Health Financial Sv	vstems	GOOD SAMARI TAN	HOSPI TAL	In Lieu	」of Form CMS-2552-10
	uired by law (42 USC 1395g; 42				
	e the beginning of the cost re				OMB NO. 0938-0050 EXPIRES 03-31-2022
HOSPITAL AND HOSPI AND SETTLEMENT SUM	TAL HEALTH CARE COMPLEX COST F MARY	REPORT CERTIFICATION	Provider CCN: 15-0042	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 7/10/2020 2:50 pm
PART I - COST REPO					
	X ]Electronically prepared co Manually prepared cost re			Date: 7/10/202	20 Time: 2:50 pm
3. [	0]If this is an amended rep F]Medicare Utilization. Ent	ort enter the number	of times the provider r _" for low.	resubmitted this co	ost report
use only ( ( (	1) As Submitted 7. Co 2) Settled without Audit 8. [	ate Received: ontractor No. N ]Initial Report fo N ]Final Report for	11. pr this Provider CCN 12.		r Code: 4 lumn 1 is 4: Enter es reopened = 0-9.
PART II - CERTIFIC	ATION				
ADMINISTRATIVE ACT PROVIDED OR PROCUR	OR FALSIFICATION OF ANY INFORM ION, FINE AND/OR IMPRISONMENT ED THROUGH THE PAYMENT DIRECTL ION, FINES AND/OR IMPRISONMENT	UNDER FEDERAL LAW. _Y OR INDIRECTLY OF A	FURTHERMORE, IF SERVICE	S IDENTIFIED IN TH	IS REPORT WERE
CERTI FI CAT	ION BY CHIEF FINANCIAL OFFICE	R OR ADMINISTRATOR OF	PROVIDER(S)		
el ectronic Expenses p ending 12/ complete a except as heal th car laws and r	ERTIFY that I have read the al sally filed or manually submit prepared by GOOD SAMARITAN HOSD (31/2019 and to the best of my and prepared from the books and noted. I further certify that re services, and that the servi- regulations.	ted cost report and t PITAL ( 15-0042 ) for knowledge and belief d records of the prov t I am familiar with ices identified in th	the Balance Sheet and St the cost reporting per , this report and state /ider in accordance with the laws and regulation his cost report were pro	atement of Revenue iod beginning 01/0 ment are true, cor applicable instru s regarding the pr wided in complianc	e and 11/2019 and rrect, actions, rovision of e with such
[ X ] I hav	ve read and agree with the abo	ve certification stat	tement. I certify that I	intend my electro	oni c

signature on this certification statement to be the legally binding equivalent of my original signature. (Signed) THOMAS COOK

Officer or Administrator of Provider(s)

CF0 Title

(Dated when report is electronically signed.)

Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	42, 229	214, 334	0	-605, 521	1.00
2.00	Subprovider - IPF	0	426, 478	278		182, 998	2.00
3.00	Subprovider - IRF	0	25, 293	-15		-30, 575	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	) Total	0	494, 000	214, 597	0	-453, 098	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.

SPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX	DENTIFICATION DA			er CCN:	15-0042	Period: From 01/01, To 12/31,	/2019 /2019	u of For Workshe Part I Date/Ti 7/10/20	et S-2 me Pre	parec
	1.00 Hospital and Hospital Health Care Co		00		3.00			4.00			
0	Street: 520 SOUTH 7TH STREET	PO Box:									1.
0	City: VINCENNES	State: I	N	Zip Code	e: 47591	Cour	nty: KNOX				2.
		Component Na		CCN	CBSA				ent Syst		
				Number	Number	r Type	Certi fi ed		, 0, or		-
		1.00		2.00	3.00	4.00	5.00	6. 00	XVIII 7.00	XI X 8.00	-
	Hospital and Hospital-Based Componen			2.00	3.00	4.00	3.00	1 0.00	17.00	0.00	
0	Hospi tal	GOOD SAMARITAN H		150042	99915	5 1	07/01/1966	N	Р	0	3.
0	Subprovider - IPF	GOOD SAMARITAN H		15S042	99915		01/01/1984		P	0	4.
0 0	Subprovider – IRF Subprovider – (Other)	GOOD SAMARITAN -	REHAB	15T042	99915	5	01/01/2001	N	P	0	5.
0	Swing Beds - SNF										7.
0	Swing Beds - NF										8.
0	Hospital-Based SNF										9.
	Hospital-Based NF										10.
00	Hospital -Based OLTC		OME	157422	99915		06/27/1995		Р	N	11.
00	Hospital-Based HHA	GOOD SAMARITAN H	UNE	157432	99915		06/2//1995	N		N N	12.
00	Separately Certified ASC										13.
	Hospi tal -Based Hospi ce	GOOD SAMARITAN L	I NCOLN	151526	99915	5	01/01/1984				14.
00	Heapital Recod Health Clinic DUC	TRAIL HOSPICE									1.5
	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15.
	Hospi tal -Based (CMHC) I										17.
00	Renal Dialysis										18.
00	Other							<u> </u>	To		19.
							From: 1.00		2.0		1
00	Cost Reporting Period (mm/dd/yyyy)						01/01/2		12/31/		20.
00	Type of Control (see instructions)						9				21.
					-	1.00	2.00		3. 0	0	-
	Inpatient PPS Information					1.00	2.00	,	5.0		
00	Does this facility qualify and is it					Y	N				22.
	disproportionate share hospital adju	stment, in accord	ance wit	h 42 CFR							
	§412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section §										
	hospital?) In column 2, enter "Y" fo			unerre							
01	Did this hospital receive interim un					Y	N				22.
	cost reporting period? Enter in colu										
	the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N										
	reporting period occurring on or aft										
02	Is this a newly merged hospital that					Ν	N				22.
	payments to be determined at cost re	port settlement?	(see ins	truction	s)						
	Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob				ves						
	or "N" for no, for the portion of th										
	October 1.										_
03	Did this hospital receive a geograph rural as a result of the OMB standar					N	N		N		22.
	adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reportin	g period prior to	0ctober	1. Ente							
	in column 2, "Y" for yes or "N" for										
	reporting period occurring on or aft Does this hospital contain at least				s						
	counted in accordance with 42 CFR 41										
	yes or "N" for no.		~ .								
UÜ	Which method is used to determine Me below? In column 1, enter 1 if date						2 N				23.
	if date of discharge. Is the method			<b>J</b> .							
	reporting period different from the	method used in th	ne prior (	cost							
	reporting period? In column 2, ente	r "Y" for yes or			toto	Out of		And: -		there	
			In-State Medicai			Out-of State		Medica HMO da		ther i cai d	
			paid day			Medi cai d	Medi cai d		~	ays	
				unpa	aid pa	aid days	eligible				
			1 00	day		2.00	unpai d	F 00		00	-
		enter the	1.00	2.0	00 1, 281	3.00	4.00	5.00	684	. 00	24.
20	It this provider is an IDDS been tel		4	50	1, 201	514	110		004	0	′  ∠4.
00	If this provider is an IPPS hospital in-state Medicaid paid days in colum	n 1, in-state			1						1
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	umn 2,									
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c	umn 2, olumn 3,									
00	in-state Medicaid paid days in colum Medicaid eligible unpaid days in col	umn 2, olumn 3, d days in column									

	<u>Financial Systems</u> TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFIC	GOOD SA CATION DAT		Provider CC	N: 15-0042	Peri od:			eet S-2	
						From 01/0 To 12/3				
			In-State	In-State	Out-of	Out-of	Medi ca		<u>020 2:5</u> )ther	50 pm
			Medi cai d	Medi cai d	State	State	HMO da		di cai d	
			paid days	eligible	Medicaid	Medi cai d			days	
				unpai d	paid days	eligible				
		-	1.00	days 2.00	3.00	unpai d 4. 00	5.00		6.00	-
. 00	If this provider is an IRF, enter the in-sta	ate	42			4.00	5.00	0	0.00	25
	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- Medicaid eligible unpaid days in column 4, M									
	HMO paid and eligible but unpaid days in col									
	,			1	· · · · ·	Urban/F	Rural S	Date of	F Geogr	
						1.	00	2.	00	
00	Enter your standard geographic classificatio cost reporting period. Enter "1" for urban o			at the beg	inning of t	ne	2			26
00	Enter your standard geographic classificatio			at the end	l of the cos	t	2			27
	reporting period. Enter in column 1, "1" for	urban or	"2" for r	ural. If ap						
00	enter the effective date of the geographic r						0			1 25
00	If this is a sole community hospital (SCH), effect in the cost reporting period.	enter the	number or	periods su	H Status In		0			35
						Begi n	ni ng:	Endi	ng:	
	1					1.	00	2.	00	
00	Enter applicable beginning and ending dates			cript line	36 for numb	er				36
. 00	of periods in excess of one and enter subseq If this is a Medicare dependent hospital (MD			r of period	ls MDH statu	s	1			37
	is in effect in the cost reporting period.					_				
. 01										37
	accordance with FY 2016 OPPS final rule? Ent instructions)	er "Y" for	r yes or "	N" for no.	(see					
. 00	If line 37 is 1, enter the beginning and end	ling dates	of MDH st	atus. Ifli	ne 37 is	06/03	/2019	12/31	/2019	38
	greater than 1, subscript this line for the									
	enter subsequent dates.					X	/N1	V	/NI	
						Y/ 1.			<u>/N</u> 00	-
. 00	Does this facility qualify for the inpatient	hospi tal	payment a	djustment f	or low volu				1	39
	hospitals in accordance with 42 CFR §412.101					n				
	1 "Y" for yes or "N" for no. Does the facili									
	accordance with 42 CFR 412.101(b)(2)(i), (ii or "N" for no. (see instructions)	), or (111	)? Enter		i i lor ye	5				
. 00	Is this hospital subject to the HAC program	reducti on	adj ustmen	t? Enter "Y	" for yes o	r   Y	(	١	(	40
	"N" for no in column 1, for discharges prior				ves or "N" f	or				
	no in column 2, for discharges on or after 0	october I.	(see inst	ructions)			V	XVIII	XIX	
							1 V			-
							1.00	_	3.00	
	Prospective Payment System (PPS)-Capital							_	3.00	
. 00	Does this facility qualify and receive Capit		t for disp	roporti onat	e share in	accordance		_	3.00 N	45
	Does this facility qualify and receive Capit with 42 CFR Section §412.320? (see instructi	ons)	·				N	2.00	N	
	Does this facility qualify and receive Capit	ons) ment excep	otion for	extraordi na	ıry circumst	ances		2.00		
. 00	Does this facility qualify and receive Capit with 42 CFR Section §412.320? (see instructi Is this facility eligible for additional pay pursuant to 42 CFR §412.348(f)? If yes, comp Pt. III.	ons) /ment excep olete Wkst.	tion for L, Pt. I	extraordina II and Wkst	ry circumst . L-1, Pt.	ances I through	N	N N	N	46
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ealth Financial Systems GOOD S OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider C		eriod: rom 01/01/2019	Worksheet S-2 Part I	pared:
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
			1.00	2.00	3.00	
0.02 If line 60 is yes, complete columns 2 and 3 for each	program	n. (see		23. 01	1	60.0
instructions)	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	-
1.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N	2.00	0.00	0.00		61.0
column 1. (see instructions) 1.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61.0
instructions) 1.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,						61.0
and primary care FTEs added under section 5503 of ACA). (see instructions) 1.03 Enter the base line FTE count for primary care						61. C
and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						
1.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. C
1.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.0
61.04 minus line 61.03). (see instructions) 1.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary						61. (
care or general surgery. (see instructions)	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Direct GME FTE	
		1.00	2.00	3.00	Count 4.00	1
1.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00	0.00	61.1
1.20 Of the FTEs in Line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				O. OC	0. 00	61.2
			,		1.00	
ACA Provisions Affecting the Health Resources and Ser 2.00 Enter the number of FTE residents that your hospital				od for which	1	62.0
2.00 Enter the humber of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc 2.01 Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog	ti ons) Teachi	ng Health Cen	ter (THC) into			62.0
Teaching Hospitals that Claim Residents in Nonprovide 3.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	er Setti ttings	ings during this co	ost reporting p		N	63. 0
, ,			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
Contion EEO/ of the ACA Door Vore STE Decider 1	00000	dor Satting	1.00	2.00	3.00	
Section 5504 of the ACA Base Year FTE Residents in No period that begins on or after July 1, 2009 and befor 4.00 Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in	<u>e June</u> y trair -primar all nor non-pr	30, 2010. ned residents ry care nprovider rimary care	0. 00	-		64. C

				riod: om 01/01/2019	Workshee Part I		
			To	12/31/2019	Date/Tim 7/10/202	ne Prepa 20 2:50	arec pm
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (co	ol. 3/	
			FTEs Nonprovider	FTEs in Hospital	(col. 3 + 4))		
			Si te	позрі таї	4))		
-	1.00	2.00	3.00	4.00	5.00	)	
.00 Enter in column 1, if line 63			0.00	0.00	0.0	000000	65.
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3							
divided by (column 3 + column 4)). (see instructions)							
			Unweighted	Unweighted	Ratio (co	ol. 1/	
			FTEs	FTEs in	(col. 1 +		
			Nonprovider Site	Hospi tal	2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Y	/ear FTE Residents i	n Nonprovider Settir					
00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonp inweighted non-prima il. Enter in column :	rovider settings. ry care resident 3 the ratio of	0. 00	0.00	0.0	000000	66.
	Program Name	Program Code	Unweighted	Unweighted	Ratio (co	ol. 3/	
		0					
			FTEs Nonprovi der	FTEs in Hospital	(col. 3 +		
			FTĔs Nonprovider Site	FTEs in Hospital	(col. 3 + 4))		
00 Enter in column 1, the program	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00	4))	)	67
.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	1.00	2.00	Nonprovi der Si te	Hospi tal	4))		67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	1.00	2.00	Nonprovi der Si te 3.00	Hospi tal 4.00	4))	)	67.
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	25		Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u>	4)) 5.00 0.0	3.00	
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	25 Ychiatric Facility (	IPF), or does it con	Nonprovi der Si te 3. 00 0. 00	Hospi tal <u>4.00</u> 0.00 <u>1.0</u> rovi der? Y	4)) 5.00 0.0	3.00	70.
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	≥S /chiatric Facility ( the facility have a fore November 15, 2 umn 2: Did this fac ≷ 412.424 (d)(1)(iii ate which program y	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for	Nonprovi der Si te 3. 00 0. 00 tain an IPF subp ing program in t yes or "N" for n s in a new teach yes or "N" for n	Hospi tal 4.00 0.00 1.00 rovi der? Y he most N ing 0.	4)) 5.00 0.0	3.00	70.
<pre>name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)</pre>	2S rchiatric Facility ( the facility have a fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii cate which program y / PPS nabilitation Facility	IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident )(D)? Enter "Y" for ear began during thi	Nonprovi der Si te         3.00         0.00         tain an IPF subp         ing program in ti yes or "N" for m         s in a new teach         yes or "N" for m         s cost reporting	Hospi tal 4.00 0.00 1.00 rovi der? Y he most N ing 0.	4)) 5.00 0.0	3.00	67. ( 70. ( 71. (

Health Financial Systems GOOD SAMAR	RITAN HOSP	TAL		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Pro	vider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet S- Part I Date/Time Pr 7/10/2020 2:	repared:
					1.00	-
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for 81.00 Is this a LTCH co-located within another hospital for par "Y" for yes and "N" for no.				g period? Enter	N N	80.00 81.00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)86.00Did this facility establish a new Other subprovider (excl					N	85.00 86.00
<ul> <li>§413. 40(f)(1)(ii)? Enter "Y" for yes and "N" for no.</li> <li>87. 00 Is this hospital an extended neoplastic disease care hospital and extended neoplastic disease care hospital and the second sec</li></ul>	pital clas	sified u	under section		N	87.00
1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.				V	XI X	
Title V and XIX Services				1.00	2.00	
90.00 Does this facility have title V and/or XIX inpatient hosp yes or "N" for no in the applicable column.	pital serv	i ces? Er	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX throug full or in part? Enter "Y" for yes or "N" for no in the				Ν	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds instructions) Enter "Y" for yes or "N" for no in the appl	(dual cer	ti fi cati			N	92.00
93.00 Does this facility operate an ICF/IID facility for purpos			d XIX? Enter	N	N	93.00
<ul> <li>"Y" for yes or "N" for no in the applicable column.</li> <li>94.00 Does title V or XIX reduce capital cost? Enter "Y" for yeapplicable column.</li> </ul>	es, and "N	" for no	o in the	Ν	Ν	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the				0.00	0.00	95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for applicable column.	5			N	N	96.00
97.00 If line 96 is "Y", enter the reduction percentage in the 98.00 Does title V or XIX follow Medicare (title XVIII) for the stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y	e interns	and resi	idents post	0. 00 N	0. 00 Y	97.00 98.00
<ul> <li>column 1 for title V, and in column 2 for title XIX.</li> <li>98.01 Does title V or XIX follow Medicare (title XVIII) for the C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title XIX.</li> </ul>				. N	Y	98.01
98.02 Does title V or XIX follow Medicare (title XVIII) for the bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for ye	title XIX.         02       Does title V or XIX follow Medicare (title XVIII) for the calculation of observation N         bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1					98.02
<ul> <li>for title V, and in column 2 for title XIX.</li> <li>98.03 Does title V or XIX follow Medicare (title XVIII) for a creimbursed 101% of inpatient services cost? Enter "Y" for for title V. and in column 2 for title XIX.</li> </ul>				N 1	N	98.03
<ul> <li>for title V, and in column 2 for title XIX.</li> <li>98.04 Does title V or XIX follow Medicare (title XVIII) for a coutpatient services cost? Enter "Y" for yes or "N" for not in column 2 for title XIX.</li> </ul>				Ν	N	98.04
<ul> <li>98.05 Does title V or XIX follow Medicare (title XVIII) and add Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no i column 2 for title XIX.</li> </ul>					Y	98.05
<ul> <li>98.06 Does title V or XIX follow Medicare (title XVIII) when co Pts. I through IV? Enter "Y" for yes or "N" for no in col column 2 for title XIX.</li> </ul>				Ν	Y	98.06
Rural Providers				N	[	105 00
105.00 Does this hospital qualify as a CAH? 106.00 If this facility qualifies as a CAH, has it elected the a	all-inclus	ive meth	hod of paymen	t N		105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If line 105 is Y, is this facility eligible for training programs? Enter "Y" for yes or "N" for no in col Column 2: If column 1 is Y and line 70 or line 75 is Y,	lumn 1. ( do you tr	see inst ain I&Rs	tructions) s in an	N		107.00
approved medical education program in the CAH's excluded Enter "Y" for yes or "N" for no in column 2. (see instru- 108.00 Is this a rural hospital qualifying for an exception to	uctions) the CRNA f			Ν		108. 00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Phy	si cal	Occupati ona		Respi ratory	/
109.00 If this hospital qualifies as a CAH or a cost provider, a		. 00 N	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						
					1.00	
110.00 Did this hospital participate in the Rural Community Hosp Demonstration) for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and	er "Y" for	yes or	"N" for no.	lf yes,	N	110.00
appl i cabl e.					I	I

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO	CN: 15-0042 Pe	eri od:	Worksheet S-	2
		rom 01/01/2019	Part I	epared
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Conduct Health Integration Project (FCHIP) demonstration for this cost reporting provide the second structure of the	period? Enter enter the column 2.	1.00 N	2.00	111. C
	1.00	2.00	3.00	-
12.00 Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	N			112. C
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1.	N			0 115. C
16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y			116. C
17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117. C
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118. C
	Premi ums	Losses	Insurance	
	1.00	2.00	3.00	_
18.01 List amounts of malpractice premiums and paid losses:	379, 378		3.00 D	0 118. 0
		1.00	2.00	_
18.02 Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing co and amounts contained therein.		N		118. (
9.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless prov		Ν	N	119. ( 120. (
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see inst	he Outpatient			
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructed in column 2, "Y" for yes or "N" for no. 21.00Did this facility incur and report costs for high cost implantable devices	he Outpatient ructions)	Y		121.0
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter</li> </ul>	he Outpatient ructions) s charged to (w)(3) of the	Y Y	5. 00	
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Hold Harmless provision in ACA §3121 and applicable amendments? (see instruction of the Harmless provision amendments? (see instruction amendments? (see instruction amendments?)</li> </ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2	Y	5.00	122.
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.</li> <li>(21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>(22.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>(25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> </ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If		5.00	122.
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.</li> <li>(21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>(22.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>(25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> </ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If	Y	5.00	122.
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.</li> <li>100 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>200 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, enter the certification date, if applicable, in column 2.</li> </ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If fication date	Y	5.00	122. ( 125. ( 126. (
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.</li> <li>(1.00) Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>(2.00) Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>(5.00) Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>(6.00) If this is a Medicare certified kidney transplant center, enter the certification date, if applicable, in column 2.</li> <li>(7.00) If this is a Medicare certified liver transplant center, enter the certification date.</li> <li>(7.00) If this is a Medicare certified liver transplant center, enter the certification date.</li> <li>(7.00) If this is a Medicare certified liver transplant center, enter the certification date.</li> <li>(7.00) If this is a Medicare certified liver transplant center, enter the certification date.</li> <li>(7.00) If this is a Medicare certified liver transplant center, enter the certification date.</li> <li>(7.00) If this is a Medicare certified liver transplant center, enter the certification date.</li> <li>(7.00) If this is a Medicare certified liver transplant center, enter the certification date.</li> <li>(7.00) If this is a Medicare certified liver transplant center, enter the certification date.</li> </ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If fication date ication date	Y	5.00	122. 125. 126. 127.
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.</li> <li>(1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>(2.00 Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>(5.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>(6.00 If this is a Medicare certified heart transplant center, enter the certifien column 1 and termination date, if applicable, in column 2.</li> <li>(7.00 If this is a Medicare certified liver transplant center, enter the certifien column 1 and termination date, if applicable, in column 2.</li> <li>(9.00 If this is a Medicare certified liver transplant center, enter the certifien column 1 and termination date, if applicable, in column 2.</li> </ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If fication date ication date ication date	Y	5.00	122. ) 125. ) 126. ) 127. ) 128. )
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.</li> <li>(1.00) Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>(2.00) Does the cost report contain healthcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>(5.00) Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>(6.00) If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>(7.00) If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>(8.00) If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>(9.00) If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>(9.00) If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>(9.00) If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>(9.00) If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>(9.00) If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column</li></ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If fication date ication date ication date cation date in	Y	5.00	122. ( 125. ( 126. ( 127. ( 128. ( 129. (
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.</li> <li>(1.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>(2.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.</li> <li>(2.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>(3.00 If this is a Medicare certified kidney transplant center, enter the certifien column 1 and termination date, if applicable, in column 2.</li> <li>(3.00 If this is a Medicare certified liver transplant center, enter the certifien column 1 and termination date, if applicable, in column 2.</li> <li>(3.00 If this is a Medicare certified liver transplant center, enter the certifien column 1 and termination date, if applicable, in column 2.</li> <li>(3.00 If this is a Medicare certified liver transplant center, enter the certifien column 1 and termination date, if applicable, in column 2.</li> <li>(3.00 If this is a Medicare certified liver transplant center, enter the certifien column 1 and termination date, if applicable, in column 2.</li> <li>(4.00 If this is a Medicare certified liver transplant center, enter the certifien column 1 and termination date, if applicable, in column 2.</li> <li>(4.00 If this is a Medicare certified pancreas transplant center, enter the certifient column 1 and termination date, if applicable, in column 2.</li> <li>(5.00 If this is a Medicare certified pancreas transplant center, enter the certifient column 1 and termination date, if applicable, in column 2.</li> <li>(5.00 If this is a Medicare cer</li></ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If fication date ication date ication date in tification	Y	5.00	122. ( 125. ( 126. ( 127. ( 128. ( 129. ( 130. (
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.</li> <li>21.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no.</li> <li>22.00 Does the cost report contain heal thcare related taxes as defined in §1903 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information</li> <li>25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" yes, enter certification date(s) (mm/dd/yyyy) below.</li> <li>26.00 If this is a Medicare certified kidney transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>27.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.</li> <li>28.00 If this is a Medicare certified lung transplant center, enter the certific olumn 1 and termination date, if applicable, in column 2.</li> <li>29.00 If this is a Medicare certified lung transplant center, enter the certific olumn 1 and termination date, if applicable, in column 2.</li> <li>29.00 If this is a Medicare certified lung transplant center, enter the certific column 1 and termination date, if applicable, in column 2.</li> <li>29.00 If this is a Medicare certified pancreas transplant center, enter the certific column 1 and termination date, if applicable, in column 2.</li> <li>20.00 If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2.</li> <li>20.00 If this is a Medicare certified pancreas transplant center, enter the certific date in column 1 and termination date, if applicable, in column 2.&lt;</li></ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If fication date ication date ication date cation date in tification ertification	Y	5.00	122. ( 125. ( 126. ( 127. ( 128. ( 129. ( 130. ( 131. (
<ul> <li>§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with &lt; 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) in the transformation of the provision of the transformation of t</li></ul>	he Outpatient ructions) s charged to (w)(3) of the r in column 2 for no. If fication date ication date ication date cation date in tification ertification ication date	Y	5.00	121. ( 122. ( 125. ( 126. ( 127. ( 129. ( 130. ( 131. ( 132. ( 133. ( 134. (

