, 2011	7.00	CFR §412. 105(f)(1)(i v)(B)(1)					1.00
then see Instructions. 8. 00 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)27(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50009 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions. 8. 02 Instructions. 8. 02 Instructions. 8. 03 The amount of increase if the hospital was awarded FTE cap slots from a capacity of the ACA. If the cost report straddles July 1, 2011, see Instructions. 8. 02 Instructions. 8. 02 Instructions. 8. 02 (see lasting hospital under section 5506 of ACA. (see instructions) 9. 00 (see instructions) 9. 00 (see instructions) 10. 00 FTE count for allopathic and osteopathic programs in the current year from your records 11. 00 FTE count for residents in dental and podiatric programs. 12. 00 Current year allowable FTE (see instructions) 13. 00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 15. 00 Sum of lines 12 through 14 divided by 3. 16. 00 Adjustment for residents in initial years of the program 17. 00 Adjustment for residents displaced by program on hospital closure 18. 00 Adjustment for residents displaced by program on hospital closure 19. 00 Occurrent year resident to bed ratio (see instructions) 19. 00 Current year resident to bed ratio (see instructions) 19. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current year resident to bed ratio (see instructions) 10. 00 Current	7. 01	i i			0.00		7. 01
Osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 41			1, 2011				
### ### ### ### ### ### ### ### ### ##	8.00				0.00		8. 00
August 1, 2002).							
Section 5503 of the ACA. If the cost report straddles July 1, 2011, see Instructions.			110 00007				
Instructions	8. 01				0.00		8. 01
closed teaching hospital under section 5506 of ACA. (see instructions) 0.00 9.00 and 8,02) (see instructions) 0.00 9.00 and 8,02) (see instructions) 0.00 10			orr, see				
Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01)	8. 02				0.00		8. 02
and 8,02) (see instructions) 10.00	9 00				0.00		9 00
From your records	7. 00		(0, 0,01		0.00		7.00
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 13.00 10.00 12.00 13.00 10.01 10.01 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 10.00 13.00 13.00 10.00 13.00 14.00 10.00 14.00 13.00 15.00 15.00 16.00 1	10. 00		t year		0.00		10. 00
12.00 Current year all lowable FTE (see instructions) 12.00 17	11. 00				0.00		11. 00
14.00 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 16.00 17.00 18.00 17.00 18.					1		
or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program 17.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 18.00 Prior year resident to bed ratio (divide Inse 18 divided by line 4). 20.00 Adjustment adjustment for colons instructions) 20.00 Adjustment adjustment for colons instructions and colons in			andad an				
16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 17.00 17.00 18.00 18.00 19.00	14.00		ended on		0.00		14.00
17.00							
18.00			re				
20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 IME payments (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (see instructions) 29.00 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 5.63		, , , , , , , , , , , , , , , , , , , ,	. 0				18. 00
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0 22.01 IME payment adjustment - Managed Care (see instructions) 0 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.000000 25.00 25.00 IME payments adjustment factor. (see instructions) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount (see instructions) 0.000000 28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.000000 28.01 29.01		,					•
22.00 IME payment adjustment (see instructions) 22.00 IME payment adjustment - Managed Care (see instructions) 22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		, , , , , , , , , , , , , , , , , , , ,			1		1
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA	22. 00	IME payment adjustment (see instructions)			0		22. 00
23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (see instructions) 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 5.63	22. 01		2 422 of t	ho MMA	0		22. 01
24. 00 IME FTE Resident Count Over Cap (see instructions) 0.00 24. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 01 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 0 29. 01 Disproportionate Share Adjustment 5. 43 30. 00 30. 00 Percentage of SI recipient patient days to Medicare Part A patient days (see instructions) 5. 43 30. 00 31. 00 Sum of lines 30 and 31 14. 39 31. 00 32. 00 Allowable disproportionate share percentage (see instructions) 5. 63 33. 00	23. 00			TIE WIWA	0.00		23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 5.63		slots under 42 Sec. 412.105 (f)(1)(iv)(C).	•				
Line 23 or line 24 (see instructions)			wer of				ł
27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 IME add-on adjustment amount - Managed Care (see instructions) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 5.63 37.00	20.00				0.00		20.00
28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 31.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions) 35.00 Sum of lines 30 and 31 36.00 Sum of lines 30 and 31 37.00 Allowable disproportionate share percentage (see instructions) 37.00 Sum of lines 30 and 31 38.00 Sum of lines 30 and 31 39.00 Sum of lines 30 and 31					1		1
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 31. 00 Sum of lines 30 and 31 32. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 34. 01 Sum of lines 30 and 31 35. 02 Sum of lines 30 and 31 36. 02 Sum of lines 30 and 31 37. 08 Sum of lines 30 and 31 38. 09 Sum of lines 30 and 31				•	0.000000		
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Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Allowable disproportionate share percentage (see instructions)		, , ,			-		ı
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Percentage of SSI recipient patient days to Medicare Part A patient days 30.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 33.00 Percentage of SSI recipient patient days to Medicare Part A patient days 30.00 Sum of lines 30 and 31 30.00 Sum of lines 30 and 31 31.00 Sum of lines 30 and 31 32.00 Sum of lines 30 and 31	29.01			l	<u> </u>		29.01
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 31.00 Sum of lines 30 and 31 32.00 Sum of lines 30 and 31	30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days		5. 43		30. 00
32.00 Sum of lines 30 and 31 19.82 32.00 33.00 Allowable disproportionate share percentage (see instructions) 5.63 33.00	31 00				14 20		31 00
							1
34. 00 DESPEODOR LEONATE SHARE AND USE INSTRUCTIONS) 303, 6/3 34. 00		, , , , , , , , , , , , , , , , , , , ,					ł
	34.00	יין sproportionate share adjustment (See Enstructions)		I	303,6/3		J 34. UU

35. 00 T	ncompensated Care Adjustment Total uncompensated care amount (see instructions) Factor 3 (see instructions) Fospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) For rata share of the hospital uncompensated care payment amount (see instructions) Fotal uncompensated care (sum of columns 1 and 2 on line 35.03) Idditional payment for high percentage of ESRD beneficiary of the fotal Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 885 (see instructions) Fotal ESRD Medicare discharges excluding MS-DRGs 652, 882, 683, 684 an 685. (see instructions) Fotal ESRD Medicare covered and paid discharges excluding	Title XVIII 0 discharges (lines 40 through	0. 000099357 759, 847 568, 324 736, 555	669, 269 168, 231	35. 00 35. 01
35. 00 T	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) Horo rata share of the hospital uncompensated care payment amount (see instructions) Hotal uncompensated care (sum of columns 1 and 2 on line 85.03) Hotal instructions (or in the standard of the standar	0	Pri or to October 1 1.00 7,647,644,885 0.000099357 759,847 568,324 736,555	0n/After 0ctober 1 2.00 6,406,145,534 0.000104473 669,269 168,231	35. 01 35. 02 35. 03 36. 00
35. 00 T	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) Horo rata share of the hospital uncompensated care payment amount (see instructions) Hotal uncompensated care (sum of columns 1 and 2 on line 85.03) Hotal instructions (or in the standard of the standar		7, 647, 644, 885 0. 000099357 759, 847 568, 324 736, 555	0ctober 1 2.00 6,406,145,534 0.000104473 669,269 168,231	35. 01 35. 02 35. 03 36. 00
35. 00 T	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) Horo rata share of the hospital uncompensated care payment amount (see instructions) Hotal uncompensated care (sum of columns 1 and 2 on line 85.03) Hotal instructions (or in the standard of the standar		1. 00 7, 647, 644, 885 0. 000099357 759, 847 568, 324 736, 555 h 46)	2. 00 6, 406, 145, 534 0. 000104473 669, 269 168, 231	35. 01 35. 02 35. 03 36. 00
35. 00 T	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) Horo rata share of the hospital uncompensated care payment amount (see instructions) Hotal uncompensated care (sum of columns 1 and 2 on line 85.03) Hotal instructions (or in the standard of the standar		7, 647, 644, 885 0. 000099357 759, 847 568, 324 736, 555 h 46)	6, 406, 145, 534 0. 000104473 669, 269 168, 231	35. 01 35. 02 35. 03 36. 00
35. 00 T	Total uncompensated care amount (see instructions) Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) Horo rata share of the hospital uncompensated care payment amount (see instructions) Hotal uncompensated care (sum of columns 1 and 2 on line 85.03) Hotal instructions (or in the standard of the standar	lischarges (Lines 40 through	0. 000099357 759, 847 568, 324 736, 555 h 46)	0. 000104473 669, 269 168, 231	35. 01 35. 02 35. 03 36. 00
35. 01 F e e 35. 03 P a a 36. 00 T e 6 6 41. 00 T 6 6 41. 01 T	Factor 3 (see instructions) Hospital uncompensated care payment (Ifline 34 is zero, enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment amount (see instructions) Fotal uncompensated care (sum of columns 1 and 2 on line 35.03) Idditional payment for high percentage of ESRD beneficiary of Fotal Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 385 (see instructions) Fotal ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	lischarges (Lines 40 through	0. 000099357 759, 847 568, 324 736, 555 h 46)	0. 000104473 669, 269 168, 231	35. 01 35. 02 35. 03 36. 00
35. 02 H e e 35. 03 P a 36. 00 T a 3 A A A A 40. 00 T e 6 6 41. 00 T T	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line 85.03) Additional payment for high percentage of ESRD beneficiary of cotal Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 885 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	lischarges (Lines 40 through	759, 847 568, 324 736, 555 h_46)	669, 269 168, 231	35. 02 35. 03 36. 00
35. 03 P P A A A A A A A A A A A A A A A A A	enter zero on this line) (see instructions) Pro rata share of the hospital uncompensated care payment amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line 45.03) dditional payment for high percentage of ESRD beneficiary of 5.03 Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	lischarges (Lines 40 throug	736, 555 h _. 46)		36. 00
36. 00 T 3 Ar 40. 00 T e 6 6 41. 01 T	amount (see instructions) Total uncompensated care (sum of columns 1 and 2 on line 15.03) Indicated the second of the second o	lischarges (Lines 40 through	736, 555 h _. 46)		36. 00
36. 00 T 3 A40. 00 T e 6 41. 00 T 6 41. 01 T	Total uncompensated care (sum of columns 1 and 2 on line 85.03) dditional payment for high percentage of ESRD beneficiary d Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 885 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	lischarges (Lines 40 through	h 46)		
40. 00 T e 6 41. 00 T 6 41. 01 T	dditional payment for high percentage of ESRD beneficiary dfortal Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	lischarges (Lines 40 through	h 46)		
40. 00 T e 6 41. 00 T T	dditional payment for high percentage of ESRD beneficiary of Foral Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) Fotal ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	lischarges (lines 40 throug			 40. 00
40. 00 T e 6 41. 00 T 6 41. 01 T	Fotal Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) Fotal ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	lischarges (lines 40 throug			40.00
41. 00 T 6	excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions) Fotal ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		O		40.00
41. 00 6 41. 01 T	685 (see instructions) Fotal ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				1
41. 00 T 6 41. 01 T	Fotal ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
41. 01 T	682, 683, 684 an 685. (see instructions)				41.00
41. 01 T			Ĭ		11.00
			o		41. 01
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
42.00 D	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
q	qualify for adjustment)				
	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43. 00
	882, 683, 684 an 685. (see instructions)				<u></u> .
	Ratio of average length of stay to one week (line 43		0. 000000		44. 00
	divided by line 41 divided by 7 days) Average weekly cost for dialysis treatments (see		0.00		45. 00
	nstructions)		0.00		45.00
1	Total additional payment (line 45 times line 44 times line				46.00
	H1. 01)				10.00
1	Subtotal (see instructions)		23, 349, 265		47.00
	Hospital specific payments (to be completed by SCH and		0		48. 00
M	MDH, small rural hospitals only. (see instructions)				
	Total payment for inpatient operating costs (see		23, 349, 265		49. 00
1	nstructions)				
	Payment for inpatient program capital (from Wkst. L, Pt. I		1, 779, 598		50.00
	and Pt. II, as applicable)				F1 00
	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		٩		51.00
1	Direct graduate medical education payment (from Wkst. E-4,		0		52.00
	ine 49 see instructions).				02.00
	Jursing and Allied Health Managed Care payment		56, 514		53.00
54. 00 S	Special add-on payments for new technologies		0		54.00
55. 00 N	Wet organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55. 00
1	ine 69)				
	Cost of physicians' services in a teaching hospital (see		0		56. 00
	ntructions)				F7 00
	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		٩		57.00
	Ancillary service other pass through costs from Wkst. D,		26, 139		58. 00
	Pt. IV, col. 11 line 200)		20, 137		30.00
	Total (sum of amounts on lines 49 through 58)		25, 211, 516		59.00
1	Primary payer payments		10, 564	l	60.00
	Total amount payable for program beneficiaries (line 59		25, 200, 952	l	61.00
1	ninus line 60)				
	Deductibles billed to program beneficiaries		2, 604, 426	l	62. 00
1	Coinsurance billed to program beneficiaries		63, 945		63.00
1	Allowable bad debts (see instructions)		249, 711		64.00
1	Adjusted reimbursable bad debts (see instructions)		162, 312	l	65.00
I .	Allowable bad debts for dual eligible beneficiaries (see		145, 319		66. 00
1	nstructions) Subtotal (line 61 plus line 65 minus lines 62 and 63)		22, 694, 893		67.00
1	Credits received from manufacturers for replaced devices		22, 074, 093		68.00
	For applicable to MS-DRGs (see instructions)				55.00
1	Outlier payments reconciliation (sum of lines 93, 95 and		o		69. 00
I .	96). (For SCH see instructions)				1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
	RURAL DEMONSTRATION PROJECT		0		70. 50
	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
	nstructions)				70 -
	HSP bonus payment HVBP adjustment amount (see		0		70. 90
	nstructions) HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
1	Bundled Model 1 discount amount (see instructions)				70. 91
1	IVBP payment adjustment amount (see instructions)		128, 945		70. 92
1	HRR adjustment amount (see instructions)		-49, 620	l	70. 94
1	Recovery of accelerated depreciation		0		70. 95

	Financial Systems GOOD SAMARITAN ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150042	Peri od:	eu of Form CMS- Worksheet E	
CALCUL	ATTON OF RETWINDORSEMENT SETTEEMENT	110VI del CCN. 150042	From 01/01/2015		
			To 12/31/2015	Date/Time Pro	
				5/25/2016 9: 5	57 am
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
		2	October 1	October 1	
70.01		0	1.00	2. 00	70.04
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the		0 0		70. 96
	period prior to 10/1)				
70 07	Low volume adjustment for federal fiscal year (yyyy)		0 0		70. 97
10. 71	(Enter in column 0 the corresponding federal year for the				10. 77
	period ending on or after 10/1)				
70. 98	Low Volume Payment-3		0		70. 98
	HAC adjustment amount (see instructions)		0		70. 99
	Amount due provider (line 67 minus lines 68 plus/minus		22, 774, 218		71. 00
	lines 69 & 70)				
71. 01	Sequestration adjustment (see instructions)		455, 484		71. 01
72. 00	Interim payments		22, 145, 937		72. 00
73. 00	Tentative settlement (for contractor use only)		0		73. 00
74. 00	Balance due provider (Program) (line 71 minus lines 71.01,		172, 797		74. 00
	72, and 73)				
75. 00	Protested amounts (nonallowable cost report items) in		162, 808		75. 00
	accordance with CMS Pub. 15-2, chapter 1, §115.2				
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			1	_
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0		90.00
01 00	instructions)				01.00
	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	1	92.00
33 00	Capital outlier reconciliation adjustment amount (see		0		93. 00
73.00	instructions)				73.00
94 00	The rate used to calculate the time value of money (see		0.00		94 00

	1.00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0.000000000	0.000000000	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			
103.00 HRR adjustment factor (see instructions)	0.0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104. 00
	1 -1	- 1	

94.00

95.00

96.00

0.00

Prior to 10/1 On/After 10/1

94.00

instructions)

instructions)

instructions)

The rate used to calculate the time value of money (see

Time value of money for operating expenses (see

96.00 Time value of money for capital related expenses (see

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 150042

					'	0 12/31/2015	5/25/2016 9:5	
					e XVIII	Hospi tal	PPS	
			Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line 0	E, Part A) 1.00	Entitlement 2.00	to 10/01 3.00	0n/After 10/01 4.00	through 4) 5.00	
1.00	DRG amounts other than outlier	1. 00	1.00	2.00	3.00		0.00	1.00
	payments	00		ŭ				
1. 01	DRG amounts other than outlier payments for discharges	1. 01	0	0	0	0	0	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges	1. 02	21, 575, 303	O	0	21, 575, 303	21, 575, 303	1. 02
1. 03	occurring on or after October 1 DRG for Federal specific	1. 03	0	0	0	0	0	1. 03
	operating payment for Model 4 BPCI occurring prior to October 1							
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	0	0	0	1. 04
2.00	Outlier payments for	2. 00	733, 734	0	0	733, 734	733, 734	2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	0	0	0	0	0	2. 01
2.01	discharges for Model 4 BPCI	2. 02	٥	O	0	0	0	2.01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju	3.00	0	0	0	0	0	4.00
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
	A, line 21 (see instructions)							
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions) Indirect Medical Education Adju	istment for the	Add-on for Se	ction 422 of t	he MMA			
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	O	O	0	0	0	8. 01
9. 00	instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
	8. 01)							
10.00	Di sproporti onate Share Adjustme Allowable di sproporti onate	33. 00	0. 0563	0. 0563	0. 0563	0. 0563		10.00
10.00	share percentage (see instructions)	33.00	0.0303	0.0303	0.0303	0.0303		10.00
11. 00	Di sproporti onate share adjustment (see instructions)	34. 00	303, 673	0	0	303, 673	303, 673	11. 00
11. 01	Uncompensated care payments	36.00	736, 555	0	568, 324	168, 231	736, 555	11. 01
12. 00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	אט beneficiary ו	di scharges 0	0	0	0	12. 00
13. 00	(see instructions) Subtotal (see instructions)	46.00	23, 349, 265	0	568, 324		23, 349, 265	
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	48. 00	0	0	0	0	0	14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	23, 349, 265	0	568, 324	22, 780, 941	23, 349, 265	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	1, 779, 598	0	71, 681	1, 707, 917	1, 779, 598	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01	Net organ aquisition cost	55.00	0	0	0	0	0	
17. 02	Credits received from manufacturers for replaced	68. 00	0	0	0	0	0	17. 02
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	0	18. 00
	Thisti detrons)		l l			I.	l	ı

	ALCONE CALCULATION EXHIBIT 4					From 01/01/2015 To 12/31/2015 Hospi tal	Part A Exhibi Date/Time Pre 5/25/2016 9:5	pared:
		W/C F Dowt A	Amounts (from	Pre/Post	Period Prior		PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3.00	4. 00	5. 00	
19 00	SUBTOTAL	Ü	1.00	0				19 00
.,	COBTO TALE	W/S L, line	(Amounts from		3 107 33	217 1007 000	207 1207 000	171.00
			L)					
		0	1. 00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	1, 707, 917	0		0 1, 707, 917	1, 707, 917	20.00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0	0		0 0	0	20. 01
	than outlier							
21. 00	Capital DRG outlier payments	2. 00	71, 681	0	71, 68	1 71, 681	143, 362	
21. 01	Model 4 BPCI Capital DRG	2. 01	0	0		0	0	21. 01
	outlier payments							
22. 00	Indirect medical education	5. 00	0. 0000	0. 0000	0. 000	0. 0000		22. 00
00.00	percentage (see instructions)			^				00.00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	U	Ü		U U	0	23. 00
24. 00	Allowable disproportionate	10, 00	0. 0000	0.0000	0.000	0.0000		24. 00
24.00	share percentage (see	10.00	0.0000	0.0000	0.000	0.0000		24.00
	instructions)							
25. 00	Di sproporti onate share	11. 00	0	0		0	0	25. 00
	adjustment (see instructions)			Ī			_	
26.00	Total prospective capital	12. 00	1, 779, 598	0	71, 68	1 1, 707, 917	1, 779, 598	26. 00
	payments (see instructions)							
		W/S E, Part A						
		line	Part A)					
	I	0	1.00	2. 00	3. 00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0. 00000	0. 000000	_	27. 00
28. 00	Low volume adjustment	70. 96				0	0	28. 00
	(transfer amount to Wkst. E,							
29. 00	Pt. A, line) Low volume adjustment	70. 97					0	29. 00
29.00	(transfer amount to Wkst. E,	70.97				U	U	29.00
	Pt. A, line)							
100.00	Transfer low volume		N					100.00
100.00	adjustments to Wkst. E, Pt. A.		''					30. 00
	, , , , , , , , , , , , , , , , , , , ,	'	'		!	!	•	•

HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
			Ti tle	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1. 00	2. 00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for discharges occurring prior to October 1	1. 00 1. 01	0		0	0	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	21, 575, 303		21, 575, 303	21, 575, 303	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0		0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	O		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	733, 734		733, 734	733, 734	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0	0	2. 01
3. 00 4. 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	0		0 0 0	0	3. 00 4. 00
	Indirect Medical Education Adjustment						
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 00000			5. 00
6.00	IME payment adjustment (see instructions)	22. 00	0		0 0	0	6. 00 6. 01
6. 01	IME payment adjustment for managed care (see instructions) Indirect Medical Education Adjustment for the	22.01	ection 422 of the		0	0	6.01
7. 00	IME payment adjustment factor (see	27. 00	0. 000000	0.00000	0. 000000		7. 00
8. 00	instructions) IME adjustment (see instructions)	28. 00	0		0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	Ö		0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29. 00	0		0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0	0	9. 01
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33.00	0. 0563	0. 056	3 0.0563		10.00
10.00	(see instructions)	33.00	0.0503	0.036	0.0363		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	303, 673		0 303, 673	303, 673	11. 00
11. 01	Uncompensated care payments	36. 00	736, 555	568, 32	4 168, 231	736, 555	11. 01
10.00	Additional payment for high percentage of ESR					0	10.00
12.00	Total ESRD additional payment (see instructions)	46. 00	0		0	0	12. 00
13.00	Subtotal (see instructions)	47. 00	23, 349, 265	568, 32	4 22, 780, 941	23, 349, 265	13. 00
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see	48. 00	0		0	0	14. 00
15. 00	<pre>instructions) Total payment for inpatient operating costs (see instructions)</pre>	49. 00	23, 349, 265	568, 32	22, 780, 941	23, 349, 265	15. 00
16. 00	Payment for inpatient program capital	50.00	1, 779, 598	53, 61	3 1, 725, 985	1, 779, 598	
17. 00	Special add-on payments for new technologies	54.00	0		0	0	
17. 01	Net organ aquisition cost	55.00	0		0	0	
17. 02	replaced devices for applicable MS-DRGs	68. 00	0		0	0	
18. 00	amount (see instructions)	93. 00	0		0	0	18. 00
19. 00	SUBTOTAL			621, 93	7 24, 506, 926	25, 128, 863	19. 00

Health Financial Systems	GOOD SAMARITAN HO	SPI TAL	u of Form CMS-2552-10	
HOSPITAL ACQUIRED CONDITION (HAC)	REDUCTION CALCULATION EXHIBIT 5	Provi der CCN: 150042		Worksheet E Part A Exhibit 5 Date/Time Prepared: 5/25/2016 9:57 am
		T' 11 \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		20

					To 12/31/2015	Date/Time Pre 5/25/2016 9:5	pared:
				e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	1, 707, 917		0 1, 707, 917	1, 707, 917	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01
21.00	Capital DRG outlier payments	2.00	71, 681	53, 61	3 18, 068	71, 681	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01
22.00	Indirect medical education percentage (see	5. 00	0.0000	0.000	0.0000		22. 00
	instructions)						
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24.00	Allowable disproportionate share percentage	10.00	0.0000	0.000	0.0000		24. 00
	(see instructions)						
25.00	Di sproporti onate share adjustment (see	11. 00	0		0 0	0	25. 00
	instructions)						
26.00	Total prospective capital payments (see	12.00	1, 779, 598	53, 61	3 1, 725, 985	1, 779, 598	26. 00
	instructions)						
		Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
07.00		0	1. 00	2.00	3. 00	4. 00	07.00
27. 00		70.0/					27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	0		0	0	
29. 00	Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30. 00	HVBP payment adjustment (see instructions)	70. 93	128, 945		0 128, 945		
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0		0	0	30. 01
	payment (see instructions)	70.04					
31.00	HRR adjustment (see instructions)	70. 94	-49, 620		0 -49, 620	1	
31. 01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0	0	31. 01
						(Amt. to Wkst.	
						E, Pt. A)	
		0	1. 00	2.00	3. 00	4. 00	
32. 00	HAC Reduction Program adjustment (see instructions)	70. 99			0	0	32. 00
100.00	Transfer HAC Reduction Program adjustment to	1	N				100. 00
	Wkst. E, Pt. A.						
	!	•		•	· ·	•	

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150042	Peri od: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Ti me Prepared: 5/25/2016 9:57 am

			To 12/31/2015	Date/Time Pre 5/25/2016 9:5	
		Title XVIII	Hospi tal	PPS	, diii
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			59, 823	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		25, 455, 325	1
3.00	PPS payments			21, 104, 109	1
4.00	Outlier payment (see instructions)			44, 336	1
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	ions)		0. 000 0	5. 00 6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	•
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		81, 570	
10.00	Organ acqui si ti ons			0	
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			59, 823	11. 00
	Reasonable charges				
12.00	Ancillary service charges			178, 118	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			178, 118	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	•
	had such payment been made in accordance with 42 CFR §413.13(e)		9		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	•
18.00	Total customary charges (see instructions)	: £ ; 10 - ;	11) (178, 118	•
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	IT TIME 18 exceeds II	ne II) (see	118, 295	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)		, ,		
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		59, 823	•
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	ctions)		0	ł
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ctrons)		21, 230, 015	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			149	•
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for			4, 489, 526 16, 800, 163	1
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of filles 22	z anu zsj (see	10, 600, 103	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			16, 800, 163	ı
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			1, 271 16, 798, 892	1
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		10, 770, 072	02.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	•		0	33. 00
34. 00	Allowable bad debts (see instructions)			603, 087	1
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		392, 007 482, 483	
	Subtotal (see instructions)	Cti ons)		17, 190, 899	
	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	a devices (see instruc	ctions)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			17, 190, 853	•
40. 01	Sequestration adjustment (see instructions)			343, 817	1
41. 00	Interim payments			16, 754, 152	1
42.00	Tentative settlement (for contractors use only)			0	•
43. 00 44. 00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	chanter 1	92, 884 0	1
44.00	§115. 2	C WITH GWO FUD. 19-2,	chapter I,		44.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91. 00 92. 00
92.00	Time Value of Money (see instructions)			0.00	•
	Total (sum of lines 91 and 93)			0	1
			·		

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150042		Worksheet E
		From 01/01/2015	
	Component CCN: 15SO42	To 12/31/2015	
			5/25/2016 9:57 am
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			961	1.00
2.00	Medical and other services reimbursed under OPPS (see instruction	ons)		498	ł
3.00	PPS payments			976	3.00
4. 00 5. 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instructions)	one)		0. 000	4. 00 5. 00
6. 00	Line 2 times line 5	UIIS)		0.000	6.00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	•
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	9. 00
10.00	Organ acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			961	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				
12. 00	Ancillary service charges			2, 672	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	e 69)		0	13. 00
14.00	Total reasonable charges (sum of lines 12 and 13)			2, 672	14. 00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for pay			0	15.00
16. 00	Amounts that would have been realized from patients liable for plad such payment been made in accordance with 42 CFR §413.13(e)	payment for services o	n a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17 00
18. 00	Total customary charges (see instructions)			2, 672	1
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	1, 711	19. 00
	instructions)			_	
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see i	nstructions)		961	21. 00
22. 00	Interns and residents (see instructions)	nati de ti ona)		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruc	ctions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			976	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	`AU coo instructions		0	25. 00 26. 00
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plu			1, 937	•
27.00	instructions)	35 the Sum of Times 22	. and 25] (300	1, 757	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			1, 937	30.00
31.00	Primary payer payments Subtotal (line 30 minus line 31)			0 1, 937	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		1, 737	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	.,		0	33. 00
34.00	Allowable bad debts (see instructions)			0	34.00
35. 00	Adjusted reimbursable bad debts (see instructions)			0	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)		1 027	36.00
37. 00 38. 00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			1, 937 0	37. 00 38. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	•
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replaced	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00	Subtotal (see instructions)			1, 937	
40. 01	Sequestration adjustment (see instructions)			39	1
41. 00 42. 00	Interim payments Tentative settlement (for contractors use only)			1, 480 0	41. 00 42. 00
43. 00	Balance due provider/program (see instructions)			418	ł
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2		·		
00.05	TO BE COMPLETED BY CONTRACTOR		1		00.00
90.00	Original outlier amount (see instructions)			0	•
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91. 00 92. 00
93. 00	Time Value of Money (see instructions)			0.00	ı
	Total (sum of lines 91 and 93)				94. 00
			'		

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150042		Worksheet E
		From 01/01/2015	Part B
	Component CCN: 15T04	2 To 12/31/2015	Date/Time Prepared:
	·		5/25/2016 9:57 am
	Title XVIII	Subprovi der -	PPS

PART B			Title XVIII	Subprovi der - I RF	PPS	
NATE 8 - MEDICAL AND OTHER REALTH SERVICES 1,444 1,00 1,0				1		
Medical and other services (see instructions)		DART R. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
Medical and other services reinbursed under OPPS (see instructions) 332 2.00	1 00				1 454	1 00
0.01 fire payment (see Instructions) 0.000 5.00 1.00 5.00 1.00 5.00 1.00 5.00 1.00 5.00 1.00 5.00 1.00 5.00 1.00 5.00 5.00 1.00 5.00 5.00 1.00 5.00			ons)			
Enter the fixed that specific payment to cost ratio (see instructions) 0.000 5.00		PPS payments	,			3. 00
Line 2 times line 5 No. Sam of line 3 plus line 4 divided by line 6 Do 7,00 Sam of line 3 plus line 4 divided by line 6 Transitional corridor payment (see instructions) On Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 On Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 Organ acquis liters On Ancillary service charges Reasonable charges Reasonable charges Reasonable charges Reasonable charges Organ acquis liter (from Wist. D4, Pt. III, col. 4, line 69) Organ acquis liter (from Wist. D		,			-	
7.00 Sum of Time 3 plus line 4 divided by line 6 0.00 7.00 8.00 Transit ional corridor payment (see instructions) 0 8.00 9.00 Ancillary service other pass through costs from West. D. Pt. IV, col. 13, line 200 0 9.00 11.00 Organ acquisit ions acquisit ions. 1.454 11.00 12.00 Ancillary service charges 4.042 12.00 14.00 Total cost (sum of line 1 and 10) (see instructions) 4.042 12.00 14.00 Total residence of the charges (from West. D. 4, Pt. III, col. 4, line 69) 0.13.00 13.00 14.00 Total residence of the charges (sum of lines 12 and 13) 4.042 14.00 15.00 Aggregate amount actually cellected from patients liable for payment for services on a charge basis 0 15.00 16.00 Ancillary services that adult have been realized from patients liable for payment for services on a charge basis 0 15.00 17.00 Batio of line 15 to line 16 (not to exceed 1.00000) 94.31.33(e) 0 16.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 2.588 19.00 </td <td></td> <td></td> <td>i ons)</td> <td></td> <td></td> <td></td>			i ons)			
8.00 Architary service other passes through costs from Wisst. D, Pt. IV, col. 13, line 200 0.0					-	
Ancillary service other pass through costs from Wist. D. Pt. IV, col. 13, line 200 0, 9, 00						
1.00 Total cost (sum of lines 1 and 10) (see instructions) 1.45 11.00		1 3 1	, col. 13, line 200		-	
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges Reasonable charges Acoustic Charges Ac	10.00	Organ acqui si ti ons			0	
Reasonable charges	11. 00				1, 454	11. 00
2.00 Ancil lary service charges 4,042 12 00 13 00 Total reasonable charges (sum of lines 12 and 13) 0 13 00 13 00 10 10 13 00 13 00 10 1						
13.00 Organ acquisition charges (from Wkst. D-4, Pt. III., col. 4, line 69)	12 00				4 042	12 00
Customary charges 0 15.00 Agrogate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 0 16.00 17.00			e 69)			
15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 16.00	14.00	Total reasonable charges (sum of lines 12 and 13)	· 		4, 042	14. 00
16.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 17.00 17.00 18.10 17.00 18.10 18	45.00					45.00
had such payment been made in accordance with 42 CFK \$413.13(e)						
17.00 Ratio of line 15 to line 16 (not to exceed 1.000000) 0.000000 17.00 18.00 19.00 Excess of customary charges (see instructions) 0.000000 17.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 2.588 19.00 19.	10.00		payment for services c	ili a Cilai gebasi s	U	16.00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 1.588 19. 00 1.582 1.588 19. 00 1.582 1.588 19. 00 1.582 1.582 1.588 19. 00 1.582 1.588 19. 00 1.582 1.588 1.5	17. 00				0.000000	17. 00
instructions						
20. 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20. 00	19. 00		if line 18 exceeds li	ne 11) (see	2, 588	19. 00
instructions	20 00		if line 11 eveneds li	ne 18) (see	0	20 00
1. 454 21. 00 22. 00 2	20.00		II IIIIe II exceeds II	116 10) (366	٥١	20.00
23. 00 Cost of physicians' services in a teaching hospital (see instructions) 24. 00 Total prospective payment (sum of lines 3, 4, 8 and 9) 24. 00 Total prospective payment (sum of lines 3, 4, 8 and 9) 24. 00 Total prospective payment (sum of lines 3, 4, 8 and 9) 24. 00 25. 00 25. 00 Deductible sand coin surance (for CAH, see instructions) 0 26. 00 25. 00 25. 00 25. 00 25. 00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 2, 205 27. 00 Instructions) 0 28. 00 28. 00 29. 00 28. 00 29. 00	21. 00	1	instructions)		1, 454	21. 00
Act Dotal prospective payment (sum of lines 3, 4, 8 and 9)		1				
COMPUTATION OF REIMBURSEMENT SETILEMENT Deductibles and coinsurance (for CAH, see instructions) 0 25.00 25.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 0 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0 26.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 0 29.00 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30.00 Subtotal (sum of lines 27 through 29) 2,205 30.00 31.00 Primary payer payments 0 31.00 32.00 Subtotal (line 30 minus line 31) 2,205 33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 0 33.00 34.00 Allowable BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 0 34.00 35.00 Allowable bad debts (see instructions) 0 35.00 36.00 Allowable bad debts (see instructions) 0 35.00 37.00 Subtotal (see instructions) 0 36.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.90 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.95 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.95 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.95 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.95 39.90 The proper ACO demonstration payment and justment (see instructions) 0 40.00 39.90 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) 0 90.00 39.90 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) 0 90.00 39.90 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) 0 90.00 39.90 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) 0 90.0			ctions)		-	
25.00 Deductibles and coinsurance (for CAH, see instructions) 0 25.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 0 26.00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions) 0 28.00 27.00 28.00 29.00 ESRD direct medical education payments (from Wkst. E-4, line 50) 0 28.00 29.0	24.00				/51	24.00
26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 0 26.00	25. 00				0	25. 00
Instructions Direct graduate medical education payments (from Wkst. E-4, line 50) 0 28.00 29.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 29	26. 00		CAH, see instructions)		0	26. 00
28.00	27. 00		us the sum of lines 22	and 23] (see	2, 205	27. 00
29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 29.00 30.0	20 00		o E0)		0	20 00
30.00 Subtotal (sum of lines 27 through 29) 2, 205 30.00 21.00 Primary payer payments 0 31.00 22.05 32.00			e 30)		-	
32.00 Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (FOR PROFESSIONAL SERVICES)					-	
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33. 00 Composite rate ESRD (from Wkst. I -5, line 11) 0 33. 00 34. 00 All lowable bad debts (see instructions) 0 34. 00 35. 00 Adjusted reimbursable bad debts (see instructions) 0 35. 00 36. 00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 36. 00 37. 00 Subtotal (see instructions) 2, 205 37. 00 38. 00 MSP-LCC reconciliation amount from PS&R 0 38. 00 39. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 90 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 90 39. 99 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 0 39. 98 40. 00 Subtotal (see instructions) 2, 205 40. 00 41. 00 Interim payments 2, 000 41. 00 42. 00 Tentative settlement (for contractors use only) 42. 00 43. 00 Bal ance due provider/program (see instructions) 0 42. 00 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50 Be COMPLETED BY CONTRACTOR 0 90. 00 91. 00 Ottlier reconciliation adjustment amount (see instructions) 0 91. 00 92. 00 The rate used to calculate the Time Value of Money 0. 00 93. 00 Time Value of Money (see instructions) 0 93. 00 93. 00 Time Value of Money (see instructions) 0 93. 00 38. 00 38. 00 38. 00 38. 00 39. 00 39. 00 39. 00 39. 00 30. 00 Time Value of Money (see instructions) 0 93. 00 30. 00 Time Value of Money (see instructions) 0 93. 00 30. 00 0 0 0 0 0 30. 00 0 0 0 0 0 30. 00 0 0 0 0 30. 00 0 0 0 0 30. 00 0 0 0 0 30. 00 0 0 0 0 30. 00 0 0 0 30. 00 0 0 0 30. 00 0 0 0 30. 00 0 0	31. 00				-	
33.00 Composite rate ESRD (from Wkst. I-5, line 11) 0 34.00 All owable bad debts (see instructions) 0 34.00 34.00 All owable bad debts (see instructions) 0 35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 All owable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 2,205 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 9.50	32. 00		2)		2, 205	32. 00
34.00	33 00		5)		0	33 00
35.00 Adjusted reimbursable bad debts (see instructions) 0 35.00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 0 36.00 37.00 Subtotal (see instructions) 2,205 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.98 RECOVERY OF ACCELERATED DEPRECIATION 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2,205 40.00 40.01 Sequestration adjustment (see instructions) 2,205 40.00 42.00 Tentative settlement (for contractors use only) 0 42.00 42.00 Tentative settlement (for contractors use only) 0 42.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 43.00 44.00 Protested amounts (see instructions) 0 90.00 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0.00 93.00					-	
37.00 Subtotal (see instructions) 2,205 37.00 38.00 MSP-LCC reconciliation amount from PS&R 0 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 39.50 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2,205 40.00 40.01 Sequestration adjustment (see instructions) 44 40.01 41.00 Interim payments 2,000 41.00 42.00 43.00 Bal ance due provider/program (see instructions) 161 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 The rate used to calculate the Time Value of Money (see instructions) 0 91.00 93.00 Time Value of Money (see instructions) 0 93.00		,			-	
38.00 MSP-LCC reconciliation amount from PS&R 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.99 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 2, 205 40.00 40.01 Sequestration adjustment (see instructions) 39.99 EQUESTRATION 10 Sequestration adjustment (see instructions) 39.99 ACCELERATED DEPRECIATION 20 Subtotal (see instructions) 39.99 ACCELERATED DEPRECIATION 3			ctions)			
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 Subtotal (see instructions) 40.00 Subtotal (see instructions) 40.01 Interim payments 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Outlier reconciliation adjustment amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Og 39.00		1				
39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 RECOVERY OF ACCELERATED DEPRECIATION 40. 00 Subtotal (see instructions) 40. 01 Sequestration adjustment (see instructions) 41. 00 Interim payments 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115. 2 TO BE COMPLETED BY CONTRACTOR 90. 00 Original outlier amount (see instructions) 91. 00 Outlier reconciliation adjustment amount (see instructions) 92. 00 The rate used to calculate the Time Value of Money 93. 00 Time Value of Money (see instructions) 93. 00 Og 93. 00						
39. 98 Partial or full credits received from manufacturers for replaced devices (see instructions) 39. 98 39. 99 RECOVERY OF ACCELERATED DEPRECIATION 50 Jay. 99 40. 00 Subtotal (see instructions) 50 Jay. 99 40. 00 Subtotal (see instructions) 50 Jay. 99 40. 00 Subtotal (see instructions) 51 Jay. 99 40. 00 Tentative settlement (see instructions) 40. 01 Interim payments 41. 00 Tentative settlement (for contractors use only) 42. 00 Tentative settlement (for contractors use only) 43. 00 Balance due provider/program (see instructions) 44. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, ounder of the contractors of t						
40.00 Subtotal (see instructions) 40.01 Sequestration adjustment (see instructions) 41.00 Interim payments 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 70 BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Og 40.00 94.00 Og 41.00 95.00 Og 42.00 96.00 Og 96.00 97.00 Og 97.00		,	d devices (see instruc	tions)		
40.01 Sequestration adjustment (see instructions) 44 40.01 41.00 Interim payments 2,000 41.00 42.00 43.00 Bal ance due provider/program (see instructions) 161 43.00 44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 From the second part of th	39. 99				-	
41.00 Interim payments 2,000 41.00 42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 79.00 The rate used to calculate the Time Value of Money 79.00 Time Value of Money (see instructions) 10 90.00 91.00 92.00 93.00 Time Value of Money (see instructions) 0 93.00		1				
42.00 Tentative settlement (for contractors use only) 43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)		1				
43.00 Balance due provider/program (see instructions) 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Og 93.00						
\$115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)					161	
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 93.00 Outlier reconciliation adjustment amount (see instructions) 94.00 Outlier reconciliation adjustment amount (see instructions) 95.00 Outlier reconciliation adjustment amount (see instructions) 97.00 Outlier reconciliation adjustment amount (see instructions)	44. 00		e with CMS Pub. 15-2,	chapter 1,	0	44. 00
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 90.00 91.00 92.00 93.00						
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0 91.00 92.00 93.00	90 00				0	90 00
92.00 The rate used to calculate the Time Value of Money 93.00 Time Value of Money (see instructions) 0.00 92.00 93.00		, ,				
	92.00				-	
94.00 Total (sum of lines 91 and 93) 0 94.00		1				
	94.00	TIOTAL (SUM OT LINES 91 AND 93)		I	0	94.00

Health Financial Systems GOO ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2015
To 12/31/2015 Part I
Date/Time Prepared: 5/25/2016 9:57 am Provi der CCN: 150042

					5/25/2016 9:5	7 am
			e XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		22, 145, 937		16, 714, 352	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0	07/17/2015	39, 800	3. 01
3. 02	ADJUST MENTS TO TROVIDER		0	077 177 2013	0	3. 02
3. 03			0			3. 02
3. 04			0			3. 04
3. 05			0			3. 05
3.03	Provider to Program					3.03
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		l ol	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		39, 800	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		22, 145, 937		16, 754, 152	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		I			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		0		0	5. 01
5. 02	TERMINA TO TROTTE IN		l ő		0	5. 02
5. 03			0		l ol	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5.51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		170 707		02.004	/ 01
6. 01	SETTLEMENT TO PROVIDER		172, 797		92, 884	6. 01
6. 02	SETTLEMENT TO PROGRAM		22 210 724		14 047 027	6. 02
7. 00	Total Medicare program liability (see instructions)		22, 318, 734	Contractor	16, 847, 036 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
					, ,	

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

		Inpatien	t Dart A	I PF		
1.00		·	t Fail A	Par	rt B	
1.00		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 341, 263 0		1, 480	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		1, 341, 263		1, 480	4. 00
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
5. 01	Program to Provider TENTATIVE TO PROVIDER		0		0	5. 01
5. 02	TENTATIVE TO PROVIDER		0			5. 01
5. 02			0			5. 02
5.05	Provider to Program		0	1	0	5. 05
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		ا ا	5. 51
5. 52			0		ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		10, 727		418	6. 01
6.02	SETTLEMENT TO PROGRAM		0		0	6. 02
7.00	Total Medicare program liability (see instructions)		1, 351, 990		1, 898	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8.00	Name of Contractor					8.00

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

		Ti tI	e XVIII	Subprovi der - I RF	PPS	
		I npati en	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		9, 193, 95		2, 000	1. 00
2.00	Interim payments payable on individual bills, either			O	0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider ADJUSTMENTS TO PROVIDER					2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER			0	0 0	3. 01 3. 02
3. 02				0		3. 02
3. 04				0	l ől	3. 04
3. 05				Ö	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				O	0	3. 51
3. 52				0	0 0	3. 52
3. 53 3. 54					0	3. 53 3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0		3. 99
0. ,,	3. 50-3. 98)					0. , ,
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		9, 193, 95	7	2, 000	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		ı			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			O	0	5. 01
5. 02				O	0	5. 02
5. 03	Provider to Program			0	0	5. 03
5. 50	TENTATI VE TO PROGRAM		1		0	5. 50
5. 51	TENTATI VE TO TROOMWI			0	0	5. 51
5. 52				Ö	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			C	0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		32, 46	3	161	6. 01
6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		1)	0	6. 02
7.00	Total Medicare program liability (see instructions)		9, 226, 42	-	2, 161	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor)	1. 00	2. 00	0.00
8. 00	Name of Contractor			1	ı l	8. 00

Heal th	Financial Systems GOOD SAMARITAN H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150042	Period: From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S	S-3, Pt. I col. 15 line	14	6, 276	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	12		13, 804	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1, 247	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	12		23, 010	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			482, 952, 627	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir	ne 20		11, 242, 860	6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of cerline 168	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			506, 528	8. 00
9.00	Sequestration adjustment amount (see instructions)			10, 131	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		496, 397	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			500, 354	30. 00
31.00	Other Adjustment (specify)			0	31. 00
32 00	Balance due provider (line 8 (or line 10) minus line 30 and lin	ne 31) (see instruction	s)	_3 957	32 00

32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)

-3, 957 32. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150042		Worksheet E-3
		From 01/01/2015	
	Component CCN: 15SO42	To 12/31/2015	
	·		5/25/2016 9:57 am
	Title XVIII	Subprovi der -	PPS

Next Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		I PF		
PART II - MEDICARE PART A SERVICES - IPF PPS			1 00	
1.00 Net Federal I IPF PPS Payments (excluding outlier, ECT, and medical education payments) 1,585,555 1,00 2,00 Net IPF PPS CUTP Payments 0,00 4,00 0,00 1,0		PART II - MEDICARE PART A SERVICES - IPE PPS	1.00	
Net IFF PPS Outlier Payments	1.00		1, 585, 555	1. 00
Univerlighted Intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions) 1, 2004. (see instructions) 2, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0, 0,	2.00			2. 00
15. 2004. (see instructions)	3.00	Net IPF PPS ECT Payments	0	3.00
Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CPR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4.00
Degram or hospital closure, that would not be counted without a temporary cap adjustment under 42 CRF \$414.244(d)(i)(iii)(F)(i) or (2) (see instructions)		15, 2004. (see instructions)		
Current year's unweighted FTE count of IAR excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 0.00 7.00		program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
teaching program" (see instructions) 7.00 Current year's unweighted IAR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 8.00 Intern and resident count for IPF PPS medical education adjustment (see instructions) 9.00 Average Dail Iy Census (see instructions) 11. 558904 9.00 12. 00 Average Dail Iy Census (see instructions) 13. 00 Teaching Adjustment (line 1 multiplied by line 10). 14. 00 Teaching Adjustment (line 1 multiplied by line 10). 15. 00 Teaching Adjustment (line 1 multiplied by line 10). 16. 00 Teaching Adjustment (line 1 multiplied by line 10). 17. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Teaching Adjustment (line 1 multiplied by line 10). 18. 00 Subtotal (line 16 less line 17). 18. 00 Subtotal (line 16 less line 17). 18. 00 Subtotal (line 16 less line 17). 18. 00 Subtotal (line 18 minus line 19). 18. 00 Subtotal (line 20 minus line 21). 18. 00 Subtotal (line 10 minus line 21). 19. 00 Coultiple mourt line 20 minus line 21). 19. 00 Deach Advolu				
2.00 Current year's unweighted IRR FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 0.00 8.00	6. 00		0.00	6. 00
teaching program" (see Instructions) 0.00 8.00				
9.00 Average Daily Census (see instructions) 11.558904 9.00 10.00 Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}. 0.000000 10.00 11.00 12.00 Adjustment (line 1 multiplied by line 10). 0.11.00 12.00 Adjustment (line 1 multiplied by line 10). 0.11.00 13.00		teaching program" (see instuctions)		
10. 00 Teaching Adjustment Factor {((1 + (line B/line 9)) raised to the power of .5150 -1). 0.000000 10. 00 0.10. 01 10. 00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00 11. 00 0.00				
11.00 Teaching Adjustment (line 1 multiplied by line 10). 11.00 11.00 12.00 Adjusted Met IPF PPS Payments (sum of lines 1, 2, 3 and 11) 1,585,555 12.00 13.00 14.00 10.0				
12.00			1	
13. 00 Nursing and Allied Health Managed Care payment (see instruction)				
14. 00 Organ acquisition (D0 NOT USE THIS LINE)				
15.00 Cost of physicians' services in a teaching hospital (see instructions) 15.00 1.585,555 16.00 1.581,555 16.00 1.581,555 16.00 1.581,555 16.00 1.581,355 18.			U	
16. 00 Subtotal (see instructions) 1,585,555 16. 00 17. 00 Primary payer payments 2,200 17. 00 18. 00 Subtotal (line 16 less line 17). 1,583,355 18. 00 19. 00 Deductibles 202,728 19. 00 21. 00 Subtotal (line 18 minus line 19) 11,970 21. 00 22. 00 Subtotal (line 20 minus line 21) 1,368,657 22. 00 24. 00 Adjusted reimbursable bad debts (exclude bad debts for professional services) (see instructions) 16,416 23. 00 24. 00 Adjusted reimbursable bad debts (see instructions) 10,670 24. 00 25. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 8,805 25. 00 27. 00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 1,379,327 26. 00 28. 00 Other pass through costs (see instructions) 255 28. 00 30. 00 Other pass through costs (see instructions) 0 29. 00 30. 00 Other pass through costs (see instructions) 0 29. 00 30. 00 Other pass through costs (see instructions) 0 0				
17. 00 Primary payer payments 2, 200 17. 00 18. 00 Subtotal (line 16 less line 17). 1. 583, 355 18. 00 202, 728 19. 00 20. 00 Subtotal (line 18 minus line 19) 1. 380, 627 20. 00 20. 00 Subtotal (line 20 minus line 21) 1. 368, 657 22. 00 23. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 16, 416 23. 00 23. 00 Allowable bad debts (exclude bad debts (see instructions) 16, 416 23. 00 25. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 8, 805 25. 00 26. 00 Subtotal (sum of lines 22 and 24) 27. 00 2				
18. 00 Subtotal (line 16 less line 17). 1,583,355 18. 00 202,728 19. 00 20. 00				
19.00 Deductible's 202,728 19.00 20.00 Subtotal (line 18 minus line 19) 1,380,627 20.00 20.0				
20. 00 Subtotal (line 18 minus line 19) 1,380,627 20. 00 21. 00 Coinsurance 13. 88,657 22. 00 21. 00 Coinsurance 1,380,627 22. 00 21. 00 21. 00 21. 00 21. 00 21. 00 22. 00 23. 00 All owable bad debts (exclude bad debts for professional services) (see instructions) 16,416 23. 00 24. 00 25		· · · · · · · · · · · · · · · · · · ·		
21.00 Coinsurance 11,970 21.00 22.00 Subtotal (line 20 minus line 21) 1,368,657 22.00 23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 16,416 23.00 24.00 Adjusted reimbursable bad debts (see instructions) 10,670 24.00 25.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 8,805 25.00 25.00 Subtotal (sum of lines 22 and 24) 1,379,327 26.00 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0 27.00 25.00 Other pass through costs (see instructions) 255 28.00 29.00 Outlier payments reconciliation 0 27.00 29.00 Outlier payments reconciliation 0 29.00 29.00 0.00				
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28.00 Other pass through costs (see instructions) 255 28.00 29.00 Outlier payments reconciliation 0 29.00 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.00 30.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.50 30.99 Recovery of Accelerated Depreciation 1,379,582 31.00 31.00 Total amount payable to the provider (see instructions) 1,379,582 31.01 32.00 Interim payments 27,592 31.01 32.00 Interim payments 1,341,263 32.00 33.00 Tentative settlement (for contractor use only) 0 33.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 10,727 34.00 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00	26.00	Subtotal (sum of lines 22 and 24)	1, 379, 327	26.00
29. 00 Outlier payments reconciliation 0 29. 00 30. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30. 00 30. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 30. 50 30. 99 Recovery of Accel erated Depreciation 0 30. 99 31. 00 Total amount payable to the provider (see instructions) 1, 379, 582 31. 01 31. 01 Sequestration adjustment (see instructions) 27, 592 31. 01 32. 00 Interim payments 1, 341, 263 32. 00 33. 00 Tentative settlement (for contractor use only) 0 33. 00 34. 00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 10, 727 34. 00 35. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35. 00 50. 00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50. 00 51. 00 Outlier reconciliation adjustment amount (see instructions) 0 51. 00 52. 00 The rate used to calculate the Time Value of Money 0. 00 52. 00	27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.00 30.50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 30.50 30.99 Recovery of Accelerated Depreciation 0 30.99 31.00 Total amount payable to the provider (see instructions) 1,379,582 31.01 Sequestration adjustment (see instructions) 27,592 31.01 Interim payments 27,592 32.00 Interim payments 1,341,263 32.00 Tentative settlement (for contractor use only) 0 33.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 10,727 35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00 The rate used to calculate the Time Value of Money 0.00 50.00 Contractor C	28.00	Other pass through costs (see instructions)	255	28.00
30.50 Pi oneer ACO demonstration payment adjustment (see instructions) 0 30.50 30.99 Recovery of Accelerated Depreciation 0 30.99 31.00 Total amount payable to the provider (see instructions) 1,379,582 31.00 31.01 Sequestration adjustment (see instructions) 27,592 31.00 32.00 Interim payments 1,341,263 32.00 33.00 Tentative settlement (for contractor use only) 0 33.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 32 and 33) 10,727 34.00 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	29. 00	Outlier payments reconciliation	0	29. 00
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50.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 Utlier reconciliation adjustment amount (see instructions) 0 51.00 10 Original outlier amount from Worksheet E-3, Part II, line 2 0 0 Utlier reconciliation adjustment amount (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		·		
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52.00 The rate used to calculate the Time Value of Money 0.00 52.00				

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150042	Peri od: From 01/01/2015	Worksheet E-3
	Component CCN: 15TO42		
	Title XVIII	Subprovi der -	PPS

DART TIT - WEDICARE PART A SERVICES - IRF PPS 1.00		IRF	113				
Name							
Net Federal PPS Payment (see Instructions)		DART LLL MEDICARE DART A CENTUCES LEE DEC	1.00				
Medicare SSI ratio (IRF PPS only) (see instructions)	1 00		0.007.704	1 00			
Inpatient Rehabilitation LIP Payments (see instructions)							
4.00		, , , , , , , , , , , , , , , , , , , ,	1				
Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)							
to November 15, 2004 (see instructions) 5.01 Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$411.424(d) (1) (11) (1) (1) (1) (1) (1) (1) (1) (
5.01 Cap Increases for the unwel ghted Intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412.474(d)(1)(III)(F)(1) or (2) (see Instructions)	5.00		0.00	5.00			
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412, 424(6) (1) (1) (1) (1) (1) (1) (1) (1) (2) (2) (see instructions) 0.00 6.0	5 01		0.00	5 01			
CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.01		0.00	0.01			
New Teaching program adjustment. (see instructions) 0.00 6.00 7.00 1.							
2.00 Current year's unwel ghted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions) 0.00 8.00	6.00		0.00	6.00			
teaching program" (see Instructions) 0.00 8.00			0.00				
teaching program" (see Instructions) 10.00							
9.00 Intern and resident count for IRF PPS medical education adjustment (see instructions) 20.00 9.00 10.00	8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8.00			
10.00 Average Daily Census (see instructions) 22.052055 10.00 10.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 10.00 Teaching Adjustment (see instructions) 0.000000 11.00 10.00 Teaching Adjustment (see instructions) 0.000000 11.00 10.00 Total PPS Payment (see instructions) 0.000000 11.00 10.00 Organ acquisition (DO NOT USE THIS LINE) 15.00 10.00 Organ acquisition (DO NOT USE THIS LINE) 15.00 10.00 Organ acquisition (See instructions) 0.00 10.00 10.00 Osubtotal (see instructions) 0.00 10.00 10.00 Osubtotal (see instructions) 0.00 10.00 10.00 Osubtotal (line 17 less line 18). 0.00 10.00 Deductibles 0.00 0.00 10.00 Deductibles 0.00 0.00 10.00 Deductibles 0.00 0.00 10.00 0.00 0.00							
11.00 Teaching Adjustment Factor (see instructions) 0.000000 11.00 12.00 1	9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00			
12.00 Teaching Adjustment (see instructions) 12.00 Total PPS Payment (see instructions) 9,612,878 13.00 14.00 Nursing and Allied Heal th Managed Care payments (see instructions) 14.00 15.00 0rgan acquisition (DN NOT USE THIS LINE) 15.00 16.00 17.00 15.00 16.00 17.00 18.00 18.00 18.00 18.00 18.00 18.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00 18.00 19.00	10.00	Average Daily Census (see instructions)	22. 052055	10.00			
13.00	11. 00	Teaching Adjustment Factor (see instructions)	0.000000	11.00			
14.00 Nursing and Allied Health Managed Care payments (see instruction) 14.00 15.00 0rgan acquisition (D0 NOT USE THIS LINE) 15.00 16.00	12.00	Teaching Adjustment (see instructions)	1				
15.00 Organ acquisition (DO NOT USE THIS LINE) 15.00			9, 612, 878				
16. 00 Cost of physicians' services in a teaching hospital (see instructions) 9, 612, 878 17. 00 18. 00 9, 612, 878 17. 00 18. 00 9, 612, 878 17. 00 18. 00 9, 612, 878 17. 00 18. 00 9, 612, 878 17. 00 18. 00 9, 612, 878 17. 00 18. 00 9, 612, 878 18. 00 19. 00 00 00 00 00 00 00 00			0				
17. 00 Subtotal (see instructions) 9, 612, 878 17. 00 18. 00 Primary payer payernaty payer payments 733 18. 00 Primary payer payernaty payer payments 9, 612, 145 19. 00							
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27. 00 Subtotal (sum of lines 23 and 25)		1 *					
28.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 29.00 Other pass through costs (see instructions) 30.00 Outlier payments reconciliation 31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 31.99 Recovery of Accelerated Depreciation 32.00 Total amount payable to the provider (see instructions) 32.01 Sequestration adjustment (see instructions) 32.01 Interim payments 34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 36.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50.00 Outlier reconciliation adjustment amount (see instructions) 50.00 The rate used to calculate the Time Value of Money 50.00 The rate used to calculate the Time Value of Money 50.00 The rate used to calculate the Time Value of Money 50.00 Dividication (See instructions) 50.00 The rate used to calculate the Time Value of Money 50.00 The rate used to calculate the Time Value of Money 50.00 The rate used to calculate the Time Value of Money 50.00 The rate used to calculate the Time Value of Money 50.00 Outlier reconciliation adjustment amount (see instructions) 50.00 The rate used to calculate the Time Value of Money		· · · · · · · · · · · · · · · · · · ·	1				
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31.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 31.00 31.50 31.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 31.50 31.99 32.00 Total amount payable to the provider (see instructions) 9,414,714 32.00 32.01 Sequestration adjustment (see instructions) 188,294 32.00 33.00 Interim payments 9,193,957 33.00 10.0			1				
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31.99 Recovery of Accelerated Depreciation 0 31.99 32.00 Total amount payable to the provider (see instructions) 9,414,714 32.00 32.01 Sequestration adjustment (see instructions) 188,294 32.01 33.00 Interim payments 9,193,957 33.00 34.00 Tentative settlement (for contractor use only) 0 34.00 35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) 32,463 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Silborate 15.2 15			1				
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32.01 Sequestration adjustment (see instructions) 188, 294 32.01 33.00 Interim payments Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 To BE COMPLETED BY CONTRACTOR Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money 188, 294 32.01 32.01 33.00 34.00 34.00 35.00 36.00 51.00 51.00 52.00 53.00 54.00 55.00 55.00 56.00 57.00 58.00 59.		,	1				
33.00 Interim payments 34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 36.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50.00 Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money 9, 193, 957 33.00 34.00 35.00 36.00 9, 193, 957 33.00 427, 463 35.00 36.00 51.00 52.00							
34.00 Tentative settlement (for contractor use only) 35.00 Balance due provider/program (line 32 minus lines 32.01, 33, and 34) 36.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 50.00 Outlier reconciliation adjustment amount (see instructions) 50.00 The rate used to calculate the Time Value of Money 34.00 35.00 36.00 36.00 36.00 37.00 38.00 39.00 30.0		, ,					
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36.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 36.00 \$\frac{\sqrt{115.2}}{\sqrt{10 BE COMPLETED BY CONTRACTOR}}\$ 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 427, 486 50.00 0utlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00		1	1				
\$115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money \$115.2 10 BE COMPLETED BY CONTRACTOR 50.00 51.00 52.00			1				
TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Wkst. E-3, Pt. III, line 4 427, 486 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 0.00 52.00	55. 55			55. 66			
51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 0.00 52.00		·					
51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 0.00 52.00	50.00		427, 486	50.00			
	51.00						
53.00 Time Value of Money (see instructions) 0 53.00			1				
	53.00	Time Value of Money (see instructions)	0	53.00			

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

Provider CCN: 150042 | Period: | Worksheet G | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

				0 12/31/2015	5/25/2016 9:5	
		General Fund	Speci fi c	Endowment Fund	Plant Fund	7 4111
			Purpose Fund			
	CHIDDENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	21, 456, 548	C	0	0	1.00
2.00	Temporary investments	30, 077, 030	l .		0	2.00
3.00	Notes recei vabl e	0	i c		0	3. 00
4.00	Accounts receivable	45, 796, 560	c	0	0	4. 00
5.00	Other recei vabl e	5, 163, 030		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-11, 570, 824	l .	<u> </u>	0	
7.00	Inventory	2, 010, 642	l .	0	0	•
8. 00 9. 00	Prepaid expenses Other current assets	3, 653, 238 5, 453, 581			0	8. 00 9. 00
10.00	Due from other funds	0, 455, 561			0	10.00
11. 00	Total current assets (sum of lines 1-10)	102, 039, 805	l .		0	1
	FI XED ASSETS	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,				
12.00	Land	7, 202, 985	C	0	0	12.00
13. 00	Land improvements	9, 191, 361	1		0	
14. 00	Accumulated depreciation	-4, 784, 197	1	0	0	
15.00	Buildings	122, 958, 810	1		0	15. 00 16. 00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-55, 987, 375		0	0	17. 00
18. 00	Accumulated depreciation			o o	0	18.00
19. 00	Fi xed equipment	0	d	Ö	0	19. 00
20.00	Accumulated depreciation	0	c	0	0	20. 00
21. 00	Automobiles and trucks	0	C	0	0	
22. 00	Accumul ated depreciation	0	C		0	1
23. 00	Maj or movable equipment	203, 683, 078	l .		0	23. 00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-123, 504, 841			0	24. 00 25. 00
26. 00	Accumulated depreciation				0	26.00
27. 00	HIT designated Assets	42, 627, 580	i c	o o	0	27. 00
28. 00	Accumulated depreciation	0) c	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	· ·		0	
30. 00	Total fixed assets (sum of lines 12-29)	201, 387, 401	<u> </u>	0	0	30. 00
21 00	OTHER ASSETS Investments	1 0	0	0	0	31. 00
31. 00 32. 00	Deposits on Leases		1		0	32.00
33. 00	Due from owners/officers				0	33. 00
34. 00	Other assets	1, 603, 307	ď	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1, 603, 307	C	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	305, 030, 513	C	0	0	36. 00
07.00	CURRENT LI ABI LI TI ES	17 (00 007			0	07.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	17, 628, 397 13, 229, 426	1		0	
39. 00	Payroll taxes payable	1, 004, 459	1		0	39.00
40. 00	Notes and Loans payable (short term)	1, 959, 161		o o	0	40.00
41.00	Deferred income	447, 302	c	0	0	41.00
42.00	Accel erated payments	0				42. 00
43. 00	Due to other funds	0	· ·		0	
	Other current liabilities	0	1	,	0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	34, 268, 745	C	0	0	45. 00
46. 00	Mortgage payable	Ι ο	C	0	0	46. 00
47. 00	Notes payable	80, 313, 219	l .		0	ł
48.00	Unsecured Loans	0) c	0	0	48. 00
49. 00	Other long term liabilities	0	C		0	ł
50. 00	Total long term liabilities (sum of lines 46 thru 49	80, 313, 219	l .		0	
51. 00	Total liabilites (sum of lines 45 and 50)	114, 581, 964	. <u> </u> C	0	0	51. 00
52. 00	CAPITAL ACCOUNTS General fund balance	190, 448, 549				52. 00
53. 00	Specific purpose fund	170, 440, 547)		53.00
54. 00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	•
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	190, 448, 549	d	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	305, 030, 513	l .	o o	0	
	[59]					