	X IDENTIFICATION DATA	Provider CC	N: 15-0042		iod: m 01/01/2019	Worksheet S- Part I	2
				To	12/31/2019	Date/Time Pr	
1.00	2	00			3.00	7/10/2020 2:	50 pm
If this facility is part of a cha	n organization, enter on	lines 141 throu		e name		of the	
home office and enter the home of		contractor numbe			N 1		
I1.00Name: I2.00Street:	Contractor's Name: PO Box:		Contra	actor s	Number:		141. (
43. 00 Ci ty:	State:		Zip C	ode:			143.
		10				1.00	-
14.00 Are provider based physicians' cos	sts included in worksneet	A?				Y	144. (
					1.00	2.00	-
15.00 If costs for renal services are cl							145. (
inpatient services only? Enter "Y' no, does the dialysis facility ind							
period? Enter "Y" for yes or "N"		IT TOT THIS COST	reporting				
6.00 Has the cost allocation methodolog	gy changed from the previ			1	N		146.
Enter "Y" for yes or "N" for no in		15-2, chapter 4	0, §4020)	lf			
yes, enter the approval date (mm/o	dd/yyyy) in column 2.						
						1.00	
47.00 Was there a change in the statist						N	147.0
48.00 Was there a change in the order of				for pr		N	148.
49.00 Was there a change to the simplifi	eu cost innung method?	Part A	Part		Title V	N Title XIX	149.
		1.00	2.00		3.00	4.00	-
Does this facility contain a prov							
or charges? Enter "Y" for yes or 55.00Hospital	<u>'N" for no for each compo</u>			<u>B. (See</u>			155.
56. 00 Subprovider - TPF		N N	N N		N N	N N	155.
57.00 Subprovi der – I RF		N	N		N	N	157.
58. 00 SUBPROVI DER							158. (
59.00 SNF 60.00 HOME HEALTH AGENCY		N	N		N	N	159.0
61. 00 CMHC		N	N N		N N	N N	160. ( 161. (
						1.00	
Multicampus 65.00[s this hospital part of a Multica	ample bospital that has o		isos in di	fforont	CRSAc2	N	165. 0
Enter "Y" for yes or "N" for no.	anipus nospi tai that has o	ne or nore campu		rierent	CDSAS?	IN IN	105.0
	Name	County	State	Zip Co		FTE/Campus	
	0	1.00	2.00	3.00	9 4.00	5.00	04//
66.00 If line 165 is yes, for each						0.0	00166.0
campus enter the name in column 0, county in column 1, state in							
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,							
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,							
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in						1.00	
campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI					ct		
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user	under §1886(n)? Enter	"Y" for yes or "	N" for no			1.00 Y	
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user	r under §1886(n)? Enter D5 is "Y") and is a meani	"Y" for yes or " ngful user (line	N" for no				
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful used 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the l 68.01 If this provider is a CAH and is n	under §1886(n)? Enter D5 is "Y") and is a meani HIT assets (see instruction not a meaningful user, do	"Y" for yes or " ngful user (line ons) es this provider	N" for no 167 is " qualify	Y"), er for a h	iter the		168. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used off this provider is a CAH (line 10 reasonable cost incurred for the I for this provider is a CAH and is n exception under §413.70(a)(6)(ii) <sup>7</sup>	under §1886(n)? Enter D5 is "Y") and is a meani HT assets (see instruction not a meaningful user, do P Enter "Y" for yes or "N	"Y" for yes or " ngful user (line ons) es this provider " for no. (see i	N" for no 2 167 is " 2 qualify nstructio	Y"), er for a h ns)	nter the nardshi p	Y	168. ( 168. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful used off this provider is a CAH (line 10 reasonable cost incurred for the I for this provider is a CAH and is n exception under §413.70(a)(6)(ii) <sup>7</sup>	under §1886(n)? Enter 5 is "Y") and is a meani 11 T assets (see instruction not a meaningful user, do 2 Enter "Y" for yes or "N user (line 167 is "Y") and	"Y" for yes or " ngful user (line ons) es this provider " for no. (see i	N" for no 2 167 is " 2 qualify nstructio	Y"), er for a h ns)	nter the nardshi p	Y	168. ( 168. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 57.00 Is this provider a meaningful user 58.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a)(6)(ii) 59.00 If this provider is a meaningful user	under §1886(n)? Enter 5 is "Y") and is a meani 11 T assets (see instruction not a meaningful user, do 2 Enter "Y" for yes or "N user (line 167 is "Y") and	"Y" for yes or " ngful user (line ons) es this provider " for no. (see i	N" for no 2 167 is " 2 qualify nstructio	Y"), er for a h ns)	nter the nardshi p	Y	167. ( 168. ( 168. ( 99169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) 99.00 If this provider is a meaningful of transition factor. (see instruction	under §1886(n)? Enter 5 is "Y") and is a meani 11 assets (see instruction a meaningful user, do 2 Enter "Y" for yes or "N user (line 167 is "Y") ani uns)	"Y" for yes or " ngful user (line ons) es this provider " for no. (see i d is not a CAH (	N" for no 2 167 is " 9 qualify nstructio 1 ine 105	Y"), er for a h ns)	nter the nardship , enter the	Y 9. 0	168. ( 168. ( 99169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful usee 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under §413.70(a) (6) (ii) / 69.00 If this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I	under §1886(n)? Enter 5 is "Y") and is a meani 11 assets (see instruction a meaningful user, do 2 Enter "Y" for yes or "N user (line 167 is "Y") ani uns)	"Y" for yes or " ngful user (line ons) es this provider " for no. (see i d is not a CAH (	N" for no 2 167 is " 9 qualify nstructio 1 ine 105	Y"), er for a h ns)	nter the nardship , enter the Beginning	Y 9. d Endi ng	168. ( 168. ( 99169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I exception under \$413.70(a) (6) (ii) 59.00 If this provider is a meaningful of transition factor. (see instruction	under §1886(n)? Enter 5 is "Y") and is a meani 11 assets (see instruction a meaningful user, do 2 Enter "Y" for yes or "N user (line 167 is "Y") ani uns)	"Y" for yes or " ngful user (line ons) es this provider " for no. (see i d is not a CAH (	N" for no 2 167 is " 9 qualify nstructio 1 ine 105	Y"), er for a h ns)	nter the nardship , enter the Beginning	Y 9. d Endi ng	168. ( 168. ( 99169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 is this provider a meaningful user 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the i exception under §413.70(a) (6) (ii) 1f this provider is a meaningful user exception factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	under §1886(n)? Enter 5 is "Y") and is a meanin HT assets (see instruction ot a meaningful user, do 2 Enter "Y" for yes or "N user (line 167 is "Y") and ons) peginning date and ending	"Y" for yes or " ngful user (line ons) es this provider " for no. (see i d is not a CAH ( date for the re	N" for no e 167 is " nstructio line 105	Y"), er for a h ns)	nter the nardship , enter the Beginning	Y 9. d Endi ng	168. ( 168. ( 99169. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 is this provider a meaningful used 68.00 if this provider is a CAH (line 10 reasonable cost incurred for the i exception under \$413.70(a) (6) (ii) 00 if this provider is a meaningful of transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy) 71.00 if line 167 is "Y", does this provider	under §1886(n)? Enter 5 is "Y") and is a meani 11 assets (see instruction that a meaningful user, down 2 Enter "Y" for yes or "N user (line 167 is "Y") and the second second second second peginning date and ending vider have any days for in	"Y" for yes or " ngful user (line ons) es this provider " for no. (see i d is not a CAH ( date for the re ndividuals enrol	N" for no e 167 is " r qualify nstructio line 105 porting led in	Y"), er for a h ns) i s "N")	nter the hardship n, enter the Beginning 1.00	Y 9. 0 Endi ng 2. 00 2. 00	168. ( 168. (
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the I 68.01 If this provider is a CAH and is in exception under \$413.70(a)(6)(ii)' 69.00 If this provider is a meaningful user transition factor. (see instruction 70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	under §1886(n)? Enter 5 is "Y") and is a meani 11 assets (see instruction a meaningful user, dow 2 Enter "Y" for yes or "N user (line 167 is "Y") and beginning date and ending vider have any days for in reported on Wkst. S-3, Pt	"Y" for yes or " ngful user (line ons) es this provider " for no. (see i d is not a CAH ( date for the re ndividuals enrol . I, line 2, col	N" for no e 167 is " r qualify nstructio line 105 porting led in . 6? Ente	Y"), er for a h ns) i s "N")	nter the nardship 1, enter the Beginning 1.00 1.00	Y 9. 0 Endi ng 2. 00 2. 00	168.   168.   99169.   

)SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0042	Period: From 01/01/2019	Worksheet S-2 Part II	2
				To 12/31/2019	Date/Time Pro 7/10/2020 2:	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	for all NO ro	sponsos Entr	1.00	2.00	
	mm/dd/yyyy format.		Sponses. Ente			_
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					-
00	Has the provider changed ownership immediately prior to the	begi nni ng of	the cost	N		1.
	reporting period? If yes, enter the date of the change in c		instructions)			
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare P	rogram? If	1.00 N	2.00	3.00	2.
00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includin	n 3, "V" for	N			3.
00	contracts, with individuals or entities (e.g., chain home o or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members o of directors through ownership, control, or family and othe relationships? (see instructions)	ffices, drug er or its f the board				5.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
~~	Financial Data and Reports					- ·
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled, ilable in	Y	A		4.
00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
	Those on the fifted financial statements: if yes, submit fee			Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lf yes, is th	ne provider is	s N		6.
00	Are costs claimed for Allied Health Programs? If "Y" see in			Y		7.
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		Ū.	N		8.
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Y		9.
0. 00	Was an approved Intern and Resident GME program initiated o cost reporting period? If yes, see instructions.	r renewed in 1	the current	Y		10.
. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N	Y/N	11.
				-	1.00	
00	Bad Debts	coo instruct	tions		V	12.
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12.
. 00	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	nts waived? If	°yes, see ins	structions.	N	14.
. 00	Did total beds available change from the prior cost reporti	<u>v</u> 1			N	15.
		Y/N	rt A Date	Par Y/N	Date	-
		1.00	2.00	3.00	4.00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	Y	03/27/2020	N	03/27/2020	16.
. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for	N		N		17.
	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)					
. 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	Ν		Ν		18.
. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	Ν		Ν		19.

|--|

HOSPI T	I TAL AND HOSPI TAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE		Period: From 01/01/2019 To 12/31/2019	Worksheet S- Part II Date/Time Pr 7/10/2020 2:	repared:	
		Descr	i pti on	Y/N	Y/N	
			0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	1.00 N	2.00	3.00 N	4.00	21.00
		1	1	I	1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC Capital Related Cost	EPT CHILDRENS H	IOSPI TALS)		1.00	_
22.00	Have assets been relifed for Medicare purposes? If yes, se	e instructions			N	22.00
	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		sals made duri	ng the cost	N	23.00
24.00	Were new leases and/or amendments to existing leases enter If yes, see instructions	porting period?	Y	24.00		
25.00	Have there been new capitalized leases entered into during instructions.	the cost repor	rting period?	lf yes, see	Y	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the instructions.	he cost reporti	ng period? I	f yes, see	Ν	26.00
27.00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit	Ν	27.00
28.00	Interest Expense Were new Loans, mortgage agreements or letters of credit en period? If yes, see instructions.	reporting	N	28.00		
29.00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst	Ν	29.00			
30.00	Has existing debt been replaced prior to its scheduled mati instructions.	Ν	30.00			
31.00	Has debt been recalled before scheduled maturity without is instructions.	Ν	31.00			
32.00	Hurchased Services Have changes or new agreements occurred in patient care se	rvi ces furni she	ad through co	atractual	N	32,00
	arrangements with suppliers of services? If yes, see instri If line 32 is yes, were the requirements of Sec. 2135.2 ap	uctions.	0		N.	33.00
	no, see instructions.	· ·	· ·			
	Provider-Based Physicians					
	Are services furnished at the provider facility under an a If yes, see instructions.	0	·		Y	34.00
35.00	If line 34 is yes, were there new agreements or amended ex physicians during the cost reporting period? If yes, see in		nts with the p		Y	35.00
				Y/N 1.00	Date 2.00	
	Home Office Costs Were home office costs claimed on the cost report?			N		36.00
	If line 36 is yes, has a home office cost statement been p	repared by the	home office?			37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home of the provider? If yes, enter in column 2 the fiscal year en					38.00
39.00	If line 36 is yes, did the provider render services to othese instructions.					39.00
40.00	If line 36 is yes, did the provider render services to the instructions.	home office?	lf yes, see			40.00
		00	_			
	Cost Report Preparer Contact Information		00			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	KYLE		SMI TH		41.00
42.00	respectively. Enter the employer/company name of the cost report	BLUE & CO, LLC				42.00
43.00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00

Heal th	Financial Systems GOOD SA	AMARI TA	AN HOSPITAL	In Lie	u of Form CMS-	2552-10
H0SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIF	RE	Provider CCN: 15-0042	Period: From 01/01/2019	Worksheet S-2 Part II	
				To 12/31/2019		pared: 0 pm
			3.00			
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/positio	n	SENI OR MANAGER			41.00
	held by the cost report preparer in columns 1, 2, and	13,				
	respecti vel y.					
42.00	Enter the employer/company name of the cost report					42.00
	preparer.					
43.00	Enter the telephone number and email address of the c	ost				43.00
	report preparer in columns 1 and 2, respectively.					

HOSPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	<u>GOOD SAMARITA</u> AL DATA	Provider CC		Period: From 01/01/2019	u of Form CMS-2 Worksheet S-3 Part I	
					To 12/31/2019		
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Avai LabLe	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	69	25, 18	35 0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO I PF Subprovider						3.00
4.00 5.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	4.00 5.00
6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	
7.00	Total Adults and Peds. (exclude observation		69	25, 18	. 00		
	beds) (see instructions)		0,	20710			
8.00	INTENSIVE CARE UNIT	31.00	30	10, 95	50 0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.0
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		99	36, 13	35 0.00		14.00
15.00 16.00	CAH visits SUBPROVIDER - IPF	40, 00	20	7, 30		0	15.00
17.00	SUBPROVIDER - IRF	40.00	20	9, 12		0	17.00
18.00	SUBPROVIDER	41.00	20	7, 12	-5	0	18.0
19.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY	101.00				0	22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPI CE	116.00	0		0		24.0
24. 10	HOSPICE (non-distinct part)	30.00					24.1
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC						26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	
27.00	Total (sum of lines 14-26)		144			0	27.0 28.0
9.00	Observation Bed Days Ambulance Trips					0	28.0
0.00	Employee discount days (see instruction)						30.0
31.00	Employee discount days (see first detroit)						31.0
32.00	Labor & delivery days (see instructions)		0		0		32.0
32.01	Total ancillary labor & delivery room		0		-		32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.0

IOSPI <sup>-</sup>	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 01/01/2019 To 12/31/2019		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)	6, 668 1, 886	395 2, 325	11, 42	1		2.00
. 00	HMO IPF Subprovider	174	1, 492				3.00
. 00	HMO IRF Subprovider	219	136				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
. 00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
. 00	Total Adults and Peds. (exclude observation	6, 668	395	11, 42	1		7.00
~~~	beds) (see instructions)	2 007	0	( 57			
. 00		3, 997	0	6, 57	0		8.00
. 00	CORONARY CARE UNIT						9.0
0.00	BURN INTENSIVE CARE UNIT						10.0
1.00	SURGICAL INTENSIVE CARE UNIT						11.0
2.00	OTHER SPECIAL CARE (SPECIFY)		(0)	84	2		12.0
3.00 4.00	NURSERY	10 ( ( 5	60 455		-	1 475 00	13.0
4.00 5.00	Total (see instructions)	10, 665 0	455	18, 83	4 0.00 0	1, 475. 00	14.0
6.00	CAH visits SUBPROVIDER - IPF	1,438	288	4, 50	-	31.73	
7.00	SUBPROVIDER - IRF	5, 957	42	7,05			
8.00	SUBPROVI DER	5, 457	42	7,05	9 0.00	33. 32	18.0
9.00	SKILLED NURSING FACILITY						19.0
0.00	NURSING FACILITY						20.0
1.00	OTHER LONG TERM CARE						21.0
2.00	HOME HEALTH AGENCY	0	0		0.00	0.00	
3.00	AMBULATORY SURGICAL CENTER (D. P. )	0	0		0.00	0.00	23.0
4.00	HOSPICE	0	0		0.00	7.51	
4.10	HOSPICE (non-distinct part)			52			24.1
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26. C
6. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0.00	0.00	26.2
7.00	Total (sum of lines 14-26)				2.02	1, 547. 56	27.0
8.00	Observation Bed Days		615	3, 28	0		28.0
9.00	Ambul ance Trips	0					29.0
0. 00	Employee discount days (see instruction)				0		30. C
1.00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	65	12	5		32.0
2.01	Total ancillary labor & delivery room				0		32.0
	outpatient days (see instructions)						
3.00		0					33.0
3 01	LTCH site neutral days and discharges	0					33.0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICA	AL DATA	Provider C	CN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 7/10/2020 2:50	pared:
	Full Time Equivalents		Di se	charges	1110/2020 210	
Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
<ol> <li>1.00 Hospital Adults &amp; Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)</li> <li>2.00 HMO and other (see instructions)</li> <li>3.00 HMO IPF Subprovider</li> <li>4.00 HMO IRF Subprovider</li> <li>5.00 Hospital Adults &amp; Peds. Swing Bed SNF</li> <li>6.00 Hospital Adults &amp; Peds. Swing Bed NF</li> <li>7.00 Total Adults and Peds. (exclude observation beds) (see instructions)</li> <li>8.00 INTENSIVE CARE UNIT</li> <li>9.00 CORONARY CARE UNIT</li> <li>10.00 BURN INTENSIVE CARE UNIT</li> <li>11.00 SURGICAL INTENSIVE CARE UNIT</li> <li>12.00 OTHER SPECIAL CARE (SPECIFY)</li> <li>13.00 NURSERY</li> <li>14.00 Total (see instructions)</li> <li>15.00 CAH visits</li> <li>16.00 SUBPROVIDER - IPF</li> <li>17.00 SUBPROVIDER - IRF</li> </ol>	0. 00 0. 00 0. 00	C C C C C	2, 89 46 2, 89	97 652 286 6 95 96 93 56	5, 356 5, 356 830 491	15.00 16.00 17.00
<ul> <li>18.00 SUBPROVIDER</li> <li>19.00 SKILLED NURSING FACILITY</li> <li>20.00 NURSING FACILITY</li> <li>21.00 OTHER LONG TERM CARE</li> <li>22.00 HOME HEALTH AGENCY</li> <li>23.00 AMBULATORY SURGICAL CENTER (D. P.)</li> <li>24.00 HOSPICE</li> <li>24.10 HOSPICE (non-distinct part)</li> <li>25.00 CMHC - CMHC</li> <li>26.00 RURAL HEALTH CLINIC</li> <li>26.25 FEDERALLY QUALIFIED HEALTH CENTER</li> <li>27.00 Total (sum of lines 14-26)</li> <li>28.00 Observation Bed Days</li> <li>29.00 Ambulance Trips</li> <li>30.00 Employee discount days (see instruction)</li> <li>31.00 Employee discount days - IRF</li> <li>32.01 Total ancillary labor &amp; delivery room outpatient days (see instructions)</li> <li>33.00 LTCH non-covered days</li> </ul>	0.00 0.00 0.00 0.00			0		18. 0 19. 0 20. 0 21. 0 22. 0 23. 0 24. 0 24. 1 25. 0 26. 0 26. 0 26. 2 27. 0 30. 0 30. 0 31. 0 32. 0 33. 0

	Financial Systems AL WAGE INDEX INFORMATION		GOOD SAMARIT	Provider C		eriod: rom 01/01/2019	worksheet S-3 Worksheet S-3 Part II Date/Time Prep 7/10/2020 2:50	pared:
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adj usted Sal ari es (col . 2 ± col . 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	6.00	
	SALARI ES							
. 00	Total salaries (see instructions)	200.00	102, 615, 860	0	102, 615, 860	3, 219, 387. 15	31. 87	1.00
. 00	Non-physician anesthetist Part		C	0	o	0.00	0.00	2.00
. 00	A Non-physician anesthetist Part		C	0	0	0.00	0. 00	3.00
	В		-		-			
. 00	Physician-Part A - Administrative		208, 638	0	208, 638	790.00	264. 10	4.00
. 01	Physicians - Part A - Teaching			-	0	0.00		
. 00	Physician and Non Physician-Part B		4, 774, 944	0	4, 774, 944	22, 933. 00	208. 21	5.00
. 00	Non-physician-Part B for hospital-based RHC and FQHC services		C	0	0	0.00	0.00	6.00
. 00	Interns & residents (in an	21.00	C	0	0	0.00	0. 00	7.00
. 01	approved program) Contracted interns and residents (in an approved		254, 224	0	254, 224	6, 160. 00	41. 27	7.0 <sup>4</sup>
. 00	programs) Home office and/or related		C	0	0	0.00	0. 00	8. 00
. 00 0. 00	organization personnel SNF Excluded area salaries (see	44.00	0 35, 651, 532		0 35, 651, 532	0. 00 873, 515. 00		
	instructions) OTHER WAGES & RELATED COSTS							1
1. 00	Contract Labor: Direct Patient		381, 084	. 0	381, 084	7, 195. 00	52. 97	11.00
2. 00	Care Contract labor: Top level management and other management and administrative		C	0	0	0.00	0. 00	12.00
3. 00	services Contract Labor: Physician-Part A - Administrative		568, 213	0	568, 213	7, 664. 00	74.14	13.0
4. 00	Home office and/or related organization salaries and		C	0	0	0.00	0.00	14.0
4. 01	wage-related costs Home office salaries		C	0	0	0.00	0.00	14.0
4. 02	Related organization salaries		C	0	0	0.00		14.0
5.00	Home office: Physician Part A - Administrative		Ĺ	0	0	0.00	0.00	15.0
6. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0.00	0.00	16. 0
6. 01	Home office Physicians Part A		C	0	0	0.00	0.00	16. 0
6. 02	- Teaching Home office contract Physicians Part A - Teaching		С	0	0	0.00	0.00	16. 0
7. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		19, 964, 589	0	19, 964, 589			17.0
8.00	instructions) Wage-related costs (other)							18.0
9.00	(see instructions) Excluded areas		7, 480, 682	0	7, 480, 682			19.0
0.00	Non-physician anesthetist Part A		C	0	0			20.0
1. 00	Non-physician anesthetist Part B		C					21.0
2.00	Physician Part A - Administrative		18, 794	0	18, 794			22.0
2. 01	Physician Part A - Teaching		C	-	0			22.0
3.00 4.00	Physician Part B Wage-related costs (RHC/FQHC)		480, 794 C		480, 794 0			23.0 24.0
5. 00	Interns & residents (in an		C	0	0			25.0
5. 50	approved program) Home office wage-related		C	0	0			25.5
	(core)		-					
5. 51 5. 52	Related organization wage-related (core) Home office: Physician Part A		C		0			25. 5 25. 5
J. JZ	- Administrative - wage-related (core)		Ĺ					20. 54

Heal th	Financial Systems		GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 01/01/2019 To 12/31/2019		pared:
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col. 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A		0	0		0		25.53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26.00	Employee Benefits Department	4.00	5, 281, 115		5, 281, 11			26.00
27.00	Administrative & General	5.00	8, 365, 059		8, 365, 05			
28.00	Administrative & General under		378, 063	0	378, 06	3 3, 303. 00	114.46	28.00
	contract (see inst.)							
29.00	Maintenance & Repairs	6.00	0	0		0 0.00		29.00
30.00	Operation of Plant	7.00	2, 254, 007	0	2, 254, 00			
31.00	Laundry & Linen Service	8.00	210, 259	0	210, 25	9 15, 183. 00	13.85	
32.00	Housekeepi ng	9.00	2,003,398	0	2, 003, 39	8 134, 396. 00	14. 91	32.00
33.00	Housekeeping under contract (see instructions)		0	0		0 0.00	0.00	33.00
34.00	Dietary	10.00	1, 613, 478	-1, 169, 359	444, 11	9 28, 294. 00	15.70	34.00
35.00	Dietary under contract (see		0	0		0 0.00		35.00
0/ 00	instructions)	11.00		4 4/0 050	1 1 ( 0 05		45 70	
36.00	Cafeteria	11.00	0	1, 169, 359	1, 169, 35			
37.00	Maintenance of Personnel	12.00	0	0		0 0.00		
38.00	Nursing Administration	13.00	1, 361, 231	0	1, 361, 23			
39.00	Central Services and Supply	14.00	370, 879		370, 87	,		
40.00	Pharmacy	15.00	2, 850, 451		2, 850, 45			
41.00	Medical Records & Medical Records Library	16. 00	2, 503, 142	0	2, 503, 14	2 103, 617. 00	24. 16	41.00
42.00	Soci al Servi ce	17.00	505,008	0	505,00	8 16, 612. 00	30. 40	42.00
43.00	Other General Service	18.00	0	0		0.00	0.00	43.00

Heal th	Financial Systems		GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CO		Period: From 01/01/2019 To 12/31/2019		
		Worksheet A	Amount	Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY				_		
1.00	Net salaries (see		97, 964, 755	0	97, 964, 75	5 3, 193, 597. 15	30. 68	1.00
	instructions)							
2.00	Excluded area salaries (see		35, 651, 532	0	35, 651, 53	2 873, 515. 00	40. 81	2.00
	instructions)							
3.00	Subtotal salaries (line 1 minus line 2)		62, 313, 223	0	62, 313, 22	3 2, 320, 082. 15	26.86	3.00
4.00	Subtotal other wages & related		949, 297	0	949, 29	7 14, 859. 00	63.89	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		19, 983, 383	0	19, 983, 38	3 0.00	32.07	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		83, 245, 903	0	83, 245, 90	3 2, 334, 941. 15	35.65	6.00
7.00	Total overhead cost (see		27, 696, 090	0	27, 696, 09	0 1, 129, 299. 00	24. 53	7.00
	instructions)							

Heal th	Financial Systems	GOOD SAMARI TAN	HOSPI TAL			In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL WAGE RELATED COSTS		Provi der	CCN:	15-0042	Peri od:	Worksheet S-3	
						From 01/01/2019		
						To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
							Amount	
							Reported	
							1.00	
	PART IV - WAGE RELATED COSTS						1.00	
	Part A - Core List							1
	RETIREMENT COST							1
1.00	401K Employer Contributions						0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contrib	oution					0	2.00
3.00	Nongualified Defined Benefit Plan Cost (see						4, 701, 077	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins	structions)					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External							
5.00	401K/TSA Plan Administration fees						0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla	an					0	6.00
7.00	Employee Managed Care Program Administration	n Fees					0	7.00
	HEALTH AND INSURANCE COST							
8.00	Health Insurance (Purchased or Self Funded)						0	8.00
8.01	Health Insurance (Self Funded without a Thir	<sup>-</sup> d Party Administr	ator)				0	8.01
8.02	Health Insurance (Self Funded with a Third F	Party Administrato	r)				14, 793, 471	8. 02
8.03	Heal th Insurance (Purchased)	3					0	8.03
9.00	Prescription Drug Plan						0	9.00
10.00	Dental, Hearing and Vision Plan						321, 514	10.00
11.00	Life Insurance (If employee is owner or bene	eficiary)					149, 087	11.00
12.00	Accident Insurance (If employee is owner or						0	
13.00	Disability Insurance (If employee is owner o						335, 927	13.00
14.00	Long-Term Care Insurance (If employee is own		r)				0	14.00
15.00	'Workers' Compensation Insurance	,	,				0	
16.00	Retirement Health Care Cost (Only current ye	ear, not the extra	ordi narvi a	accrua	al require	ed by FASB 106.	0	16.00
	Non cumulative portion)		j					
	TAXES							1
17.00	FICA-Employers Portion Only						6, 799, 750	17.00
18.00	Medicare Taxes - Employers Portion Only						0	18.00
19.00	Unemployment Insurance						38, 706	19.00
20.00	State or Federal Unemployment Taxes						0	20.00
	OTHER							1
21.00	Executive Deferred Compensation (Other Than	Retirement Cost R	eported or	line	es 1 throu	igh 4 above. (see	0	21.00
	instructions))		-					
22.00	Day Care Cost and Allowances						52, 251	22.00
23.00	Tuition Reimbursement						218, 664	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	)					27, 410, 447	24.00
	Part B - Other than Core Related Cost							
25.00	OTHER WAGE RELATED COSTS (SPECIFY)							25.00

Heal th	Financial Systems	GOOD SAMARI TAN	HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
HOSPI 1	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 15-0042	Peri od:	Worksheet S-3	
				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	7/10/2020 2:50	
	Cost Center Description			Contract Labor		
				1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identif					
1.00	Total facility's contract labor and benefit of	cost		381, 084	27, 410, 447	1.00
2.00	Hospi tal			381, 084	27, 410, 447	
3.00	Subprovider - IPF			0	0	3.00
4.00	Subprovider - 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	Hospital-Based SNF					8.00
9.00	Hospital-Based NF					9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA			0	0	11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice			0	0	13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
	3					17.00
18.00	Other			0	0	18.00

	Financial Systems	DATA	GOOD SAMARIT.		N 15 0040		eu of Form CMS-2	
IOSPI I	TAL-BASED HOSPICE IDENTIFICATION	DATA		Provider CO		Period: From 01/01/2019	Worksheet S-9 PARTS I THROU	
				Hospi ce CCI		To 12/31/2019		
				1.00001 000 000		10 12/01/2017	7/10/2020 2:5	
						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		cols. 1, 2 &	
				Nursi ng	Facility		5)	
				Facility				
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS FOR CO	ST REPORTING F	PERIODS BEGINNI	NG BEFORE OCTO	BER 1, 2015		1	
. 00	Hospice Continuous Home Care							1.0
. 00	Hospice Routine Home Care							2.0
. 00	Hospice Inpatient Respite Care							3.0
. 00	Hospice General Inpatient Care							4. C
. 00	Total Hospice Days							5.0
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGI NNI NG	BEFORE OCTOBER	1, 2015	_		
. 00	Number of patients receiving							6.0
	hospice care							
. 00	Total number of unduplicated							7.0
	Continuous Care hours billable							
	to Medicare							
. 00	Average Length of Stay (line 5							8.0
	/ line 6)							
. 00	Unduplicated census count							9.0
OTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							cols. 1	
							through 3)	
				1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	G PERIODS BEGIN	NING ON OR AFT	ER OCTOBER 1,	2015		
0. 00	Hospice Continuous Home Care			0		0 0	0	10. C
1.00	Hospice Routine Home Care			6, 077	12	9 162	6, 368	11. C
2.00	Hospice Inpatient Respite Care			22		0 31	53	12. C
3.00	Hospice General Inpatient Care			384	1	0 86	480	13.0
					13	9 279		14.0

0 15.00 0 16.00

 PART IV
 CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015

 15.00
 Hospice Inpatient Respite Care
 0
 0
 0

 16.00
 Hospice General Inpatient Care
 0
 0
 0

Heal th	Financial Systems GOOD SAMARITAN	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-0042	Period: From 01/01/2019	Worksheet S-1	
				To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
					1.00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 d	ivided by li	ne 202 colum	ו 8)	0. 236496	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				11, 262, 943	
3.00 4.00	Did you receive DSH or supplemental payments from Medicaid?	ntal navmant	o from Modio	1 40	Y Y	3.00
4.00 5.00	If line 3 is yes, does line 2 include all DSH and/or suppleme If line 4 is no, then enter DSH and/or supplemental payments			11 0 ?	r O	
6.00	Medicaid charges		u		80, 916, 086	
7.00	Medicaid cost (line 1 times line 6)				19, 136, 331	
8.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(line 7 min	us sum of lir	nes 2 and 5; if	7, 873, 388	•
	Children's Health Insurance Program (CHIP) (see instructions	for each line	e)			
9.00	Net revenue from stand-alone CHIP		,		0	9.00
10.00	Stand-al one CHIP charges				0	10.00
	Stand-alone CHIP cost (line 1 times line 10)				0	
12.00	Difference between net revenue and costs for stand-alone CHIP enter zero)	(line 11 mi	nus line 9; i	f < zero then	0	12.00
	Other state or local government indigent care program (see in				-	]
	Net revenue from state or local indigent care program (Not in				0	
14.00	Charges for patients covered under state or local indigent ca	re program (	Not included	in lines 6 or	0	14.00
15.00	10) State or local indigent care program cost (line 1 times line	14)			0	15.00
	Difference between net revenue and costs for state or local i		program (lir	ne 15 minus line	0	
10.00	13; if $<$ zero then enter zero)	nurgent eure	program (TT		Ŭ	10.00
	Grants, donations and total unreimbursed cost for Medicaid, C	HIP and state	e∕local indig	gent care program	ns (see	1
17 00	instructions for each line)	<u> </u>				1 4 7 66
	Private grants, donations, or endowment income restricted to				0	
	Government grants, appropriations or transfers for support of Total unreimbursed cost for Medicaid, CHIP and state and loc			c (sum of lines	7, 873, 388	
17.00	8, 12 and 16)	ar margent s			1,073,000	17.00
			Uni nsured pati ents	I nsured pati ents	Total (col. 1 + col. 2)	
			1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)		1.00	2.00	0.00	
20.00	Charity care charges and uninsured discounts for the entire f (see instructions)	acility	8, 432, 8	38 2, 271, 598	10, 704, 436	20.00
21.00	Cost of patients approved for charity care and uninsured disc instructions)	ounts (see	1, 994, 3	32 2, 271, 598	4, 265, 930	21.00
22.00	Payments received from patients for amounts previously writte	n off as		0 0	0	22.00
23.00	charity care Cost of charity care (line 21 minus line 22)		1, 994, 3	32 2, 271, 598	4, 265, 930	23.00
					1.00	
24.00	Does the amount on line 20 column 2, include charges for pati	ent days heve	ond a length	of stay limit	N 1.00	24.00
24.00	imposed on patients covered by Medicaid or other indigent car		ond a rength	or stay rimit		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond stay limit		care program	n's length of	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see i	nstructions)			16, 613, 777	26.00
	Medicare reimbursable bad debts for the entire hospital complex (see i				760, 007	•
	Medicare allowable bad debts for the entire hospital complex				1, 169, 242	
	Non-Medicare bad debt expense (see instructions)		-		15, 444, 535	28.00
	Cost of non-Medicare and non-reimbursable Medicare bad debt e	xpense (see	instructions)	)	4, 061, 806	•
	Cost of uncompensated care (line 23 column 3 plus line 29)				8, 327, 736	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus	line 30)			16, 201, 124	31.00

	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	- EXPENSES	Provider CO	F	eriod: rom 01/01/2019	Worksheet A	
				Т	o 12/31/2019	Date/Time Pre 7/10/2020 2:5	
	Cost Center Description	Sal ari es	Other		Reclassificati	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	
0	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		19, 057, 699	19, 057, 699	6, 095, 688	25, 153, 387	1 1
0	00200 CAP REL COSTS-MUBLE EQUIP		21, 758	21, 758		23, 133, 307	
0	00400 EMPLOYEE BENEFITS DEPARTMENT	653, 390	1, 581, 276				
)1	00401 COMMUNI CATI ONS	279, 672	83, 842	363, 514		281, 072	4
2	00402 PURCHASING & RECEIVING	624, 086	539, 966	1, 164, 052		904, 432	
3	00403 REGI STRATI ON	1, 377, 517	467, 311	1, 844, 828		1, 400, 162	
)4 )0	00404 PATIENT ACCOUNTS 00500 ADMINISTRATIVE & GENERAL	2, 346, 450 8, 365, 059	1, 741, 512 24, 296, 537	4, 087, 962 32, 661, 596	-398, 733 -2, 556, 637	3, 689, 229 30, 104, 959	
0	00700 OPERATION OF PLANT	2, 254, 007	4, 352, 879	6, 606, 886		5, 931, 456	
0	00800 LAUNDRY & LINEN SERVICE	210, 259	177, 185				
0	00900 HOUSEKEEPI NG	2, 003, 398	969, 840	2, 973, 238		2, 216, 072	9
	01000 DI ETARY	1, 613, 478	1, 978, 365			829, 442	
	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	1 2(1 221	0	0 1, 901, 341	2, 214, 828 -300, 629	2, 214, 828 1, 600, 712	
	01400 CENTRAL SERVICES & SUPPLY	1, 361, 231 370, 879	540, 110 291, 894	662, 773		584, 426	
	01500 PHARMACY	2, 850, 451	18, 618, 088	21, 468, 539		3, 161, 079	
	01600 MEDICAL RECORDS & LIBRARY	2, 503, 142	1, 359, 828	3, 862, 970		3, 059, 798	
	01700 SOCIAL SERVICE	0	0	0	0	0	17
	01701 MENTAL HEALTH OH	505, 008	350, 571	855, 579		730, 199	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	01( 250	254, 224			254, 224	
	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-RADI OLOGY	816, 358 111, 300	556, 745 37, 719			1, 158, 041 116, 175	
	02300 PARAMED ED PRGM-RADIOLOGI 02301 PARAMED ED PRGM-LAB	230, 594	67, 509				
	INPATIENT ROUTINE SERVICE COST CENTERS	200,071	07,007	270,100	00, 170	212,000	
00	03000 ADULTS & PEDIATRICS	4, 222, 643	1, 615, 573	5, 838, 216	-883, 945	4, 954, 271	30
	03100 I NTENSI VE CARE UNI T	3, 327, 354	1, 321, 432	4, 648, 786		3, 715, 320	
00	04000 SUBPROVI DER – I PF	1, 928, 648	563, 178				
	04100 SUBPROVI DER – I RF 04300 NURSERY	1, 684, 195 253, 202	610, 373 88, 593	2, 294, 568 341, 795		1, 792, 196 274, 278	
00	ANCI LLARY SERVI CE COST CENTERS	200, 202	00, 373	541,775	-07, 317	274,270	
00	05000 OPERATI NG ROOM	3, 210, 829	5, 440, 191	8, 651, 020	-3, 676, 478	4, 974, 542	50
	05100 RECOVERY ROOM	0	0	0	0	0	51
	05101 ENDOSCOPY	982, 771	1, 140, 568	2, 123, 339		1, 636, 766	
00	05200 DELIVERY ROOM & LABOR ROOM	1, 171, 076	363, 072	1, 534, 148	-539, 110	995, 038	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	3, 675, 309	0 3, 609, 226	0 7, 284, 535	0	0 5, 483, 038	
	05500 RADI OLOGY - THERAPEUTI C	2, 517, 144	1, 722, 961	4, 240, 105			
	06000 LABORATORY	2, 306, 141	5, 059, 076	7, 365, 217	-658, 519	6, 706, 698	
00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
	06500 RESPI RATORY THERAPY	2, 203, 973	1, 778, 168				
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	3, 653, 980 5, 350, 054	1, 086, 672 3, 512, 785	4, 740, 652 8, 862, 839		3, 755, 547 6, 033, 944	
	07000 ELECTROENCEPHALOGRAPHY	5, 350, 054	3, 512, 765	0, 002, 039	-2, 020, 093	0, 033, 944	69
	07001 NEURODI AGNOSTI CS	391, 626	302, 712	694, 338	-90, 338	604,000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	4, 258, 628	4, 258, 628	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	5, 879, 217	5, 879, 217	72
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	17, 624, 491	17, 624, 491	
	07500 ASC (NON-DISTINCT PART)	1, 187, 873	2, 079, 322	3, 267, 195	-1, 392, 237	1, 874, 958	
	03950 MH ANCI LLARY OUTPATI ENT 03951 I NPATI ENT DI ALYSI S	0	0 656, 192	0 656, 192	-5, 576	0 650, 616	
51	OUTPATIENT SERVICE COST CENTERS	0	000, 172	030, 192		000, 010	1 '`
00	09000 CLI NI C	122, 981	27, 038	150, 019	-24, 965	125, 054	90
	04950 WOUND CLINIC	407, 558	3, 622, 017				
	09100 EMERGENCY	3, 746, 603	2, 919, 473	6, 666, 076	-961, 572	5, 704, 504	
00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	98, 826	93, 598	192, 424	-18, 125	174, 299	96
	10100 HOME HEALTH AGENCY	70, 020	<sup>73, 370</sup>	0	-10, 123		101
	SPECIAL PURPOSE COST CENTERS	-1	-				
. 00	11300 INTEREST EXPENSE		6, 140, 006	6, 140, 006	-6, 140, 006	0	113
	11600 H0SPI CE	441, 450	797, 623			1, 136, 296	
. 00		71, 360, 515	121, 894, 707	193, 255, 222	7, 474, 885	200, 730, 107	1118
00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190
	19200 PHYSI CLANS' PRI VATE OFFICES	22, 546, 214	0 15, 124, 677	0 37, 670, 891	-	32, 586, 351	
	19201 FP PETERSBURG	265, 754	13, 124, 077	403, 876	-50, 195	353, 681	
	19202 PEDI ATRI CS	1, 417, 461	908, 154			1, 944, 766	
. 03	19203 WASHINGTON PRIMARY CARE	1, 192, 973	593, 532	1, 786, 505	-335, 724	1, 450, 781	192
	07950 COMMUNITY HEALTH SERVICES	0	12, 652	12, 652		12, 652	
	07952 MARKETING AND PUBLIC RELATIONS	178, 524	387, 787	566, 311	-47, 783	518, 528	1194

Health Financial Systems	GOOD SAMARITA	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC		Period: From 01/01/2019	Worksheet A	
				To 12/31/2019		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	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	
194.04 07954 UNUSED SPACE	0	0	(	0 0	0	194.04
194.0507955 MOB	0	35, 278	35, 278	3 0	35, 278	194.05
194. 06 07956 FOUNDATI ON	0	0	(	0 0	0	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0	(	0 0	0	194.07
194. 08 07958 I NDUSTRI AL HEALTH	o	0	(	0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	5, 221, 563	2, 149, 725	7, 371, 288	-1, 458, 433	5, 912, 855	194.09
200.00 TOTAL (SUM OF LINES 118 through 199)	102, 615, 860	141, 400, 567	244, 016, 42	0	244, 016, 427	200. 00

LOLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CCN	15-0042	Period: From 01/01/2019	Worksheet A	1
						Date/Time F 7/10/2020 2	
	Cost Center Description	Adjustments	Net Expenses			1//10/2020 2	
		(See A-8) F 6.00	For Allocation 7.00				
	GENERAL SERVICE COST CENTERS	0.00	7.00				
. 00	00100 CAP REL COSTS-BLDG & FIXT	-1, 195, 592	23, 957, 795				1.
. 00	00200 CAP REL COSTS-MVBLE EQUIP	0	21, 758				2
. 00 . 01	00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNI CATI ONS	-18,005	28, 488, 574 281, 072				4
02	00402 PURCHASI NG & RECEI VI NG	-362, 893	541, 539				4
03	00403 REGI STRATI ON	0	1, 400, 162				4
04	00404 PATIENT ACCOUNTS	-85,664	3, 603, 565				4
00 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	-13, 346, 455 -33, 000	16, 758, 504				5
00	00800 LAUNDRY & LINEN SERVICE	-33,000	5, 898, 456 275, 844				8
00	00900 HOUSEKEEPI NG	-34,000	2, 182, 072				9
0. 00	01000 DI ETARY	0	829, 442				10
. 00		-1, 129, 297	1,085,531				11
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	-3, 228	1, 597, 484 584, 426				13
	01500 PHARMACY	-11, 243	3, 149, 836				15
. 00	01600 MEDI CAL RECORDS & LI BRARY	-72, 673	2, 987, 125				16
	01700 SOCIAL SERVICE	0	0				17
	01701 MENTAL HEALTH OH 02100 I&R SERVICES-SALARY & FRINGES APPRVD	-49, 591 -91	680, 608 254, 133				17
	02200 I &R SERVICES-SALART & TRINGES APPRVD	200, 000	1, 358, 041				22
. 00	02300 PARAMED ED PRGM-RADI OLOGY	-13, 598	102, 577				23
. 01	02301 PARAMED ED PRGM-LAB	-18, 106	224, 524				23
	INPATIENT ROUTINE SERVICE COST CENTERS	0.0	4 05 4 101				
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	- 80	4, 954, 191 3, 715, 320				30
	04000 SUBPROVI DER – I PF	-390, 263	1, 677, 698				40
. 00	04100 SUBPROVI DER – I RF	0	1, 792, 196				41
. 00	04300 NURSERY	0	274, 278				43
. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	-1, 817, 645	3, 156, 897				50
	05100 RECOVERY ROOM	-1, 017, 043	3, 130, 097				51
. 01	05101 ENDOSCOPY	-6, 280	1, 630, 486				51
	05200 DELIVERY ROOM & LABOR ROOM	0	995, 038				52
3.00 1.00	05300 ANESTHESI OLOGY	0	0				53 54
. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	1, 574-1, 574-1, 420, 618-	5, 481, 464 2, 233, 313				55
. 00	06000 LABORATORY	-1, 311	6, 705, 387				60
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63
. 00		-1,031,699	2, 131, 887				65
0.00 0.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	-915 -3, 569, 579	3, 754, 632 2, 464, 365				66
	07000 ELECTROENCEPHALOGRAPHY	-3, 307, 377	2,404,303				70
	07001 NEURODI AGNOSTI CS	-30	603, 970				70
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	-590	4, 258, 038				71
. 00 . 00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 -388, 398	5, 879, 217 17, 236, 093				72
	07500 DRUGS CHARGED TO PATTENTS	-300, 390 -47, 276	1, 827, 682				75
	03950 MH ANCI LLARY OUTPATI ENT	0	0				76
. 01	03951 I NPATI ENT DI ALYSI S	-199, 297	451, 319				76
00		100	104 074				
. 00 . 01	09000 CLINIC 04950 WOUND CLINIC	-180 0	124, 874 1, 040, 162				90
. 00	09100 EMERGENCY	-1, 331, 318	4, 373, 186				91
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
~ ~	OTHER REIMBURSABLE COST CENTERS		174 000				
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	0	174, 299 0				96 101
1.00	SPECIAL PURPOSE COST CENTERS	0	0				-101
3.00	11300 I NTEREST EXPENSE	0	0				113
	11600 HOSPI CE	0	1, 136, 296				116
8.00		-26, 394, 751	174, 335, 356				118
0 00	NONREIMBURSABLE COST CENTERS	0	0				190
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	0	32, 586, 351				190
	19201 FP PETERSBURG	0	353, 681				192
2. 02	19202 PEDI ATRI CS	0	1, 944, 766				192
	19203 WASHINGTON PRIMARY CARE	0	1, 450, 781				192
	07950 COMMUNITY HEALTH SERVICES 207952 MARKETING AND PUBLIC RELATIONS	0	12, 652 518, 528				194 194
	07952 MARKETING AND POBLIC RELATIONS	0	471, 428				194
	07954 UNUSED SPACE	Ö	0				194
	07955 MOB						194

GOOD SAMARITAN HOSPITAL

In Lieu of Form CMS-2552-10

Health Financial Systems

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC	CN: 15-0042	Peri od:	Worksheet A	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	narod
				10 12/31/2019	7/10/2020 2:5	
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For Allocation				
	6.00	7.00				
194. 06 07956 FOUNDATI ON	0	0				194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0				194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0				194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	5, 912, 855				194.09
200.00 TOTAL (SUM OF LINES 118 through 199)	-26, 394, 751	217, 621, 676				200.00

	Financial Systems SIFICATIONS		GOOD SAMARITA	N HOSPITAL Provider CCN	V: 15-0042	In Lie Period:	u of Form CMS Worksheet A-	
						From 01/01/2019 To 12/31/2019		
		Increases					7/10/2020 2:	50 pm
	Cost Center	Li ne #	Salary	Other				
	2.00	3.00	4.00	5.00				
1 00	A - DRUGS CHARGED TO PATIENTS		0	17 ( )4 401				1.00
1.00	DRUGS_CHARGED_TO_PATIENTS		0	<u>17, 624, 491</u> 17, 624, 491				1.00
	B - MEDI CAL SUPPLI ES CHARGED	TO PATIENTS		1770217171				
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	4, 258, 628				1.00
2.00	PATIENTS IMPL. DEV. CHARGED TO	72.00	0	5, 879, 217				2.00
2.00	PATI ENTS	72.00	Ŭ	5, 677, 217				2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	О	49, 927				3.00
4.00		0.00	0	0				4.00
5.00 6.00		0.00 0.00	0	0				5.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00 10.00		0.00 0.00	0 0	0				9.00 10.00
11.00		0.00	0	0				11.00
12.00		0.00	О	0				12.00
13.00		0.00	0	0				13.00
14. 00 15. 00		0.00 0.00	0	0				14.00 15.00
16.00		0.00	0	0				16.00
17.00		0.00	О	0				17.00
18.00		0.00	0	0				18.00
19. 00 20. 00		0.00 0.00	0	0				19.00 20.00
20.00		0.00	0	0				20.00
22.00		0.00	0	0				22.00
23.00		0.00	0	0				23.00
24.00 25.00		0.00 0.00	0	0				24.00 25.00
26.00		0.00	0	0				26.00
	0		0	10, 187, 772				
1 00	C - EMPLOYEE BENEFITS EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26, 315, 707				1 00
1.00 2.00	LINFLOTEL BENETITS DEFARTMENT	0.00	0	20, 313, 707				1.00
3.00		0.00	0	0				3.00
4.00		0.00	0	0				4.00
5.00 6.00		0.00 0.00	0	0				5.00
7.00		0.00	0	0				7.00
8.00		0.00	0	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		0.00	0	0				12.00