Provider CCN: 150042 | Period: | Worksheet G-1 | From 01/01/2015 | To 12/21/2017 Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

					T		Date/Time Pro 5/25/2016 9:5		
		General	Fund	Speci al	Pu	rpose Fund	Endowment Fund		
	T	1.00	2. 00	3. 00		4. 00	5. 00		
1.00	Fund balances at beginning of period		195, 141, 510	1		0		1.00	
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)		-4, 692, 961 190, 448, 549	1		0		2.00	
4.00	Additions (credit adjustments) (specify)		190, 446, 549		0	_		1	
5. 00	(open ty)	l o			0				
6.00		0			0		C	6. 00	
7.00		0			0		C		
8.00		0			0		C	1	
9. 00 10. 00	Total additions (sum of line 4-9)	0	0		0	0	C	9.00	
11. 00	Subtotal (line 3 plus line 10)		190, 448, 549			0		11.00	
12. 00	Deductions (debit adjustments) (specify)	0	170, 440, 547		0	-			
13. 00		o			0		d		
14.00		0			0		C		
15. 00		0			0		C		
16.00		0			0				
17. 00 18. 00	Total deductions (sum of lines 12-17)	١	0		U	0	C	17. 00 18. 00	
19. 00	Fund balance at end of period per balance		190, 448, 549			0		19. 00	
	sheet (line 11 minus line 18)								
		Endowment Fund	PI ant	Fund					
		6. 00	7. 00	8. 00					
1.00	Fund balances at beginning of period	0			0			1. 00	
2. 00 3. 00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)				0			2.00	
4. 00	Additions (credit adjustments) (specify)	١	0		U			4.00	
5. 00	(Specify)		0					5. 00	
6.00			0					6.00	
7.00			0					7. 00	
8.00			0					8.00	
9. 00 10. 00	Total additions (sum of line 4-9)		0		0			9.00	
11. 00	Subtotal (line 3 plus line 10)				0			11.00	
12. 00	Deductions (debit adjustments) (specify)		0		-			12. 00	
13.00			0					13.00	
14.00			0	1				14.00	
15.00			0					15. 00 16. 00	
16. 00 17. 00			0					17.00	
18. 00	Total deductions (sum of lines 12-17)	0	Ü		0			18.00	
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00	

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150042

			To 12/31/2015	Date/Time Pre 5/25/2016 9:5	
	Cost Center Description	I npati ent	Outpati ent	Total	/ dill
		1.00	2.00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	18, 321, 43	32	18, 321, 432	1. 00
2.00	SUBPROVI DER - I PF	5, 742, 64	8	5, 742, 648	2. 00
3.00	SUBPROVI DER - I RF	7, 672, 35	55	7, 672, 355	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	
7. 00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE	04 707 40		04 707 405	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)	31, 736, 43	55	31, 736, 435	10.00
11 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT	15 071 5/		15 071 5/2	11 00
11. 00 12. 00	CORONARY CARE UNIT	15, 071, 56	02	15, 071, 562	11. 00 12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	15, 071, 56	.2	15, 071, 562	
10.00	11-15)	13, 071, 30	,,,	13, 071, 302	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	46, 807, 99	7	46, 807, 997	17. 00
18. 00	Ancillary services	131, 779, 15			18. 00
19.00	Outpati ent servi ces		0 0	0	19. 00
20.00	RURAL HEALTH CLINIC		0 0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22.00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24.00	CMHC				24. 00
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE	513, 62			
27. 00	PHYLCIAN OFFICE	13, 858, 74	1 ' '		
27. 01	MH RESIDENTIAL		0 295, 082		
27. 02	MOB	1, 28			
27. 03	ASC	90, 47			
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	193, 051, 28	381, 945, 707	574, 996, 990	28. 00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		227, 089, 520		29. 00
30.00	NURSI NG HOME EXPENSES	72, 703, 44			30.00
31. 00	THORITIES TISTILE EAR ELIGES	,2,,00,	0		31. 00
32. 00			o		32. 00
33. 00			O		33. 00
34.00			0		34.00
35.00			0		35. 00
36.00	Total additions (sum of lines 30-35)		72, 703, 444		36. 00
37.00	MI SC EXPENSES	432, 92	18		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40. 00			0		40. 00
41. 00			0		41. 00
42. 00	Total deductions (sum of lines 37-41)		432, 928		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	^	299, 360, 036		43. 00
	to Wkst. G-3, line 4)	1	1	I	

Norksheet G-3 Provider CN: 150042 Prom 01/10/2015 To 01/2015	Heal th	Financial Systems GOOD SAMARITAN H	OSPI TAL	In Lie	u of Form CMS-2	2552-10	
To 12/31/2015 Date/Time Prepared: 5728/2016 9:57 am 72/25/2016 9:57 am 72	STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 150042		Worksheet G-3		
1.00							
1.00							
2.00 Less contractual allowances and discounts on patients' accounts 385.164,526 2.00 3.00 Net patient revenues (line 1 minus line 2) 189,832,464 3.00 3	1 00	T	00)			1 00	
3.00 Net patient revenues (line 1 minus line 2) 189, 832, 464 3.00 189, 812, 464 3.00 189, 812, 464 3.00 189, 812, 464 3.00 189, 812, 464 3.00 189, 812, 464 3.00 189, 812, 464 3.00 189, 812, 465 3.00 189, 812, 465 3.00 189, 812, 478							
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43) 299, 360, 036 4.00 Net income from service to patients (line 3 minus line 4) -109, 527, 572 5.00 The Income from service to patients (line 3 minus line 4) -109, 527, 572 5.00 The Income from investments 3, 284, 798 6.00 10, 000			5				
Net income from service to patients (line 3 minus line 4)			2)				
OTHER INCOME 3, 284, 798 6.00 7.00 Income from investments 257,528 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 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 455,437 14.00 15.00 Revenue from seals of medical and surgical supplies to other than patients 9,875,286 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 19.00 Tuit ion (fees, sale of textbooks, uniforms, etc.) 0 19.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 22.00 21.00 Rental of vending machines 0 22.00 22.00 Total other income (sum of lines 6-24) 90,961,562 24.00			3)				
6.00 Contributions, donations, bequests, etc 3, 284,798 6.00 7.00 Income from investments 257,528 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 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 455,437 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 9,875,286 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 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 <td>5.00</td> <td></td> <td></td> <td></td> <td>-109, 527, 572</td> <td>5.00</td>	5.00				-109, 527, 572	5.00	
7.00 Income from investments 257,528 7.00 8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 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 455, 437 14.00 15.00 Revenue from sale of medical and surgical supplies to other than patients 9,875, 286 16.00 17.00 Revenue from sale of drugs to other than patients 9,875, 286 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gifts, flowers, coffee shops, and canteen 0 17.00 20.00 Revenue from gifts, flowers, coffee shops, and canteen 0 21.00 22.00 Rental of hospital space 0 22.00 23.00 Rovernmental appropriations 90,961,562	6 00				3 284 798	6.00	
8.00 Revenues from telephone and other miscellaneous communication services 0 8.00 9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 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 455, 437 14.00 15.00 Revenue from meals sold to employees and guests 455, 437 14.00 16.00 Revenue from sale of medical and surgical supplies to other than patients 9, 875, 286 16.00 17.00 Revenue from sale of drugs to other than patients 9, 875, 286 16.00 17.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 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							
9.00 Revenue from television and radio service 0 9.00 10.00 Purchase discounts 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 455, 437 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 than patients 9, 875, 286 16.00 17.00 Revenue from sale of medical records and abstracts 0 17.00 18.00 Revenue from gale 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 24.0			servi ces				
10.00 Purchase discounts 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 Iaundry and Linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 455, 437 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 than patients 9, 875, 286 16.00 17.00 Revenue from sale of drugs to other than patients 9, 875, 286 16.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 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 NURSING HOME REVENUE 90, 961, 562 24.00 25.00 Total other income (sum of lines 6-24) 104, 834, 611 25.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00		•	30. 1. 303		- 1		
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 455,437 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 than patients 9,875,286 16.00 17.00 Revenue from sale of drugs to other than patients 9,875,286 16.00 18.00 Revenue from sale of medical records and abstracts 0 17.00 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 NURSI NG HOME REVENUE 90,961,562 24.00 25.00 Total other income (sum of lines 6-24) 104,834,611 25.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00							
12.00	11. 00	Rebates and refunds of expenses			0	11. 00	
13.00 Revenue from laundry and linen service 0 13.00 14.00 Revenue from meals sold to employees and guests 455, 437 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 than patients 9, 875, 286 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 NURSING HOME REVENUE 90, 961, 562 24.00 25.00 Total other income (sum of lines 6-24) 104, 834, 611 25.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0	12. 00				0	12. 00	
14.00 Revenue from meals sold to employees and guests 455, 437 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 than patients 9,875,286 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 NURSING HOME REVENUE 90, 961, 562 24.00 25.00 Total other income (sum of lines 6-24) 104, 834, 611 25.00 27.00 OTHER EXPENSES (SPECIFY) -4, 692, 961 26.00 27.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	13.00				0	13. 00	
16.00 Revenue from sale of medical and surgical supplies to other than patients 9,875,286 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 NURSING HOME REVENUE 90,961,562 24.00 25.00 Total other income (sum of lines 6-24) 104,834,611 25.00 26.00 Total (line 5 plus line 25) -4,692,961 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	14.00				455, 437	14. 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 NURSI NG HOME REVENUE 90, 961, 562 24. 00 25. 00 Total other income (sum of lines 6-24) 104, 834, 611 25. 00 26. 00 Total (line 5 plus line 25) -4, 692, 961 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	15. 00	Revenue from rental of living quarters			0	15. 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 NURSING HOME REVENUE 90, 961, 562 24.00 25.00 Total other income (sum of lines 6-24) 104, 834, 611 25.00 26.00 Total (line 5 plus line 25) -4, 692, 961 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	16.00	Revenue from sale of medical and surgical supplies to other that	an patients		9, 875, 286	16. 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 NURSING HOME REVENUE 90, 961, 562 24.00 25.00 Total other income (sum of lines 6-24) 104, 834, 611 25.00 26.00 Total (line 5 plus line 25) -4, 692, 961 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	17.00	Revenue from sale of drugs to other than patients	•		0	17. 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 NURSING HOME REVENUE 90, 961, 562 24.00 25.00 Total other income (sum of lines 6-24) 104, 834, 611 25.00 26.00 Total (line 5 plus line 25) -4, 692, 961 26.00 27.00 OTHER EXPENSES (SPECIFY) 0 27.00 28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	18.00	Revenue from sale of medical records and abstracts			0	18. 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 NURSING HOME REVENUE 90, 961, 562 24. 00 25. 00 Total other income (sum of lines 6-24) 104, 834, 611 25. 00 26. 00 Total (line 5 plus line 25) -4, 692, 961 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00	
22. 00 Rental of hospital space 0 22. 00 23. 00 Governmental appropriations 0 23. 00 24. 00 NURSI NG HOME REVENUE 90, 961, 562 24. 00 25. 00 Total other income (sum of lines 6-24) 104, 834, 611 25. 00 26. 00 Total (line 5 plus line 25) -4, 692, 961 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
23. 00 Governmental appropriations 0 23. 00 24. 00 NURSING HOME REVENUE 90, 961, 562 24. 00 25. 00 Total other income (sum of lines 6-24) 104, 834, 611 25. 00 26. 00 Total (line 5 plus line 25) -4, 692, 961 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	21.00	Rental of vending machines			0	21.00	
24. 00 NURSING HOME REVENUE 90,961,562 24. 00 25. 00 Total other income (sum of lines 6-24) 104,834,611 25. 00 26. 00 Total (line 5 plus line 25) -4,692,961 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	22. 00	Rental of hospital space			0	22. 00	
25. 00 Total other income (sum of lines 6-24) 104, 834, 611 25. 00 26. 00 Total (line 5 plus line 25) 26. 00 27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	23.00	Governmental appropriations			0	23.00	
26. 00 Total (line 5 plus line 25) 27. 00 OTHER EXPENSES (SPECIFY) 28. 00 Total other expenses (sum of line 27 and subscripts) -4, 692, 961 26. 00 27. 00 28. 00 28. 00	24.00	NURSING HOME REVENUE			90, 961, 562	24.00	
27. 00 OTHER EXPENSES (SPECIFY) 0 27. 00 28. 00 Total other expenses (sum of line 27 and subscripts) 0 28. 00	25. 00	Total other income (sum of lines 6-24)			104, 834, 611	25. 00	
28.00 Total other expenses (sum of line 27 and subscripts) 0 28.00	26.00	Total (line 5 plus line 25)			-4, 692, 961	26. 00	
	27. 00				0		
29.00 Net income (or loss) for the period (line 26 minus line 28) -4,692,961 29.00					- 1		
	29. 00	Net income (or loss) for the period (line 26 minus line 28)			-4, 692, 961	29. 00	

Sal ari es (From Semiloyse Transportation Contracted Semiloyse West K-1) Semiloyse West K-1 Semiloyse				Hospi ce		To 12/31/2015	Date/Time Pre 5/25/2016 9:5	
WRST. K-1) Senefit S (From WRST. K-2) Services (From WRST. K-3) Services (From						Hospi ce I		
WRST. K-1) Senefit S (From WRST. K-2) Services (From WRST. K-3) Services (From		·	Salaries (from	Employee	Transportatio	n Contracted	Other	
Capit all Related Costs-Bidg and Fixt.			Wkst. K-1)	Benefits (fro	m (see inst.)	Services (from		
GENERAL SERVICE OST CENTERS				Wkst. K-2)		Wkst. K-3)		
1.00			1.00	2.00	3. 00	4. 00	5. 00	
2.00		GENERAL SERVICE COST CENTERS						
1.00	1.00	Capital Related Costs-Bldg and Fixt.				0	0	1. 00
4. 00	2.00	Capital Related Costs-Movable Equip.				0	0	2. 00
5.00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 0	3.00	Plant Operation and Maintenance	C		0	0 0	0	3. 00
Administrative and General 634, 218 177, 949 67, 911 371, 954 77, 645 6.00	4.00	Transportation - Staff	C		0	0 0	0	4. 00
INPATIENT CARE SERVICE	5.00	Volunteer Service Coordination	C)	o	o o	0	5. 00
Total Inpatient - General Care 0 0 0 0 0 0 0 0 0	6.00	Administrative and General	634, 218	177, 94	9 67, 91	1 371, 954	77, 645	6. 00
Note		INPATIENT CARE SERVICE						
VISITING SERVICES	7.00	Inpatient - General Care	C)	0	0 0	877	7. 00
9. 00 Physician Services	8.00	Inpatient - Respite Care	C)	0	0 0	0	8. 00
10. 00 Nursing Care 0 0 0 0 0 0 0 0 11. 00		VISITING SERVICES			_			
11. 00 Nursing Care-Continuous Home Care 0 0 0 0 0 11. 00 12. 00 Physical Therapy 0 0 0 0 0 0 13. 00 Occupational Therapy 0 0 0 0 0 14. 00 Speech/ Language Pathology 0 0 0 0 0 15. 00 Medical Social Services 0 0 0 0 0 16. 00 Spiritual Counseling 0 0 0 0 0 17. 00 Dietary Counseling 0 0 0 0 0 18. 00 Counseling 0 0 0 0 0 18. 00 Counseling 0 0 0 0 0 19. 00 Hald Aide and Homemaker 0 0 0 0 0 19. 00 Hald Aide and Homemaker 0 0 0 0 0 19. 00 Other 0 0 0 0 0 19. 00 Other 0 0 0 0 0 19. 00 Other 0 0 0 0 0 22. 00 Other 0 0 0 0 0 23. 00 Anal gesics 0 0 0 0 0 24. 00 Sedatives / Hypnotics 0 0 0 0 0 25. 00 Other - Specify 0 0 0 0 0 26. 00 Unable Medical Equipment/Oxygen 0 0 0 0 0 27. 00 Patient Transportation 0 0 0 0 0 28. 00 Imaging Services 0 0 0 0 0 29. 00 Labs and Diagnostics 0 0 0 0 0 20. 00 Radiation Therapy 0 0 0 0 0 20. 00 Radiation Therapy 0 0 0 0 0 20. 00 Other - Specify 0 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0 0 0 20. 00 Other - Specify 0 0	9.00	Physi ci an Servi ces	C)	0	0 0	0	9. 00
12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 13.00 Occupational Therapy 0 0 0 0 0 14.00 Speech/ Language Pathology 0 0 0 0 0 15.00 Medical Social Services 0 0 0 0 0 15.00 Medical Social Services 0 0 0 0 0 15.00 Occupational Therapy 0 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 18.00 Counseling 0 0 0 0 0 0 19.00 Home Health Aide and Homemaker 0 0 0 0 0 19.00 Home Health Aide and Homemaker 0 0 0 0 0 20.00 HI Aide & Homemaker - Cont. Home Care 0 0 0 0 0 21.00 Other 0 0 0 0 0 21.00 Other 0 0 0 0 0 22.00 Other Other 0 0 0 0 23.00 Analgesics 0 0 0 0 0 24.00 Sedatives / Hypnotics 0 0 0 0 0 25.00 Other - Specify 0 0 0 0 0 26.00 Other - Specify 0 0 0 0 0 27.00 Patient Transportation 0 0 0 0 0 28.00 Labs and Diagnostics 0 0 0 0 0 29.00 Against Carrell Transportation 0 0 0 0 29.00 Against Carrell Transportation 0 0 0 0 29.00 Against Carrell Transportation 0 0 0 0 29.00 Chemotherapy 0 0 0 0 0 29.00 Against Carrell Transportation 0 0 0 0 29.00	10.00	Nursing Care	C)	0	0 0	0	10.00
13.00 Occupational Therapy 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 0 0 0 0 0 15.00 Medical Social Services 0 0 0 0 0 16.00 Spiritual Counseling 0 0 0 0 0 16.00 Spiritual Counseling 0 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 19.00 Hell Aide and Homemaker 0 0 0 0 0 19.00 Hell Aide and Homemaker 0 0 0 0 0 19.00 Hell Aide & Homemaker - Cont. Home Care 0 0 0 0 0 19.00 Other Other 0 0 0 0 0 21.00 Other	11.00	Nursing Care-Continuous Home Care	C)	0	0 0	0	11. 00
14. 00 Speech / Language Pathology	12.00	Physi cal Therapy	C)	0	0 0	0	12.00
15. 00 Medical Social Services	13.00	Occupational Therapy	C)	0	0 0	0	13. 00
16.00 Spiritual Counseling	14.00	Speech/ Language Pathology	C)	0	0 0	0	14. 00
17. 00 Di etary Counseling	15. 00	Medical Social Services	C		0	0 0	0	15. 00
18.00 Counseling - Other O O O O O O 18.00 19.00 Home Heal th Aide and Homemaker O O O O O O 20.00 Hi Aide & Homemaker - Cont. Home Care O O O O 21.00 Other O O O O O THER HOSPICE SERVICE COSTS O O O O O 22.00 Anal gesics O O O O O 23.00 Anal gesics O O O O O 25.00 Other - Specify O O O O 26.00 Durable Medical Equipment/Oxygen O O O O 27.00 Patient Transportation O O O O 28.00 Labs and Diagnostics O O O O 29.00 Labs and Diagnostics O O O 30.00 Medical Supplies O O O 31.00 Outpatient Services (including E/R Dept.) O O O 32.00 Other Specify O O O 33.00 Other Services O O O O 34.00 Outpatient Services O O O O 35.00 Outpatient Services O O O O 36.00 Outpatient Services O O O O 37.00 Outpatient Services O O O O 38.00 Other Services O O O O 39.00 Other Services O O O O 31.00 Outpatient Services O O O O 31.00 Outpatient Services O O O O 32.00 Sedation Therapy O O O O 33.00 Other O O O O 34.00 Other O O O O 35.00 Other Program Costs O O O O 36.00 Other Program Costs O O O O 37.00 Other O O O O 38.00 Other Other O O O 38.00 Other Other O O O 38.00 Other Ot	16.00	Spiritual Counseling	C)	0	0 0	0	16. 00
19.00 Home Heal th Ai de and Homemaker	17. 00	Di etary Counsel i ng	C		0	0 0	0	17. 00
20.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 0	18.00	Counseling - Other	C		0	0 0	0	18. 00
21.00 Other Othe	19. 00	Home Health Aide and Homemaker	C		0	0 0	0	19. 00
OTHER HOSPICE SERVICE COSTS O	20.00	HH Aide & Homemaker - Cont. Home Care	C		0	0 0	0	20. 00
22.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 22.00	21.00		C		0	0 0	0	21. 00
23. 00								
24.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 24.00 25.00 Other - Specify 0 0 0 0 0 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 0 0 0 26.00 27.00 Patient Transportation 0 0 0 0 0 0 0 27.00 28.00 Inaging Services 0 0 0 0 0 0 27.00 29.00 Labs and Diagnostics 0 0 0 0 0 0 28.00 29.00 Medical Supplies 0 0 0 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0	22. 00	Drugs, Biological and Infusion Therapy	C)	0	0 0	0	22. 00
25.00 Other - Specify 0 0 0 0 0 0 25.00	23. 00	Anal gesi cs	C)	0	0 0	0	23. 00
26. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 26. 00 27. 00 Pati ent Transportation 0 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 29. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 0 0 32. 00 33. 00 Other 0 0 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 0 0 0 0 <	24. 00	Sedatives / Hypnotics	C)	0	0 0	0	24. 00
27.00 Patient Transportation 0 0 0 0 0 27.00	25.00	Other - Specify	C)	0	0 0	0	25. 00
28. 00 Imaging Services 0 0 0 0 0 0 28. 00 29. 00 Labs and Diagnostics 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 30. 00 31. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 31. 00 32. 00 Radiation Therapy 0 0 0 0 0 0 0 0 32. 00 33. 00 Chemotherapy 0 0 0 0 0 0 0 0 0 33. 00 34. 00 Other 0 0 0 0 0 0 0 0 34. 00 HOSPICE NONREIMBURSABLE SERVICE 8 0 0 0 0 0 0 0 35. 00 36. 00 Vol unteer Program Costs 0 0 0 0 0 0 0 0 0 0 0 0	26.00	Durable Medical Equipment/Oxygen	C)	0	0 0	0	26. 00
29.00 Labs and Diagnostics 0 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 35.00 36.00 Vol unteer Program Costs 0 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 0 0 0 37.00 0 0 0 0 0 0 0 <td< td=""><td>27.00</td><td>Patient Transportation</td><td>C</td><td>)</td><td>0</td><td>0 0</td><td>0</td><td>27. 00</td></td<>	27.00	Patient Transportation	C)	0	0 0	0	27. 00
30.00 Medical Supplies 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 35.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 36.00 Other 35.00 Bereavement Program Costs 0 0 0 0 0 0 36.00 Volunteer Program Costs 0 0 0 0 0 37.00 Fundraising 0 0 0 0 0 38.00 Other Program Costs 0 0 0 0 30.00 Other Program Costs 0 0 0 0 30.00 Other Program Costs 0 0 30.00 Other Program Costs 0 0 0 0 30.00 Other Program Costs 0 0 0 0 30.00 Other Program Costs 0 0 0 0 0 30.00 Output Out	28. 00	I maging Services	C)	0	0 0	0	28. 00
31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 33.00 34.00 Other Oth	29. 00	Labs and Diagnostics	C)	0	0 0	0	29. 00
32.00 Radiation Therapy 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 HOSPICE NONREIMBURSABLE SERVICE	30.00	Medical Supplies	C)	0	0 0	0	30. 00
33.00 Chemotherapy 0 0 0 0 0 0 33.00 0 0 0 0 0 34.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	Outpatient Services (including E/R Dept.)	C)	0	0 0	0	31.00
34. 00 Other O O O O O HOSPI CE NONREI MBURSABLE SERVI CE 35. 00 Bereavement Program Costs O O O O O 35. 00 36. 00 Vol unteer Program Costs O O O O O O 36. 00 37. 00 Fundrai si ng O O O O O O O 37. 00 38. 00 Other Program Costs O	32.00	Radi ati on Therapy	C		0	0 0	0	32.00
HOSPICE NONREIMBURSABLE SERVICE	33.00	Chemotherapy	C		0	0 0	0	33. 00
35.00 Bereavement Program Costs 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00	34.00	Other	C		0	0 0	0	34. 00
36.00 Volunteer Program Costs 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 38.00		HOSPICE NONREIMBURSABLE SERVICE						
37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 38.00	35.00	Bereavement Program Costs	C		0	0 0	0	35. 00
38.00 Other Program Costs 0 0 0 0 38.00			C		0	0 0	0	
	37.00	Fundrai si ng	C)	0	0 0	0	37. 00
39.00 Total (sum of lines 1 thru 38) 634,218 177,949 67,911 371,954 78,522 39.00	38. 00	Other Program Costs	C		0	0 0	0	38. 00
	39. 00	Total (sum of lines 1 thru 38)	634, 218	177, 94	9 67, 91	1 371, 954	78, 522	39. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS	Provi der CCN: 150042	Period: Worksheet K