13.00		0.00	0	0				13.00
14. 00 16. 00		0.00 0.00	0 0	0 0				14.00 16.00
17.00		0.00	0	0				17.00
18.00		0.00	0	0				18.00
19.00		0.00	0	0				19.00
20. 00 21. 00		0.00 0.00	0 0	0 0				20.00 21.00
22.00		0.00	0	0				22.00
23.00		0.00	0	0				23.00
24. 00 25. 00		0.00 0.00	0 0	0 0				24.00 25.00
25.00 26.00		0.00	0	0				25.00
27.00		0.00	0	0				27.00
28.00		0.00	0	0				28.00
29. 00 30. 00		0.00 0.00	0 0	0 0				29.00 30.00
30.00 31.00		0.00	0	0				30.00
32.00		0.00	0	0				32.00
33.00		0.00	0	0				33.00
34. 00 35. 00		0.00 0.00	0 0	0 0				34.00 35.00
35.00 36.00		0.00	0	0				36.00
37.00		0.00	0	0				37.00
38.00		0.00	0	0				38.00
39. 00 40. 00		0. 00 0. 00	0 0	0 0				39.00 40.00
41.00		0.00	0	0				40.00

RECLASSI FI CATIONS         Provider CN: 15-0042         Period: From 01/01/2019 To 12/31/2019         Worksheet A-6 bate/Time Prepared: 7/10/2020 2:50 pm           Increases         0         0         12/31/2019         Worksheet A-6           Atternational Construction         Cost Center         Line #         Salary         Other           2.00         3.00         4.00         5.00         42.00         43.00         44.00           42.00         0.00         0         0         0         43.00         44.00         43.00           44.00         0.00         0         0         0         44.00         43.00         44.00           45.00         0.00         0         0         0         0         44.00         45.00           46.00         0         0         0         0         0         46.00           0         0.00         0         5.762.064         2.00         40.00         2.00           1.00         CAP REL COSTS-BLDG & FIXT         1.00         0.77.2942         2.00         333.624         2.00         2.00           0         0         1.00         1.169.359         1.045.469         1.00         333.624         1.00         1.00	Heal th	Financial Systems		GOOD SAMARI TAN	N HOSPI TAL		In Lieu	u of Form CMS-255	52-10
To         12/31/2019         Date/Time Prepared: 7/10/2020 2:50 pm           Cost Center         Line #         Salary         Other           2.00         3.00         4.00         5.00           42.00         0.00         0         0           43.00         0.00         0         0           44.00         0.00         0         0           45.00         0.00         0         0           46.00         0.00         0         0           0         0.00         0         0           0         0.00         0         0           46.00         0.00         0         46.00           0         0.00         0         5.762.064           1.00         CAP REL COSTS-BLDG & FIXT         1.00         0         5.762.064           2.00         PATLENT ACCOUNTS         4.04         0         377.942         2.00           0         1.00         0         333.624         1.00         2.00           E         INSURANCE EXPENSE         1.00         333.624         1.00           1.00         CAFETERIA         0         333.624         1.00           0 <td< td=""><td>RECLASS</td><td>SEFECATIONS</td><td></td><td></td><td>Provider C</td><td>CN: 15-0042</td><td></td><td>Worksheet A-6</td><td></td></td<>	RECLASS	SEFECATIONS			Provider C	CN: 15-0042		Worksheet A-6	
$ \begin{array}{ c c c c c c c c c c c c c c c c c c c$									
$\begin{array}{ c c c c c c c c c c c c c c c c c c c$									
$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	-								
43.00       0.00       0       0       0       43.00         44.00       0.00       0       0       0       44.00         45.00       0.00       0       0       0       44.00         45.00       0.00       0       0       0       45.00         46.00       0       0       0       0       46.00         0       0       0       5,762,064       1.00       46.00         2.00       PATI ENT ACCOUNTS       4.04       0       377,942       2.00       2.00         0       0       6,140,006       0       1.00       2.00       333,624       1.00       2.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       333,624       1.00       1.00         6       0       0       333,624       1.00       1.00       1.00       1.00         6       0       1.169,359       1.045,469       1.00       1.00       1.00         6       0       0       257,637       24,143       1.00       1.00         1.00       ADULTS & PEDI ATRI CS       30.00       257,637       24,143       1.00		2.00		4.00	5.00				
44.00       0.00       0       0       44.00         45.00       0.00       0       0       0       45.00         46.00       0       0.00       0       0       46.00         0       0       0       0       26.315.707       46.00         0       0       0       5,762,064       1.00       46.00         2.00       PATI ENT ACCOUNTS       4.04       0       377,942       2.00         0       0       0       6,140,006       1.00       2.00         E       - INSURANCE EXPENSE       1.00       0       333,624       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       333,624       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       333,624       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       1.169,359       1.045,469       1.00         0       0       1.169,359       1.045,469       1.00       1.00       1.00         0       0       257,637       24,143       1.00       1.00       1.00         0       0       257,637       24,143       1.00       1.00 <td></td> <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td> <td></td>				0	0				
45.00       0       0.00       0       0       0       45.00       45.00         46.00       0       0.00       0       0       0       0       46.00       46.00         0       0       0       26,315,707       0       1.00       26,315,707       46.00       46.00         0       - INTEREST EXPENSE       -       0       377,942       1.00       2.00       2.00         0       -       0       0       5,762,064       0       2.00       2.00         0       -       0       0       333,624       2.00       2.00         0       -       0       0       333,624       1.00       2.00         0       -       0       333,624       1.00       1.00       1.00         1.00       CAP REL COSTS - BLDG & FI XT       1.00       0       333,624       1.00       1.00         1.00       CAP REL COSTS - BLDG & FI XT       1.00       1.169,359       1.045,469       1.00       1.00         0       -       0       1.045,469       1.045,469       1.00       1.00       1.00         1.00       ADULTS & PEDI ATRI CS       30.00       257,637				0	0				
46.00				0	0				
$\begin{array}{c ccccccccccccccccccccccccccccccccccc$				0	0				
$\begin{array}{c c c c c c c c c c c c c c c c c c c $	46.00			0	0			4	6. 00
1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       5,762,064       1.00         2.00       PATI ENT ACCOUNTS       4.04       0       377,942       2.00         0       0       6,140,006       6.140,006       2.00       2.00         E - INSURANCE EXPENSE       1.00       0       333,624       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       333,624       1.00         F - DI ETARY RECLASS       11.00       1,169,359       1,045,469       1.00       1.00         0       0       1,169,359       1,045,469       1.00       1.00       1.00         0       0       257,637       24,143       1.00       1.00		0		0	26, 315, 707				
2.00       PATI ENT ACCOUNTS       4.04       0       377,942       2.00         0       6.140,006       0       6.140,006       1.00       1.00         E - INSURANCE EXPENSE       1.00       0       333,624       1.00       1.00         F - DI ETARY RECLASS       1.00       1,169,359       1,045,469       1.00       1.00         G - OB RECLASS       1.00       1,169,359       1,045,469       1.00       1.00         G - OB RECLASS       1.00       257,637       24,143       1.00       1.00									
0				0					
E - INSURANCE EXPENSE       1.00       0       333, 624       1.00         1.00       CAP REL COSTS-BLDG & FIXT       1.00       0       333, 624       1.00         F - DI ETARY RECLASS       0       1.00       1, 169, 359       1, 045, 469       1.00         0       0       1, 169, 359       1, 045, 469       1.00       1.00         0       0       257, 637       24, 143       1.00         1.00       ADULTS & PEDIATRICS       30.00       257, 637       24, 143       1.00	2.00	PATI ENT_ACCOUNTS	4.04	0					2.00
1.00       CAP_REL_COSTS-BLDG & FIXT       1.00       0       333, 624       1.00         0       0       333, 624       0       333, 624       1.00       1.00         F - DI ETARY RECLASS       11.00       1, 169, 359       1, 045, 469       1.00       1.00         0       0       1, 169, 359       1, 045, 469       1.00       1.00       1.00         6       0       0       257, 637       24, 143       1.00       1.00         1.00       ADULTS & PEDIATRICS       30.00       257, 637       24, 143       1.00		0		0	6, 140, 006				
O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O         O		E – I NSURANCE EXPENSE							
F - DI ETARY RECLASS         1. 00       CAFETERI A       11.00       1,169,359       1,045,469       1.00         0       0       1,169,359       1,045,469       1.00       1.00         G - OB RECLASS       0       257,637       24,143       1.00         1. 00       ADULTS & PEDIATRICS       30.00       257,637       24,143       1.00	1.00	CAP_REL_COSTS-BLDG_&_FLXT	1.00	0	333, 624				1.00
1. 00       CAFETERIA       11. 00       1, 169, 359       1, 045, 469       1. 00         0       1, 169, 359       1, 045, 469       1. 045, 469       1. 00       1. 00         G - OB RECLASS       30. 00       257, 637       24, 143       1. 00       1. 00         1. 00       ADULTS & PEDIATRICS       30. 00       257, 637       24, 143       1. 00		0		0	333, 624				
0 1, 169, 359 1, 045, 469 G - OB RECLASS 1. 00 ADULTS & PEDIATRICS 30.00 257, 637 24, 143 TOTALS 1. 00 1. 00		F – DIETARY RECLASS							
G - OB         RECLASS           1.00         ADULTS & PEDI ATRI CS         30.00         257, 637         24, 143         1.00           TOTALS         257, 637         24, 143         1.00         1.00	1.00	CAFETERI A	11.00	1, 169, 359	1,045,469				1.00
1. 00         ADULTS & PEDIATRICS         30.00         257,637         24,143         1.00           TOTALS         257,637         24,143         1.00		0		1, 169, 359	1,045,469				
TOTALS 257, 63724, 143		G – OB RECLASS							
	1.00	ADULTS & PEDIATRICS	30.00	257, 637	24, 143				1.00
500.00 Grand Total: Increases 1, 426, 996 61, 671, 212 500.00		TOTALS		257, 637	24, 143				
	500.00	Grand Total: Increases		1, 426, 996	61, 671, 212			50	0.00

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

## GOOD SAMARITAN HOSPITAL

Heal th	Financial Systems		GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CM	IS-2552-10
RECLAS	SIFICATIONS			Provi der (	CCN: 15-0042	Period: Worksheet A	<b>\-6</b>
						From 01/01/2019 To 12/31/2019 Date/Time F	Prepared:
		D				7/10/2020 2	2:50 pm
	Cost Center	Decreases Line #	Salary	Other	 Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00	<u> </u>	
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	<u>15.</u> 00	<u>0</u>	<u>17, 624, 491</u>		2	1.00
	U B - MEDICAL SUPPLIES CHARGED	TO PATIENTS	U	17, 624, 491	I		_
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43, 794	1		1.00
2.00	PURCHASING & RECEIVING	4. 02	0	1, 468			2.00
3.00	ADMI NI STRATI VE & GENERAL	5.00	0	539			3.00
4.00 5.00	OPERATION OF PLANT HOUSEKEEPING	7.00 9.00	0	1, 348 50			4.00 5.00
6.00	DI ETARY	10.00	0	11, 742			6.00
7.00	PHARMACY	15.00	0	14, 024			7.00
8.00	ADULTS & PEDIATRICS	30.00	0	30, 876			8.00
9.00	INTENSIVE CARE UNIT	31.00	0	53, 243			9.00
10. 00 11. 00	SUBPROVI DER – I PF SUBPROVI DER – I RF	40.00 41.00	0	1, 161 8, 286			10.00 11.00
12.00	NURSERY	43.00	0	5, 963			12.00
13.00	OPERATING ROOM	50.00	0	2, 848, 953			13.00
14.00	ENDOSCOPY	51.01	0	248, 835			14.00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	13, 260			15.00
16.00 17.00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54.00 55.00	0	823, 064 8, 129			16.00 17.00
18.00	LABORATORY	60.00	0	3, 444			18.00
19.00	RESPI RATORY THERAPY	65.00	0	206, 120			19.00
20.00	PHYSI CAL THERAPY	66.00	0	17, 518	3		20.00
21.00	ELECTROCARDI OLOGY	69.00	0	1, 787, 643			21.00
22.00	NEURODI AGNOSTI CS	70.01	0	1,455			22.00
23.00 24.00	ASC (NON-DISTINCT PART)	75.00 76.01	0	1, 059, 003 5, 576			23.00 24.00
24.00	WOUND CLINIC	90.01	0	2, 907, 721			24.00
26.00	EMERGENCY	91.00	o	84, 557			26.00
	0		0	10, 187, 772	2		
	C - EMPLOYEE BENEFITS						
1.00 2.00	COMMUNI CATI ONS PURCHASI NG & RECEI VI NG	4.01 4.02	0	82, 442 258, 152			1.00
2.00 3.00	REGI STRATI ON	4.02	0	444, 666			3.00
4.00	PATI ENT ACCOUNTS	4.04	0	776, 675			4.00
5.00	ADMI NI STRATI VE & GENERAL	5.00	О	2, 222, 474	1		5.00
6.00	OPERATION OF PLANT	7.00	0	674, 082			6.00
7.00	LAUNDRY & LINEN SERVICE	8.00	0	97, 338			7.00
8.00 9.00	HOUSEKEEPI NG DI ETARY	9.00 10.00	0	757, 116 535, 831			8.00 9.00
10.00	NURSING ADMINISTRATION	13.00	0	300, 629			10.00
11.00	CENTRAL SERVICES & SUPPLY	14.00	0	128, 274			11.00
12.00	PHARMACY	15.00	0	668, 945			12.00
13.00	MEDICAL RECORDS & LIBRARY	16.00	0	803, 172			13.00
14.00 16.00	MENTAL HEALTH OH I&R SERVICES-OTHER PRGM	17.01 22.00	0	125, 380 215, 062			14.00 16.00
10.00	COSTS APPRVD	22.00	0	215,002	<u>-</u>		10.00
17.00	PARAMED ED PRGM-RADI OLOGY	23.00	о	32, 844	1		17.00
18.00	PARAMED ED PRGM-LAB	23. 01	0	55, 473			18.00
19.00	ADULTS & PEDIATRICS	30.00	0	1, 134, 849			19.00
20. 00 21. 00	I NTENSI VE CARE UNI T SUBPROVI DER – I PF	31.00 40.00	0	880, 223 422, 704			20.00 21.00
21.00	SUBPROVIDER - IRF	40.00	0	494, 086			21.00
23.00	NURSERY	43.00	0	61, 554			23.00
24.00	OPERATING ROOM	50.00	О	827, 525			24.00
25.00	ENDOSCOPY	51.01	0	237, 738			25.00
26.00	DELIVERY ROOM & LABOR ROOM	52.00	0	244, 070			26.00
27.00 28.00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54.00 55.00	0	978, 433 578, 045			27.00 28.00
28.00	LABORATORY	60.00	0	655, 075			28.00
30.00	RESPIRATORY THERAPY	65.00	0	612, 435			30.00
31.00	PHYSICAL THERAPY	66.00	0	967, 587			31.00
32.00	ELECTROCARDI OLOGY	69.00	0	1, 041, 252			32.00
33.00	NEURODI AGNOSTI CS	70.01	0	88, 883			33.00
34.00	ASC (NON-DISTINCT PART)	75.00 90.00	0	333, 234			34.00
35.00 36.00	CLINIC WOUND CLINIC	90.00 90.01	0	24, 965 81, 692			35.00 36.00
37.00	EMERGENCY	91.00	0	877, 015			37.00
38.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	18, 125			38.00
39.00	HOSPI CE	116.00	0	102, 777			39.00
40.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	5,084,540			40.00
41.00 42.00	FP PETERSBURG PEDI ATRI CS	192.01 192.02	0	50, 195 380, 849			41.00 42.00
12.00	<u> </u>	1 1/2.02	<u>Ч</u>	500, 04 5	.1		1 12.00

Heal th	Financial Systems		GOOD SAMARI TAN	HOSPI TAL		In Lieu	u of Form CMS	-2552-10
RECLASS	SEFECATIONS			Provider (	CCN: 15-0042	Peri od:	Worksheet A-	6
						From 01/01/2019 To 12/31/2019	Date/Time Pr 7/10/2020 2:	
		Decreases						
	Cost Center	Line #	Sal ary	Other	Wkst. A-7 Ref	,		
	6. 00	7.00	8.00	9.00	10.00			
43.00	WASHINGTON PRIMARY CARE	192.03	0	335, 724		0		43.00
44.00	MARKETING AND PUBLIC RELATIONS	194.02	0	47, 783		0		44.00
45.00	MH RESIDENTIAL	194.03	0	117, 361		0		45.00
46.00	COMMUNITY MENTAL HEALTH	194.09	0	1, 458, 433		0		46.00
	<u>CENTER</u>							
	0		0	26, 315, 707				
	D - INTEREST EXPENSE							
1.00	INTEREST EXPENSE	113.00	0	6, 140, 006	1	1		1.00
2.00		0.00	0	0		Q		2.00
	0		0	6, 140, 006				
	E – I NSURANCE EXPENSE				P	1		
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	33 <u>3, 6</u> 24		2		1.00
	0		0	333, 624				
	F - DIETARY RECLASS	-				1		_
1.00	DI ETARY		<u>1, 169, 3</u> 59	<u>1, 045, 469</u>		Ō		1.00
	0		1, 169, 359	1, 045, 469				
	G – OB RECLASS							_
1.00	DELIVERY ROOM & LABOR ROOM	52.00	257,637	2 <u>4, 1</u> 43		Ō		1.00
	TOTALS		257, 637	24, 143				
500.00	Grand Total: Decreases		1, 426, 996	61, 671, 212				500.00

Heal th	Financial Systems	GOOD SAMARITA	N HOSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0042		riod: om 01/01/2019 12/31/2019		pared:
				Acquisition	IS			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES		_				
1.00	Land	6, 781, 448	0		0	0	200, 000	1.00
2.00	Land Improvements	10, 676, 928	13, 697		0	13, 697	81, 343	2.00
3.00	Buildings and Fixtures	161, 037, 809	2, 908, 752		0	2, 908, 752	128, 369	3.00
4.00	Building Improvements	862, 950	2, 521		0	2, 521	14, 909	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	217, 250, 999	8, 084, 375		0	8, 084, 375	6, 890, 059	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	396, 610, 134	11, 009, 345		0	11, 009, 345	7, 314, 680	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	396, 610, 134	11, 009, 345		0	11,009,345	7, 314, 680	10.00
		Ending Balance	Fully				i	
		5	Depreciated					
			Assets					
		6.00	7.00	]				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES						
1.00	Land	6, 581, 448	0					1.00
2.00	Land Improvements	10, 609, 282	0					2.00
3.00	Buildings and Fixtures	163, 818, 192	0					3.00
4.00	Building Improvements	850, 562	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	218, 445, 315	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	400, 304, 799	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	400, 304, 799	0					10.00

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-0042	Peri od:	Worksheet A-7	
					From 01/01/2019 To 12/31/2019		pared <sup>.</sup>
						7/10/2020 2:5	0 pm
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	· ·	
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2	-		
1.00	CAP REL COSTS-BLDG & FIXT	19, 057, 699	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	18, 19			2.00
3.00	Total (sum of lines 1-2)	19, 057, 699		18, 19	3, 560	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	19, 057, 699				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	21, 758				2.00
3.00	Total (sum of lines 1-2)	0	19, 079, 457				3.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2019 To 12/31/2019	Worksheet A-7 Part III Date/Time Prep 7/10/2020 2:50	
	COM	PUTATION OF RAT	FI 0S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-WVBLE EQUIP 3.00 Total (sum of lines 1-2)	181, 859, 484 218, 445, 315 400, 304, 799	0	181, 859, 484 218, 445, 315 400, 304, 799 CAPI TAL	0. 545697	0 0 F CAPITAL	1.00 2.00 3.00
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				10.057.000		
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0	0		) 19, 057, 699 ) 0 19, 057, 699	0 0	1.00 2.00 3.00
	0	9	IMMARY OF CAPI			3.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		222 (24			22.057.705	1 00
1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP	4, 566, 472 18, 198				23, 957, 795 21, 758	1.00 2.00
3.00 Total (sum of lines 1-2)	4, 584, 670				23, 979, 553	3.00

ADJUST	Financial Systems MENTS TO EXPENSES			AN HOSPITAL Provider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2019 To 12/31/2019		
				Expense Classification of	n Worksheet A	7/10/2020 2:50	0 pm
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		C	CAP REL COSTS-BLDG & FIXT	1.00	0	1. C
2.00	Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		C		0.00	0	3. (
. 00	(chapter 2) Trade, quantity, and time	В	-1,465	PURCHASI NG & RECEI VI NG	4. 02	0	4. (
	discounts (chapter 8)		,				
5. 00	Refunds and rebates of expenses (chapter 8)		L		0.00	0	5. (
o. 00	Rental of provider space by suppliers (chapter 8)		C	D	0.00	0	6.0
. 00	Telephone services (pay stations excluded) (chapter	В	-29, 028	OPERATION OF PLANT	7.00	0	7. (
. 00	21) Television and radio service		C		0.00	0	8.
. 00	(chapter 21) Parking lot (chapter 21)		C		0.00	0	9.1
	Provider-based physician	A-8-2	-9, 424, 151			0	10. (
1. 00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11.
2.00	(chapter 23) Related organization	A-8-1	C			0	12.
3 00	transactions (chapter 10) Laundry and linen service		C		0.00	0	13.
4.00	Cafeteria-employees and guests	В	-487, 137	CAFETERI A	11.00	0	14.
5.00	Rental of quarters to employee and others		Ĺ		0.00	0	15.
6. 00	Sale of medical and surgical supplies to other than patients	В	-388, 398	DRUGS CHARGED TO PATIENTS	73.00	0	16.
7.00	Sale of drugs to other than patients		C		0.00	0	17.
8. 00	Sale of medical records and		C		0.00	0	18.
9.00	abstracts Nursing and allied health		C		0.00	0	19.
	education (tuition, fees, books, etc.)						
	Vending machines		C		0.00	0	
1. 00	Income from imposition of interest, finance or penalty		C		0.00	0	21.
2 00	charges (chapter 21) Interest expense on Medicare		C		0.00	0	22.
2.00	overpayments and borrowings to		(		0.00	0	22.
3. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	C	RESPI RATORY THERAPY	65.00		23.
	therapy costs in excess of limitation (chapter 14)						
4.00	Adjustment for physical	A-8-3	C	PHYSICAL THERAPY	66.00		24.
	therapy costs in excess of limitation (chapter 14)						
5.00	Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	* 114.00		25.
	(chapter 21)				1.00		
6.00	Depreciation - CAP REL COSTS-BLDG & FIXT		Ĺ	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
7.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		C	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
	Non-physician Anesthetist		C	*** Cost Center Deleted ***			28.
	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	C	) *** Cost Center Deleted **;	0.00 * 67.00	0	29. 30.
). 99	limitation (chapter 14) Hospice (non-distinct) (see		r	ADULTS & PEDIATRICS	30.00		30.
	instructions)						
1.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	C	*** Cost Center Deleted ***	68.00		31.
2.00	CAH HIT Adjustment for		C		0.00	0	32.
13 00	Depreciation and Interest MISC INCOME	В	_1 015	EMPLOYEE BENEFITS DEPARTMEN	NT 4.00	0	33.

	Financial Systems MENTS TO EXPENSES		GOOD SAMARITA	Provi der CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet A-8	1002 1
ADJUSI	MENTS TO EXPENSES			PLOVI del CCN. 15-0042	From 01/01/2019	WULKSHEEL A-0	
					To 12/31/2019	Date/Time Pre	
				Expense Classification o	n Warkshoot A	7/10/2020 2:50	0 pm
				To/From Which the Amount is			
					s to be Aujusteu		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
	MISC INCOME	В		PURCHASING & RECEIVING	4. 02	0	
33. 02	MISC INCOME	В		PATIENT ACCOUNTS	4.04	0	33.0
33.03	MISC INCOME	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.0
	MISC INCOME	В		OPERATION OF PLANT	7.00	0	33.0
33.05	MI SC I NCOME	В		LAUNDRY & LINEN SERVICE	8.00	0	33.0
33.06 33.07	MISC INCOME	B B		HOUSEKEEPING	9.00	0	33. 0 33. 0
33.07	MISC INCOME	В			15.00 16.00	0	33.0
33.00	MISC INCOME MISC INCOME	В		MEDICAL RECORDS & LIBRARY MENTAL HEALTH OH	17.01	0	33.0
33.10	MI SC I NCOME	B		PARAMED ED PRGM-RADIOLOGY	23.00	0	33.1
33.10	MI SC I NCOME	B		PARAMED ED PRGM-LAB	23.00	0	33.1
	MI SC I NCOME	B		ENDOSCOPY	51.01	0	33.1
	MI SC I NCOME	B		LABORATORY	60.00	0	33.1
33.14	MI SC I NCOME	B		PHYSICAL THERAPY	66.00	0	33.1
33.15	MI SC I NCOME	В		ELECTROCARDI OLOGY	69.00	0	33.1
33.16	MI SC I NCOME	В		MEDICAL SUPPLIES CHARGED TO		0	33.1
				PATI ENTS			
33.17	MISC INCOME	В	-354	ASC (NON-DISTINCT PART)	75.00	0	33.1
33. 18	MISC INCOME	В	-180	CLINIC	90.00	0	33.1
33.19	OTHER MISC FEES	В	-642, 160	CAFETERI A	11.00	0	33.1
33.20	PROVIDER ASSESSMENT FEE	A	-11, 838, 968	ADMINISTRATIVE & GENERAL	5.00	0	33. 2
33. 21	GME CONSORTIUM FEES	A	200, 000	I&R SERVICES-OTHER PRGM	22.00	0	33. 2
				COSTS APPRVD			
33. 22	INTEREST INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00	11	
33.23	PHYSICIAN BILLING COSTS	A		PATIENT ACCOUNTS	4.04	0	33.2
33.24	DONATIONS EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.2
33.25	ADVERTI SI NG	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.2
33.26	ADVERTI SI NG	A		NURSING ADMINISTRATION	13.00	0	33.2
33. 27	ADVERTI SI NG	A	-91	I&R SERVICES-SALARY &	21.00	0	33. 2
33. 28	ADVERTI SI NG	А	-80	FRINGES APPRVD ADULTS & PEDIATRICS	30.00	0	33. 2
33.29	ADVERTI SI NG	A		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 2
33.30	ADVERTI SI NG	A		PHYSICAL THERAPY	66.00	0	33.3
33.31	ADVERTI SI NG	A		ELECTROCARDI OLOGY	69.00	0	33.3
33.32	ADVERTI SI NG	A		NEURODI AGNOSTI CS	70.01	0	33.3
33.33	2012 BOND ISSUE COSTS	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.3
33.34	AHA LOBBYING OFFSET	A		ADMINISTRATIVE & GENERAL	5.00	0	33.3
33.35	IHA LOBBYING OFFSET	A	-5, 323	ADMI NI STRATI VE & GENERAL	5.00	0	33.3
33.36	INDIANA CHAMBER LOBBYING	A		ADMI NI STRATI VE & GENERAL	5.00	0	
	OFFSET						
33. 37	RENTAL	В		ADMI NI STRATI VE & GENERAL	5.00	0	
33. 38	RENTAL	В		OPERATING ROOM	50.00	0	33. 3
	RENTAL	В		ELECTROCARDI OLOGY	69.00	0	
	RENTAL	В		INPATIENT DIALYSIS	76.01	0	33.4
	MISC INCOME	В		OPERATING ROOM	50.00	0	33.4
	PHYSICIAN LOAN EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.4
33.43	PHYSICIAN LOAN EXPENSE	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.4
33.44	PHYSICIAN LOAN EXPENSE	A		OPERATING ROOM	50.00	0	33.4
33.45	PHYSICIAN LOAN EXPENSE	A		RADI OLOGY-THERAPEUTI C	55.00	0	33.4
33.46	PHYSICIAN LOAN EXPENSE	A			69.00 5.00	0	33.4
33.47	I HRA LOBBYING OFF	A	-5,000	ADMINISTRATIVE & GENERAL	5.00	0	33.4
33. 48	OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33.4
33. 49	(3) OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33. 4
JJ. 47	(3)		0		0.00	0	33. 4
50.00	TOTAL (sum of lines 1 thru 49)		-26, 394, 751				50.00
	(Transfer to Worksheet A,		28, 071, 701				

(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.
(2) Additional ediustrate results are the read on the and subparients thereaft

(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.

Health F	i nanci al	Systems	
PROVI DEF	R BASED F	PHYSI CI AN	ADJUSTMENT

## GOOD SAMARITAN HOSPITAL

In Lieu of Form CMS-2552-10 Worksheet A-8-2

PROVIDER BASED PHYSICIAN ADJUSTMENT				Provider (		Period:	Worksheet A-8	3-2
					1		From 01/01/2019 To 12/31/2019 Date/Time Pr 7/10/2020 2:	
	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Prov ider Component	
	1.00	2.00	3.00	4.00	5.00	6.00	Hours 7.00	
1.00		EMPLOYEE BENEFITS DEPARTMENT	16, 790				0	1.00
2.00		ADMINISTRATIVE & GENERAL	194, 265				2, 728	2.00
3.00	13.00	NURSING ADMINISTRATION	15, 400	0	15, 400	211, 500	120	3.00
4.00		PHARMACY	12, 252		12, 252		30	4.00
5.00		SUBPROVIDER - IPF	414, 667				240	5.00
6.00		OPERATING ROOM	1, 771, 524				94	6.00
7.00 8.00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	984 1, 430, 292	984 1, 390, 567			0 227	7.00 8.00
8.00 9.00		LABORATORY	1, 430, 292	1, 390, 587			2, 813	9.00
10.00		RESPI RATORY THERAPY	1, 049, 699				300	10.00
11.00		ELECTROCARDI OLOGY	3, 478, 343				520	11.00
12.00		NEURODI AGNOSTI CS	18,000		18,000		331	12.00
13.00		ASC (NON-DISTINCT PART)	76, 207				288	13.00
14.00		INPATIENT DIALYSIS	40, 000				336	
15.00	91.00	EMERGENCY	1, 409, 614				770	15.00
200.00	Wkst. A Line #	Cost Center/Physician	10, 063, 888 Unadj usted RCE		852,058 Cost of	Provi der	8, 797 Physi ci an Cost	200.00
	WKSL A LINE #	I denti fi er	Limit	Unadiusted RCF	Memberships &		of Malpractice	
				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		EMPLOYEE BENEFITS DEPARTMENT	0				0	1.00
2.00 3.00		ADMINISTRATIVE & GENERAL NURSING ADMINISTRATION	277, 390 12, 202	13, 870 610			0	2.00 3.00
4.00		PHARMACY	3, 050		-		0	4.00
5.00		SUBPROVIDER - IPF	24, 404	1, 220			0	5.00
6.00		OPERATING ROOM	11, 135			0	0	6.00
7.00		RADI OLOGY-DI AGNOSTI C	0		-		0	7.00
8.00		RADI OLOGY-THERAPEUTI C	29, 674				0	8.00
9.00			286, 033				0	9.00
10. 00 11. 00		RESPI RATORY THERAPY ELECTROCARDI OLOGY	39, 216 52, 875			-	0	10. 00 11. 00
12.00		NEURODI AGNOSTI CS	33, 657	1, 683			0	12.00
13.00		ASC (NON-DISTINCT PART)	29, 285			-	0	13.00
14.00		INPATIENT DIALYSIS	34, 165			0	0	14.00
15.00	91.00	EMERGENCY	78, 296	3, 915	C	0	0	15.00
200.00			911, 382			-	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		l denti fi er	Component Share of col.	Limit	Di sal I owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		EMPLOYEE BENEFITS DEPARTMENT	0					1.00
2.00		ADMI NI STRATI VE & GENERAL	0					2.00
3.00 4.00		NURSI NG ADMI NI STRATI ON PHARMACY	0					3.00 4.00
4.00 5.00		SUBPROVIDER - IPF	0					4.00 5.00
6.00		OPERATI NG ROOM	0					6.00
7.00		RADI OLOGY-DI AGNOSTI C	0			984		7.00
8.00	55.00	RADI OLOGY-THERAPEUTI C	0	29, 674	10, 051	1, 400, 618		8.00
9.00		LABORATORY	0					9.00
10.00			0			.,		10.00
11. 00 12. 00		ELECTROCARDI OLOGY NEURODI AGNOSTI CS	0			3, 425, 468 0		11. 00 12. 00
12.00		ASC (NON-DISTINCT PART)	0			-		12.00
14.00		INPATIENT DIALYSIS	0					14.00
15.00		EMERGENCY	0					15.00
200.00			0					200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	GOOD SAMARITA	Provi der CC		eriod: com 01/01/2019		pared:
			CAPI TAL REL	ATED COSTS		1771072020 2. 5	
	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	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	23, 957, 795	23, 957, 795				1.00
	00200 CAP REL COSTS-MUBLE EQUIP	23, 737, 773	23, 731, 173	21, 758			2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	28, 488, 574	124, 967	110	28, 613, 651		4.00
4.01		281,072	0	0	78, 484	359, 556	4.01
4.02 4.03	00402 PURCHASI NG & RECEI VI NG 00403 REGI STRATI ON	541, 539 1, 400, 162	431, 966 0	377 0	175, 137 386, 571	3, 155 5, 813	4. 02 4. 03
	00404 PATIENT ACCOUNTS	3, 603, 565	0	0	658, 482		4.04
	00500 ADMI NI STRATI VE & GENERAL	16, 758, 504	1, 172, 069	1, 140	2, 347, 478		5.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	5, 898, 456 275, 844	3, 633, 696 146, 370	3, 432 131	632, 540 59, 005	21, 922	7.00 8.00
	00900 HOUSEKEEPING	2, 182, 072	203, 906	183	562, 212	6, 311	9.00
	01000 DI ETARY	829, 442	0	0	124, 633	4, 318	1
	01100 CAFETERIA	1,085,531	347, 969	312	328, 156	0	11.00
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 597, 484 584, 426	238, 761 2, 502	214 2	382, 001 104, 079	3, 322 1, 495	
	01500 PHARMACY	3, 149, 836	172, 025	154	799, 919		
	01600 MEDI CAL RECORDS & LI BRARY	2, 987, 125	131, 110	118	702, 454	8, 636	1
	01700 SOCIAL SERVICE 01701 MENTAL HEALTH OH	0 680, 608	0 95, 671	0 86	0 141, 720	0 33, 714	17.00 17.01
-	02100 I &R SERVICES-SALARY & FRINGES APPRVD	254, 133	111, 237	100	0	0	21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	1, 358, 041	0	0	229, 094	3, 820	
	02300 PARAMED ED PRGM-RADI OLOGY	102, 577	0	0	31, 234	498	
23. 01	02301 PARAMED ED PRGM-LAB INPATIENT ROUTINE SERVICE COST CENTERS	224, 524	0	0	64, 711	0	23.01
30.00	03000 ADULTS & PEDI ATRI CS	4, 954, 191	1, 941, 414	1, 743	1, 257, 296	26, 074	30.00
	03100 I NTENSI VE CARE UNI T	3, 715, 320	743, 161	667	933, 752	15, 943	
	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	1, 677, 698 1, 792, 196	362, 283 477, 883	325 429	541, 235 472, 634	0 11, 625	40.00
	04300 NURSERY	274, 278	477,003	429	71, 056		1
	ANCI LLARY SERVI CE COST CENTERS						
	05000 OPERATING ROOM 05100 RECOVERY ROOM	3, 156, 897	525, 469	472 0	901, 052 0	23, 915	50.00 51.00
	05101 ENDOSCOPY	1, 630, 486	340, 130	305	275, 794	4, 152	
52.00	05200 DELIVERY ROOM & LABOR ROOM	995, 038	0	0	256, 337	10, 961	52.00
	05300 ANESTHESI OLOGY	0 E 401 444	0 917, 187	0	0	9, 965	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	5, 481, 464 2, 233, 313	213, 940	824 192	1, 031, 398 706, 384	6, 145	1
	06000 LABORATORY	6, 705, 387	201, 182	181	647, 170		1
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	2, 131, 887 3, 754, 632	157, 849 613, 163	142 551	618, 499 1, 025, 413	6, 311 4, 982	65.00 66.00
	06900 ELECTROCARDI OLOGY	2, 464, 365	505, 345	454	1, 501, 380		1
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
	07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	603, 970 4, 258, 038	212, 495	191	109, 902	3, 322	70.01
	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 879, 217	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	17, 236, 093	Ō	0	0	0	73.00
	07500 ASC (NON-DI STI NCT PART)	1, 827, 682	0	0	333, 352	0	75.00
	03950 MH ANCILLARY OUTPATIENT 03951 INPATIENT DIALYSIS	0 451, 319	0 238, 539	0 214	0	0 498	76.00 76.01
	OUTPATIENT SERVICE COST CENTERS		200,007				,
	09000 CLINIC	124, 874	74, 158	67	34, 512	1, 329	90.00
	04950 WOUND CLINIC 09100 EMERGENCY	1, 040, 162 4, 373, 186	80, 106 482, 053	72 433	114, 373 1, 051, 405		90.01 91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 373, 100	402,000	400	1, 031, 403	10, 740	92.00
	OTHER REIMBURSABLE COST CENTERS	1					
	09600 DURABLE MEDI CAL EQUI P-RENTED	174, 299 0	10, 951	10	27, 733 0		
	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	0	L0	101.00
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	1, 136, 296	110, 375	99	123, 884		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	174, 335, 356	15, 019, 932	13, 730	19, 842, 471	297, 610	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	32, 586, 351	3, 203, 289	2, 877	6, 327, 145	54, 140	
				0	74 570		1102 01
192.01	19201 FP PETERSBURG 19202 PEDI ATRI CS	353, 681 1, 944, 766	0	0	74, 578 397, 781		192. 01 192. 02

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2019 To 12/31/2019		pared: D pm
		CAPI TAL REL	LATED 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	
194.00 07950 COMMUNI TY HEALTH SERVICES	12, 652	70, 489	e	3 0	3, 322	194.00
194.0207952 MARKETING AND PUBLIC RELATIONS	518, 528	52, 450	4	7 50, 099	830	194. 02
194.0307953 MH RESIDENTIAL	471, 428	563, 131	50	6 121, 472	0	194.03
194.0407954UNUSED SPACE	0	3, 221, 106	2, 89	3 0	0	194.04
194. 05 07955 MOB	35, 278	665, 529	59	8 0	0	194.05
194. 06 07956 FOUNDATI ON	0	12, 953	1	2 0	332	194.06
194.0707957KNOX COUNTY HEALTH DEPT	0	130, 971	11	8 0	0	194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08
194.0907959COMMUNITY MENTAL HEALTH CENTER	5, 912, 855	1, 017, 945	91	4 1, 465, 322	0	194.09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	217, 621, 676	23, 957, 795	21, 75	28, 613, 651	359, 556	202.00

COST A	Financial Systems LLOCATION - GENERAL SERVICE COSTS	GOOD SAMARITA	Provider CCN		riod: om 01/01/2019	u of Form CMS-2 Worksheet B Part I Date/Time Prep 7/10/2020 2:50	pared:
	Cost Center Description	PURCHASING & RECEIVING	REGI STRATI ON	PATI ENT ACCOUNTS	Subtotal	ADMI NI STRATI VE & GENERAL	
		4.02	4.03	4.04	4A. 04	5.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-BLOG & FIXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401 COMMUNI CATI ONS						4.01
4. 02	00402 PURCHASI NG & RECEI VI NG	1, 152, 174					4. 02
4.03	00403 REGI STRATI ON	627	1, 793, 173				4.03
4.04		562	0	4, 269, 750	20 22/ 227	20 22/ 227	4.04
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	20, 740 7, 326	0	0	20, 326, 337 10, 197, 372	20, 326, 337 1, 050, 584	5.00
3.00	00800 LAUNDRY & LINEN SERVICE	4, 128	0	0	485, 478	50, 016	
9.00	00900 HOUSEKEEPI NG	10, 113	0	0	2, 964, 797	305, 448	
10.00	01000 DI ETARY	75, 738	0	0	1, 034, 131	106, 541	10.00
11.00	01100 CAFETERI A	0	0	0	1, 761, 968	181, 527	11.00
	01300 NURSING ADMINISTRATION	448	0	0	2, 222, 230	228, 945	
14.00	01400 CENTRAL SERVICES & SUPPLY	4,766	0	0	697, 270	71,836	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	3, 007 267	0	0	4, 130, 089 3, 829, 710	425, 502 394, 556	
	01700 SOCIAL SERVICE	0	0	0	3, 029, 710	394, 550	17.00
	01701 MENTAL HEALTH OH	68	0	0	951, 867	98, 066	
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	365, 470	37, 653	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	520	0	0	1, 591, 475	163, 962	22.00
23.00	02300 PARAMED ED PRGM-RADI OLOGY	2	0	0	134, 311	13, 837	
23. 01	02301 PARAMED ED PRGM-LAB	205	0	0	289, 440	29, 820	23.01
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	21, 652	85, 363	203, 250	8, 490, 983	874, 784	30.00
30.00 31.00	03100 INTENSIVE CARE UNIT	15, 125	47, 417	112, 901	5, 584, 286	575, 321	31.00
10.00	04000 SUBPROVI DER – I PF	1,065	22, 827	54, 351	2, 659, 784	274, 024	
41.00	04100 SUBPROVI DER – I RF	3, 839	20, 792	49, 506	2, 828, 904	291, 448	
43.00	04300 NURSERY	844	3, 292	7, 838	357, 308	36, 812	43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00 51.00	05000 OPERATING ROOM	30, 554	120, 902	287, 871	5, 047, 132	519, 981	50.00 51.00
51.00 51.01	05100 RECOVERY ROOM 05101 ENDOSCOPY	28, 616	30, 447	72, 496	2, 382, 426	0 245, 449	
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 547	13, 588	32, 353	1, 311, 824	135, 151	52.00
53.00	05300 ANESTHESI OLOGY	0	0	02,000	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	11, 561	255, 987	609, 677	8, 318, 063	856, 968	
55.00	05500 RADI OLOGY-THERAPEUTI C	4, 184	66, 175	157, 565	3, 387, 898	349, 038	55.00
50.00	06000 LABORATORY	134, 682	191, 307	455, 506	8, 340, 729	859, 304	60.00
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
55.00 56.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 594 1, 691	38, 848	92, 498	3, 050, 628	314, 291 580, 270	65.00 66.00
	06900 ELECTROCARDI OLOGY	5, 886	68, 587 108, 420	163, 307 258, 150	5, 632, 326 4, 856, 954	500, 270	
	07000 ELECTROENCEPHALOGRAPHY	0	0	230, 130	4,000,704		70.00
	07001 NEURODI AGNOSTI CS	1, 134	15, 530	36, 977	983, 521	101, 327	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	235, 827	13, 355	31, 798	4, 539, 018	467, 632	
	07200 IMPL. DEV. CHARGED TO PATIENTS	321, 449	34, 981	83, 290	6, 318, 937	651, 008	
	07300 DRUGS CHARGED TO PATIENTS	0	236, 334	562, 716	18, 035, 143	1, 858, 071	
	07500 ASC (NON-DI STI NCT PART) 03950 MH ANCI LLARY OUTPATI ENT	19, 399	64, 946	154, 638	2, 400, 017	247, 262 0	75.00
	03951 INPATIENT DIALYSIS	109	3, 923	9, 342	703, 944	72, 524	
0.01	OUTPATIENT SERVICE COST CENTERS	107	0,720	7,012	700, 711	72,021	1 / 0. 0
90.00	09000 CLI NI C	92	454	1, 081	236, 567	24, 372	90.00
	04950 WOUND CLINIC	5, 859		47, 229	1, 309, 298	134, 890	
	09100 EMERGENCY	16, 445	142, 835	340, 094	6, 423, 391	661, 770	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
04 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	1,247	1, 301	3, 097	218, 638	22, 525	04 00
	10100 HOME HEALTH AGENCY	1, 247	1, 301	3, 097	210,030		101.00
	SPECIAL PURPOSE COST CENTERS	0	ч	0	Ÿ	0	
	11300 I NTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	1, 094	9, 238	21, 997	1, 406, 803	144, 936	116.00
118.00		999, 012	1, 616, 685	3, 849, 528	155, 806, 467	13, 957, 839	118.00
100 - ·	NONREI MBURSABLE COST CENTERS	1					100 -
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	120,009	154,060	366, 820	42, 814, 691	4, 410, 969	
192.00	19201 FP PETERSBURG	1, 350 20, 527	1, 734 10, 813	4, 129 25, 747	435, 472 2, 402, 956	44, 865 247, 565	
192.00 192.01	19202 PEDIATRICS	20, 327	10,013				
192.00 192.01 192.02	19202 PEDIATRICS 19203 WASHINGTON PRIMARY CARE		סאג א	10 07/1	1 821 720	187 6821	1197 11.
192.00 192.01 192.02 192.03	19203 WASHINGTON PRIMARY CARE	7, 793	8, 389 0	19, 974 0	1, 821, 720 86, 630	187, 683 8, 925	
192.00 192.01 192.02 192.03 194.00					1, 821, 720 86, 630 622, 063		194.00
192.00 192.01 192.02 192.03 194.00 194.02 194.03	19203 WASHINGTON PRIMARY CARE 07950 COMMUNITY HEALTH SERVICES	7, 793 104	0 0		86, 630	8, 925	194. 00 194. 02 194. 03

Health Finar	Health Financial Systems         GOOD SAMARITAN HOSPITAL         In Lieu						2552-10
COST ALLOCA	TION - GENERAL SERVICE COSTS	Provider CCN: 15-0042			Period: From 01/01/2019	Worksheet B	
		_			To 12/31/2019		
	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	
194.0607956	FOUNDATION	0	0		0 13, 297	1, 370	194.06
194.0707957	KNOX COUNTY HEALTH DEPT	0	0		0 131, 089	13, 505	194.07
194.0807958	INDUSTRIAL HEALTH	0	0		0 0	0	194.08
194.0907959	COMMUNITY MENTAL HEALTH CENTER	2, 127	0		0 8, 399, 163	865, 324	194.09
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers	0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1, 152, 174	1, 793, 173	4, 269, 75	0 217, 621, 676	20, 326, 337	202.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	GOOD SAMARITA	AN HOSPITAL Provider CC	F	In Lie Period: From 01/01/2019 To 12/31/2019		pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7/10/2020 2:5 CAFETERI A	0 pm
	cost center bescription	PLANT	LINEN SERVICE				
		7.00	8.00	9.00	10.00	11.00	
1.00	GENERAL SERVICE COST CENTERS 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 4.03	00402 PURCHASI NG & RECEI VI NG 00403 REGI STRATI ON						4.02
4.03	00404 PATIENT ACCOUNTS						4.03
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	11, 247, 956					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	88, 537					8.00
9.00	00900 HOUSEKEEPING	123, 340		3, 435, 204			9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0 210, 482	11, 008 0	89, 515 21, 278		2, 175, 255	10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	144, 424		21, 2, 0		29, 976	
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 513		37, 755	i 0	22, 834	
15.00	01500 PHARMACY	104,056		29, 739		72, 676	
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	79, 307	0	26, 523 0		104, 986 0	1
17.00	01701 MENTAL HEALTH OH	57, 870	Ŭ	91, 989	-	16, 832	1
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	67,286		C		0	
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	52, 699	0	12, 075	22.00
23.00	02300 PARAMED ED PRGM-RADI OLOGY	0	0	C	-	2, 902	
23.01	02301 PARAMED ED PRGM-LAB	0	0	C	0 0	6, 863	23.01
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1, 174, 339	199, 470	845, 269	568, 427	188, 828	30.00
31.00	03100 I NTENSI VE CARE UNI T	449, 530		273, 641		123, 387	1
40.00	04000 SUBPROVI DER – I PF	219, 141	0	C	167, 051	67, 247	
41.00	04100 SUBPROVIDER - IRF	289,066		148, 449		70, 218	
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	1, 446	9, 253	0	8, 050	43.00
50.00	05000 OPERATING ROOM	317, 850	22, 787	190, 757	0	76, 127	50.00
51.00	05100 RECOVERY ROOM	0	0	C		0	
51.01	05101 ENDOSCOPY	205, 741	18, 158	50, 522		31, 317	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	7, 682	12, 222		28, 352	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 554, 796	0 43, 051	C 163, 986	-	0 115, 941	
54.00 55.00	05500 RADI OLOGY-THERAPEUTI C	129, 410		103, 980		53, 313	
60.00	06000 LABORATORY	121, 693		47, 801	0	105, 209	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	-	0	
65.00		95, 481	122	36, 271		64, 680	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	370, 895 305, 677		91, 395 141, 967		117, 929 96, 742	66.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	-		70.00
70.01	07001 NEURODI AGNOSTI CS	128, 535	8, 836	36, 815	i 0		70.01
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0			0	
	07500 ASC (NON-DI STINCT PART)	0	22, 257	148, 300	, i		75.00
76.00	03950 MH ANCI LLARY OUTPATI ENT	0	0	C	0	0	1
76.01	03951 I NPATI ENT DI ALYSI S	144, 289	0	C	0 0	0	76.01
90.00		44.957	204	EE 172		1 112	
90.00 90.01	09000 CLINIC 04950 WOUND CLINIC	44, 857 48, 455				4, 113 12, 112	
91.00	09100 EMERGENCY	291, 588				135, 771	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
o (   o o	OTHER REIMBURSABLE COST CENTERS	( ( ) )				0.705	
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	6, 624 0		C			96.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	0	<u> </u>		/0	0	101.00
113.00	11300 INTEREST EXPENSE						113.00
	11600 HOSPI CE	66, 764		46, 811			116.00
118.00		5, 841, 546	604, 082	2, 887, 676	1, 241, 195	1, 646, 348	118.00
	NONREI MBURSABLE COST CENTERS	0	0	C		0	190.00
190 00		-	19, 949	523, 430	-	421, 975	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	1, 937, 632	17,7471				
192.00 192.01	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 FP PETERSBURG	1,937,632 0	0	C	0		192. 01
192.00 192.01 192.02	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 FP PETERSBURG 19202 PEDI ATRI CS	1, 937, 632 0 0	0	C	0 0	31, 281	192. 02
192.00 192.01 192.02 192.03	19200 PHYSI CLANS' PRI VATE OFFICES 19201 FP PETERSBURG 19202 PEDI ATRI CS 19203 WASHI NGTON PRI MARY CARE	0 0 0	0 0 0	C C C		31, 281 32, 845	192. 02 192. 03
192.00 192.01 192.02 192.03 194.00	19200 PHYSI CLANS' PRI VATE OFFICES 19201 FP PETERSBURG 19202 PEDI ATRI CS 19203 WASHI NGTON PRI MARY CARE 07950 COMMUNI TY HEALTH SERVI CES	0 0 42,638	0 0 0	C C C 16, 676		31, 281 32, 845 0	192. 02 192. 03 194. 00
192.00 192.01 192.02 192.03 194.00 194.02	19200 PHYSI CLANS' PRI VATE OFFICES 19201 FP PETERSBURG 19202 PEDI ATRI CS 19203 WASHI NGTON PRI MARY CARE	0 0 0	0 0 0 0	C C C	0	31, 281 32, 845 0 6, 972	192. 02 192. 03
192.00 192.01 192.02 192.03 194.00 194.02 194.03 194.04	19200 PHYSICIANS' PRIVATE OFFICES 19201 FP PETERSBURG 19202 PEDIATRICS 19203 WASHINGTON PRIMARY CARE 07950 COMMUNITY HEALTH SERVICES 07952 MARKETING AND PUBLIC RELATIONS	0 0 42, 638 31, 726	0 0 0 0 0 0	C C 16, 676 2, 969		31, 281 32, 845 0 6, 972 26, 252 0	192. 02 192. 03 194. 00 194. 02

Health Finar	ncial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCA	TION - GENERAL SERVICE COSTS		Provider CO		Peri od:	Worksheet B		
					From 01/01/2019 To 12/31/2019		pared: 0 pm	
	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		
194.0607956	FOUNDATI ON	7,835	0		0 0	0	194.06	
194.0707957	KNOX COUNTY HEALTH DEPT	79, 223	0		0 0	0	194.07	
194.0807958	INDUSTRIAL HEALTH	0	0		0 0	0	194.08	
194.0907959	COMMUNITY MENTAL HEALTH CENTER	615, 743	0	4, 45	53 0	0	194.09	
200.00	Cross Foot Adjustments						200.00	
201.00	Negative Cost Centers	0	0		0 0	0	201.00	
202.00	TOTAL (sum lines 118 through 201)	11, 247, 956	624, 031	3, 435, 20	1, 241, 195	2, 175, 255	202.00	

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	GOOD SAMARITA	N HOSPITAL Provider CC	N: 15_0042	In Lie Period:	u of Form CMS- Worksheet B	2552-10
CUST	LLUCATION - GENERAL SERVICE COSTS				From 01/01/2019	Part I	norod.
					To 12/31/2019	7/10/2020 2:5	jo pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS	1					1
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401 COMMUNI CATI ONS						4.01
4.02	00402 PURCHASI NG & RECEI VI NG						4.02
4.03 4.04	00403 REGISTRATION 00404 PATIENT ACCOUNTS						4.03
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 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	2, 625, 575					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	839, 321		_		14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	2, 455 218	4, 764, 51	7 0 4, 435, 300		15.00
17.00	01700 SOCIAL SERVICE	0	210		0 4, 433, 300	0	
17.01	01701 MENTAL HEALTH OH	0	56		0 0	0	17.01
21.00	02100 I & R SERVI CES-SALARY & FRI NGES APPRVD	0	0		0 0	0	
22.00 23.00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM-RADI OLOGY	35, 822 0	425 2		0 0 0 0	0	
23.00	02301 PARAMED ED PRGM-RADIOLOGI	0	2 167		0 0	0	
20.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		107		<u> </u>		20101
30.00	03000 ADULTS & PEDIATRICS	560, 162	17, 682	2, 46		0	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	366,031	12, 352 869	1, 91 24		0	
40.00	04000 SUBPROVIDER - TPF	198, 387 208, 303	3, 135	24 1, 06		0	
43.00	04300 NURSERY	23, 880	689	7		0	
	ANCI LLARY SERVI CE COST CENTERS	1					
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	173, 172	24, 953 0	6, 75	3   131, 028 0    0	0	
51.00	05101 ENDOSCOPY	92, 904	23, 370	71		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	84, 106	2, 896	31		0	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	34, 743 98, 281	9, 442 3, 417	44, 52 65		0	54.00 55.00
60.00	06000 LABORATORY	90, 201	109, 990	59		0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	1
65.00	06500 RESPI RATORY THERAPY	0	3, 752	59		0	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	117, 945	1, 381 4, 807	88		0	
70.00	07000 ELECTROCARDI OLOGI	0	4, 807	17, 96	0 0	0	
70.01	07001 NEURODI AGNOSTI CS	7, 773	926		7 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	192, 592		0 0	0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	262, 530 0	4, 194, 02	0 0	0	
75.00	07500 ASC (NON-DI STINCT PART)	128, 744	15, 843	4, 194, 02		0	
76.00	03950 MH ANCI LLARY OUTPATI ENT	0	0		0 0	0	
76.01	03951 I NPATI ENT DI ALYSI S	0	89	1, 32	7 0	0	76.01
90.00	OUTPATIENT SERVICE COST CENTERS		75			0	90.00
90.00 90.01	04950 WOUND CLINIC	10, 535	4, 785	4, 62	9 196, 542	0	
91.00	09100 EMERGENCY	402, 767	13, 431	3, 98		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
o (   o o	OTHER REIMBURSABLE COST CENTERS		4 040				
	09600 DURABLE MEDICAL EQUIP-RENTED	0	1, 018 0		0 0 0 0		96.00 101.00
101.00	SPECIAL PURPOSE COST CENTERS	9			<u> </u>		101.00
	11300 INTEREST EXPENSE						113.00
		46, 928	893	11			116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 590, 483	714, 240	4, 293, 06	8 4, 435, 300	0	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	35, 092	98, 008	356, 23	7 0	0	192.00
	19201 FP PETERSBURG	0	1, 102	4, 95			192.01
	2 19202 PEDIATRICS 3 19203 WASHINGTON PRIMARY CARE	0	16, 763	81, 92			192.02 192.03
	07950 COMMUNITY HEALTH SERVICES	0	6, 364 85	28, 26	0 0		192.03
	07952 MARKETING AND PUBLIC RELATIONS	0	89		0 0	0	194.02
	07953 MH RESIDENTIAL	0	933	7			194.03
194.04	07954 UNUSED SPACE	0	0		0 0	0	194.04

Health Financial Systems		In Lieu of Form CMS-2552-10				
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0042	Period:	Worksheet B Part I	
				From 01/01/2019 To 12/31/2019		oared:
					7/10/2020 2:50	
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	
194. 05 07955 MOB	0	0		0 0	0	194.05
194. 06 07956 FOUNDATI ON	0	0		0 0	0	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0 0	0	194.07
194.0807958 INDUSTRIAL HEALTH	0	0		0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	1, 737		0 0	0	194.09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	2, 625, 575	839, 321	4, 764, 51	4, 435, 300	0	202. 00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	GOOD SAMARITA	AN HOSPITAL Provider CC		In Lieu eriod: rom 01/01/2019	u of Form CMS-: Worksheet B Part I	2552-10
				Te		Date/Time Pre 7/10/2020 2:5	pared: 0 pm
			INTERNS &	RESI DENTS		771072020 2.0	
	Cost Center Description	MENTAL HEALTH	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	PARAMED ED	
		0H 17.01	Y & FRI NGES 21.00	PRGM COSTS 22.00	PRGM-RADI OLOGY 23.00	PRGM-LAB 23.01	
	GENERAL SERVICE COST CENTERS		211.00	22.00	20100	20101	
1.00 2.00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01 4.02	00401 COMMUNI CATI ONS 00402 PURCHASI NG & RECEI VI NG						4.01 4.02
4.02	00403 REGI STRATI ON						4.02
4.04 5.00	00404 PATI ENT ACCOUNTS 00500 ADMI NI STRATI VE & GENERAL						4.04 5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERIA						11.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.00 14.00
15.00	01500 PHARMACY						15.00
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE						16.00 17.00
17.01	01701 MENTAL HEALTH OH	1, 227, 830					17.01
21. 00 22. 00	02100 I & R SERVICES-SALARY & FRINGES APPRVD 02200 I & R SERVICES-OTHER PRGM COSTS APPRVD	0	470, 409	1, 856, 458			21.00 22.00
22.00	02200 PARAMED ED PRGM-RADIOLOGY	0		1, 830, 438	151, 052		22.00
23.01	02301 PARAMED ED PRGM-LAB	0				326, 290	23. 01
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	0	0	0	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	0	0	0	31.00
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	615, 389 0	235, 205 0	928, 229 0	0	0	40.00
43.00	04300 NURSERY	0	0	0	0	0	
50, 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
51. 01 52. 00	05101 ENDOSCOPY 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	51.01 52.00
52.00 53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	151, 052	0	54.00
55.00 60.00	05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY	0	0	0	0	0 326, 290	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	0	0	0	65.00 66.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS	0	0	0	0	0	70.00 70.01
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0	0	0	0	71.00
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72.00 73.00
	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	75.00
76. 00 76. 01	03950 MH ANCI LLARY OUTPATI ENT 03951 I NPATI ENT DI ALYSI S	0	0	0	0	0 0	76. 00 76. 01
76.01	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76.01
		0	0	0	0	0	90.00
	04950 WOUND CLINIC 09100 EMERGENCY	0	0 19, 813	0 78, 193	0	0	90. 01 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
96.00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
113.00	SPECIAL PURPOSE COST CENTERS						113.00
116.00	11600 HOSPI CE	0	055 010	1 007 100	0		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	615, 389	255, 018	1, 006, 422	151, 052	326, 290	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 19201 FP PETERSBURG	0	215, 391 0	850, 036 0	0		192. 00 192. 01
192.02	19202 PEDI ATRI CS	0	0	0	0 0	0	192. 02
	19203 WASHINGTON PRIMARY CARE 07950 COMMUNITY HEALTH SERVICES	0	0	0	0		192. 03 194. 00
194.02	07952 MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	194. 02
194.03	07953 MH RESIDENTIAL	0	0	0	0	0	194.03

Health Financial Systems	GOOD SAMARITAN HOSPITAL				In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2019	Worksheet B Part I		
				To 12/31/2019	Date/Time Pre		
					7/10/2020 2:5	<u>Opm</u>	
		INTERNS &	RESI DENTS				
Cost Center Description	MENTAL HEALTH	SERVI CES-SALAR	SERVI CES-OTHE	R PARAMED ED	PARAMED ED		
	OH	Y & FRINGES	PRGM COSTS	PRGM-RADI OLOGY	PRGM-LAB		
	17.01	21.00	22.00	23.00	23.01		
194. 04 07954 UNUSED SPACE	0	0		0 0	0	194.04	
194. 05 07955 MOB	0	0		0 0	0	194.05	
194. 06 07956 FOUNDATI ON	0	0		0 0	0	194.06	
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0 0	0	194.07	
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08	
194.0907959 COMMUNITY MENTAL HEALTH CENTER	612, 441	0		0 0	0	194.09	
200.00 Cross Foot Adjustments		0		0 0	0	200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00 TOTAL (sum lines 118 through 201)	1, 227, 830	470, 409	1, 856, 45	8 151, 052	326, 290	202.00	

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS	GOOD SAMARITA	AN HOSPITAL Provider CCI		<u>In Lie</u> Period: From 01/01/2019	worksheet B Part I
				To 12/31/2019	
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments		_	
GENERAL SERVI CE COST CENTERS	24.00	25.00	26.00		
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
4. 01 00401 COMMUNI CATI ONS 4. 02 00402 PURCHASI NG & RECEI VI NG					4.01
4. 03 00403 REGI STRATI ON					4.03
4. 04 00404 PATIENT ACCOUNTS					4.04
5. 00 00500 ADMINI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE					7.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERIA					11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY					13.00
15. 00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00 01700 SOCIAL SERVICE					17.00
17.01 01701 MENTAL HEALTH OH 21.00 02100 I&R SERVICES-SALARY & FRINGES APPR	2VD				17.01 21.00
22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPR					22.00
23.00 02300 PARAMED ED PRGM-RADI OLOGY					23.00
23. 01 02301 PARAMED ED PRGM-LAB					23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	14, 265, 451	0	14, 265, 45	1	30.00
31. 00 03100 I NTENSI VE CARE UNI T	7, 863, 008		7, 863, 00		31.00
40. 00 04000 SUBPROVIDER - IPF	5, 856, 929		5, 856, 92	9	40.00
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	4, 428, 427 509, 579	0	4, 428, 42 <sup>°</sup> 509, 57°		41.00 43.00
ANCI LLARY SERVICE COST CENTERS	509, 579	U	509, 57	7	43.00
50. 00 05000 OPERATI NG ROOM	6, 510, 540	0	6, 510, 54	C	50.00
51.00 05100 RECOVERY ROOM	0	0		2	51.00
51. 01 05101 ENDOSCOPY 52. 00 05200 DELIVERY ROOM & LABOR ROOM	3, 050, 597 1, 582, 545	0	3, 050, 59 1, 582, 54		51. 01 52. 00
53. 00 05300 ANESTHESI OLOGY	0	0			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 292, 564	0	10, 292, 56		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 022, 008	0	4, 022, 00		55.00
60. 00 06000 LABORATORY 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	9, 911, 606 0	0	9, 911, 60		60. 00 63. 00
65. 00 06500 RESPI RATORY THERAPY	3, 565, 824	0	3, 565, 82		65.00
66. 00 06600 PHYSI CAL THERAPY	6, 921, 418		6, 921, 41		66.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	5, 937, 543	0	5, 937, 54	3	69.00
70.00         07000         ELECTROENCEPHALOGRAPHY           70.01         07001         NEURODI AGNOSTI CS	0 1, 282, 685	0	1, 282, 68	-	70.00 70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN		0	5, 199, 24		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	7, 232, 475		7, 232, 47		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 75. 00 07500 ASC (NON-DISTINCT PART)	24, 087, 242 3, 887, 387	0	24, 087, 24 3, 887, 38		73.00 75.00
76. 00 03950 MH ANCI LLARY OUTPATI ENT	3,007,307	0			76.00
76. 01 03951 I NPATI ENT DI ALYSI S	922, 173	0	922, 17	3	76. 01
	2/5 2/2	0	245 24	2	00.00
90. 00 09000 CLINIC 90. 01 04950 WOUND CLINIC	365, 363 1, 749, 458		365, 365 1, 749, 45		90.00 90.01
91. 00 09100 EMERGENCY	9, 200, 041	0	9, 200, 04		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	PT)	0			92.00
OTHER         REIMBURSABLE         COST         CENTERS           96.00         09600         DURABLE         MEDI CAL         EQUI P-RENTED	252, 510	0	252, 51		96.00
101.00 10100 HOME HEALTH AGENCY	252, 510				101.00
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE	1 700 670		4 700 67		113.00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through	1, 729, 070 117) 140, 625, 685		1, 729, 070 140, 625, 68		116. 00 118. 00
NONREI MBURSABLE COST CENTERS	140, 025, 065	U0	170, 020, 00	<u> </u>	113.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEE		0		D	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	51, 683, 410	0	51, 683, 410		192.00
192. 01 19201 FP PETERSBURG 192. 02 19202 PEDI ATRI CS	495, 971 2, 780, 491	0	495, 97 2, 780, 49		192. 01 192. 02
192. 03 19203 WASHI NGTON PRI MARY CARE	2, 780, 491	, i i i i i i i i i i i i i i i i i i i	2, 076, 87		192. 02
194.00 07950 COMMUNI TY HEALTH SERVICES	154, 954	0	154, 95	4	194.00
194.0207952 MARKETING AND PUBLIC RELATIONS	727,907	0	727,90	7	194.02

Health Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part I Date/Time Prepared: 7/10/2020 2:50 pm		
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total				
	24.00	25.00	26.00				
194. 03 07953 MH RESI DENTI AL	1, 650, 405	0	1, 650, 4	)5	194.03		
194.04 07954 UNUSED SPACE	5, 504, 561	0	5, 504, 5	51	194.04		
194.0507955 MOB	1, 176, 238	0	1, 176, 2	38	194.05		
194. 06 07956 FOUNDATI ON	22, 502	0	22, 5	)2	194.06		
194.0707957 KNOX COUNTY HEALTH DEPT	223, 817	0	223, 8	17	194.07		
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0	194.08		
194.0907959 COMMUNITY MENTAL HEALTH CENTER	10, 498, 861	0	10, 498, 8	51	194.09		
200.00 Cross Foot Adjustments	0	0		0	200.00		
201.00 Negative Cost Centers	0	0		0	201.00		
202.00 TOTAL (sum lines 118 through 201)	217, 621, 676	0	217, 621, 6	76	202.00		

	Financial Systems TION OF CAPITAL RELATED COSTS	GOOD SAMARITA	AN HOSPITAL Provider CC		riod: om 01/01/2019	u of Form CMS-: Worksheet B Part II Date/Time Pre 7/10/2020 2:5	pared:
			CAPI TAL REL	ATED COSTS		//10/2020 2.5	
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	1					
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	124, 967	110	125, 077	125, 077	4.00
4.01	00401 COMMUNICATIONS	0	0	0	0	343	•
4.02	00402 PURCHASI NG & RECEI VI NG	0	431, 966	377	432, 343	766	
4.03 4.04	00403 REGISTRATION 00404 PATIENT ACCOUNTS	0	0	0	0	1, 690 2, 879	4.03 4.04
5.00	00500 ADMI NI STRATI VE & GENERAL	0	1, 172, 069	1, 140	1, 173, 209	10, 264	5.00
7.00	00700 OPERATION OF PLANT	0	3, 633, 696	3, 432	3, 637, 128	2, 766	
8.00	00800 LAUNDRY & LINEN SERVICE	0	146, 370	131	146, 501	258	•
9.00	00900 HOUSEKEEPI NG	0	203, 906	183	204, 089	2, 458	•
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	347, 969	0 312	348, 281	545 1, 435	•
13.00	01300 NURSI NG ADMI NI STRATI ON	0	238, 761	214	238, 975	1, 670	•
14.00	01400 CENTRAL SERVICES & SUPPLY	0	2, 502	2	2, 504	455	•
15.00	01500 PHARMACY	0	172, 025		172, 179	3, 498	•
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	131, 110	118 0	131, 228	3, 071 0	
17.00	01701 MENTAL HEALTH OH	0	95, 671	86	95, 757	620	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	111, 237	100	111, 337	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	1, 002	•
23. 00 23. 01	02300 PARAMED ED PRGM-RADI OLOGY 02301 PARAMED ED PRGM-LAB	0	0	0	0	137 283	23.00 23.01
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	U	203	23.01
30.00	03000 ADULTS & PEDIATRICS	0	1, 941, 414	1, 743	1, 943, 157	5, 497	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	743, 161	667	743, 828	4, 083	1
40.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	0	362, 283	325 429	362, 608	2,366	•
41.00 43.00	04300 NURSERY	0	477, 883 0	429	478, 312 0	2, 067 311	41.00 43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	0	525, 469	472	525, 941	3, 940	•
51.00 51.01	05100 RECOVERY ROOM 05101 ENDOSCOPY	0	0 340, 130	0 305	0 340, 435	0 1, 206	51.00 51.01
51.01	05200 DELIVERY ROOM & LABOR ROOM	0	340, 130	0	340, 435	1, 200	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	917, 187	824	918, 011	4, 510	•