Hospi ce CCN: 151526 To 12/31/2015 Date/Ti me Prepared:

			Hospi ce (CN: 151526 10) 12/31/2015	5/25/2016 9:5	
					Hospi ce I	0,20,2010 7.0	7 GIII
		Total (cols.	RecLassi fi cati	Subtotal (col.	Adjustments	Total (col. 8	
		1-5)	on	6 ± col . 7)		± col . 9)	
		6.00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	O	0	0	0	1.00
2.00	Capital Related Costs-Movable Equip.	o	0	0	0	0	2. 00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3. 00
4.00	Transportation - Staff	0	0	0	0	0	4. 00
5.00	Volunteer Service Coordination	0	0	0	0	0	5. 00
6.00	Administrative and General	1, 329, 677	-148, 698	1, 180, 979	-125	1, 180, 854	6. 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	877	-6, 497	-5, 620	0		7. 00
8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0	- 1	0	0	9. 00
10.00	Nursing Care	0	0	0	0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0	0	0	0	11. 00
12.00	Physi cal Therapy	0	0	0	0	0	12.00
13. 00	Occupational Therapy	0	0	0	0	0	13. 00
14. 00	Speech/ Language Pathology	0	0	0	0	0	14. 00
15. 00	Medical Social Services	0	0	0	0	0	15. 00
16. 00	Spiritual Counseling	0	0	0	0	0	16. 00
17. 00	Dietary Counseling	0	0	0	0	0	17. 00
18. 00	Counseling - Other	0	0	0	0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0	0	0	0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0	-	0	0	20. 00
21. 00	Other	0	0	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS			TT	_1	_	
22. 00	Drugs, Biological and Infusion Therapy	0	0	-	0	0	22. 00
23. 00	Anal gesi cs	0	0	١	0	0	23. 00
24. 00	Sedatives / Hypnotics	0	Ü	0	0	0	24. 00
25. 00	Other - Specify	0	Ü	0	0	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	Ü	0	0	0	26. 00
27. 00	Pati ent Transportation	0	0	0	0	0	27. 00
28. 00	I maging Services	0	U	0	0	0	28. 00
29. 00	Labs and Diagnostics	0	0	0	0	0	29. 00
30.00	Medical Supplies	0	0	0	0	_	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	U	١	U	0	31.00
32. 00	Radi ati on Therapy	0	U	0	0	0	32.00
33. 00	Chemotherapy	0	0	-	0	0	33. 00 34. 00
34. 00	Other HOSPICE NONREIMBURSABLE SERVICE	l V		<u> </u>	U	U	34.00
35. 00	Bereavement Program Costs		0	O	0	0	35. 00
36. 00	Volunteer Program Costs		0		0	0	36.00
37. 00	Fundrai si ng		0	0	0	0	37.00
38. 00	Other Program Costs		0		0	0	38.00
	Total (sum of lines 1 thru 38)	1, 330, 554	-155, 1 9 5	١	-125		
37.00	1.013. (33 01 111103 1 1111 4 00)	1, 555, 554	100, 170	1, 1, 1, 5, 55 /	123	1, 1, 5, 254	1 37. 00

						5/25/2016 9:5	7 am
					Hospi ce I		
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS			•			
1.00	Capital Related Costs-Bldg and Fixt.						1. 00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance	0	(0	0	3. 00
4.00	Transportation - Staff	o	(0 0	0	4. 00
5.00	Volunteer Service Coordination	o	(0 0	0	5. 00
6.00	Administrative and General	634, 218	(0 0	0	6. 00
	I NPATI ENT CARE SERVI CE	<u> </u>		•	<u> </u>		
7.00	Inpatient - General Care	0	(0 0	0	7. 00
8.00	Inpatient - Respite Care	o	(0 0	0	8. 00
	VI SI TI NG SERVI CES	<u>'</u>		•			
9.00	Physi ci an Servi ces	0	(0 0	0	9. 00
10.00	Nursing Care	o	(0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	o	(0 0	0	11.00
12.00	Physi cal Therapy	o	(ol	0 0	0	12. 00
13.00	Occupational Therapy	o	(ol	0 0	0	13. 00
14.00	Speech/ Language Pathology	o	(ol	0 0	0	14. 00
15.00	Medical Social Services	o	(ol	0 0	0	15. 00
16.00	Spiritual Counseling	o	(ol	0 0	0	16. 00
17.00	Di etary Counseling	o	(ol	0 0	0	17. 00
18.00	Counseling - Other	o	(0 0	0	18. 00
19.00	Home Health Aide and Homemaker	o	(0 0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	o	(0 0	0	20.00
21.00	Other	o	(0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy						22. 00
23.00	Anal gesi cs						23. 00
24.00	Sedatives / Hypnotics						24. 00
25.00	Other - Specify						25. 00
26.00	Durable Medical Equipment/Oxygen						26. 00
27.00	Patient Transportation	0	(0 0	0	27. 00
28.00	I maging Services	0	(0 0	0	28. 00
29.00	Labs and Diagnostics	0	(0 0	0	29. 00
30.00	Medical Supplies	0	(0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	(0 0	0	31.00
32.00	Radi ati on Therapy	0	(0	0	32. 00
33.00	Chemotherapy	0	(0	0	33. 00
34.00	Other	o	(0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	(0 0	0	35. 00
36.00	Volunteer Program Costs		(0	0	36. 00
37.00	Fundrai si ng		(0	0	37. 00
38.00	Other Program Costs		(0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	634, 218	(0 0	0	39. 00

Health Financial Systems	GOOD SAMARITA	AN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES			Provi der	CCN: 150042	Peri od: From 01/01/2015	Worksheet K-1	
			Hospi ce (CCN: 151526	To 12/31/2015		oared: 7 am
					Hospi ce I		
	Total		Ai des	All-Other	Total (1)		
	Therapi sts						

						5/25/2016 9:57 am
					Hospi ce I	
		Total	Ai des	All-Other	Total (1)	
		Therapi sts				
		6. 00	7. 00	8.00	9. 00	
	GENERAL SERVICE COST CENTERS					
1.00	Capital Related Costs-Bldg and Fixt.					1. 00
2.00	Capital Related Costs-Movable Equip.					2. 00
3.00	Plant Operation and Maintenance		C)	0 0	3. 00
4.00	Transportation - Staff		C		0 0	4. 00
5.00	Volunteer Service Coordination		C		0 0	5. 00
6.00	Administrative and General		C)	0 634, 218	6. 00
	INPATIENT CARE SERVICE					
7.00	Inpatient - General Care		C)	0 0	7. 00
8.00	Inpatient - Respite Care		C)	0 0	8. 00
	VISITING SERVICES					
9.00	Physi ci an Servi ces		C)	0 0	9. 00
10.00	Nursing Care		C		0 0	10.00
11.00	Nursing Care-Continuous Home Care		C		0 0	11. 00
12.00	Physical Therapy	0	C		0 0	12. 00
13.00	Occupational Therapy	0	C		0 0	13. 00
14.00	Speech/ Language Pathology	0	C		0 0	14. 00
15.00	Medical Social Services		C		o o	15. 00
16.00	Spiritual Counseling		C		o o	16. 00
17. 00	Di etary Counseling		C		o o	17. 00
18. 00	Counseling - Other		C		o o	18. 00
19.00	Home Health Aide and Homemaker		C		0 0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care		C		0 0	20. 00
21.00	Other		C		0 0	21. 00
	OTHER HOSPICE SERVICE COSTS	•				
22.00	Drugs, Biological and Infusion Therapy					22. 00
23.00	Anal gesi cs					23. 00
24.00	Sedatives / Hypnotics					24. 00
25.00	Other - Specify					25. 00
26.00	Durable Medical Equipment/Oxygen					26. 00
27. 00	Patient Transportation		C		o o	27. 00
28. 00	Imaging Services		C		o o	28. 00
29. 00	Labs and Diagnostics		C		o o	29. 00
30. 00	Medical Supplies		Ċ		o o	30.00
31. 00	Outpatient Services (including E/R Dept.)		Ċ		o o	31. 00
32. 00	Radi ati on Therapy		Ċ		0	32. 00
33. 00	Chemotherapy		Č		o o	33.00
34. 00	Other		Č		o o	
01.00	HOSPI CE NONREI MBURSABLE SERVI CE			1	0	31.00
35 00	Bereavement Program Costs		C		0 0	35. 00
36. 00	Volunteer Program Costs	1		1		36.00
37. 00	Fundrai si ng	1				37. 00
38. 00	Other Program Costs	1	Ċ		o o	38. 00
	Total (sum of lines 1 thru 38)	0	-	1	0 634, 218	
	1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		· ~	1	33 17 2 10	1 07.00

 Heal th Financial
 Systems
 GOOD SAMARITAN HOSPITAL

 HOSPICE
 COMPENSATION
 ANALYSIS
 EMPLOYEE
 BENEFITS
 (PAYROLL RELATED)
 Provide
 Provi der CCN: 150042 | Peri od: From 01/01/2015 | Date/Ti me Prepared: 5/25/2016 9: 57 am

			1.0001.00	7011	12, 01, 2010	5/25/2016 9:5	7 am
					Hospi ce I		
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		2.00	0.00		0.00	
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2. 00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	
4. 00	Transportation - Staff	0	0		0 0		
5. 00	Volunteer Service Coordination	0	0		0 0		
6.00	Administrative and General	0	177, 949		0 0	-	
0.00	I NPATI ENT CARE SERVI CE	٩	.,,,,,,		<u> </u>		0.00
7.00	Inpatient - General Care	0	0		0 0	0	7. 00
8.00	Inpatient - Respite Care	o	0		0 0		1
	VI SI TI NG SERVI CES	-	-				
9. 00	Physi ci an Servi ces	0	0		0 0	0	9.00
10. 00	Nursing Care	0	0		0 0		
11. 00	Nursing Care-Continuous Home Care	0	0		0 0	0	
12. 00	Physical Therapy	0	0		0 0	_	
13. 00	Occupational Therapy	0	0		0 0	0	
14. 00	Speech/ Language Pathology	0	0		0 0	Ö	
15. 00	Medical Social Services	0	0		0 0	0	
16. 00	Spiritual Counseling	0	0		0 0	Ö	
17. 00	Di etary Counsel i ng		0		0 0	0	
18. 00	Counseling - Other		0		0 0	0	
19. 00	Home Health Aide and Homemaker	0	0		0 0	0	
20. 00	HH Aide & Homemaker - Cont. Home Care		0		0 0	_	
21. 00	Other	0	0		0 0		
21.00	OTHER HOSPICE SERVICE COSTS	9			<u> </u>		1
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26.00
27. 00	Patient Transportation	0	0		0	0	
28. 00	Imaging Services	0	0		0 0	0	
29. 00	Labs and Diagnostics	o	0		0 0	0	29. 00
30.00	Medical Supplies	o	0		0 0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	o	0		0 0	0	31.00
32. 00	Radi ati on Therapy	0	0		0 0	0	
33. 00	Chemotherapy	0	0		0 0	-	
34. 00	Other	0	0		0 0	-	
5 50	HOSPI CE NONREI MBURSABLE SERVI CE	<u> </u>			-1 0		1
35. 00	Bereavement Program Costs	0	0		0 0	0	35. 00
36. 00	Volunteer Program Costs		0	1	0 0	-	
37. 00	Fundrai si ng		0		0 0	_	
38. 00	Other Program Costs		0		0 0		
	Total (sum of lines 1 thru 38)		177, 949		0 0		1
		1		•	1		

Health Financial Systems	GOOD SAM	ARITAN HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPICE COMPENSATION ANALYSIS EMPLOYEE	BENEFITS (PAYROLL RELA	TED) Provi der CCN: 1	50042 Peri od:	Worksheet K-2	

From 01/01/2015 To 12/31/2015 Hospi ce CCN: 151526 Date/Time Prepared: 5/25/2016 9:57 am Hospi ce I All-Other Total Ai des Total (1) Therapi sts 7.00 8.00 9. 00 6.00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 Capital Related Costs-Movable Equip. 2.00 2.00 3.00 0 3 00 Plant Operation and Maintenance 0 4.00 Transportation - Staff 0 0 4.00 5.00 Volunteer Service Coordination 0 5.00 6.00 Administrative and General 0 0 177, 949 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 7.00 8.00 0 0 0 8.00 VISITING SERVICES 9.00 Physi ci an Servi ces 0 0 0 9.00 10.00 Nursing Care 0 0 0 10.00 Nursing Care-Continuous Home Care 0 0 11.00 0 11.00 12.00 Physical Therapy 0 12.00 0 0 13.00 Occupational Therapy 0 0 0 0 0 0 0 0 13.00 14.00 Speech/ Language Pathology 0 14.00 0 Medical Social Services 0 0 0 15.00 15.00 0 16.00 Spiritual Counseling 16.00 17.00 Dietary Counseling 17.00 0 0 18.00 Counseling - Other 18.00 0 Home Health Aide and Homemaker 0 19.00 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 21.00 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesi cs 23.00 Sedatives / Hypnotics 24.00 24.00 25.00 Other - Specify 25.00 Durable Medical Equipment/Oxygen 26.00 26.00 27.00 Patient Transportation 27.00 0 28. 00 Imaging Services 0 0 0 28.00 0 29 00 Labs and Diagnostics 0 29.00 0 30.00 Medical Supplies 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 31.00 Radiation Therapy 0 0 32.00 0 32.00 0 0 33.00 Chemotherapy 33.00 34.00 0ther 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 Bereavement Program Costs 0 0 0 35.00

0 0 0

0

0

0

177, 949

36.00

37.00

38.00

39.00

0

0

0

36.00

37.00

38.00

Volunteer Program Costs

39.00 Total (sum of lines 1 thru 38)

Other Program Costs

Fundrai si ng

 Heal th
 Financial
 Systems
 GOOD
 SAMARITAN HO

 HOSPICE
 COMPENSATION
 ANALYSIS
 CONTRACTED
 SERVICES/PURCHASED
 SERVICES
 150042 | Peri od: From 01/01/2015 | Worksheet κ-3 | From 12/31/2015 | Date/Time Prepared: 5/25/2016 9:57 am Provi der CCN: 150042 Hospi ce CCN:

					-		5/25/2016 9:	5/	alli
		1			Ц,	Hospi ce I		_	
		Admi ni strator	Di rector	Soci al		Supervi sors	Nurses		
		1.00	2.00	Servi ces		4.00	F 00	+	
	GENERAL SERVICE COST CENTERS	1. 00	2. 00	3. 00		4. 00	5. 00	+	
1 00	Capital Related Costs-Bldg and Fixt.			T					1. 00
1.00							I	-	
2.00	Capital Related Costs-Movable Equip.					0	I		2.00
3.00	Plant Operation and Maintenance	0	(0	0		0	3.00
4.00	Transportation - Staff	0	(0	٩		0	4. 00
5.00	Volunteer Service Coordination	074 054	(0	0		0	5. 00
6. 00	Administrative and General	371, 954	(الا	0	0		0	6. 00
7.00	I NPATI ENT CARE SERVI CE					ما			7 00
7.00	Inpatient - General Care	0	(0	0		0	7. 00
8. 00	Inpatient - Respite Care	0	(<u> </u>	0	0		0	8. 00
	VI SI TI NG SERVI CES					al			
9. 00	Physician Services	0	(1	0	0		0	9. 00
10.00	Nursing Care	0	()	0	0		0	10.00
11. 00	Nursing Care-Continuous Home Care	0	()	0	0		0	11. 00
12. 00	Physi cal Therapy	0	(0	0		0	12. 00
13. 00	Occupational Therapy	0	(0	0		0	13.00
14. 00	Speech/ Language Pathology	0	(0	0		0	14.00
15. 00	Medical Social Services	0	(0	0		0	15. 00
16. 00	Spiritual Counseling	0	(0	0		0	16. 00
17. 00	Di etary Counseling	0	(0	0		0	17. 00
18. 00	Counseling - Other	0	(0	0		0	18. 00
19. 00	Home Health Aide and Homemaker	0	(0	0		0	19. 00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	(1	0	0		0	20.00
21. 00	Other	0	()	0	0	L	0	21.00
	OTHER HOSPICE SERVICE COSTS								
	Drugs, Biological and Infusion Therapy						I		22. 00
23. 00	Anal gesi cs						I		23. 00
24. 00							I		24. 00
25. 00							I		25. 00
26. 00	Durable Medical Equipment/Oxygen						I		26. 00
27. 00	Patient Transportation	0	(0	0		0	27. 00
28. 00	I maging Services	0	(0	0		0	28. 00
29. 00	Labs and Diagnostics	0	(0	0		0	29. 00
30. 00	Medical Supplies	0	(0	0		0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	(0	0		0	31. 00
32. 00	Radiation Therapy	0	(0	0		0	32.00
33. 00	Chemotherapy	0	(1	0	0		0	33. 00
34.00	Other	0	(0	0		0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE								
35. 00	Bereavement Program Costs	0	(0	0		0	35.00
36. 00	3	0	(0	0		0	36. 00
37. 00	Fundrai si ng	0	(0	0		0	37. 00
38. 00	Other Program Costs	0	(0	0		0	38. 00
39. 00	Total (sum of lines 1 thru 38)	371, 954	()	0	0	ı	0	39. 00
	, ,	371, 954	(- 1	-			

Heal th	Financial Systems	GOOD SAMARITAN	I HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI C	E COMPENSATION ANALYSIS CONTRACTED SERVICES/F	URCHASED SERVICE	S Provi der	CCN: 150042	Peri od:	Worksheet K-3	
					From 01/01/2015		
			Hospi ce (CCN: 151526			
						5/25/2016 9:5	/ am
					Hospi ce I		
		Total	Ai des	All-Other	Total (1)		
		Therapi sts					
	T	6. 00	7. 00	8. 00	9. 00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1. 00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance		0		0 0		3. 00
4.00	Transportation - Staff		0		0 0		4. 00
5.00	Volunteer Service Coordination		0		0 0		5. 00
6.00	Administrative and General		0		0 371, 954		6, 00
	I NPATI ENT CARE SERVI CE				, , , , , ,		
7.00	Inpatient - General Care		0		0 0		7. 00
8. 00	Inpatient - Respite Care		0		o o		8. 00
0.00	VI SI TI NG SERVI CES				9 9		0.00
9. 00	Physician Services		0		0 0		9. 00
			-				
10.00	Nursing Care		0	1	-		10.00
11. 00	Nursing Care-Continuous Home Care		0		0 0		11. 00
12. 00	Physi cal Therapy	0	0		0 0		12. 00
13. 00	Occupational Therapy	0	0		0		13. 00
14. 00	Speech/ Language Pathology	0	0		0		14. 00
15. 00	Medical Social Services		0		0		15. 00
16.00	Spiritual Counseling		0		0 0		16. 00
17.00	Di etary Counsel i ng		0		0 0		17. 00
18. 00	Counseling - Other		0		0 0		18. 00
19.00	Home Health Aide and Homemaker		0		o o		19. 00
20.00	HH Aide & Homemaker - Cont. Home Care		0		ol ol		20. 00
21. 00	Other		0		0 0		21. 00
	OTHER HOSPICE SERVICE COSTS	<u> </u>					
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26.00
27. 00	Patient Transportation		0		0 0		27. 00
			0		1		
28. 00	I maging Services		0		0 0		28. 00
29. 00	Labs and Diagnostics		0		0 0		29. 00
30. 00	Medi cal Supplies		0		0 0		30. 00
31. 00	Outpatient Services (including E/R Dept.)		0		0		31. 00
32. 00	Radi ati on Therapy		0		0 0		32. 00
33. 00	Chemotherapy		0		0		33. 00
34.00	Other		0		0 0		34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs		0		0 0		35. 00
36.00	Volunteer Program Costs		0		0 0		36. 00
37.00	Fundrai si ng		0		o o		37. 00
38. 00	Other Program Costs		0		o o		38. 00
39.00	Total (sum of lines 1 thru 38)	o	0		0 371, 954		39. 00
				•			

NET_EXPENSES FOR COST CENTERS FIXTURES MAINT: ALLOCATION ALLOC				·			5/25/2016 9: 5	7 am
NET EXPENSES FOR COST ALLOCATION COUNTY						Hospi ce I		
FOR COST ALLOCATION CALLOCATION ALLOCATION ALLO				CAPITAL RE	LATED COST			
CENERAL SERVICE COST CENTERS			FOR COST			OPERATION &	TRANSPORTATI ON	
1.00			0	1.00	2. 00	3. 00	4. 00	
2.00		GENERAL SERVICE COST CENTERS						
1.00	1.00	Capital Related Costs-Bldg and Fixt.	0	0				1. 00
4.00	2.00	Capital Related Costs-Movable Equip.	o			0		2. 00
S. 00 Volunteer Service Coordination 0 0 0 0 0 0 0 0 0	3.00	Plant Operation and Maintenance	o	0		0		3. 00
Administrative and General	4.00	Transportation - Staff	0	0		0	0	4.00
IMPATIENT CARE SERVICE Inpatient - General Care -5,620 0 0 0 0 0 0 0 0 0	5.00	Volunteer Service Coordination	0	0		0	0	5. 00
Type	6.00	Administrative and General	1, 180, 854	0		0	0	6. 00
Inpatient - Respite Care O O O O O O O O O		INPATIENT CARE SERVICE						
VISITING SERVICES	7.00	Inpatient - General Care	-5, 620	0		0 0	0	7. 00
9. 00 10. 00 11.	8.00	Inpatient - Respite Care	0	0		0	0	8. 00
10.00 Nursing Care 0		VISITING SERVICES						
11.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 11.00	9.00	Physi ci an Servi ces	0	0		0 0	0	9. 00
12.00 Physical Therapy 0 0 0 0 0 0 12.00 13.00 Occupational Therapy 0 0 0 0 0 0 14.00 Speech/ Language Pathology 0 0 0 0 0 15.00 Medical Social Services 0 0 0 0 0 16.00 Spiritual Counseling 0 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 0 19.00 Home Health Aide and Homemaker 0 0 0 0 0 19.00 Home Health Aide and Homemaker - Cont. Home Care 0 0 0 0 0 19.00 Other 0 0 0 0 0 20.00 Other Other 0 0 0 0 0 21.00 Other Othe	10.00	Nursi ng Care	O	0		0	0	10.00
13.00	11.00	Nursing Care-Continuous Home Care	O	0		0	0	11. 00
14.00 Spech Language Pathology 0 0 0 0 0 14.00 15.00 Medical Social Services 0 0 0 0 0 0 16.00 Spiritual Counseling 0 0 0 0 0 17.00 Dietary Counseling 0 0 0 0 0 18.00 Counseling - Other 0 0 0 0 19.00 Home Health Aide and Homemaker 0 0 0 0 0 19.00 Home Health Aide and Homemaker 0 0 0 0 0 19.00 Hid Aide & Homemaker - Cont. Home Care 0 0 0 0 0 19.00 There 10 0 0 19.00 There 10 0 0 19.00 There 10	12.00	Physi cal Therapy	o	0		0	0	12. 00
15.00 Medical Social Services	13.00	Occupational Therapy	0	0		0	0	13. 00
16.00 Spiritual Counseling	14.00	Speech/ Language Pathology	o	0		0	0	14.00
17. 00 Dietary Counseling	15.00	Medical Social Services	o	0		0	0	15. 00
18.00 Counseling - Other 0 0 0 0 0 18.00 19.00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 20.00 HI Aide & Homemaker - Cont. Home Care 0 0 0 0 0 21.00 Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Other Sedatives / Hypnotics Other Other Other Sedatives / Hypnotics Other Other Other - Specify Other - Specify Other Other Other - Specify Other - S	16.00	Spiritual Counseling	0	0		0	0	16. 00
19.00 Home Heal th Ai de and Homemaker	17.00	Di etary Counsel i ng	0	0		0	0	17. 00
20.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 0	18.00	Counseling - Other	0	0		0	0	18. 00
21.00 Other	19.00	Home Health Aide and Homemaker	0	0		0	0	19. 00
OTHER HOSPI CE SERVI CE COSTS	20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20. 00
22. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 22. 00 23. 00 Anal gesics 0 0 0 0 0 0 23. 00 24. 00 Sedatives / Hypnotics 0 0 0 0 0 0 24. 00 25. 00 Other - Specify 0 0 0 0 0 0 0 25. 00 26. 00 Durable Medical Equipment/0xygen 0 0 0 0 0 0 0 26. 00 27. 00 Pati ent Transportation 0 0 0 0 0 0 0 0 0 26. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 0 28. 00 30. 00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21.00		0	0		0 0	0	21. 00
23. 00								
24.00 Sedatives / Hypnotics	22. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22. 00
25.00 Other - Specify 0 0 0 0 0 0 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 25.00 26.00 Patient Transportation 0 0 0 0 0 0 0 0 27.00 28.00 Imaging Services 0 0 0 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 0 0 0 0 0 0 31.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 0 0 0 33.00 34.00 Other HOSPICE NONREIMBURSABLE SERVICE	23.00	Anal gesi cs	0	0		0 0	0	23. 00
26.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 26.00 27.00 Patient Transportation 0 0 0 0 0 0 0 27.00 28.00 Imaging Services 0 0 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 0 0 0 29.00 30.00 Medical Supplies 0	24.00	Sedatives / Hypnotics	0	0		0 0	0	24. 00
27. 00 Patient Transportation 0 0 0 0 0 27. 00 28. 00 Imaging Services 0 0 0 0 0 0 28. 00 29. 00 Labs and Di agnostics 0 0 0 0 0 0 0 0 29. 00 30. 00 Medical Supplies 0 <td< td=""><td>25.00</td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>0</td><td>25. 00</td></td<>	25.00		0	0		0 0	0	25. 00
28.00 Imaging Services 0 0 0 0 0 28.00 29.00 Labs and Diagnostics 0 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 0 33.00 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 0 0 36.00 37.00 Other Program Costs 0 0 0 </td <td>26.00</td> <td>Durable Medical Equipment/Oxygen</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>26. 00</td>	26.00	Durable Medical Equipment/Oxygen	0	0		0	0	26. 00
29.00 Labs and Diagnostics 0 0 0 0 0 29.00 30.00 Medical Supplies 0 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 34.00 4HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 0 0	27. 00	Pati ent Transportation	0	0		0	0	27. 00
30.00 Medical Supplies 0 0 0 0 0 30.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 33.00 34.00 Other O 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE	28. 00	I maging Services	0	0		0	0	28. 00
31.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 0 0 33.00 34.00 Other O 0 0 0 0 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 0 0 38.00	29. 00	Labs and Diagnostics	0	0		0	0	29. 00
32.00 Radiation Therapy 0 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 HOSPICE NONREIMBURSABLE SERVICE	30.00	Medical Supplies	0	0		0	0	30. 00
33.00 Chemotherapy 0 0 0 0 0 33.00 34.00 Other 0 0 0 0 0 0 34.00 Other O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	31. 00
34. 00 Other O O O O O 34. 00 HOSPI CE NONREI MBURSABLE SERVI CE 35. 00 Bereavement Program Costs O O O O O O 35. 00 36. 00 Vol unteer Program Costs O	32.00	Radiation Therapy	0	0		0	0	32. 00
HOSPI CE NONREI MBURSABLE SERVI CE	33.00	Chemotherapy	0	0		0	0	33. 00
35.00 Bereavement Program Costs 0 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00	34.00		0	0		0 0	0	34.00
36.00 Volunteer Program Costs 0 0 0 0 36.00 37.00 Fundraising 0 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00		HOSPICE NONREIMBURSABLE SERVICE						
37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 0 38.00	35.00	Bereavement Program Costs	0	0		0 0	0	35. 00
38.00 Other Program Costs 0 0 0 0 38.00			0	0		0	_	
			0	0		0		
39.00 Total (sum of lines 1 thru 38) 1,175,234 0 0 0 0 39.00			0	0				
	39. 00	Total (sum of lines 1 thru 38)	1, 175, 234	0		0 0	0	39. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - HOSPICE GENERAL SERVICE COST	Provi der CCN: 150042	Period: Worksheet K-4

From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: Hospi ce CCN: 151526 5/25/2016 9:57 am Hospi ce I VOLUNTEER SUBTOTAL ADMINISTRATIVE TOTAL (col. 5A SERVI CES (cols. 0 - 5) & GENERAL ± col. 6) COORDI NATOR 5A 6.00 7. 00 5.00 GENERAL SERVICE COST CENTERS Capital Related Costs-Bldg and Fixt. 1.00 2.00 Capital Related Costs-Movable Equip. 2.00 3.00 Plant Operation and Maintenance 3.00 4.00 Transportation - Staff 4.00 5.00 Volunteer Service Coordination 5.00 Administrative and General 0 1, 180, 854 1, 180, 854 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 -5, 620 1, 180, 854 1, 175, 234 7.00 8.00 0 8.00 VISITING SERVICES 9.00 Physician Services 0 0 0 0 0 0 0 0 0 0 0 9.00 0 10.00 Nursing Care 0 10.00 0 Nursing Care-Continuous Home Care 0 11.00 11.00 0 12.00 Physical Therapy 0 12.00 13.00 Occupational Therapy 0 13.00 0 0 0 0 0 Speech/ Language Pathology Medical Social Services 0 0 14.00 14.00 0 0 15.00 15.00 16.00 Spiritual Counseling 0 16.00 Dietary Counseling 0 0 17.00 17.00 0 0 Counseling - Other 18.00 18.00 01 0 19.00 Home Health Aide and Homemaker 19.00 0 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 0 0 0 21.00 0ther 0 21.00 OTHER HOSPICE SERVICE COSTS 0 0 22.00 Drugs, Biological and Infusion Therapy 0 0 22.00 23.00 Anal gesi cs 0 0 0 0 0 0 0 0 0 0 0 0 0 23.00 0 0 24.00 Sedatives / Hypnotics 0 0 24.00 0 25.00 Other - Specify 0 25.00 26.00 Durable Medical Equipment/Oxygen 0 26.00 0 0 0 0 0 0 0 27.00 Patient Transportation 27.00 Imaging Services 28 00 0 0 28.00 0 29.00 Labs and Diagnostics 29.00 0 30.00 Medical Supplies 0 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 31.00 0 32 00 0 32.00 Radiation Therapy 0 33.00 Chemotherapy 0 33.00 34.00 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 Bereavement Program Costs 0 0 0 0 0 35.00 0 0 36.00 Volunteer Program Costs 0 0 36.00 37.00 Fundrai si ng 0 37.00

0

1, 175, 234

0

1, 175, 234

38.00

39.00

Other Program Costs

39.00 Total (sum of lines 1 thru 38)

38.00

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150042
 Period: From 01/01/2015
 Worksheet K-4 Part II Date/Time Prepared: 5/25/2016 9:57 am

						5/25/2016 9:5	7 am
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION		
		FIXTURES (SQ. FT.)	EQUI PMENT (\$ VALUE)	OPERATION & MAINT. (SQ.	(MI LEAGE)	SERVI CES COORDI NATOR	
			,	FT.)		(HOURS)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2. 00
3.00	Plant Operation and Maintenance	0	0	0			3. 00
4.00	Transportation - Staff	0	0	0	0		4. 00
5.00	Volunteer Service Coordination	0	0	0	0	0	
6.00	Administrative and General	0	0	C	0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		1	0	
8.00	Inpatient - Respite Care	0	0	C	0	0	8. 00
	VISITING SERVICES						
9. 00	Physi ci an Servi ces	0	0	0	1	0	
10. 00	Nursing Care	0	0	0	0	0	1
11. 00	Nursing Care-Continuous Home Care	0	0	0	0	0	11. 00
12. 00	Physi cal Therapy	0	0	1	-	0	1
13. 00	Occupational Therapy	0	0	1	0	0	
14. 00	Speech/ Language Pathology	0	0	1	0	0	1
15. 00	Medical Social Services	0	0		0	0	1
	Spiritual Counseling	0	0	l ~	0	0	16. 00
	Di etary Counseling	0	0	0	0	0	1
18. 00	Counseling - Other	0	0	C	0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0	C	0	0	
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0		1	0	
21. 00	Other	0	0	C	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS				1		
22. 00	Drugs, Biological and Infusion Therapy	0	0			0	
	Anal gesi cs	0	0		-	0	
24. 00	Sedatives / Hypnotics	0	0	1	-	0	
	Other - Specify	0	0	1	0	0	
26. 00	Durable Medical Equipment/Oxygen	0	0	~	0	0	
27. 00	Patient Transportation	0	0	1	-	0	1
28. 00	I maging Services	0	0	l ~	i i	0	
29. 00	Labs and Diagnostics	0	0		0	0	
30.00	Medical Supplies	0	0	0	0	0	00.00
31. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32. 00	Radi ati on Therapy	0	0	· ·	0	0	
33. 00	Chemotherapy	0	0	1	0	0	
34. 00	Other	0	0	C	0	0	34. 00
	HOSPI CE NONREI MBURSABLE SERVI CE						
35. 00	Bereavement Program Costs	0	0			0	
36. 00	Volunteer Program Costs	0	0	C	0	0	
37. 00	Fundrai si ng	0	0		0	0	
38. 00	Other Program Costs	0	0			0	
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	0 000000	0 000000	0.000000	0 000000	0 000000	39. 00
40.00	Unit Cost Multiplier	0. 000000	0. 000000	0.000000	0. 000000	0. 000000	40. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS GOOD SAMARITAN HOSPITAL

					5/25/2016 9:5	/ alli
		DECONOLI LATI ON	ADMINI CEDATINE	Hospi ce I		
		RECONCI LI ATI ON				
			& GENERAL			
		/ A	(ACC. COST)			
	CENEDAL CEDALCE COCT CENTEDO	6A	6. 00			
1 00	GENERAL SERVICE COST CENTERS					1 00
1.00	Capital Related Costs-Bldg and Fixt.	0				1.00
2.00	Capital Related Costs-Movable Equip.					2.00
3.00	Plant Operation and Maintenance	0				3. 00
4.00	Transportation - Staff	0				4. 00
5.00	Volunteer Service Coordination	4 400 054	F (00			5. 00
6. 00	Administrative and General	-1, 180, 854	-5, 620			6. 00
7 00	I NPATI ENT CARE SERVI CE		F (20			7 00
7. 00 8. 00	Inpatient - General Care	0	-5, 620			7. 00 8. 00
8.00	Inpatient - Respite Care	U U	0			8.00
9. 00	VI SI TI NG SERVI CES Physi ci an Servi ces		0			9. 00
10. 00	Nursi ng Care		0			10.00
11. 00	Nursing Care-Continuous Home Care		0			11. 00
12. 00	Physical Therapy		O O			12. 00
13. 00	Occupational Therapy		O O			13. 00
14. 00	Speech/ Language Pathology		o			14. 00
15. 00	Medical Social Services		o			15. 00
16. 00	Spiritual Counseling		o			16. 00
17. 00	Dietary Counseling		0			17. 00
18. 00	Counseling - Other		o			18. 00
19. 00	Home Health Aide and Homemaker		o			19. 00
20. 00	HH Ai de & Homemaker - Cont. Home Care		Ö			20. 00
21. 00	Other	0	o			21. 00
21.00	OTHER HOSPICE SERVICE COSTS	<u> </u>	<u> </u>			200
22. 00	Drugs, Biological and Infusion Therapy	0	0			22. 00
23. 00	Anal gesi cs	0	o			23. 00
24. 00	Sedatives / Hypnotics	0	o			24. 00
25. 00	1	0	0			25. 00
26. 00	Durable Medical Equipment/Oxygen	0	o			26. 00
27. 00	Pati ent Transportation	0	o			27. 00
28. 00	Imaging Services	0	o			28. 00
29. 00	Labs and Diagnostics	0	0			29. 00
30. 00	Medical Supplies	o	O			30. 00
31. 00	Outpatient Services (including E/R Dept.)	o	O			31. 00
32.00	Radi ati on Therapy	o	o			32. 00
33. 00	Chemotherapy	0	O			33. 00
34.00	Other	o	o			34.00
	HOSPI CE NONREI MBURSABLE SERVI CE		<u>'</u>			
35. 00	Bereavement Program Costs	0	0			35. 00
36.00	Volunteer Program Costs	0	o			36. 00
37.00	Fundrai si ng	0	0			37. 00
38. 00	Other Program Costs	0	o			38. 00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)		1, 180, 854			39. 00
40.00	Unit Cost Multiplier		-210. 116370			40. 00
		·	·			

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150042
 Period: From 01/01/2015 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/25/2016 9: 57 am
 Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

Cost Center Description							3/23/2010 9.3	<i>i</i> alli
Cost Center Description						Hospi ce I		
Semble S				CAPI TAL REI	CAPITAL RELATED COSTS			
Semble S								
Administrative and General		Cost Center Description		BLDG & FIXT	MVBLE EQUIP		COMMUNI CATI ONS	
1.00			Bal ance (1)					
1.00								
2.00 Inpatient - General Care 1,175,234 0 0 0 0 2.00 3.00 Inpatient - Respite Care 0 </td <td></td> <td>1</td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		1	0					
3.00 Inpatient - Respite Care 0 0 0 0 0 0 3.00				116, 930	0	156, 592	1	
4.00 Physician Services 0 0 0 0 0 4.00 5.00 Nursing Care 0 0 0 0 0 5.00 7.00 Physical Therapy 0 0 0 0 0 0 0 7.00 8.00 Cocupational Therapy 0<			1, 175, 234	0	0	0	1	
5.00 Nursing Care 0 0 0 0 0 0 5.00 6.00 Nursing Care-Continuous Home Care 0			0	0	0	0		
6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0			0	0	0	0	1	
7. 00 Physical Therapy			0	0	0	0	1	
8.00 Occupational Therapy 0 0 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 0 0 9.00 Speech/ Language Pathology 0 0 0 0 0 9.00 Occupational Therapy 0 0 0 0 0 9.00 Occupational Therapy 0 0 0 9.00 Occupational T			0	0	0	0	1	
9.00 Speech/ Language Pathology 0 0 0 0 0 9.00 10.00 Medical Social Services 0 0 0 0 0 10.00 0 0 0 10.00 0 0 10.00 0 0 0 11.00 0 0 0 0 0 11.00 0 0 0 0 11.00 0 0 0 0 0 11.00 0 0 0 0 0 0 0 0 0 0 12.00 0 0 0 0 12.00 0 0 0 0 0 0 12.00 0 0 0 0 0 12.00 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>1</td> <td></td>			0	0	0	0	1	
10.00 Medical Social Services			0	0	0	0	0	8. 00
11.00 Spiritual Counseling 0 0 0 0 0 11.00 12.00 Dietary Counseling 0 0 0 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 0 0 13.00 14.00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 0 16.00 18.00 Anal gesics 0 0 0 0 0 0 0 0 17.00 0 18.00 0 0 0 18.00 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0 0 <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td>			0	0	0	0	0	
12.00 Diletary Counselling 0 0 0 0 0 0 12.00 13.00 Counselling - Other 0 0 0 0 0 0 14.00 Home Heal th Aide and Homemaker 0 0 0 0 0 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 15.00 Other 0 0 0 0 0 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 18.00 Anal gesics 0 0 0 0 0 19.00 Sedatives / Hypnotics 0 0 0 0 0 19.00 Sedatives / Hypnotics 0 0 0 0 19.00 Other - Specify 0 0 0 0 10.00 Durable Medical Equipment/Oxygen 0 0 0 0 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 22.00 Patient Transportation 0 0 0 0 23.00 Imaging Services 0 0 0 0 24.00 Labs and Diagnostics 0 0 0 0 25.00 Medical Supplies 0 0 0 0 27.00 Radiation Therapy 0 0 0 0 28.00 Other Otherapy 0 0 0 0 29.00 Other Otherapy 0 0 0 0 20.00 0 0 0 0 20.00 0 0 0 0 20.00 0 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 20.00 0 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0			0	0	0	0	0	
13.00 Counseling - Other 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 17.00 0 0 0 17.00 0 0 0 0 17.00 0			0	0	0	0	0	
14.00 Home Health Aide and Homemaker 0 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 0 15.00 16.00 Other 0			0	0	0	0	0	
15.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 0 0 17.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 18.00 20.00 Other - Specify 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td>			0	0	0	0	0	
16.00 Other 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 17.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 0 19.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 0 20.00 21.00 Patient Transportation 0 0 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 0 22.00 24.00 Labs and Diagnostics 0 0 0 0 0 24.00 0 0 0 24.00 0 0 0 0 22.00 0 0 0 0 0 0 <	14.00		0	0	0	0	0	14.00
17. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 17. 00 18. 00 Anal gesics 0 0 0 0 0 18. 00 19. 00 Sedatives / Hypnotics 0 0 0 0 0 0 19. 00 20. 00 Other - Specify 0	15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	ol	15. 00
18.00 Anal gesics 0 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 0 0 20.00 0 <td></td> <td>Other</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>16. 00</td>		Other	0	0	0	0	0	16. 00
19.00 Sedatives / Hypnotics 0 0 0 0 19.00 20.00 Other - Specify 0	17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
20.00 Other - Specify 0 0 0 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 0 21.00 22.00 Pati ent Transportation 0 0 0 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 0 0 0 23.00 24.00 Labs and Di agnostics 0 0 0 0 0 0 0 0 0 0 0 23.00 25.00 Medical Supplies 0 0 0 0 0 0 0 0 0 25.00 26.00 Outpati ent Services (including E/R Dept.) 0 0 0 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 0 0 0 0 0 0 0 <td< td=""><td>18.00</td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>18. 00</td></td<>	18.00		0	0	0	0	0	18. 00
21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 21.00 22.00 Patient Transportation 0 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 0 24.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
22.00 Patient Transportation 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 24.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 25.00 27.00 Radiation Therapy 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 <t< td=""><td>20.00</td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>20. 00</td></t<>	20.00		0	0	0	0	0	20. 00
23.00 Imaging Services 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0	21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	
24.00 Labs and Diagnostics 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 0 0 0 31.00 32.00 Fundraising 0	22. 00	Pati ent Transportation	0	0	0	0	0	22. 00
25.00 Medical Supplies 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 0 0 0 0 0 31.00 31.00 Vol unteer Program Costs 0 0 0 0 0 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td>			0	0	0	0	0	
26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 0 0 31.00 31.00 Vol unteer Program Costs 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 0 33.00			0	0	0	0	0	
27. 00 Radiation Therapy 0 0 0 0 27. 00 28. 00 Chemotherapy 0 0 0 0 0 28. 00 29. 00 Other 0 0 0 0 0 0 29. 00 30. 00 Bereavement Program Costs 0 0 0 0 0 30. 00 31. 00 Vol unteer Program Costs 0 0 0 0 0 31. 00 32. 00 Fundraising 0 0 0 0 0 32. 00 33. 00 Other Program Costs 0 0 0 0 0 33. 00			0	0	0	0	0	
28.00 Chemotherapy 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 33.00			0	0	0	0	0	
29.00 Other 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 33.00			0	0	0	0	0	
30.00 Bereavement Program Costs 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 33.00		Chemotherapy	0	0	0	0	0	
31.00 Volunteer Program Costs 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 33.00			0	0	0	0	0	
32.00 Fundraising			0	0	0	0	0	
33.00 Other Program Costs 0 0 0 0 33.00			0	0	0	0	0	
			0	0	0	0	ol	
	33.00		0	0	0	0	1	33. 00
		Total (sum of lines 1 thru 33) (2)	1, 175, 234	116, 930	0	156, 592	432	
35.00 Unit Cost Multiplier (see instructions) 35.00	35. 00	Unit Cost Multiplier (see instructions)						35. 00