55.00	05500 RADI OLOGY-THERAPEUTI C 06000 LABORATORY	0	213, 940 201, 182		214, 132	3, 089	•
60.00 63.00	06300 BLOOD STORING. PROCESSING & TRANS.	0	201, 182	181 0	201, 363 0	2, 830 0	•
65.00	06500 RESPI RATORY THERAPY	0	157, 849	142	157, 991	2, 704	
66.00	06600 PHYSI CAL THERAPY	0	613, 163	551	613, 714	4, 483	•
69.00 70.00		0	505, 345	454	505, 799	6, 565	•
70.00	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS	0	212, 495	191	212, 686	0 481	70.00 70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 75.00	07300 DRUGS CHARGED TO PATIENTS 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	1, 458 0	1
76.01	03951 I NPATI ENT DI ALYSI S	0	238, 539	214	238, 753	0	76.01
	OUTPATIENT SERVICE COST CENTERS			L			
90. 00 90. 01	09000 CLINIC 04950 WOUND CLINIC	0	74, 158 80, 106		74, 225 80, 178	151	90.00
90.01 91.00	09100 EMERGENCY	0	482, 053	433	482, 486	500 4, 597	90.01 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		,		0	.,	92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	10, 951	10	10, 961	121	•
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	110, 375		110, 474		116.00
118.00		0	15, 019, 932	13, 730	15, 033, 662	86, 762	118.00
190 00	NONREIMBURSABLE COST CENTERS	0	0	0	n	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFICES	0	3, 203, 289	2, 877	3, 206, 166		190.00
192.01	19201 FP PETERSBURG	0	0	0	0	326	192. 01
	19202 PEDIATRICS	0	0	0	0		192.02
	19203 WASHINGTON PRIMARY CARE 07950 COMMUNITY HEALTH SERVICES	0	0 70, 489	63	0 70, 552		192. 03 194. 00
		0	1 , 0, 107	1 00	, 5, 552	0	1.71.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS				Period: From 01/01/2019	Worksheet B Part II	
				To 12/31/2019		
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Di rectl y	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4.00	
194.0207952 MARKETING AND PUBLIC RELATIONS	0	52, 450	4	7 52, 497	219	194.02
194.0307953MH RESIDENTIAL	0	563, 131	50	6 563, 637	531	194.03
194.0407954UNUSED SPACE	0	3, 221, 106	2, 89	3 3, 223, 999	0	194.04
194. 05 07955 MOB	0	665, 529	59	8 666, 127	0	194.05
194. 06 07956 FOUNDATI ON	0	12, 953	1	2 12, 965	0	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	130, 971	11	8 131, 089	0	194.07
194.0807958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	1, 017, 945	91	4 1, 018, 859	6, 407	194.09
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	0	23, 957, 795	21, 75	8 23, 979, 553	125, 077	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	GOOD SAMARITA	N HOSPITAL Provider C		riod: om 01/01/2019	w of Form CMS- Worksheet B Part II Date/Time Pre	
	Cost Center Description	COMMUNI CATI ONS	PURCHASING &	REGI STRATI ON		Date/Time Pre 7/10/2020 2:5 ADMI NI STRATI VE	0 pm
		4.01	RECEI VI NG	4.02	ACCOUNTS	& GENERAL	
	GENERAL SERVICE COST CENTERS	4.01	4.02	4.03	4.04	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01 4.02	00401 COMMUNI CATI ONS 00402 PURCHASI NG & RECEI VI NG	343	433, 112				4. 01 4. 02
4.02	00403 REGI STRATI ON	6	236				4.02
4.04	00404 PATIENT ACCOUNTS	7	211		3, 097		4.04
5.00	00500 ADMI NI STRATI VE & GENERAL	25	7, 796		0	1, 191, 294	
7.00	00700 OPERATION OF PLANT	21	2, 754		0	61, 572	
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	1, 552 3, 801		0	2, 931 17, 901	
10.00	01000 DI ETARY	4	28, 470		0	6, 244	1
11.00	01100 CAFETERIA	0	0		0	10, 639	1
13.00	01300 NURSING ADMINISTRATION	3	168		0	13, 418	
14.00	01400 CENTRAL SERVICES & SUPPLY	1	1, 791	1 1	0	4, 210	
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	5	1, 130 100	1 1	0	24, 937 23, 124	
17.00	01700 SOCIAL SERVICE	0	00		0	23, 124	17.00
17.01	01701 MENTAL HEALTH OH	32	26		0	5, 747	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	C		0	2, 207	
22.00	02200 I & SERVI CES-OTHER PRGM COSTS APPRVD	4	196		0	9, 609	
23. 00 23. 01	02300 PARAMED ED PRGM-RADI OLOGY 02301 PARAMED ED PRGM-LAB	0	1 77		0	811 1, 748	1
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	0		0	U	1, 740	23.01
30.00	03000 ADULTS & PEDIATRICS	25	8, 139	94	157	51, 269	30.00
31.00	03100 INTENSIVE CARE UNIT	15	5, 686	1	87	33, 718	1
40.00	04000 SUBPROVIDER - IPF	0	400		42	16,060	1
41.00 43.00	04100 SUBPROVIDER - IRF 04300 NURSERY	11 0	1, 443 317	1	38 6	17, 081 2, 157	1
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	517	4	0	2,137	43.00
50.00	05000 OPERATI NG ROOM	23	11, 485	133	222	30, 475	50.00
51.00	05100 RECOVERY ROOM	0	C	-	0	0	51.00
51.01	05101 ENDOSCOPY	4	10, 757		56	14, 385	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	10 0	1, 333 0	1	25 0	7, 921 0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10	4, 346		272	50, 224	
55.00	05500 RADI OLOGY-THERAPEUTI C	6	1, 573		122	20, 456	1
60.00	06000 LABORATORY	5	50, 627		352	50, 361	
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	-	0	0	63.00
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	o 5	1, 727 636	1 1	71 126	18, 420 34, 008	
69.00	06900 ELECTROCARDI OLOGY	12	2, 212	1 1	199	29, 326	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C		0	0	
70.01	07001 NEURODI AGNOSTI CS	3	426	1	29	5, 938	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	88, 647 120, 845		25	27, 407 38, 154	
72.00 73.00	07300 DRUGS CHARGED TO PATIENTS	0	120, 843		64 435	108, 896	
75.00	07500 ASC (NON-DI STI NCT PART)	0	7, 292		119		
76.00	03950 MH ANCI LLARY OUTPATI ENT	0	0	0	0	0	76.00
76.01	03951 I NPATI ENT DI ALYSI S	0	41	4	7	4, 250	76.01
90.00	OUTPATI ENT SERVICE COST CENTERS	1	34	1	1	1, 428	90.00
90.01	04950 WOUND CLINIC	2	2, 202		36		
91.00	09100 EMERGENCY	16	6, 182	1	263		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
04 00	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	0	469	1	2	1 220	96.00
	10100 HOME HEALTH AGENCY	0	409		2		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
	11600 HOSPICE	4	411		17		116.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	283	375, 539	1, 737	2, 773	818, 027	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
	19200 PHYSICIANS' PRIVATE OFFICES	53	45, 111	1 1	283	258, 541	
	19201 FP PETERSBURG	0	507	1 1	3		192.01
	2 19202 PEDIATRICS 3 19203 WASHINGTON PRIMARY CARE	3	7, 716 2, 929		20 15	14, 509 11, 000	
	07950 COMMUNITY HEALTH SERVICES	2	2, 929 39	1 1	15		192.03
	207952 MARKETING AND PUBLIC RELATIONS	1	41		0		194.02
194.03	07953 MH RESIDENTIAL	0	430		3	7, 021	194. 03
	O7954 UNUSED SPACE	0	0		0		194.04
194.0	07955 MOB	0	0	0	0	4, 235	194.05

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provider CCN: 15-0042 Period:				Worksheet B	
				From 01/01/2019 To 12/31/2019		narod
				10 12/31/2019	7/10/2020 2:5	
Cost Center Description	COMMUNI CATI ONS	PURCHASING &	REGI STRATI ON	I PATI ENT	ADMI NI STRATI VE	
		RECEI VI NG		ACCOUNTS	& GENERAL	
	4.01	4.02	4.03	4.04	5.00	
194. 06 07956 FOUNDATI ON	0	0		0 0	80	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0 0	792	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	800		0 0	50, 714	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	343	433, 112	1, 93	3, 097	1, 191, 294	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	GOOD SAMARITA	AN HOSPITAL Provider CO		Peri od:	u of Form CMS-2 Worksheet B	2552-10
				F	rom 01/01/2019 o 12/31/2019	Part II Date/Time Pre	pared:
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	7/10/2020 2: 5 CAFETERI A	0 pm
		PLANT 7.00	LINEN SERVICE				
	GENERAL SERVICE COST CENTERS	7.00	8.00	9.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00 4.01	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00 4.01
4.01	00401 COMMUNI CATI ONS 00402 PURCHASI NG & RECEI VI NG						4.01
4.03	00403 REGI STRATI ON						4.03
4.04	00404 PATIENT ACCOUNTS						4.04
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	3, 704, 241	100,100				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	29, 158	180, 400	200,005			8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	40, 619 0	12, 031 3, 182	280, 905 7, 320			9.00 10.00
11.00	01100 CAFETERI A	69, 317	3, 102	1, 740		431, 412	
13.00	01300 NURSI NG ADMI NI STRATI ON	47, 562	0	(		5, 945	
14.00	01400 CENTRAL SERVICES & SUPPLY	498	2, 345	3, 087	0	4, 529	14.00
15.00	01500 PHARMACY	34, 268	0	2, 432		14, 414	
16.00	01600 MEDI CAL RECORDS & LI BRARY	26, 118	0	2, 169		20, 822	
17.00 17.01	01700 SOCIAL SERVICE 01701 MENTAL HEALTH OH	0 19, 058	0 3, 223	7 500	-	0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	22, 159	3, 223	7, 522		3, 338 0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	4, 309		2, 395	
23.00	02300 PARAMED ED PRGM-RADI OLOGY	0	0	C		576	
23. 01	02301 PARAMED ED PRGM-LAB	0	0		0 0	1, 361	23.01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	386, 740	57, 666			37, 450	
31.00 40.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	148, 042 72, 169	21, 835 0	22, 376		24, 471 13, 337	
41.00	04100 SUBPROVIDER - IRF	95, 197	10, 883	12, 139		13, 926	
43.00	04300 NURSERY	0	418	757		1, 597	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	104, 676	6, 587	15, 599		15, 098	
51.00	05100 RECOVERY ROOM	0	0	(		0	
51.01 52.00	05101 ENDOSCOPY 05200 DELIVERY ROOM & LABOR ROOM	67, 756 0	5, 249 2, 221	4, 131 999		6, 211 5, 623	
53.00	05300 ANESTHESI OLOGY	0	2, 221			5, 023	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	182, 709	12, 445	13, 410	-	22, 994	
55.00	05500 RADI OLOGY - THERAPEUTI C	42, 618	0	C		10, 573	
60.00	06000 LABORATORY	40, 076	0	3, 909	0	20, 866	60.00
63.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	)	-	0	
65.00		31, 444	35	2,966		12,828	
66.00 69.00	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	122, 145 100, 667	2, 427 3, 771	7, 474 11, 609		23, 389 19, 187	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	3,771	(		0	
70.01	07001 NEURODI AGNOSTI CS	42, 330	2, 554	3, 010	0		70.01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	10 10	0	0	
75.00 76.00	07500 ASC (NON-DISTINCT PART) 03950 MH ANCILLARY OUTPATIENT	0	6, 434	12, 127		8, 607 0	
76.01	03951 I NPATI ENT DI ALYSI S	47, 518	0			0	
/0/0/	OUTPATIENT SERVICE COST CENTERS						10.01
90.00	09000 CLI NI C	14, 773	60	4, 512	2 0	816	90.00
90.01	04950 WOUND CLINIC	15, 958		1, 436	0	2, 402	
91.00	09100 EMERGENCY	96, 027	18, 189	18, 152	0	26, 927	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
06 00	09600 DURABLE MEDICAL EQUIP-RENTED	2, 182	0	(	0	735	96.00
	10100 HOME HEALTH AGENCY	2,102					101.00
	SPECIAL PURPOSE COST CENTERS						101100
113.00	11300 INTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	21, 987		3, 828	0	3, 137	116.00
118.00		1, 923, 771	174, 633	236, 132	45, 765	326, 518	118.00
100 0	NONREI MBURSABLE COST CENTERS						100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6 420 112	U E 747	42.902	0		190.00
	19200 PHYSI CI ANS' PRI VATE OFFI CES 19201 FP PETERSBURG	638, 112 0	5, 767 0	42, 802		83, 686 1 900	192.00
	19202 PEDIATRI CS	n 0	0				192.01
	19203 WASHI NGTON PRI MARY CARE	0	0		o o		192.03
194.00	07950 COMMUNI TY HEALTH SERVI CES	14, 042	0	1, 364	0	0	194.00
	07952 MARKETING AND PUBLIC RELATIONS	10, 448		243			194. 02
	07953 MH RESIDENTIAL	112, 179		0	-		194.03
	07954 UNUSED SPACE 07955 MOB	641, 662		0	Ŭ		194. 04 194. 05
104 0		132, 577	. 0		0	0	IIYA ()F

Heal th Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B	
				From 01/01/2019 Fo 12/31/2019		pared: 0 pm
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE				
	7.00	8.00	9.00	10.00	11.00	
194. 06 07956 FOUNDATI ON	2, 580	0	(	0 0	0	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	26, 090	0	(	0 0	0	194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	(	0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	202, 780	0	364	4 0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	(	0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	3, 704, 241	180, 400	280, 90	5 45, 765	431, 412	202.00

ALLOCATION OF CAPITAL RELATED COSTS         Product Colt	Health Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-	2552-10
Instruction         NUESTING         PHARMAY         EXECUTE         DOCUMENT         DOCUMENT <thdocument< th=""></thdocument<>	ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0042			
Cost Center Description         NUMBERS NO. (2001) CS 2001         CENTURAL SCRUCES & 1000         PHARMACY         NEED CAL (2001) CS 2001         CENTURAL (2001) CS 2001         PHARMACY         NEED CAL (2001) CS 2001         CENTURAL (2001) CS 2001         PHARMACY         NEED CAL (2001) CS 2001         CENTURAL (2001) CS 2001         PHARMACY         NEED CAL (2001) CS 2001         PHARMACY						Date/Time Pre	
Supply         Supply         LIBBORY         Type         Type           1.00         00000/PARTL COST END 4. FLWT         33.00         15.00         10.00         20.00           0.00000/PARTL COST END 4. FLWT         2.00         2.00         2.00         2.00         2.00           0.00000/PARTL COST END 4. FLWT         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00         2.00	Cost Center Description			PHARMACY			
Design Service Cost Cost Cost Cost Cost Cost Cost Cost		ADMI NI STRATI ON					
1.00         DOTOD GAP KEL COSTS-BLUE & FLAT         2.00           2.00         DOTOD GAP KEL COSTS-BLUE E FAUP         2.00           4.00         DOTOD GAP REL COSTS-BLUE E FAUP         2.00           4.00         DOTOD GAP REL COSTS-BLUE E FAUP         2.00           4.00         DOTOD GAP REL TACCOUNT FERSION         4.01           4.00         DOTOD GAP REL TACCOUNT FERSION         5.00           7.00         DOTOD GAP REL TACCOUNT FERSION         5.00           9.00         DOTOD GAP REL TACCOUNT FERSION         5.00           9.00         DOTOD CAP REL STRATON         5.07           9.00         DOTOD REL AND STATON         5.07           9.00         DOTOD CAP REL STRATON         5.07           13.00         DITAD RESINCE AND STATON         5.07           13.00         DITAD RESINCE AND STATON         5.07           10.00         DITAD RESINCE AND STATON         0         1           10.00         DITAD RESINCE AND STATON         0         1         0           10.00         DITAD RESINCE AND STATON         0         1         0         0           10.00         DITAD RESINCE AND STATON         0         1         0         0         0         0         0     <		13.00		15.00		17.00	
2.00         000000         CAURAGEL COSTS-WORLE LOUP         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00         4.00 <t< td=""><td></td><td>     </td><td></td><td></td><td></td><td></td><td>1 1 00</td></t<>							1 1 00
4. 00         DOUDD (CAMARIN LATIONS)         4.00           4. 00         DOUDD (CAMARIN LA RECEIVING         4.00           4. 00         DOUDD (CAMARIN LA RECEIVING         4.00           4. 00         DOUDD (CAMARIN LA RECEIVING         4.00           4. 00         DOUDD (CAMARIN LA LINES)         4.00           6. 00         DOUDD (CAMARIN LA LINES)         6.00           7. 00         DOUDD (MIRST NG ANARINI STRATT IN         307, 741         10.40           10. 00         DITOG (MIRST NG ANARINI STRATT IN         307, 741         10.40           10. 00         DITOG MIRTAL ANARINI STRATT IN         307, 741         10.40           10. 00         DITOG MIRTAL ANARINI STRATT IN         307, 741         10.40           10. 00         DITOG MIRTAL ANARINA STRATT IN         307, 741         10.40           10. 00         DITOG MIRTAL ANARINA STRATT IN         307, 741         10.40           10.							
4 02         00000 PURCHAST NO.         4.02           4 03         000000 PRT EXT ACOUNTS         4.03           4 04         000000 PRT EXT ACOUNTS         4.03           5 00         000000 PRT EXT ACOUNTS         6           0 00000 PRT ACOUNTS         6           0 000000 PR	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						
4.02       00001 REGISTRATION       4.03         4.03       00001 ARMINISTRATION       4.04         5.00       00000 ARMINISTRATION       5.00         6.00       00000 ARMINISTRATION       5.00         9.00       00000 ARMINISTRATION       1.00         9.00       00000 INNEW A LIBINS AND CL       9.00         9.00       00000 INNEW A LIBINS AND CL       9.00         9.00       01000 CLARESCRE & SUPPLY       0.07,741         11.00       01100 CARTTER A       SUPPLY       0         10.01       01100 CRATTER AND							
4.04       00000       D0000       D0000       D1000       D10000       D1000       D10000       D10000       D1000       D10000       D10000							
7.00         00/200 DEPENT NO OF PLANT         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00         7.00							
8.00         CORROL LAURDAY & LINEN SERVICE         8.00         6.00         6.00         6.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70.00         70							
9.00 00000 PUISECREP NG 00000 PETAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
11.00       DO TINO CAFETERIA       11.00       11.00       DETRIA       11.00         12.00       DI TONO CAFETERIA       110.00       DETRIA       SERVICES & SUPPLY       0         13.00       DI TONO CRETTRA       SERVICES & SUPPLY       0       0       0         13.00       DI TONO CRETTRA       SERVICES & SUPPLY       0       0       0       0         17.00       DI TONO CRETTRA       SERVICES - SUPPLY       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
13.00       01300       NURSH MS ADMINI STRATION       307, 741       1       1         14.00       01400       PHARMAL-SPEN (CERTALL SFRU CERTARLL SFRU CES & SUPPLY)       0       1570       252, 220       206, 645       16.00         15.00       01500       PHARMACY       0       15       0       252, 220       206, 645       16.00         17.00       1700       DUCLAL SERVICE SALWY A FINCES APPRVD       0       0       0       0       0       22.00         21.00       C7010       RARMED ED PRACH ADRY A FINCES APPRVD       4.190       0       0       0       22.00       23.01         23.01       D3000       RARMED ED PRACH ADRY A FINCES APPRVD       4.190       0       0       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.01       0       23.0							
14.00       01400       CENTRAL SERVICES & SUPPLY       0       19.400       19.400       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       15.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14.00       14		307 741					
16. 00         01600         01600         01600         01600         01600         01600         01600         01600         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01         017.01			19, 420				
17.00       00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td>0</td> <td></td> <td>252, 92</td> <td></td> <td></td> <td></td>		0		252, 92			
17. 01       01701       IMENTAL HEALTH OH       0       1       0       0       17. 01       02100       188 SENICES-SALRY & FINGES APPRVD       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		0	5			C	
22 00         2200 (1AR SERVICES-OTHER PROX COSTS APPRVD (230) PARAMED ED PROX-LAB         4.199         10         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		0	1		0 0		
23.00       02300 PARAMED ED PRGU-LAB OLOGY       0       0       0       0       23.00         INVATI ENT ROUTINE SERVICE COST CENTERS       0       4       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td></td><td>-</td><td>0</td><td></td><td>0 0</td><td></td><td></td></t<>		-	0		0 0		
23.01         0         4         0         0         23.01           INPARTER TRUTT RESTINCE COST CENTERS         0.5,657         4007         131         62.573         0         30.00           01.00         03000 (DINESS) V CASE UNIT         42,902         28.6         101         7,326         0         31.00           01.00         04000 SUBPROVIDER - IPF         23,253         20         13         22,893         0         40.00           04300 AURIS REV         2,799         1.6         4         3,358         0         41.00           04300 AURIS REV         2,799         1.6         4         3,358         0         50.00           05000 OPERATING ROOM         20,297         577         358         6,105         0         50.00           05100 ISS00 ENCORY FOM         8 ADR ROOM         9,658         6,71         7         60         0         50.00           05300 ISS00 ENCORY FOM R LABOR ROOM         9,658         6,71         7         363         0         50.00         55.00           00         0         0         0         0         0         0         0         50.00         55.00           00         0.000 CONTRINC, PROCEN					-		
30.00         3000 ADULTS & PEDIATRICS         65,657         409         131         62,573         0         30.00           30.00         3000 INTENSIVE CARE UNIT         42,902         286         101         7,326         0         30.00           40.00         04000 SUBPROVIDER - IPF         23,253         20         13         22,893         0         40.00           41.00         04000 SUBPROVIDER - IPF         23,253         20         13         22,893         0         43.00           43.00         04300 NURSERY         2,799         16         4         3,358         0         43.00           44.100 KCOVERY ROOM         0         0         0         0         51.01         55.00         0         51.01         52.00         53.00         53.00         54.00         53.00         54.00         53.00         54.00         53.00         55.00         50.00         55.00         50.00         55.00         50.00         55.00         50.00         55.00         50.00         55.00         50.00         55.00         50.00         55.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00<							
31.00       03100   INTENSIVE CARE UNIT       42,902       266       101       7,324       0       31.00         41.00       04100 SUBPROVIDER - IPF       23,253       20       13       22,993       0       41.00         41.00       04100 SUBPROVIDER - IPF       23,253       20       13       22,993       0       43.00         43.00       04300 (PERATING ROM       20,297       577       558       6,106       50.00       51.00         51.00       05100 (PERATING ROM       20,297       577       588       6,106       51.00       51.00         52.00       05200 DELLVERY ROM & LABOR ROM       9,458       67       17       0       0       53.00       53.00       53.00       53.00       55.00       53.00       55.00       53.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       67.00       67.00       67.00       67.							
40.00         40000 SUBPROVIDER - IPF         23,253         20         13         22,893         0         0.00           41.00         41.00         41.00         41.00         41.00         41.00         41.00         41.00           43.00         43.00         43.00         43.00         43.00         43.00         43.00           43.00         00         0000         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         50.00         0         51.01         0         52.00         0         0         53.00         54.00         53.00         54.00         53.00         54.00         53.00         54.00         55.00         0         55.00         0         55.00         0         55.00         0         55.00         0         56.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         67.00         67.00         67.00         67.00							
43. 00         04300 NURSERY         2,799         16         4         3.358         0         43. 00           ANCLULARY SERVICE COST CENTES         50.00         05000 OPEATINC ROOM         20.297         577         358         6,105         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         51.00         52.00         52.00         52.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         53.00         55.00         53.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         50.00         55.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00							
ANCILLARY SERVICE COST CONTENS           0.00         OFFORT INC ROOM         20, 297         577         358         6, 105         0         55.00           51.00         OSTOD PERATINE ROOM         0         0         0         0         0         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         56.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0				Ę			
50.00         05000         0FERATING ROM         20,297         577         558         6,105         0         50.00           51.00         05100         0FECOVERY ROM         0         0         0         0         0         0         0         0         0         0         0         0         51.00         0         51.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		2, 799	16		4 3, 358	0	43.00
51.01       ENDOSCOPY       10,889       541       38       0       0       51.01         52.00       GS200       PRESTREST PLOGY       9,858       67       77       0       0       52.00         53.00       OS300       ANESTREST OLOGY       9,858       67       77       0       0       52.00         54.00       OS400       RADI OLOGY-THERAPEUTIC       4,072       218       2,363       0       55.00         60.00       06000       LABORATORY       0       2,445       31       0       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       66.00       67.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		20, 297	577	35	6, 105	C	50.00
52.00         05200         DELUREY         ROOM         9,858         67         17         0         0         52.00           53.00         05300         NESTHESIDLOGY         0         0         0         0         53.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         55.00         56.00         55.00         56.00         55.00         56.00         55.00         56.00         55.00         56.00         55.00         56.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         66.00         67.00         0         0         66.00         67.00         66.00         67.00         67.00         67.00         77.00         70.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00         77.00 <td></td> <td>-</td> <td>-</td> <td></td> <td></td> <td></td> <td></td>		-	-				
53.00         OS300         AMESTHESI OLOGY         O         O         O         O         S3.00           54.00         OS500         RADI OLOGY-THERAPUTI C         11,519         7.9         35         O         55.00           00.00         OB6000         LABORATORY         0         2,545         31         O         60.00           00         06000         LABORATORY         0         2,545         31         O         63.00           00         06500         RADI OLOGY-THERAPEUTI C         11,519         7.9         33         O         65.00           064000         LABORATORY         0         0         0         0         0         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00         65.00							
55.00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
60         00000         LABORATORY         0         2,545         31         0         60.00         63.00           63         06300         06000         LADORING,         PROCESSING & TRANS.         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>						-	
63:00         0c3:00         Decode RESPIRATORY THERAPY         0         0         0         63:00         0         65:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         66:00         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0							
66.00       0600       PHYSI CAL THERAPY       13,824       32       47       0       0       66.00         69.00       06900       LECETROENCEPHALOGRAPI V       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		-					
69:00       best of the second s		0					
70:00         COUDE         COUDE (ELECTROENCEPHALOGRAPHY         0         0         0         0         0         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00         70:00		13, 824					
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       4,455       0       0       71.00         72.00       07300       IMPL. DEV. CHARGED TO PATIENTS       0       6,075       0       0       72.00         73.00       07300       DRUS CHARGED TO PATIENTS       0       0       0222,637       0       0       73.00         75.00       03950       MH AKCILLARY OUTPATIENT       15,090       367       543       40,596       0       76.00         76.01       03951       INPATIENT DIALYSIS       0       2       70       0       76.01         0000       CUNTRATTENT SERVICE COST CENTERS       0       2       0       0       0       76.01         90.00       09000       CLINIC       1,235       111       246       9,157       90.01         91.00       09200       DERGENCY       47,208       311       211       41,207       91.00         92.00       09200       DURBLE MEDI CAL EQUIP-RENTED       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td></td><td>0</td><td></td><td></td><td></td><td></td><td></td></t<>		0					
72.00       07200       IMPL.       DEV. CHARGED TO PATIENTS       0       0       72.00       73.00       0       73.00       0       73.00       0       0       73.00       0       0       73.00       0       0       73.00       0       0       0       73.00       0       0       0       73.00       0       0       73.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0<		911			0 0		
73.00       07300       DRUGS CHARGED TO PATLENTS       0       0       222,637       0       0       73.00         75.00       0750.00       ASC (NON-DI STINCT PART)       15,090       367       543       40,596       0       75.00         76.00       03950       MH ANCILLARY OUTPATLENT       0       0       0       0       0       0       76.00         00.00       G0000       CLINIC       0       2       70       0       0       76.01         00.01       04950       WOUND CLINIC       0       2       0       0       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00       90.00 <t< td=""><td></td><td>0</td><td></td><td></td><td>0 0</td><td></td><td></td></t<>		0			0 0		