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150042
 Period: From 01/01/2015 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/25/2016 9: 57 am
 Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						3/23/2010 9.3	/ aiii
					Hospi ce I		
	Cost Center Description	PURCHASING &	REGI STRATI ON	PATI ENT	Subtotal	ADMI NI STRATI VE	
		RECEI VI NG		ACCOUNTS		& GENERAL	
		4. 02	4. 03	4.04	4A. 04	5. 00	
1.00	Administrative and General	737	6, 992	27, 936	309, 619	36, 834	1. 00
2.00	Inpatient - General Care	0	(0	1, 175, 234	139, 812	2. 00
3.00	Inpatient - Respite Care	0	(0	0	0	3. 00
4.00	Physi ci an Servi ces	0	(0	0	0	4. 00
5.00	Nursi ng Care	0	(0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	(0	0	0	6. 00
7.00	Physi cal Therapy	0	(0	0	0	7. 00
8.00	Occupational Therapy	0	(0	0	0	8. 00
9.00	Speech/ Language Pathology	0	(0	0	0	9. 00
10.00	Medical Social Services	0	(0	0	0	10.00
11.00	Spiritual Counseling	0	(0	0	0	11. 00
12.00	Di etary Counsel i ng	0		0	0	0	12.00
13.00	Counseling - Other	0		0	0	0	13. 00
14.00	Home Health Aide and Homemaker	0		0	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0		0	0	0	15. 00
16.00	Other	0		0	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0		0	0	0	17. 00
18.00	Anal gesi cs	0		0	0	0	18. 00
19.00	Sedatives / Hypnotics	0		0	0	0	19. 00
20.00	Other - Specify	0		0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	(0	0	0	21. 00
22.00	Patient Transportation	0		0	0	0	22. 00
23.00	I maging Services	0		0	0	0	23. 00
24.00	Labs and Diagnostics	0		0	0	0	24. 00
25.00	Medical Supplies	0		0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0		0	0	0	26. 00
27.00	Radi ati on Therapy	0		0	0	0	27. 00
28.00	Chemotherapy	0		0	0	0	28. 00
29.00	Other	0		0	0	0	29. 00
30.00	Bereavement Program Costs	0		0	0	0	30. 00
31.00	Volunteer Program Costs	0		0	0	0	31. 00
32.00	Fundrai si ng	0		0	0	0	32. 00
33. 00	Other Program Costs	0	ď	o	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	737	6, 992	27, 936	1, 484, 853	176, 646	34.00
35. 00	Unit Cost Multiplier (see instructions)	1	.,		0.000000		35. 00
		į.	!	į.		'	

Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS 150042 | Peri od: | Worksheet K-5 | From 01/01/2015 | Part I | Date/Time Prepared: | 5/25/2016 9:57 am Provider CCN: 150042 Hospi ce CCN:

					3/23/2010 9.3	<i>i</i> aiii	
					Hospi ce I		
	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		7. 00	8. 00	9. 00	10.00	11. 00	
1. 00	Administrative and General	83, 227	0.00	60, 827	0	21, 172	1. 00
2.00	Inpatient - General Care	0	0	0	0	. 0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursing Care	0	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7. 00	Physical Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	0	0	0	0	0	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11.00
12.00	Di etary Counsel i ng	0	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18. 00	Anal gesi cs	0	0	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Patient Transportation	0	0	0	0	0	22.00
23.00	I maging Services	0	0	0	0	0	23.00
24. 00	Labs and Diagnostics	0	0	0	0	0	24. 00
25. 00	Medical Supplies	0	0	0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	02 227	0	0	0	0	33.00
34. 00	Total (sum of lines 1 thru 33) (2)	83, 227	0	60, 827	O	21, 172	34. 00
35. 00	Unit Cost Multiplier (see instructions)	1	l		ļ		35. 00

 SPITAL
 In Lieu of Form CMS-2552-10

 Provi der CCN: 150042
 Peri od: From 01/01/2015 Part I
 Worksheet K-5 Part I

 Hospi ce CCN: 151526
 To 12/31/2015 Date/Time Prepared: 5/25/2016 9:57 am
 Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						5/25/2016 9:5	/ alli
					Hospi ce I		
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
	ļ.		SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
		13. 00	14.00	15. 00	16. 00	17. 00	
1.00	Administrative and General	92, 171	629		8	0	1.00
2.00	Inpatient - General Care	0	0		0	0	2.00
3.00	Inpatient - Respite Care	0	0		0	0	3. 00
4.00	Physi ci an Servi ces	0	0		0 0	0	4. 00
5.00	Nursi ng Care	0	0		0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7. 00
8.00	Occupational Therapy	0	0		0 0	0	8. 00
9.00	Speech/ Language Pathology	0	0		0 0	0	9. 00
10.00	Medical Social Services	0	0		0 0	0	10.00
11. 00	Spiritual Counseling	0	0		0 0	0	11. 00
12.00	Di etary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	O	0		0 0	0	13. 00
14.00	Home Health Aide and Homemaker	O	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15. 00
16.00	Other	0	0		0 0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17. 00
18.00	Anal gesi cs	0	0		0 0	0	18. 00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19. 00
20.00	Other - Specify	0	0		0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21. 00
22. 00	Patient Transportation	0	0		0 0	0	22. 00
23.00	I maging Services	0	0		0 0	0	23. 00
24.00	Labs and Diagnostics	0	0		0 0	0	24. 00
25.00	Medical Supplies	0	0		0 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26. 00
27. 00	Radi ati on Therapy	0	0		0 0	0	27. 00
28. 00	Chemotherapy	0	0		0 0	0	28. 00
29. 00	Other	o	0		o c	o o	29. 00
30. 00	Bereavement Program Costs	0	0		0	0	30.00
31. 00	Volunteer Program Costs	0	0		o c	o o	31.00
32. 00	Fundrai si ng	0	0		0	o o	32. 00
33. 00	Other Program Costs	0	0		0	ol o	•
34. 00	Total (sum of lines 1 thru 33) (2)	92, 171	629		8	ol o	•
	Unit Cost Multiplier (see instructions)		02,				35. 00
	(222)	1		1	1	1	

Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						5/25/2016 9:5	7 am
					Hospi ce I		
	Cost Center Description	MENTAL HEALTH	PARAMED ED	PARAMED ED	Subtotal	Intern &	
		OVERHEAD	PGRM	PGRM	(col s. 4A-23)	Residents Cost	
						& Post	
						Stepdown	
						Adjustments	
		17. 01	23. 00	23. 01	24. 00	25. 00	
1.00	Administrative and General	0	0		0 604, 487		1. 00
2.00	Inpatient - General Care	0	0		0 1, 315, 046	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	0	3. 00
4.00	Physici an Services	0	0		0	0	4. 00
5.00	Nursing Care	0	0		0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	6. 00
7.00	Physi cal Therapy	0	0		0	0	7. 00
8.00	Occupational Therapy	0	0		0	0	8. 00
9.00	Speech/ Language Pathology	0	0		0 0	0	9. 00
10.00	Medical Social Services	0	0		0	0	10.00
11. 00	Spiritual Counseling	0	0		0 0	0	11. 00
12.00	Di etary Counsel i ng	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	o	0		0 0	0	15. 00
16.00	Other	o	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	o	0		0 0	0	17. 00
18.00	Anal gesi cs	o	0		0 0	0	18. 00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19. 00
20.00	Other - Specify	0	0		0 0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21. 00
22.00	Patient Transportation	0	0		0 0	0	22. 00
23.00	I maging Services	0	0		0 0	0	23. 00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medi cal Supplies	0	0		0 0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26. 00
27.00	Radi ati on Therapy	0	0		0 0	0	27. 00
28. 00	Chemotherapy	0	0		0 0	0	28. 00
29.00	Other	0	0		0 0	0	29. 00
30.00	Bereavement Program Costs	0	0		0 0	0	30. 00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	o	0		0 0	0	32. 00
33.00	Other Program Costs	0	0		0 0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0 1, 919, 533	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00

Provi der CCN: 150042 | Peri od: From 01/01/2015 | Part I | Worksheet K-5 | Part I | Date/Time Prepared: 5/25/2016 9:57 am

			Hospi ce I	
Cost Center Description Subtotal	Allocated	Total Hospice		
(col s. 24 ± 1	Hospi ce A&G	Costs (cols.		
	(See Part II)	26 ± 27)		
26. 00	27. 00	28. 00		
1.00 Administrative and General				1. 00
2.00 Inpatient - General Care 1,315,046	604, 487	1, 919, 533		2. 00
3.00 Inpatient - Respite Care 0	0	0		3. 00
4.00 Physi ci an Servi ces 0	0	0		4. 00
5.00 Nursing Care 0	0	0		5. 00
6.00 Nursing Care-Continuous Home Care 0	0	0		6. 00
7.00 Physical Therapy 0	0	0		7. 00
8.00 Occupational Therapy 0	0	0		8. 00
9.00 Speech/ Language Pathology 0	0	0		9. 00
10.00 Medical Social Services 0	0	0		10.00
11.00 Spiritual Counseling 0	0	0		11. 00
12.00 Dietary Counseling 0	0	0		12. 00
13.00 Counseling - Other 0	0	0		13. 00
14.00 Home Health Aide and Homemaker 0	0	0		14.00
15.00 HH Aide & Homemaker - Cont. Home Care 0	0	0		15. 00
16.00 Other 0	0	0		16. 00
17.00 Drugs, Biological and Infusion Therapy 0	0	0		17. 00
18. 00 Anal gesi cs 0	0	0		18. 00
19.00 Sedatives / Hypnotics 0	0	0		19. 00
20.00 Other - Specify 0	0	0		20. 00
21.00 Durable Medical Equipment/Oxygen 0	0	0		21. 00
22.00 Patient Transportation 0	0	0		22. 00
23. 00 I magi ng Servi ces 0	0	0		23. 00
24.00 Labs and Diagnostics 0	0	0		24. 00
25. 00 Medical Supplies 0	0	0		25. 00
26.00 Outpatient Services (including E/R Dept.)	0	0		26. 00
27.00 Radiation Therapy 0	0	0		27. 00
28.00 Chemotherapy 0	0	0		28. 00
29.00 Other 0	0	0		29. 00
30.00 Bereavement Program Costs 0	0	0		30.00
31.00 Volunteer Program Costs 0	0	0		31. 00
32. 00 Fundrai si ng 0	0	0		32. 00
33.00 Other Program Costs 0	0	0		33. 00
34.00 Total (sum of lines 1 thru 33) (2) 1,919,533		1, 919, 533		34. 00
35.00 Unit Cost Multiplier (see instructions)	0. 459670			35. 00

STATISTICAL BASIS

						5/25/2016 9:5	7 am
					Hospi ce I		
	·	CAPITAL REL	ATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ONS	PURCHASING &	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		RECEI VI NG	
				DEPARTMENT	(NUMBER OF	(SUPPLIES C	
				(GROSS	PHONES)	OST)	
				SALARI ES)			
		1.00	2. 00	4. 00	4. 01	4. 02	
1.00	Administrative and General	4, 861	4, 861	634, 217	7 3	24, 077	1. 00
2.00	Inpatient - General Care	0	0		o o	0	2.00
3.00	Inpatient - Respite Care	0	0		0	0	3.00
4.00	Physi ci an Servi ces	0	0		0	0	4.00
5.00	Nursing Care	0	0		0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	6.00
7. 00	Physical Therapy	0	0		0	0	7. 00
8.00	Occupational Therapy	0	0		0	0	8.00
9. 00	Speech/ Language Pathology	0	0		0	0	9.00
10. 00	Medical Social Services	0	0		0	0	10.00
11. 00	Spiritual Counseling	0	0			Ö	11.00
12. 00	Di etary Counsel i ng	0	0			Ö	12.00
13. 00	Counseling - Other	0	0			Ö	13.00
14. 00	Home Health Aide and Homemaker	0	0			Ö	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0			Ö	15. 00
16. 00	Other	0	0		-	Ö	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18. 00	Anal gesi cs	0	0		0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0		0	Ō	19.00
20. 00	Other - Specify	0	0		0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
22. 00	Patient Transportation	0	0		0	0	22. 00
23. 00	I maging Services	0	0		0	0	23. 00
24.00	Labs and Diagnostics	0	0		0	0	24.00
25. 00	Medical Supplies	0	0		0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	26. 00
27. 00	Radiation Therapy	0	0		0	0	27. 00
28. 00	Chemotherapy	0	0		0	0	28. 00
29. 00	Other	0	0		0	0	29. 00
30.00	Bereavement Program Costs	0	0		0	0	30.00
31. 00	Volunteer Program Costs	0	l o		ol o	Ö	31.00
32. 00	Fundrai si ng	0	o o		o o	Ö	32.00
33. 00	Other Program Costs	0	l o		ol o	Ö	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	4, 861	4, 861	634, 217	3	24, 077	
35. 00	Total cost to be allocated	116, 930	0	156, 592		737	35. 00
	Unit Cost Multiplier (see instructions)	24. 054721	0. 000000			l e	

 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150042
 Period: From 01/01/2015 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/25/2016 9: 57 am
 STATISTICAL BASIS

Cost Center Description							5/25/2016 9:5	/ am
1.00						Hospi ce I		
1.00		Cost Center Description	REGISTRATION	PATI ENT	Reconciliatio	n ADMI NI STRATI VE	OPERATION OF	
1.00		·	(GROSS CHAR	ACCOUNTS				
1.00			GES)	(GROSS CHAR		(ACCUM. COST)	(SQUARE FEET)	
1.00				GES)				
2.00			4. 03	4. 04	5A	5. 00	7. 00	
3.00	1.00	Administrative and General	3, 022, 996	3, 022, 996		0 309, 619	4, 861	1. 00
4. 00 Physician Services 0 0 0 0 0 0 4. 00	2.00	Inpatient - General Care	0	0		0 1, 175, 234	0	2. 00
5.00 Nursing Care 0 0 0 0 0 5.00 6.00 Nursing Care-Continuous Home Care 0	3.00	Inpatient - Respite Care	0	0		0	0	3. 00
6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 7.00 7.00 Physical Therapy 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00	Physi ci an Servi ces	0	0		0	0	4. 00
7. 00 Physical Therapy	5.00	Nursi ng Care	0	0		0	0	5. 00
8. 00 Occupational Therapy 0 <td>6.00</td> <td>Nursing Care-Continuous Home Care</td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>6. 00</td>	6.00	Nursing Care-Continuous Home Care	0	0		0	0	6. 00
9.00 Speech/ Language Pathology 0 0 0 0 0 9.00 10.00 Medical Social Services 0 0 0 0 0 0 11.00 Spiritual Counseling 0 0 0 0 0 12.00 Dietary Counseling 0 0 0 0 0 13.00 Counseling 0 0 0 0 0 14.00 Home Health Alde and Homemaker 0 0 0 0 0 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 16.00 Other 0 0 0 0 0 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 18.00 Analgesics 0 0 0 0 0 0 19.00 Sedatives / Hypnotics 0 0 0 0 0 20.00 Other - Specify 0 0 0 0 0 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 22.00 Patient Transportation 0 0 0 0 23.00 Imaging Services 0 0 0 0 24.00 Labs and Diagnostics 0 0 0 0 25.00 Medical Supplies 0 0 0 0 26.00 Other - Specify 0 0 0 0 27.00 Radiation Therapy 0 0 0 0 28.00 Chemotherapy 0 0 0 0 28.00 Chemotherapy 0 0 0 0 29.00 Other - Program Costs 0 0 0 0 23.00 Under Program Costs 0 0 0 0 23.00 Other - Program Costs 0 0 0 0 24.00 Labs and Diagnost of the Program Costs 0 0 0 29.00 Other - Program Costs 0 0 0 0 29.00 Other - Program Costs 0 0 0 0 20.00 Other - Program Costs 0 0 0 0 20.00 Other - Program Costs 0 0 0 0 20.00 Other - Program Costs 0 0 0 0 20.01 Other - Program Costs 0 0 0 0 20.02 Other - Program Costs 0 0 0 0 20.03 Other - Program Costs 0 0 0 0 20.00 Other - Program Costs 0 0 0 0 20.01 Other - Program Costs 0 0 0 0 20.02 Other - Program Costs 0 0 0 0 20.03 Other - Program Costs 0 0 0 0 20.04 Other - Program Costs 0 0 0 0 20.05 Other - Program Costs 0 0 0 0 20.07 Other - Program Costs 0 0 0 0 20.08 Other - Program Costs 0 0 0 0 20.09 Other - Program Costs	7.00	Physi cal Therapy	0	0		0	0	7. 00
10.00 Medical Social Services	8.00	Occupational Therapy	0	0		0	0	8. 00
11.00 Spiritual Counseling	9.00	Speech/ Language Pathology	0	0		0	0	9. 00
12. 00 Di etary Counseling 0 0 0 0 0 0 12. 00 13. 00 Counseling - Other 0 0 0 0 0 13. 00 14. 00 Home Heal th Aide and Homemaker 0 0 0 0 0 0 15. 00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 16. 00 Other 0 0 0 0 0 0 17. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 18. 00 Analgesics 0 0 0 0 0 0 19. 00 Sedatives / Hypnotics 0 0 0 0 0 20. 00 Other - Specify 0 0 0 0 0 21. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 22. 00 Patient Transportation 0 0 0 0 23. 00 Imaging Services 0 0 0 0 0 24. 00 Labs and Diagnostics 0 0 0 0 0 25. 00 Medical Supplies 0 0 0 0 26. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 27. 00 Radiation Therapy 0 0 0 0 28. 00 Other Program Costs 0 0 0 0 31. 00 Volunteer Program Costs 0 0 0 0 32. 00 Total (sum of lines 1 thru 33) (2) 3, 022, 996 1, 484, 853 4, 861 34. 00 35. 00 Total (sum of lines 1 thru 33) (2) 3, 022, 996 176, 646 83, 227 35. 00 35. 00 Total (sum of lines 1 thru 33) (2) 3, 022, 996 176, 646 83, 227 35. 00 36. 00 Total (sum of lines 1 thru 33) (2) 3, 022, 996 176, 646 83, 227 35. 00 37. 00 Total (sum of lines 1 thru 33) (2) 3, 022, 996 176, 646 83, 227 35. 00 38. 00 Total cost to be allocated 6, 992 27, 936 176, 646 83, 227 35. 00 38. 00 Total cost to be allocated 6, 992 27, 936 176, 646 83, 227 35. 00 38. 00 Total cost to be allocated 6, 992 27, 936 176, 646 83, 227 35. 00 38. 00 Total cost to be allocated 6, 992 27, 936 176, 646 83, 227 35. 00 38. 00 Total cost to be allocated 6, 992 27, 936 176, 646 83. 278 176, 646 83. 278 176, 646 83. 278 176, 646 83. 278 176, 646 83. 278 176, 646 83. 278 176, 646 83. 278 176, 646 83. 278 176, 646 83. 278 176, 6	10.00	Medical Social Services	0	0		0	0	10. 00
13. 00 Counseling - Other 0 0 0 0 0 0 13. 00 14. 00 Home Health Aide and Homemaker 0 0 0 0 0 0 14. 00 15. 00 HI Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 16. 00 Other 0 0 0 0 0 0 0 17. 00 Drugs, Blological and Infusion Therapy 0 0 0 0 0 0 18. 00 Anal gesics 0 0 0 0 0 0 19. 00 Sedatives / Hypnotics 0 0 0 0 0 0 20. 00 Other - Specify 0 0 0 0 0 21. 00 Durable Medical Equipment/Oxygen 0 0 0 0 0 22. 00 Patient Transportation 0 0 0 0 0 23. 00 Imaging Services 0 0 0 0 0 24. 00 Labs and Diagnostics 0 0 0 0 0 25. 00 Medical Supplies 0 0 0 0 0 26. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 27. 00 Radiation Therapy 0 0 0 0 0 28. 00 Chemotherapy 0 0 0 0 0 29. 00 Other Program Costs 0 0 0 0 0 31. 00 Other Program Costs 0 0 0 0 33. 00 Other Program Costs 0 0 0 0 35. 00 Total (csum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35. 00 Total (csum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35. 00 Total (csum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00	11.00	Spiritual Counseling	0	0		0	0	11. 00
14. 00 Home Heal th Ai de and Homemaker 0 0 0 0 0 14. 00 15. 00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 15. 00 16. 00 Other 0 0 0 0 0 0 0 15. 00 17. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 0 0 17. 00 0 0 0 0 0 0 0 17. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12.00	Di etary Counsel i ng	0	0		0	0	12.00
15.00 HH Ai de & Homemaker - Cont. Home Care 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 19.00 20.00 Other - Speci fy 0 0 0 0 0 0 19.00 21.00 Durable Medical Equipment/Oxygen 0	13.00	Counseling - Other	0	0		0	0	13.00
16.00 Other 0 0 0 0 0 16.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00 18.00 Anal gesics 0 0 0 0 0 17.00 19.00 Sedatives / Hypnotics 0 0 0 0 0 18.00 20.00 Other - Specify 0 0 0 0 0 0 0 0 19.00 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 0 0 0 0 20.00 22.00 Patient Transportation 0 0 0 0 0 0 0 22.00 0 0 0 0 0 22.00 0 0 0 0 0 0 0 0 0 0 22.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	14.00	Home Health Aide and Homemaker	0	0		0	0	14.00
17. 00 Drugs, Biological and Infusion Therapy 0 0 0 0 17. 00 18. 00 Anal gesics 0 0 0 0 0 18. 00 19. 00 Sedati ves / Hypnotics 0 0 0 0 0 19. 00 20. 00 Other - Speci fy 0 <td>15.00</td> <td>HH Aide & Homemaker - Cont. Home Care</td> <td>o</td> <td>0</td> <td></td> <td>0</td> <td>0</td> <td>15. 00</td>	15.00	HH Aide & Homemaker - Cont. Home Care	o	0		0	0	15. 00
18.00 Analgesics 0 0 0 0 18.00 19.00 Sedatives / Hypnotics 0 0 0 0 20.00 Other - Specify 0 0 0 21.00 Durable Medical Equipment/Oxygen 0 0 0 22.00 Patient Transportation 0 0 0 0 23.00 Imaging Services 0 0 0 0 24.00 Labs and Diagnostics 0 0 0 0 25.00 Medical Supplies 0 0 0 0 26.00 Outpatient Services (including E/R Dept.) 0 0 0 27.00 Radiation Therapy 0 0 0 0 28.00 Chemotherapy 0 0 0 0 29.00 Other 0 0 20.01 Other 0 0 20.02 Other 0 0 20.03 Other 0 0 20.04 Other 0 20.05 Other 0 20.06 0 0 21.07 0 22.09 0 23.00 Other 0 24.00 0 0 25.00 0 26.00 0 27.00 0 28.00 0 0 29.00 0 29.00 0 29.00 0 29.00 29.00 0 20.01 0 20.02 0 20.03 0 20.04 0 20.05 0 20.06 0 20.07 0 20.08 0 20.08 0 20.08 0 20.08 0 20.09 0 20.00 0	16.00	Other	o	0		0	0	16. 00
19.00 Sedatives / Hypnotics	17.00	Drugs, Biological and Infusion Therapy	o	0		0	0	17. 00
20.00 Other - Specify 0 0 0 0 0 0 0 20.00 21.00 Durable Medical Equipment/Oxygen 0 0 0 0 0 0 0 21.00 22.00 Patient Transportation 0 0 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	18.00	Anal gesi cs	o	0		0	0	18. 00
21.00 Durable Medical Equipment/Oxygen 0 0 0 0 21.00 22.00 Patient Transportation 0 0 0 0 0 22.00 23.00 Imaging Services 0 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 0 0 24.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0	19.00	Sedatives / Hypnotics	o	0		0	0	19. 00
22. 00 Pati ent Transportation 0 0 0 0 0 22. 00 23. 00 Imaging Services 0 0 0 0 0 0 23. 00 24. 00 Labs and Diagnostics 0 0 0 0 0 0 24. 00 25. 00 Medical Supplies 0 0 0 0 0 0 0 0 25. 00 26. 00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 0 0 0 25. 00 27. 00 Radiation Therapy 0 0 0 0 0 0 0 0 27. 00 28. 00 Chemotherapy 0 0 0 0 0 0 0 27. 00 28. 00 Other 0 0 0 0 0 0 0 0 28. 00 29. 00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0	20.00	Other - Specify	o	0		0	0	20. 00
23.00 Imaging Services 0 0 0 0 0 23.00 24.00 Labs and Diagnostics 0 0 0 0 0 25.00 Medical Supplies 0 0 0 0 26.00 Outpatient Services (including E/R Dept.) 0 0 0 27.00 Radiation Therapy 0 0 0 0 28.00 Chemotherapy 0 0 0 0 29.00 Other 0 0 0 0 30.00 Bereavement Program Costs 0 0 0 0 31.00 Volunteer Program Costs 0 0 0 32.00 Fundraising 0 0 0 33.00 Other Program Costs 0 0 0 34.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35.00 Total cost to be allocated 6,992 27,936 176,646 83,227 35.00	21.00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
24.00 Labs and Diagnostics 0 0 0 0 0 24.00 25.00 Medical Supplies 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 0 0 0 30.00 31.00 Vol unteer Program Costs 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853	22.00	Patient Transportation	o	0		0 0	0	22. 00
25.00 Medical Supplies 0 0 0 0 0 0 25.00 26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	23.00	I maging Services	o	0		0 0	0	23. 00
26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 0 0 30.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35.00 Total cost to be allocated 6,992 27,936 176,646 83,227 35.00	24.00	Labs and Diagnostics	o	0		0	0	24. 00
26.00 Outpatient Services (including E/R Dept.) 0 0 0 0 26.00 27.00 Radiation Therapy 0 0 0 0 0 0 27.00 28.00 Chemotherapy 0 0 0 0 0 0 0 28.00 29.00 Other 0 0 0 0 0 0 0 29.00 30.00 Bereavement Program Costs 0 0 0 0 0 0 30.00 31.00 Volunteer Program Costs 0 0 0 0 0 0 30.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35.00 Total cost to be allocated 6,992 27,936 176,646 83,227 35.00	25.00	Medical Supplies	o	0		0	0	25. 00
28.00 Chemotherapy	26.00		o	0		0	0	26. 00
29.00 Other 30.00 Bereavement Program Costs 31.00 Volunteer Program Costs 32.00 Fundraising 33.00 Other Program Costs 0 0	27.00	Radi ati on Therapy	o	0		0	0	27. 00
30.00 Bereavement Program Costs 0 0 0 0 0 30.00 31.00 31.00 Volunteer Program Costs 0 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 0 32.00 33.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35.00 Total cost to be allocated 6,992 27,936 176,646 83,227 35.00	28.00	Chemotherapy	o	0		0	0	28. 00
31.00 Volunteer Program Costs 0 0 0 0 0 31.00 32.00 Fundraising 0 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35.00 Total cost to be allocated 6,992 27,936 176,646 83,227 35.00	29.00	Other	o	0		0	0	29. 00
32.00 Fundraising 0 0 0 0 0 32.00 33.00 Other Program Costs 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35.00 Total cost to be allocated 6,992 27,936 176,646 83,227 35.00	30.00	Bereavement Program Costs	o	0		0	0	30. 00
33.00 Other Program Costs 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35.00 Total cost to be allocated 6,992 27,936 176,646 83,227 35.00	31.00	Volunteer Program Costs	o	0		0	0	31. 00
33.00 Other Program Costs 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35.00 Total cost to be allocated 6,992 27,936 176,646 83,227 35.00	32.00		o	0		o o	0	32.00
34.00 Total (sum of lines 1 thru 33) (2) 3,022,996 3,022,996 1,484,853 4,861 34.00 35.00 Total cost to be allocated 6,992 27,936 176,646 83,227 35.00			o	0		o o	0	33. 00
35. 00 Total cost to be allocated 6, 992 27, 936 176, 646 83, 227 35. 00			3, 022, 996	3, 022, 996		1, 484, 853	4, 861	34.00
	35.00		6, 992					
	36.00	Unit Cost Multiplier (see instructions)	0. 002313	0. 009241		0. 118965	17. 121374	36. 00

STATISTICAL BASIS

					5/25/2016 9:5	7 am	
				_	Hospi ce I		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(TIME SPENT)	(PATIENT DA	(MAN HOURS)	ADMI NI STRATI ON	
		(LBS OF LAU		YS)			
		NDRY)				(DI RECT NUR	
						SI NG)	
		8.00	9. 00	10.00	11. 00	13. 00	
1.00	Administrative and General	0	1, 163	0	24, 828	24, 828	1.00
2.00	Inpatient - General Care	0	C	0	0	0	2.00
3.00	Inpatient - Respite Care	0	C	0	0	0	3.00
4.00	Physi ci an Servi ces	0	C	0	0	0	4.00
5.00	Nursi ng Care	0		0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	(0	0	0	6.00
7.00	Physi cal Therapy	0		0	0	0	7.00
8.00	Occupational Therapy	0		0	0	0	8.00
9.00	Speech/ Language Pathology	0	C	0	0	0	9. 00
10.00	Medical Social Services	0	C	0	0	0	10.00
11.00	Spiritual Counseling	0	C	0	0	0	11.00
12.00	Di etary Counsel i ng	0	C	0	0	0	12.00
13.00	Counseling - Other	0	(0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	(0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	l c	0	0	0	15. 00
16.00	Other	0		0	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0		0	0	0	17. 00
18.00	Anal gesi cs	0	l c	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0		0	0	0	19. 00
20.00	Other - Specify	0		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	(0	0	0	21.00
22.00	Patient Transportation	0		0	0	0	22. 00
23.00	I maging Services	0		0	0	0	23. 00
24.00	Labs and Diagnostics	0	(0	0	0	24.00
25.00	Medical Supplies	0	(0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	l	0	0	0	26. 00
27.00	Radi ati on Therapy	0	(0	0	0	27. 00
28. 00	Chemotherapy	0		0	0	0	28. 00
29. 00	Other	0	l c	0	0	0	29. 00
30.00	Bereavement Program Costs	0		0	0	0	30.00
31.00	Volunteer Program Costs	0	[c	0	0	0	31. 00
32.00	Fundrai si ng	0	(0	0	0	32.00
33.00	Other Program Costs	0	(0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	1, 163	0	24, 828	24, 828	34.00
35.00	Total cost to be allocated	0	60, 827	0	21, 172	92, 171	35. 00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	52. 301806	0.000000	0. 852747	3. 712381	36. 00

						5/25/2016 9:5	7 am
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	MENTAL HEALTH	
		SERVICES &	(COSTED REC	RECORDS &		OVERHEAD	
		SUPPLY	QUIS)	LI BRARY	(TIME SPENT)	(CHARGES)	
		(SUPPLI ES C		(TIME SPENT)			
		OST)					
			15. 00	16.00	17. 00	17. 01	
1.00	Administrative and General	24, 077	22		0	0	1. 00
2.00	Inpatient - General Care	0	0	(0	0	2. 00
3.00	Inpatient - Respite Care	0	0	(0	0	3. 00
4.00	Physician Services	0	0	(0	0	4. 00
5.00	Nursi ng Care	0	0	(0	0	5. 00
6.00	Nursing Care-Continuous Home Care	O	0	(0	0	6. 00
7.00	Physical Therapy	o	0		0	0	7. 00
8.00	Occupational Therapy	o	0		0	0	8. 00
9.00	Speech/ Language Pathology	o	0		0	0	9. 00
10.00	Medical Social Services	o	0		0	0	10.00
11.00	Spiritual Counseling	0	0	(0	0	11. 00
12.00	Di etary Counsel i ng	0	0	(0	0	12. 00
13.00	Counseling - Other	0	0	(0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0	(0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	o	0		0	0	15. 00
16.00	Other	o	0		0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	o	0		0	0	17. 00
18.00	Anal gesi cs	0	0	(0	0	18. 00
19.00	Sedatives / Hypnotics	O	0	(0	0	19. 00
20.00	Other - Specify	O	0	(0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0	(0	0	21. 00
22.00	Patient Transportation	0	0	(0	0	22. 00
23.00	I maging Services	o	0	(0	0	23. 00
24.00	Labs and Diagnostics	o	0	(0	0	24. 00
25.00	Medical Supplies	o	0	(0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0	(0	0	26. 00
27.00	Radi ati on Therapy	o	0	(0	0	27. 00
28.00	Chemotherapy	o	0	(0	0	28. 00
29.00	Other	o	0		0	0	29. 00
30.00	Bereavement Program Costs	o	0		0	0	30.00
31.00	Volunteer Program Costs	o	0		0	0	31. 00
32.00	Fundrai si ng	o	0		0	0	32. 00
33.00	Other Program Costs	o	0		0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	24, 077	22		0	0	34. 00
35.00	Total cost to be allocated	629	8		0	0	35. 00
	Unit Cost Multiplier (see instructions)	0. 026125	0. 363636	0. 000000	0.000000	0. 000000	
		'		•	•	•	

Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS GOOD SAMARITAN HOSPITAL Provi der CCN: 150042 STATISTICAL BASIS

Hospi ce CCN: 151526

				Hospi ce I	
	Cost Center Description	PARAMED ED	PARAMED ED		
		PGRM	PGRM		
		(ASSI GNED	(ASSI GNED		
		TIME)	TIME)		
		23. 00	23. 01		
1.00	Administrative and General	0	0		1.00
2.00	Inpatient - General Care	0	0		2. 00
3.00	Inpatient - Respite Care	0	0		3.00
4.00	Physi ci an Servi ces	0	0		4. 00
5.00	Nursi ng Care	0	0		5. 00
6.00	Nursing Care-Continuous Home Care	0	0		6. 00
7.00	Physi cal Therapy	0	0		7. 00
8.00	Occupational Therapy	0	0		8. 00
9.00	Speech/ Language Pathology	0	0		9. 00
10.00	Medical Social Services	o	o		10.00
11. 00	Spiritual Counseling	o	o		11. 00
12.00	Di etary Counsel i ng	l ol	o		12. 00
13.00	Counseling - Other	o	o		13. 00
14.00	Home Health Aide and Homemaker	o	o		14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	o	o		15. 00
16.00	Other	o	o		16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	o		17. 00
18.00	Anal gesi cs	o	0		18. 00
19. 00	Sedatives / Hypnotics	o	0		19.00
20.00	Other - Specify	o	0		20.00
21.00	Durable Medical Equipment/Oxygen	o	0		21. 00
22. 00	Patient Transportation	O	0		22. 00
23.00	I maging Services	0	0		23. 00
24.00	Labs and Diagnostics	0	0		24. 00
25.00	Medical Supplies	0	0		25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		26. 00
27.00	Radiation Therapy	0	0		27. 00
28. 00	Chemotherapy	0	0		28. 00
29. 00	Other	0	0		29. 00
30.00	Bereavement Program Costs	0	0		30.00
31.00	Volunteer Program Costs	0	0		31.00
32.00	Fundrai si ng	0	0		32.00
33.00	Other Program Costs	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		34.00
35.00	Total cost to be allocated	0	0		35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000		36. 00

Heal th	Financial Systems GO	OOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150042	Period: From 01/01/2015	Worksheet K-5	
			Hospi ce (CCN: 151526		Date/Time Pre	
						5/25/2016 9:5	<u>7 am</u>
					Hospi ce I		
	Cost Center Description				ge Total Hospice		
			I, col. 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
					Records)	x 2)	
			0	1.00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66. 00	0. 16498	35 0	0	1. 00
2.00	OCCUPATI ONAL THERAPY		67. 00				2.00
3.00	SPEECH PATHOLOGY		68.00				3.00
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 35962	26 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	0. 29702	26 0	0	5.00
6.00	LABORATORY		60.00	0. 13818	37 0	0	6.00
6. 01	BLOOD LABORATORY		60. 01				6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT		71. 00	1. 1071	55 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8. 00
9.00	RADI OLOGY-THERAPEUTI C		55. 00				9. 00
10.00	MH ANCILLARY OUTPATIENT		76. 00	l .	00	0	10.00
10. 01	INPATIENT DIALYSIS		76, 01	l .		0	10. 01
11. 00	Totals (sum of lines 1-10)		70.01	0.7070		0	
	•	,		•	'	'	

<u>Heal th</u>	Financial Systems GOOD SAMARITA	AN HOSI	PITAL			In Lie	u of Form CMS-2	<u> 2552-10</u>
CALCUL	ATION OF HOSPICE PER DIEM COST	F	Provi der	CCN: 150042	Peri		Worksheet K-6	
		ŀ	Hospice C	CCN: 151526		n 01/01/2015 12/31/2015		
					H	Hospi ce I		
		Title	e XVIII	Title XIX		Other	Total	
		1	. 00	2. 00		3. 00	4. 00	
1.00	Total cost (see instructions)						1, 919, 533	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)						0	2.00
3.00	Average cost per diem (line 1 divided by line 2)						0.00	3.00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)		0					4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)		0					5. 00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)				0			6. 00
7.00	Aggregate Medicaid cost (line 3 time line 60)				0			7. 00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)		0					8. 00
9.00	Aggregate SNF cost (line 3 time line 8)		0					9. 00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)				0			10.00
11.00	Aggregate NF cost (line 3 times line 10)				0			11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)					0		12.00
13 00	Aggregate cost for other days (line 3 times line 12)	1				ام		13 00

13.00 Aggregate cost for other days (line 3 times line 12)

13.00

				u of Form CMS-2	2552-10
CALCULATION OF CAPITAL PAYMENT		Provi der CCN: 150042	Period: From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD			1.00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			1, 707, 917	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			71, 681	2.00
2. 01 3. 00	Model 4 BPCI Capital DRG outlier payments Total inpatient days divided by number of days in the cost r	connecting pariod (see inst	ructions)	0 63.35	2. 01 3. 00
4. 00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by th	ne sum of lines 1 and 1.01	. columns 1 and	0	6. 00
	1.01) (see instructions)		,		
7.00	Percentage of SSI recipient patient days to Medicare Part A	patient days (Worksheet E	, part A line	0.00	7. 00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see instructions)			0.00	
9. 00 10. 00				0. 00 0. 00	
11. 00	Disproportionate share adjustment (see instructions)	15)		0.00	11.00
12. 00	Total prospective capital payments (see instructions)			1, 779, 598	
12.00	prospective depictal payments (see thetraetrone)			1,777,070	12.00
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST			_	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2. 00 3. 00	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0	
4. 00	Capital cost payment factor (see instructions)				4.00
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	
	The same of the sa				
				_	0.00
				1.00	0.00
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)	unas (saa instructions)		0	1. 00
2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan	nces (see instructions)		0	1. 00
2. 00 3. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2)	nces (see instructions)		0 0	1. 00 2. 00 3. 00
2.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)	nces (see instructions)		0	1. 00 2. 00 3. 00 4. 00
2. 00 3. 00 4. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2)	,		0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00
2. 00 3. 00 4. 00 5. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)	nstructions)	: line 6)	0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7)	nstructions) ry circumstances (line 2 x	line 6)	0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl	nstructions) ry circumstances (line 2 x icable)	ŕ	0 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to	nstructions) ry circumstances (line 2 x icable) capital payments (line 8	less line 9)	0 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	nstructions) ry circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri	less line 9) or year	0 0 0.00 0 0.00 0 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p	nstructions) y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 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	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente	nstructions) y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri payments (line 10 plus line er the amount on this line	less line 9) or year e 11)	0 0 0 0.00 0.00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over	nstructions) y circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri payments (line 10 plus line er the amount on this line	less line 9) or year e 11)	0 0 0 0.00 0 0.00 0 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 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	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, enter Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	nstructions) Ty circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri payments (line 10 plus line the amount on this line capital payment for the f	less line 9) or year e 11)	0 0 0 0.00 0 0.00 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
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over	nstructions) Ty circumstances (line 2 x icable) capital payments (line 8 capital payment (from pri payments (line 10 plus line the amount on this line capital payment for the f	less line 9) or year e 11)	0 0 0 0.00 0.00 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