76.00       03950       NHA NCI LLARY OUTPATI ENT       0       0       0       0       0       76.00         0       03951       INPATI ENT DI ALYSI S       0       2       70       0       0       76.01         0UTPATI ENT SERVICE COST CENTERS       0       2       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		0		222, 63	37 O		
76. 01 OUTPATI ENT DIALYSIS         0         2         70         0         76. 01           0UTPATI ENT SERVICE COST CENTERS         0         2         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 </td <td></td> <td>15, 090</td> <td></td> <td>54</td> <td></td> <td></td> <td></td>		15, 090		54			
OUTPATI ENT SERVICE COST CENTERS           90.00         OPODO CLINIC         O         2         O         O         O         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0		0	0	-			
90. 01       04950       WOUND CLINIC       1,235       111       246       9,157       0       90. 01         91. 00       09100       EMERGENCY       47,208       311       211       41,207       0       91. 00         92. 00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0       0       0       92. 00         OTHER REIMBURSABLE COST CENTERS       0       0       0       0       0       96. 00         101. 00       HOME HEALTH AGENCY       0       0       0       0       0       101. 00         SPECIAL PURPOSE COST CENTERS       113.00       I1300       INTEREST EXPENSE       113. 00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       113.00       114.00       0       0       0       114.00       0       115.00       118.00       118.00       118.00       118.00       118.00       118.00       192.00       192.00       192.00       192.00       192.00       192.00       0       0       192.00       192.00       192.00       192.00	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	Z				
91.00       09100       EMERGENCY       47, 208       311       211       41, 207       0       91.00         92.00       09200       005SERVATI ON BEDS (NON-DI STI NCT PART)       92.00       92.00       92.00         0THER REI MBURSABLE COST CENTERS       96.00       0600       DURBALE MEDI CAL EQUI P-RENTED       0       24       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0		0	2		-	-	
92.00       OBSERVATI ON BEDS (NON-DI STI NCT PART)       92.00         OTHER REIMBURSABLE COST CENTERS       96.00       O9600 DURABLE MEDI CAL EQUI P-RENTED       0       24       0       0       0       10100         101.00       HOME HEALTH AGENCY       0       0       0       0       0       101.00         SPECIAL PURPOSE COST CENTERS       113.00       INTEREST EXPENSE       113.00       11300       INTEREST EXPENSE       113.00         116.00       SUBTOTALS (SUM OF LI NES 1 through 117)       303,628       16,527       227,894       206,645       118.00         118.00       SUBTOTALS (SUM OF LI NES 1 through 117)       303,628       16,527       227,894       206,645       118.00         190.00       GIFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       192.00       19200       PHYSI CI ANS' PRI VATE OFFICES       4,113       2,267       18,910       0       192.00         192.01       19200       FP PETERSBURG       0       25       263       0       192.00       192.02       192.02       192.02       192.02       192.02       192.03       192.03       0       0       192.02       192.02       192.03       192.02       192.03       0       0       192.02<							
OTHER         REI MBURSABLE         COST CENTERS           96. 00         OPG600         DURABLE         MEDI CAL         EQUIP-RENTED         0         24         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         113.00         113.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         114.00         1192.00         190.00         192.00         190.00         192.00         192.00		47,200	511	Z	41,207		
101.00         10100         HOME HEALTH AGENCY         0         0         0         0         0         0         0         0         101.00           SPECIAL PURPOSE COST CENTERS           113.00         11300         INTEREST EXPENSE         113.00         113.00         113.00           116.00         11600         HOSPI CE         5,500         21         6         0         0         116.00           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         303,628         16,527         227,894         206,645         0         118.00           NONREI MBURSABLE COST CENTERS           190.00         19000         GFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         190.00         192.00         192.00         192.01         192.01         192.01         192.01         FP ETERSBURG         0         25         263         0         192.01           192.02         19202         PEDIATRICS         4, 113         2, 267         18, 910         0         192.02           192.02         19202         PEDIATRICS         0         388         4, 349         0         0         192.02           192.03         19203         VASHI NG	OTHER REIMBURSABLE COST CENTERS	· · · · ·	1		_	-	
SPECIAL PURPOSE COST CENTERS           113.00         11300         INTEREST EXPENSE         113.00           116.00         105PI CE         5,500         21         6         0         0           118.00         SUBTOTALS (SUM OF LINES 1 through 117)         303,628         16,527         227,894         206,645         0         118.00           NONREI MBURSABLE COST CENTERS         113.00         0         0         0         0         118.00           190.00         IGFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           192.00         19200         PHYSI CI ANS' PRI VATE OFFICES         4, 113         2, 267         18, 910         0         0         192.00           192.01         19201         FP PETERSBURG         0         25         263         0         192.01           192.02         19202         PEDI ATRI CS         0         388         4, 349         0         0         192.02           192.03         19203         WASHI NGTON PRI MARY CARE         0         147         1, 500         0         0         192.03           194.00         07952         COMMUNI TY HEALTH SERVI CES         0         2							
116.00       11600       HOSPI CE       5,500       21       6       0       0       116.00         118.00       SUBTOTALS (SUM OF LINES 1 through 117)       303,628       16,527       227,894       206,645       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 OFFICES       4,113       2,267       18,910       0       192.00         192.01       19201       FP PETERSBURG       0       25       263       0       192.01         192.02       19202       PEDI ATRI CS       0       388       4,349       0       192.02         192.03       19203       WASHI NGTON PRI MARY CARE       0       147       1,500       0       192.03         194.00       07950       COMUNITY HEALTH SERVICES       0       2       0       0       194.00         194.03       07953       MH RESI DENTI AL       0       2       4       0       194.03		<u> </u>	0				
Image: 188.00         SUBTOTALS (SUM OF LINES 1 through 117)         303,628         16,527         227,894         206,645         0         118.00           NONREL MBURSABLE COST CENTERS           190.00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           192.00         19200         PHYSI CLANS' PRI VATE OFFICES         4,113         2,267         18,910         0         192.00           192.01         19201         FP PETERSBURG         0         25         263         0         192.01           192.02         19202         PEDI ATRI CS         0         388         4,349         0         192.02           192.03         19203         WASHI NGTON PRI MARY CARE         0         147         1,500         0         192.03           194.00         07950         COMMUNI TY HEALTH SERVICES         0         2         0         0         194.00           194.03         07953         MH RESI DENTI AL         0         22         4         0         0         194.03							
NORREI MBURSABLE COST CENTERS           190. 00         19000         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190. 00           192. 00         19200         PHYSI CI ANS' PRI VATE OFFI CES         4, 113         2, 267         18, 910         0         0         192. 00           192. 01         19200         PHYSI CI ANS' PRI VATE OFFI CES         4, 113         2, 267         18, 910         0         0         192. 00           192. 01         19202         PEDI ATRI CS         0         25         263         0         0         192. 01           192. 02         19203         WASHI NGTON PRI MARY CARE         0         388         4, 349         0         0         192. 02           192. 03         19203         WASHI NGTON PRI MARY CARE         0         147         1, 500         0         0         192. 03           194. 00         07950         COMUNIT TY HEALTH SERVICES         0         2         0         0         0         194. 02           194. 02         07952         MARKETI NG AND PUBLIC RELATIONS         0         2         0         0         0         194. 02           194. 03         07953         MH RESI DENTI AL				222 00			•
192.00       19200       PHYSI CLANS' PRI VATE OFFICES       4, 113       2, 267       18, 910       0       0       192.00         192.01       19201       FP PETERSBURG       0       25       263       0       0       192.01         192.02       19202       PEDI ATRI CS       0       388       4, 349       0       0       192.02         192.03       19203       WASHI NGTON PRI MARY CARE       0       147       1, 500       0       192.03         194.00       07950       COMMUNI TY HEALTH SERVICES       0       2       0       0       194.02         194.02       07952       MARKETI NG AND PUBLIC RELATIONS       0       2       0       0       194.02         194.03       07953       MH RESI DENTIAL       0       22       4       0       0       194.03		303, 020	10, 527	227, 05	200, 043		1118.00
192.01       19201       FP PETERSBURG       0       25       263       0       192.01         192.02       19202       PEDI ATRI CS       0       388       4, 349       0       0       192.02         192.03       19203       WASHI NGTON PRI MARY CARE       0       147       1, 500       0       192.03         194.00       07950       COMMUNI TY HEALTH SERVICES       0       2       0       0       194.00         194.02       07952       MARKETI NG AND PUBLI C RELATI ONS       0       2       0       0       194.02         194.03       07953       MH RESI DENTI AL       0       22       4       0       0       194.03	190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	-	0				
192.02       19202       PEDI ATRI CS       0       388       4, 349       0       0       192.02         192.03       19203       WASHI NGTON PRI MARY CARE       0       147       1, 500       0       192.03         194.00       07950       COMMUNI TY HEALTH SERVICES       0       2       0       0       194.00         194.02       07952       MARKETI NG AND PUBLI C RELATI ONS       0       2       0       0       194.02         194.03       07953       MH RESI DENTI AL       0       22       4       0       0       194.03		4, 113					
192.03       19203       WASHI NGTON PRI MARY CARE       0       147       1,500       0       192.03         194.00       07950       COMMUNI TY HEALTH SERVICES       0       2       0       0       194.00         194.02       07952       MARKETI NG AND PUBLIC RELATIONS       0       2       0       0       194.02         194.03       07953       MH RESI DENTI AL       0       22       4       0       0       194.03		0					
194. 02         07952         MARKETING AND PUBLIC RELATIONS         0         2         0         0         194. 02           194. 03         07953         MH RESIDENTIAL         0         22         4         0         0         194. 03	192. 03 19203 WASHI NGTON PRI MARY CARE	0				C	192. 03
194. 03 07953 MH RESIDENTIAL 0 0 194. 03		0	2		0 0		•
		0	2 22		4 0		
	194.04 07954 UNUSED SPACE	0			0 0		

Health Financial Systems	GOOD SAMARITA	N HOSPI TAL	In Lie	eu of Form CMS-2	2552-10	
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0042	Period: From 01/01/2019	Worksheet B Part II	
				To 12/31/2019	Date/Time Pre	
					7/10/2020 2:5	
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	
194. 05 07955 MOB	0	0		0 0	0	194.05
194. 06 07956 FOUNDATI ON	0	0		0 0	0	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0 0	0	194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0	0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	40		0 0	0	194.09
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	307, 741	19, 420	252, 92	206, 645	0	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	GOOD SAMARITA	Provi der CO		Period:	u of Form CMS- Worksheet B	
				From 01/01/2019 To 12/31/2019	Part II Date/Time Pre 7/10/2020 2:5	
		INTERNS &	RESI DENTS		771072020 2.3	
Cost Center Description	MENTAL HEALTH	FRVICES-SALAR	SERVI CES-OTHE	R PARAMED ED	PARAMED ED	
	OH	Y & FRINGES	PRGM COSTS	PRGM-RADI OLOGY	PRGM-LAB	
GENERAL SERVICE COST CENTERS	17.01	21.00	22.00	23.00	23.01	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS						4.00
4. 02 00402 PURCHASI NG & RECEI VI NG						4. 02
4. 03 00403 REGI STRATI ON						4.03
4. 04   00404  PATI ENT ACCOUNTS 5. 00   00500  ADMI NI STRATI VE & GENERAL						4.04
7. 00 00700 OPERATION OF PLANT						7.0
B. 00 00800 LAUNDRY & LINEN SERVICE						8.0
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY						9.0
11. 00 01100 CAFETERIA						11.0
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY						14.0
16. 00 01600 MEDICAL RECORDS & LIBRARY						16.0
17.00 01700 SOCIAL SERVICE						17.00
17.01 01701 MENTAL HEALTH OH	135, 324	125 702				17.0
21.00 02100 & SERVICES-SALARY & FRINGES APPRVD 22.00 02200 & SERVICES-OTHER PRGM COSTS APPRVD	0	135, 703	21, 72	4		21.00
23. 00 02300 PARAMED ED PRGM-RADI OLOGY	0		,	1, 525		23.00
23. 01 02301 PARAMED ED PRGM-LAB	0				3, 473	3 23.0
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30.00         O3000         ADULTS & PEDI ATRI CS	0					30.00
31. 00  03100   NTENSI VE CARE UNI T	0					31.00
40. 00 04000 SUBPROVIDER - IPF	67, 823					40.0
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0					41.0
ANCI LLARY SERVICE COST CENTERS	0					43.00
50. 00 05000 OPERATI NG ROOM	0					50.00
51.00 05100 RECOVERY ROOM 51.01 05101 ENDOSCOPY	0					51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0					52.00
53. 00 05300 ANESTHESI OLOGY	0					53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	0					54.0
60. 00 06000 LABORATORY	0					60.0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0					63.0
65. 00 06500 RESPIRATORY THERAPY	0					65.0
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	0					66. 0 69. 0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0					70.0
70. 01 07001 NEURODI AGNOSTI CS	0					70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					71.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					73.0
75.00 07500 ASC (NON-DISTINCT PART)	0					75.0
76.00 03950 MH ANCILLARY OUTPATIENT 76.01 03951 INPATIENT DIALYSIS	0					76.00
OUTPATIENT SERVICE COST CENTERS	0					/0.0
90. 00 09000 CLINIC	0					90.00
90. 01 04950 WOUND CLINIC	0					90.0
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					91.00
OTHER REI MBURSABLE COST CENTERS						,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0					96.00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0					101.00
113. 00 11300 I NTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	0					116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	67, 823	0		0 0	(	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0					192.00
192. 01 19201 FP PETERSBURG	0					192.0
192. 02 19202 PEDI ATRI CS 192. 03 19203 WASHI NGTON PRI MARY CARE	0					192. 02 192. 03
192. 03 19203 WASHINGTON PRIMART CARE 194. 00 07950 COMMUNITY HEALTH SERVICES	0					192.0
194.0207952 MARKETING AND PUBLIC RELATIONS	0					194. 02
194. 02 07952 MARKETING AND PUBLIC RELATIONS 194. 03 07953 MH RESIDENTIAL	0					1

Health Financial Systems	GOOD SAMARITAN HOSPITAL				In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period:	Worksheet B		
				From 01/01/2019		nonod.	
				To 12/31/2019	Date/Time Pre 7/10/2020 2:5	n n n n n n n n n n n n n n n n n n n	
		INTERNS &	RESI DENTS		1771072020 2.0		
Cost Center Description	MENTAL HEALTH	SERVI CES-SALAR	SERVI CES-OTHE	R PARAMED ED	PARAMED ED		
	OH	Y & FRINGES	PRGM COSTS	PRGM-RADI OLOGY	PRGM-LAB		
	17.01	21.00	22.00	23.00	23.01		
194. 04 07954 UNUSED SPACE	0					194.04	
194. 05 07955 MOB	0					194.05	
194. 06 07956 FOUNDATI ON	0					194.06	
194.0707957 KNOX COUNTY HEALTH DEPT	0					194.07	
194. 08 07958 I NDUSTRI AL HEALTH	0					194.08	
194.0907959COMMUNITY MENTAL HEALTH CENTER	67, 501					194.09	
200.00 Cross Foot Adjustments		135, 703	21, 72	4 1, 525	3, 473	200.00	
201.00 Negative Cost Centers	0	0		0 0	0	201.00	
202.00   TOTAL (sum lines 118 through 201)	135, 324	135, 703	21, 72	4 1, 525	3, 473	202.00	

	Financial Systems TON OF CAPITAL RELATED COSTS	GOOD SAMARITA	Provider CC	N: 15-0042	Peri od:	of Form CMS-255 Worksheet B
					To 12/31/2019	Part II Date/Time Prepar
	Cost Center Description	Subtotal	Intern &	Total		<u>7/10/2020 2:50 p</u>
	cost center bescription	50510121	Residents Cost	iotai		
			& Post			
			Stepdown			
		24.00	Adjustments	24.00		
0	GENERAL SERVICE COST CENTERS	24.00	25.00	26.00		
	DO100 CAP REL COSTS-BLDG & FIXT					1
00 0	DO200 CAP REL COSTS-MVBLE EQUIP					2
	00400 EMPLOYEE BENEFITS DEPARTMENT					4
01 0	DO401 COMMUNI CATI ONS					4
	DO402 PURCHASI NG & RECEI VI NG					4
	00403 REGI STRATI ON					4
	DO404 PATIENT ACCOUNTS					4
	00500 ADMINI STRATI VE & GENERAL					5
	DO700 OPERATION OF PLANT DO800 LAUNDRY & LINEN SERVICE					1
	00900 HOUSEKEEPING					
	D1000 DI ETARY					10
	D1100 CAFETERI A					11
	D1300 NURSI NG ADMI NI STRATI ON					13
	01400 CENTRAL SERVICES & SUPPLY					14
	D1500 PHARMACY					15
	01600 MEDICAL RECORDS & LIBRARY					16
00	D1700 SOCIAL SERVICE					17
	D1701 MENTAL HEALTH OH					17
	02100 I &R SERVICES-SALARY & FRINGES APPRVD					21
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD					22
	02300 PARAMED ED PRGM-RADI OLOGY					23
	D2301 PARAMED ED PRGM-LAB					23
	NPATIENT ROUTINE SERVICE COST CENTERS	2 700 042	0	2 700 0	10	20
	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT	2, 709, 042 1, 063, 797		2, 709, 0 1, 063, 7		30
	04000 SUBPROVIDER - IPF	587, 168		587, 1		40
	04100 SUBPROVI DER – I RF	678, 753		678, 7		41
	04300 NURSERY	11, 744		11, 7		43
	ANCILLARY SERVICE COST CENTERS			,		
00	D5000 OPERATING ROOM	741, 516	0	741, 5	16	50
	D5100 RECOVERY ROOM	0	0		0	51
	D5101 ENDOSCOPY	461, 692		461, 6		51
	D5200 DELIVERY ROOM & LABOR ROOM	29, 210		29, 2		52
	05300 ANESTHESI OLOGY	0		4 045 0	0	53
	05400 RADI OLOGY -DI AGNOSTI C	1, 215, 818		1, 215, 8		54
	D5500 RADI OLOGY-THERAPEUTI C D6000 LABORATORY	304, 275 373, 176		304, 2 373, 1		60
	06300 BLOOD STORING, PROCESSING & TRANS.	0		575, 1	0	63
	06500 RESPI RATORY THERAPY	228, 354		228, 3		65
	D6600 PHYSI CAL THERAPY	822, 386		822, 3		66
	06900 ELECTROCARDI OLOGY	680, 532		680, 5		69
	D7000 ELECTROENCEPHALOGRAPHY	0			0	70
01 0	07001 NEURODI AGNOSTI CS	271, 370	0	271, 3	70	70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	120, 549		120, 5		71
	07200 IMPL. DEV. CHARGED TO PATIENTS	165, 177		165, 1		72
	D7300 DRUGS CHARGED TO PATIENTS	332, 229		332, 2		73
	07500 ASC (NON-DI STI NCT PART)	107, 196	1	107, 1		75
	03950 MH ANCI LLARY OUTPATI ENT	0	-	200 (	0	76
	D3951 INPATIENT DIALYSIS	290, 645	0	290, 6	40	76
	DOTPATIENT SERVICE COST CENTERS	96, 004	0	96, 0	04	90
	D4950 WOUND CLINIC	96, 004 124, 469		96, 0 124, 4		90
	D9100 EMERGENCY	780, 718		780, 7		91
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	, 50, , 10	0	, ,	-	92
	OTHER REIMBURSABLE COST CENTERS					
00	09600 DURABLE MEDICAL EQUIP-RENTED	15, 815	0	15, 8	15	96
	10100 HOME HEALTH AGENCY	0	0		0	101
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113
	11600 HOSPI CE	154, 431		154, 4		116
3.00	SUBTOTALS (SUM OF LINES 1 through 117)	12, 366, 066	0	12, 366, 0	66	118
	NONREIMBURSABLE COST CENTERS				0	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		4 000 -	0	190
	19200 PHYSI CLANS' PRI VATE OFFI CES	4, 333, 610		4, 333, 6		192
	19201 FP PETERSBURG	5, 655		5,6		192
	19202 PEDIATRICS	34, 940		34, 9 22 E		192
z. 03ľ	19203 WASHINGTON PRIMARY CARE 07950 COMMUNITY HEALTH SERVICES	23, 578 86, 525		23, 5 86, 5		192 194
				86 5	2.01	1192

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-0042	Period: From 01/01/2019 To 12/31/2019	
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
194. 03 07953 MH RESI DENTI AL	689, 036	0	689, 0	36	194.03
194.04 07954 UNUSED SPACE	3, 885, 128	0	3, 885, 1	28	194.04
194. 05 07955 MOB	802, 939	0	802, 9	39	194.05
194. 06 07956 FOUNDATI ON	15, 625	0	15, 6	25	194.06
194.0707957 KNOX COUNTY HEALTH DEPT	157, 971	0	157, 9	71	194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0	194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	1, 347, 465	0	1, 347, 4	65	194.09
200.00 Cross Foot Adjustments	162, 425	0	162, 4	25	200.00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118 through 201)	23, 979, 553	0	23, 979, 5	53	202.00

Cost Center Description       CAPITAL RELATED COSTS       EMPLOYEE       COMMUNICATIONS       PUF         BLDG & FIXT       MVBLE EQUIP       EMPLOYEE       COMMUNICATIONS       PUF         (SQUARE FEET)       (SQUARE FEET)       SALARI ES)       (NUMBER OF       PHONES)       (NUMBER OF         1.00       2.00       4.00       4.01       1	Ate/Time Prep (10/2020 2:50 IRCHASING & RECEIVING (SUPPLIES COST) 4.02	
Cost Center Description       BLDG & FIXT (SQUARE FEET)       MVBLE EQUIP (SQUARE FEET)       EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)       COMMUNICATIONS PUF (SQUARE FEET)       EMPLOYEE (SQUARE FEET)       COMMUNICATIONS BENEFITS DEPARTMENT (GROSS SALARIES)       PUF (SQUARE FEET)	JRCHASI NG & RECEI VI NG (SUPPLI ES COST)	
(SQUARE FEET)       (SQUARE FEET)       BENEFITS       R         DEPARTMENT       (NUMBER OF       (COMPARIANT)         (GROSS       PHONES)       SALARI ES)         1.00       2.00       4.00       4.01	RECEI VI NG (SUPPLI ES COST)	
(SQUARE FEET)       (SQUARE FEET)       BENEFITS       R         DEPARTMENT       (NUMBER OF       (COMPARIANT)         (GROSS       PHONES)       SALARI ES)         1.00       2.00       4.00       4.01	RECEI VI NG (SUPPLI ES COST)	
(GROSS SALARI ES)         PHONES)           1.00         2.00         4.00         4.01	COST)	
SALARI ES)           1.00         2.00         4.00         4.01		
1.00 2.00 4.00 4.01	4. 02	
GENERAL SERVICE COST CENTERS		
1. 00 00100 CAP REL COSTS-BLDG & FIXT 861, 939 2. 00 00200 CAP REL COSTS-MVBLE EQUIP 871, 688		1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 496 4, 401 101, 962, 470		2.00 4.00
4. 01 00401 COMMUNICATIONS 0 0 279, 672 2, 165		4.01
4. 02 00402 PURCHASI NG & RECEI VI NG 15, 541 15, 121 624, 086 19	21, 072, 471	4.02
4. 03       00403       REGI STRATI ON       0       0       1, 377, 517       35         4. 04       00404       PATI ENT ACCOUNTS       0       0       2, 346, 450       43	11, 462 10, 287	4.03 4.04
5. 00 00500 ADMI NI STRATI VE & GENERAL 42, 168 45, 660 8, 365, 059 159	379, 321	5.00
7.00         00700         OPERATION OF PLANT         130, 731         137, 503         2, 254, 007         132	133, 988	7.00
8.00         00800         LAUNDRY & LINEN SERVICE         5, 266         5, 266         210, 259         0           9.00         00900         HOUSEKEEPING         7, 336         7, 336         2, 003, 398         38	75, 493	8.00 9.00
9. 00 00900 HOUSEKEEPING 7, 336 7, 336 2, 003, 398 38 10. 00 01000 DI ETARY 0 0 444, 119 26	184, 954 1, 385, 181	9.00 10.00
11. 00 01100 CAFETERIA 12, 519 12, 519 1, 169, 359 0	0	11.00
13. 00         01300         NURSI NG         ADMI NI STRATI ON         8, 590         8, 590         1, 361, 231         20	8, 198	13.00
14. 00         01400         CENTRAL SERVICES & SUPPLY         90         90         370, 879         9           15. 00         01500         PHARMACY         6, 189         6, 189         2, 850, 451         31	87, 161 54, 987	14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 4, 717 4, 717 2, 503, 142 52	4, 880	16.00
17. 00 01700 SOCIAL SERVICE 0 0 0 0	0	17.00
17. 01 01701 MENTAL HEALTH OH 3, 442 3, 442 505, 008 203	1, 248	17.01
21. 00         02100         I &R SERVI CES-SALARY & FRI NGES APPRVD         4,002         4,002         0         0           22. 00         02200         I &R SERVI CES-OTHER PRGM COSTS APPRVD         0         0         816,358         23	0 9, 513	21.00 22.00
23. 00 02300 PARAMED ED PRGM-RADI OLOGY 0 0 111, 300 3	42	23.00
23. 01 02301 PARAMED ED PRGM-LAB 0 0 230, 594 0	3, 742	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS         69, 847         69, 847         4, 480, 280         157	395, 990	30. 00
30. 00  03000  ADDELTS & PEDIATRICS   09, 847   69, 847   4, 480, 280   157   31. 00  03100  INTENSI VE CARE UNIT   26, 737   26, 737   3, 327, 354   96	276, 627	30.00
40. 00 04000 SUBPROVI DER - I PF 13, 034 13, 034 1, 928, 648 0	19, 470	40.00
41. 00 04100 SUBPROVI DER - I RF 17, 193 17, 193 1, 684, 195 70	70, 218	41.00
43. 00 04300 NURSERY 0 0 253, 202 0 ANCI LLARY SERVI CE COST CENTERS	15, 430	43.00
50. 00 05000 OPERATI NG ROOM 18, 905 18, 905 3, 210, 829 144	558, 816	50.00
51.00 05100 RECOVERY ROOM 0 0 0	0	51.00
51. 01       05101       ENDOSCOPY       12, 237       12, 237       982, 771       25         52. 00       05200       DELI VERY ROOM & LABOR ROOM       0       0       913, 439       66	523, 360 64, 865	51.01 52.00
53. 00 05300 ANESTHESI OLOGY 0 0 0 0	04, 803	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 32, 998 32, 998 3, 675, 309 60	211, 445	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 7, 697 7, 697 2, 517, 144 37	76, 521	55.00
60. 00         06000         LABORATORY         7, 238         7, 238         2, 306, 141         32           63. 00         06300         BLOOD STORING, PROCESSING & TRANS.         0         0         0         0	2, 463, 222 0	60. 00 63. 00
65. 00 06500 RESPI RATORY THERAPY 5, 679 5, 679 2, 203, 973 38	84, 022	65.00
66. 00         06600         PHYSI CAL THERAPY         22,060         3,653,980         30	30, 927	66.00
69. 00         06900         ELECTROCARDI OLOGY         18, 181         18, 181         5, 350, 054         78           70. 00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0	107, 647 0	69.00 70.00
70. 01 07001 NEURODI AGNOSTI CS 7, 645 7, 645 391, 626 20	20, 742	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0	4, 313, 091	71.00
72. 00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	5, 879, 217 0	72.00 73.00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 1, 187, 873 0	354, 795	75.00
76.00 03950 MH ANCI LLARY OUTPATI ENT 0 0 0 0	0	76.00
76. 01 03951   NPATI ENT_DI ALYSI S 8, 582 0 3	1, 986	76. 01
OUTPATI ENT SERVI CE COST CENTERS           90. 00         09000         CLI NI C         2, 668         2, 668         122, 981         8	1, 675	90.00
90. 01 04950 WOUND CLINIC 2, 882 2, 882 407, 558 10	107, 160	90.01
91. 00 09100 EMERGENCY 17, 343 17, 343 3, 746, 603 102	300, 775	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) OTHER REIMBURSABLE COST CENTERS		92.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 394 394 98, 826 0	22, 799	96.00
101.00 HOME HEALTH AGENCY 0 0 0		101.00
SPECIAL PURPOSE COST CENTERS		112 00
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 H0SPI CE 3, 971 3, 971 441, 450 23	20, 007	113.00 116.00
SUBTOTALS         SUBTOTALS         SUB OF LINES 1         through 117         540, 378         550, 127         70, 707, 125         1, 792	18, 271, 264	
NONREIMBURSABLE COST CENTERS		100.00
190. 00         GI FT,         FLOWER,         COFFEE         SHOP & CANTEEN         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	0] 2, 194, 872	190.00 192.00
192. 01 19201 FP PETERSBURG 0 0 265, 754 0	24, 683	
192. 02 19202 PEDI ATRI CS 0 0 1, 417, 461 20	375, 416	
192. 03         19203         WASHI NGTON         PRI MARY         CARE         0         1, 192, 973         0	142, 522	192.03

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2019	Worksheet B-1	
				o 12/31/2019	Date/Time Pre 7/10/2020 2:5	pared: 0 pm
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	COMMUNI CATI ONS (NUMBER OF PHONES)	PURCHASI NG & RECEI VI NG (SUPPLI ES COST)	
	1.00	2.00	4.00	4.01	4.02	
194.00 07950 COMMUNI TY HEALTH SERVICES	2, 536			20		194.00
194.0207952 MARKETING AND PUBLIC RELATIONS	1, 887					194. 02
194. 03 07953 MH RESIDENTIAL	20, 260		432, 856	0		194. 03
194.0407954UNUSED SPACE	115, 887		C	0 0		194.04
194. 05 07955 MOB	23, 944		C	0 0		194.05
194. 06 07956  FOUNDATI ON	466		C	2		194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	4, 712	4, 712	C	0 0		194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	C	0 0		194.08
194.0907959COMMUNITY MENTAL HEALTH CENTER	36, 623	36, 623	5, 221, 563	3 0	38, 902	
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)	23, 957, 795	21, 758	28, 613, 651	359, 556	1, 152, 174	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	27. 795233	0. 024961	0. 280629	166. 076674	0. 054677	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			125, 077	343	433, 112	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 001227	0. 158430	0. 020553	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

15.00       01500       PHARMACY       0       0       4, 130, 089       6, 18         16.00       01600       MEDI CAL RECORDS & LI BRARY       0       0       0       3, 829, 710       4, 7         17.00       01700       SOCI AL SERVI CE       0       0       0       0       0         17.01       01701       MENTAL HEALTH OH       0       0       0       951, 867       3, 44         21.00       02100       I & R SERVI CES-SALARY & FRINGES APPRVD       0       0       0       365, 470       4, 00         22.00       02200       I & R SERVI CES-OTHER PRGM COSTS APPRVD       0       0       0       17, 475         23.00       02301       PARAMED ED PRGM-RADI 0LOGY       0       0       0       289, 440	Prepared: 1:50 pm F
Cost Center Description         REGISTRATION (GROSS CHARGES)         PATIENT ACCOUNTS (GROSS CHARGES)         Reconciliation ADMINISTRATIVE & GENERAL (ACCUM. COST)         OPPRATION OF PLANT (ACCUM. COST)           1.00         00100         CAP REL COSTS - BLDG & FIXT 2.00         4.03         4.04         5A         5.00         7.00           2.00         00200         CAP REL COSTS - MUBLE EQUIP 4.00         4.03         4.04         5A         5.00         7.00           4.03         4.04         5A         5.00         7.00           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT 4.01         00401         COMUNINI CATIONS 4.02         4.04         5A         5.00         7.00           4.03         0401         COMUNINI CATIONS 4.02         659, 531, 844         659, 531, 844         -20, 326, 337         197, 295, 339         6659, 50, 50, 50, 50, 50, 50, 50, 50, 50, 50	E: 50 pm F F 1.00 2.00 4.00 4.01
Cost Center Description         REGISTRATION (GROSS CHARGES)         PATIENT ACCOUNTS (GROSS CHARGES)         Reconciliation (ACUM. COST CHARGES)         DUMINISTRATIVE (ACUM. COST CHARGES)         OPERATION (ACUM. COST CHARGES)           1.00         CODIO         CAP REL COSTS-BLDG & FIXT	F T) 1.00 2.00 4.00 4.01
CHARGES)         CHARGES)         CHARGES)         CACCUM. COST)         (SOUARE FEET)           1.00         00100         CAP REL COSTS CENTERS         4.04         5A         5.00         7.00           1.00         00200         CAP REL COSTS -BUG & FLXT         4.04         5A         5.00         7.00           4.00         00400         CAP REL COSTS -MUBLE COULP         4.04         5A         5.00         7.00           4.01         00401         COMMUNI CATIONS         659, 531, 844         69, 531, 844         69, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659, 531, 844         659	1.00 2.00 4.00 4.01
4.03         4.04         5A         5.00         7.00           GENERAL SERVICE COST CENTERS	2.00 4.00 4.01
GENERAL         SERVICE         COST         CENTERS           1.00         O0100         CAP         REL         COSTS-BLDG & FIXT           2.00         00200         CAP         REL         COSTS-MVBLE         EQUIP           4.01         00401         COMMUNICATIONS         659, 531, 844             4.02         00403         REGISTRATION         659, 531, 844             5.00         00500         ADMINISTRATIVE & GENERAL         0          -20, 326, 337         197, 295, 339           7.00         00700         OPERATION OF PLANT         0         0         10, 197, 372         669, 00           8.00         00800         LAUNDRY & LINEN SERVICE         0         0         0         10, 197, 372         669, 00           10.00         01000         DIETARY         0         0         0         10, 197, 372         669, 00           11.00         01000         DIETARY         0         0         0         1, 334, 131         1           11.00         01100         CAFETERIA         0         0         0         2, 222, 230         8, 55           13.00         01300         NURSI NG ADMINI STRATI ON	2.00 4.00 4.01
2.00       00200       CAP REL COSTS-MVBLE EQUI P         4.00       00400       EMPLOYEE BENEFITS DEPARTMENT         4.01       00401       COMMUNI CATI ONS         4.02       00402       PURCHASI NG & RECEI VI NG         4.03       00403       REGI STRATI ON         659, 531, 844       659, 531, 844         5.00       00500       ADMI NI STRATI VE & GENERAL       0         0.00       00500       OPERATI ON OF PLANT       0       0         0.00       00500       ADMI NI STRATI VE & GENERAL       0       0         0.00       00500       ADMI NI STRATI VE & GENERAL       0       0         0.00       00500       ADMI NI STRATI VE & GENERAL       0       0       10, 197, 372       669, 00         8.00       00800       LAUNDRY & LI NEN SERVI CE       0       0       0       2, 964, 797       7, 33         10.00       DI ETARY       0       0       0       1, 761, 968       12, 5'         13.00       01300       NURSI NG ADMI NI STRATI ON       0       0       0       67, 720       0         14.00       01400       CAFTRAL SERVI CES       0       0       0       6, 18       1, 761, 968       12, 5'	2.00 4.00 4.01
4.00       00400       EMPLOYEE BENEFITS DEPARTMENT	4. 00 4. 01
4. 01       00401       COMMUNI CATI ONS       659, 531, 844         4. 02       00403       REGI STRATI ON       659, 531, 844         4. 04       00404       PATI ENT ACCOUNTS       0         5. 00       00500       ADMI NI STRATI VE & GENERAL       0         7. 00       00700       OPERATI ON OF PLANT       0       0         8. 00       00800       LAUNDRY & LI NEN SERVI CE       0       0         9. 00       00900       DUSEKEEPI NG       0       0       0         11. 00       01000       DI ETARY       0       0       0       2, 964, 797       7, 33         11. 00       01000       DI ETARY       0       0       0       1, 761, 968       12, 55         13. 00       01300       NURSI NG ADMI NI STRATI ON       0       0       0       2, 222, 230       8, 54         14. 00       01400       CAFETERI A       0       0       0       2, 222, 230       8, 55         14. 00       01400       CENTRAL SERVI CES & SUPPLY       0       0       697, 270       0         15. 00       01500       PHARMACY       0       0       0       3, 829, 710       4, 77         16. 00 <td>4.01</td>	4.01
4.03       00403       REGI STRATI 0N       659, 531, 844         4.04       00404       PATI ENT ACCOUNTS       0         5.00       00500       ADMI NI STRATI VE & GENERAL       0       0         7.00       00700       OPERATI ON OF PLANT       0       0       107, 295, 339         7.00       00800       LAUNDRY & LI NEN SERVI CE       0       0       0       485, 478       5, 22         9.00       00900       HOUSEKEEPI NG       0       0       0       2, 964, 797       7, 33         10.00       01000       DI ETARY       0       0       0       1, 034, 131         11.00       01100       CAETERI A       0       0       0       1, 761, 968       12, 57         13.00       01300       NURSI NG ADMI NI STRATI ON       0       0       0       2, 222, 230       8, 50         14.00       01400       CENTRAL SERVI CES & SUPPLY       0       0       0       47, 77       7, 73         15.00       01500       PHARMACY       0       0       0       4, 77       7, 70       669, 00         16.00       01600       MEDI CAL RECORDS & LI BRARY       0       0       0       9, 829, 710	4. 02
4. 04       00404       PATI ENT ACCOUNTS       0       659, 531, 844         5. 00       00500       ADMI NI STRATI VE & GENERAL       0       0       -20, 326, 337       197, 295, 339         7. 00       00700       OPERATI ON OF PLANT       0       0       0       10, 197, 372       669, 00         8. 00       00800       LAUNDRY & LINEN SERVICE       0       0       0       485, 478       5, 26         9. 00       00900       HOUSEKEEPI NG       0       0       0       2, 964, 797       7, 33         10. 00       01000       DI ETARY       0       0       0       1, 761, 968       12, 57         13. 00       01300       NURSI NG ADMI NI STRATI ON       0       0       0       2, 222, 230       8, 55         14. 00       01400       CENTRAL SERVI CES & SUPPLY       0       0       0       4, 130, 089       6, 11         15. 00       01500       PHARMACY       0       0       0       0       9, 51, 867       3, 44         21. 00       02100       I&R SERVI CES       SUPPRVD       0       0       0       951, 867       3, 44         22. 00       02200       I &R SERVI CES-SALARY & FRI NGES APPRVD	4.03
7.00       00700       OPERATION OF PLANT       0       0       10, 197, 372       669, 00         8.00       00800       LAUNDRY & LINEN SERVICE       0       0       485, 478       5, 26         9.00       00900       HOUSEKEEPING       0       0       0       2, 964, 797       7, 33         10.00       01000       DI ETARY       0       0       0       1, 034, 131         11.00       01100       CAFETERIA       0       0       1, 761, 968       12, 55         13.00       01300       NURSI NG ADMINI STRATION       0       0       0       697, 270       669         14.00       01400       CENTRAL SERVICES & SUPPLY       0       0       0       697, 270       6         15.00       01500       PHARMACY       0       0       0       649, 77       7       7         16.00       01600       MEDI CAL RECORDS & LI BRARY       0       0       0       0       0       0         17.01       01701       SCI AL SERVICE       0       0       0       0       0       0       0         16.00       01600       MEDI CAL RECORDS & LI BRARY       0       0       0       0 <td>4.03</td>	4.03
8.00         00800         LAUNDRY & LINEN SERVICE         0         0         485, 478         5, 26           9.00         00900         HOUSEKEEPING         0         0         0         2, 964, 797         7, 33           10.00         01000         DI ETARY         0         0         0         1, 034, 131           11.00         01100         CAFETERIA         0         0         0         1, 761, 968         12, 55           13.00         01300         NURSI NG ADMINISTRATION         0         0         0         697, 270         0           14.00         01400         CENTRAL SERVICES & SUPPLY         0         0         0         697, 270         0         0           15.00         01500         PHARMACY         0         0         0         0         4, 130, 089         6, 18           16.00         01600         MEDI CAL RECORDS & LI BRARY         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	5.00
9.00       00900       HOUSEKEEPING       0       0       2,964,797       7,33         10.00       01000       DIETARY       0       0       0       1,034,131         11.00       01100       CAFETERIA       0       0       0       1,761,968       12,55         13.00       01300       NURSI NG ADMI NI STRATI ON       0       0       0       2,222,230       8,56         14.00       01400       CENTRAL SERVI CES & SUPPLY       0       0       0       697,270       8,56         15.00       01500       PHARMACY       0       0       0       4,130,089       6,18         16.00       01600       MEDI CAL RECORDS & LI BRARY       0       0       0       0       0         17.01       01701       SOCI AL SERVI CE       0       0       0       0       0       0       0         17.01       01701       MENTAL HEALTH OH       0       0       0       0       365,470       3,44         21.00       02100       I & RERVI CES-SALARY & FRI NGES APPRVD       0       0       0       1,591,475         23.00       02200       I & RERVI CES-SOTHER PRGM COSTS APPRVD       0       0       13	
11.00       01100       CAFETERIA       0       0       1,761,968       12,55         13.00       01300       NURSI NG ADMI NI STRATI ON       0       0       0       2,222,230       8,56         14.00       01400       CENTRAL SERVI CES & SUPPLY       0       0       0       697,270       0         15.00       01500       PHARMACY       0       0       0       4,130,089       6,18         16.00       01600       MEDI CAL RECORDS & LI BRARY       0       0       0       3,829,710       4,77         17.00       01700       SOCI AL SERVI CES       0       0       0       0       951,867       3,44         21.00       02100       I&R SERVI CES-SALARY & FRI NGES APPRVD       0       0       0       365,470       4,00         22.00       02200       I &R SERVI CES-SOTHER PRGM COSTS APPRVD       0       0       0       1,591,475         23.00       02301       PARAMED ED PRGM-RADI 0LOGY       0       0       0       289,440	36 9.00
13.00       01300       NURSI NG ADMI NI STRATI ON       0       0       2,222,230       8,54         14.00       01400       CENTRAL SERVI CES & SUPPLY       0       0       0       697,270       60         15.00       01500       PHARMACY       0       0       0       4,130,089       6,18         16.00       01600       MEDI CAL RECORDS & LI BRARY       0       0       0       3,829,710       4,77         17.00       01700       SOCI AL SERVI CES       0       0       0       0       14,77         17.01       01701       MENTAL HEALTH OH       0       0       0       0       3,829,710       4,77         17.00       02100       I & SERVI CES-SALARY & FRI NGES APPRVD       0       0       0       951,867       3,44         21.00       02100       I & SERVI CES-SALARY & FRI NGES APPRVD       0       0       0       1,591,475         23.00       02300       PARAMED ED PRGM-RADI OLOGY       0       0       0       134,311         23.01       02301       PARAMED ED PRGM-LAB       0       0       0       289,440	0 10.00
15.00       01500       PHARMACY       0       0       4, 130, 089       6, 18         16.00       01600       MEDI CAL RECORDS & LI BRARY       0       0       0       3, 829, 710       4, 7'         17.00       01700       SOCI AL SERVI CE       0       0       0       0       0         17.01       01701       MENTAL HEALTH OH       0       0       0       951, 867       3, 44         21.00       02100       I & SERVI CES-SALARY & FRI NGES APPRVD       0       0       365, 470       4, 00         22.00       02200       I & SERVI CES-OTHER PRGM COSTS APPRVD       0       0       1, 591, 475       423.00       02300       PARAMED ED PRGM-RADI 0LOGY       0       0       134, 311       440         23.01       02301       PARAMED ED PRGM-LAB       0       0       0       289, 440       440	
16.00       01600       MEDI CAL RECORDS & LI BRARY       0       0       3,829,710       4,77         17.00       01700       SOCI AL SERVI CE       0       0       0       0         17.01       01701       MENTAL HEALTH OH       0       0       0       951,867       3,44         21.00       02100       I &R SERVI CES-SALARY & FRI NGES APPRVD       0       0       0       365,470       4,00         22.00       02200       I &R SERVI CES-SOLARY & FRI NGES APPRVD       0       0       0       1,591,475         23.00       02301       PARAMED ED PRGM-RADI OLOGY       0       0       0       134,311         23.01       02301       PARAMED ED PRGM-LAB       0       0       0       289,440	90 14.00
17.00       01700       SOCI AL SERVICE       0       0       0         17.01       01701       MENTAL HEALTH OH       0       0       0       951, 867       3, 44         21.00       02100       I &R SERVICES-SALARY & FRINGES APPRVD       0       0       0       365, 470       4, 00         22.00       02200       I &R SERVICES-OTHER PRGM COSTS APPRVD       0       0       0       1, 591, 475         23.00       02301       PARAMED ED PRGM-RADIOLOGY       0       0       0       134, 311         23.01       02301       PARAMED ED PRGM-LAB       0       0       0       289, 440	
21.00         02100         I &R SERVICES-SALARY & FRINGES APPRVD         0         0         365, 470         4, 00           22.00         02200         I &R SERVICES-OTHER PRGM COSTS APPRVD         0         0         0         1, 591, 475           23.00         02300         PARAMED ED PRGM-RADIOLOGY         0         0         0         134, 311           23.01         02301         PARAMED ED PRGM-LAB         0         0         0         289, 440	0 17.00
22. 00         02200         I &R         SERVICES-OTHER         PRGM         COSTS         APPRVD         0         0         1, 591, 475           23. 00         02300         PARAMED         ED         PRGM-RADIOLOGY         0         0         0         134, 311           23. 01         02301         PARAMED         ED         PRGM-LAB         0         0         0         289, 440	
23. 01 02301 PARAMED ED PRGM-LAB 0 0 0 289, 440	0 22.00
	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS	0 23.01
30. 00         03000         ADULTS & PEDI ATRI CS         31, 394, 830         31, 394, 830         0         8, 490, 983         69, 84	47 30.00
31.00         03100         I NTENSI VE CARE UNIT         17, 439, 101         17, 439, 101         0         5, 584, 286         26, 73           40.00         04000         SUBPROVI DER - I PF         8, 395, 319         8, 395, 319         0         2, 659, 784         13, 03	
40. 00         04000         SUBPROVI DER         - I PF         8, 395, 319         8, 395, 319         0         2, 659, 784         13, 03           41. 00         04100         SUBPROVI DER         - I RF         7, 646, 926         7, 646, 926         0         2, 828, 904         17, 14	
43. 00 04300 NURSERY 1, 210, 619 1, 210, 619 0 357, 308	0 43.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM 44, 465, 642 44, 465, 642 0 5, 047, 132 18, 90	05 50.00
51.00 05100 RECOVERY ROOM 0 0 0	0 51.00
51. 01       05101       ENDOSCOPY       11, 198, 024       11, 198, 024       0       2, 382, 426       12, 23         52. 00       05200       DELIVERY ROOM & LABOR ROOM       4, 997, 311       4, 997, 311       0       1, 311, 824	
52.00         05200         DELIVERY         R00M         LABOR         R00M         4, 997, 311         0         1, 311, 824         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0<	0 52.00
54.00         05400         RADI OLOGY - DI AGNOSTI C         94, 183, 136         94, 183, 136         0         8, 318, 063         32, 94	
55. 00         05500         RADI OLOGY-THERAPEUTI C         24, 338, 045         24, 338, 045         0         3, 387, 898         7, 66           60. 00         06000         LABORATORY         70, 359, 222         70, 359, 222         0         8, 340, 729         7, 23	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0	0 63.00
65. 00         06500         RESPI RATORY THERAPY         14, 287, 574         14, 287, 574         0         3, 050, 628         5, 65           66. 00         06600         PHYSI CAL THERAPY         25, 225, 037         25, 225, 037         0         5, 632, 326         22, 06	
69. 00 06900 ELECTROCARDI OLOGY 25, 225, 037 25, 225, 037 0 5, 632, 326 22, 06 69. 00 06900 ELECTROCARDI OLOGY 39, 874, 916 0 4, 856, 954 18, 18	
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0	0 70.00
70. 01         07001         NEURODI AGNOSTI CS         5, 711, 543         5, 711, 543         0         983, 521         7, 64           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         4, 911, 589         4, 911, 589         0         4, 539, 018	45 70.01 0 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 12, 865, 322 12, 865, 322 0 6, 318, 937	0 72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 86, 919, 352 0 18, 035, 143	0 73.00
75. 00         07500         ASC         (NON-DI STINCT PART)         23, 885, 938         23, 885, 938         0         2, 400, 017           76. 00         03950         MH         ANCI LLARY OUTPATI ENT         0         0         0         0         0         0	0 75.00 0 76.00
76. 01         03951         I NPATI ENT_DI ALYSI S         1, 442, 945         1, 442, 945         0         703, 944         8, 56	
OUTPATI ENT_SERVICE_COST_CENTERS           90.00         09000         CLINIC         166, 911         166, 911         0         236, 567         2, 66	68 90.00
90. 01 04950 WOUND CLINIC 7, 295, 159 7, 295, 159 0 1, 309, 298 2, 88	
91. 00 09100 EMERGENCY 52, 532, 260 52, 532, 260 0 6, 423, 391 17, 34	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	92.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 478, 307 478, 307 0 218, 638 34	94 96.00
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 SPECIAL PURPOSE COST CENTERS	0 101.00
113.00 11300 I NTEREST EXPENSE	113.00
	71 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 594, 622, 778 594, 622, 778 -20, 326, 337 135, 480, 130 347, 44 NONREI MBURSABLE COST CENTERS	42 118.00
190.00 J9000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0	
192.00         PHYSI CI ANS'         PRI VATE         OFFI CES         56, 660, 417         56, 660, 417         0         42, 814, 691         115, 24           192.01         PP PETERSBURG         637, 859         637, 859         0         435, 472	0 190. 00
192. 02 19202 PEDI ATRI CS 3, 976, 924 3, 976, 924 0 2, 402, 956	46 192. 00
192. 03 19203 WASHI NGTON PRI MARY CARE 3, 085, 257 3, 085, 257 0 1, 821, 720	46 192.00 0 192.01 0 192.02
	46 192.00 0 192.01 0 192.02 0 192.03
194. 03 07953 MH RESI DENTI AL 548, 609 548, 609 0 1, 162, 724 20, 20	46 192.00 0 192.01 0 192.02 0 192.03 36 194.00 87 194.02

Health Financial Systems	GOOD SAMARITA	N HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0042	Peri od:	Worksheet B-1	
				From 01/01/2019 To 12/31/2019	7/10/2020 2:5	
Cost Center Description	REGI STRATI ON		Reconciliatio	on ADMI NI STRATI VE		
	(GROSS	ACCOUNTS		& GENERAL	PLANT	
	CHARGES)	(GROSS		(ACCUM. COST)	(SQUARE FEET)	
		CHARGES)				
	4.03	4.04	5A	5.00	7.00	
194.0407954UNUSED SPACE	0	0		0 3, 223, 999		
194. 05 07955  MOB	0	0		0 701, 405		
194. 06 07956 FOUNDATI ON	0	0		0 13, 297		194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0		0 131, 089		194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0		194.08
194.0907959COMMUNITY MENTAL HEALTH CENTER	0	0		0 8, 399, 163		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)	1, 793, 173	4, 269, 750		20, 326, 337	11, 247, 956	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 002719	0. 006474		0. 103025	16. 813013	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	1, 932	3, 097		1, 191, 294	3, 704, 241	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000003	0. 000005		0. 006038	5. 536957	205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

COST ALLOCATION - STATISTICAL BASIS		Provider C		eriod: com 01/01/2019	Worksheet B-1	
			То		Date/Time Pre 7/10/2020 2:5	
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI ON (DI RECT	
	8.00	9.00	10.00	11.00	NURSI NG) 13.00	
GENERAL SERVICE COST CENTERS	0.00	9.00	10.00	11.00	13.00	
BLINENAL SLEWICL COSTS - BLOG & FLXT           2.00         00100 CAP REL COSTS-BLOG & FLXT           2.00         00200 CAP REL COSTS-BLOG & FLXT           4.00         00400 EMPLOYEE BENEFITS DEPARTMENT           4.01         00401 COMMUNI CATI ONS           4.02         00402 PURCHASI NG & RECEI VI NG           4.03         00403 REGI STRATI ON           4.04         00404 PATI ENT ACCOUNTS           5.00         00500 ADMI NI STRATI VE & GENERAL           7.00         00700 OPERATI ON OF PLANT           8.00         00800 LAUNDRY & LI NEN SERVI CE           9.00         00900 HOUSEKEEPI NG           10.00         01000 DI ETARY           11.00         01100 CAFETERI A           13.00         01300 NURSI NG ADMI NI STRATI ON           14.00         01400 CENTRAL SERVI CES & SUPPLY           15.00         01500 PHARMACY           16.00         01600 MEDI CAL RECORDS & LI BRARY           17.00         01701 MENTAL HEALTH OH           21.00         02100 I & SERVI CES-SALARY & FRINGES APPRVD           22.00         02200 I & SERVI CES-OTHER PRGM COSTS APPRVD           23.00         02300 PARAMED ED PRGM-RADI OLOGY	908, 893 60, 617 16, 033 0 11, 817 0 0 0 11, 240 0 0 16, 240 0 0 0	69, 422 1, 809 430 0 7633 601 536 0 1, 859 0 1, 859 0 1, 065	33, 450 0 0 0 0 0 0 0 0 0 0 0 0	2, 146, 884 29, 585 22, 536 71, 728 103, 617 0 16, 612 0 11, 918 2, 864	873, 525 0 0 0 0 0 11, 918	$\begin{array}{c} 1.00\\ 2.00\\ 4.00\\ 4.00\\ 4.02\\ 4.03\\ 4.04\\ 5.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 13.00\\ 11.00\\ 15.00\\ 15.00\\ 15.00\\ 17.0\\ 21.00\\ 22.00\\ 23.00\\ 23.00\\ \end{array}$
23. 01 02300 PARAMED ED PRGM-RADIOLOGY 23. 01 02301 PARAMED ED PRGM-LAB	0	0		2, 804 6, 773	0	23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	200 520	17 000	15 210	10/ 2/5	10/ 2/5	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	290, 528 110, 007	17, 082 5, 530		186, 365 121, 778	186, 365 121, 778	
40. 00 04000 SUBPROVIDER - IPF	0	0		66, 370	66, 003	
41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY	54, 829 2, 106	3, 000 187		69, 302 7, 945	69, 302 7, 945	
ANCI LLARY SERVI CE COST CENTERS	2,100	10,				
50. 00 05000 OPERATI NG ROOM	33, 189	3, 855		75, 134	57, 614	50.00
51.00 05100 RECOVERY ROOM 51.01 05101 ENDOSCOPY	0 26, 447	0 1, 021	0	0 30, 909	0 30, 909	51.00 51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	11, 188	247	0	27, 982	27, 982	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	-	0	0	53.00
54. 00   05400  RADI OLOGY-DI AGNOSTI C 55. 00   05500  RADI OLOGY-THERAPEUTI C	62, 703 0	3, 314 0		114, 429 52, 618	11, 559 32, 698	
60. 00 06000 LABORATORY	0	966		103, 837	0	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	177 12, 229	733 1, 847		63, 836 116, 391	0 39, 240	
69. 00 06900 ELECTROCARDI OLOGY	18, 998	2, 869		95, 480	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	-	0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	12, 869	744 0		14, 750	2, 586 0	70.0 <sup>°</sup> 71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	-	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART) 76.00 03950 MH ANCI LLARY OUTPATI ENT	32, 417	2, 997	0	42, 833	42, 833 0	75.00 76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0	0	0	0	76.0
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC 90. 01 04950 WOUND CLINIC	300 15, 506	1, 115 355		4, 059 11, 954	0 3, 505	90.00 90.01
91. 00 09100 EMERGENCY	91, 638	4, 486		134,000		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				,		92.00
OTHER REIMBURSABLE COST CENTERS				2 (57	0	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 101.00 10100 HOME HEALTH AGENCY	0	0 0		3, 657 0		96.00 101.00
SPECIAL PURPOSE COST CENTERS		0				
113.00 11300 INTEREST EXPENSE						113.00
116.00 11600 HOSPI CE	0	946		15,613		
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	879, 838	58, 357	33, 450	1, 624, 875	861, 850	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	29, 055	10, 578		416, 471	11, 675	
192. 01 19201 FP PETERSBURG 192. 02 19202 PEDI ATRI CS	0	0	0	9, 457 30, 873		192. 01 192. 02
192. 02 19202 PEDIATRICS 192. 03 19203 WASHINGTON PRIMARY CARE	0	0	0	30, 873 32, 417		192. 02
194. 00 07950 COMMUNI TY HEALTH SERVICES	0	337	0	0	0	194.00
194.0207952 MARKETING AND PUBLIC RELATIONS	0	60	0	6, 881	0	194. 02

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Peri od:	Worksheet B-1	
				From 01/01/2019 To 12/31/2019		
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE		(PATIENT DAYS	) (MAN HOURS)	ADMI NI STRATI ON	
	(POUNDS OF	SERVI CE)				
	LAUNDRY)				(DI RECT	
					NURSING)	
	8.00	9.00	10.00	11.00	13.00	
194. 03 07953 MH RESIDENTIAL	0	0		0 25, 910		194.03
194. 04 07954 UNUSED SPACE	0	0		0 0		194.04
194. 05 07955 MOB	0	0		0 0	-	194.05
194. 06 07956 FOUNDATI ON	0	0		0 0		194.06
194.0707957 KNOX COUNTY HEALTH DEPT	0	0		0 0		194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0		194.08
194.0907959 COMMUNITY MENTAL HEALTH CENTER	0	90		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,	624,031	3, 435, 204	1, 241, 19	5 2, 175, 255	2, 625, 575	202.00
Part I)			07 40507			
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 686584					
204.00 Cost to be allocated (per Wkst. B, Part II)	180, 400	280, 905	45, 76	5 431, 412	307, 741	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 198483	4. 046340	1. 36816	1 0. 200948	0. 352298	205.00
206.00 NAHE adjustment amount to be allocated						206.00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D,						207.00
Parts III and IV)						

	Financial Systems LLOCATION - STATISTICAL BASIS	GOOD SAMARITAN	Provider CO	CN: 15-0042	Period:	worksheet B-1	
0001 /1				F	rom 01/01/2019		
					o 12/31/2019	Date/Time Pre 7/10/2020 2:5	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	MENTAL HEALTH	
		SERVICES & SUPPLY	(COSTED REQUI S. )	RECORDS & LI BRARY	(NET CHARGES)	OH (NET CHARGES)	
		(SUPPLI ES	RECOID. )	(TIME SPENT)			
		COST)					
		14.00	15.00	16.00	17.00	17.01	
1.00	GENERAL SERVICE COST CENTERS 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
1.01	00401 COMMUNI CATI ONS						4.0
1.02 1.03	00402 PURCHASI NG & RECEI VI NG 00403 REGI STRATI ON						4.0
4.03 1.04	00404 PATIENT ACCOUNTS						4.0
5.00	00500 ADMI NI STRATI VE & GENERAL						5.0
7.00	00700 OPERATION OF PLANT						7.0
3.00	00800 LAUNDRY & LINEN SERVICE						8.0
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.0 10.0
11.00	01100 CAFETERI A						11.0
3.00	01300 NURSING ADMINISTRATION						13.0
14.00	01400 CENTRAL SERVI CES & SUPPLY	18, 796, 426					14.0
15.00	01500 PHARMACY	54, 987	20, 021, 840				15.0
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	4, 880 0	0	677			16.0
	01701 MENTAL HEALTH OH	1, 248	0			16, 750, 477	17.0
	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0		0	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	9, 513	0	C	0 0	0	22.0
23.00	02300 PARAMED ED PRGM-RADI OLOGY	42	0	C			
23. 01	02301 PARAMED ED PRGM-LAB	3, 742	0	(	0 0	0	23.0
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	395, 990	10, 376	205	5 O	0	30.0
31.00	03100 I NTENSI VE CARE UNI T	276, 627	8, 029	24			
40.00	04000 SUBPROVI DER – I PF	19, 470	1, 042	75	ō 0	8, 395, 319	40.0
41.00	04100 SUBPROVI DER – I RF	70, 218	4, 478	44			
13.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	15, 430	319	11	0	0	43.0
50.00	05000 OPERATI NG ROOM	558, 816	28, 377	20	0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0			
	05101 ENDOSCOPY	523, 360	2, 984	C		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	64, 865	1, 312	0		0	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 211, 445	0 187, 094			0	
55.00	05500 RADI OLOGY-THERAPEUTI C	76, 521	2, 736	(		0	
50.00	06000 LABORATORY	2, 463, 222	2, 478	C	0	0	
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0 0		
	06500 RESPI RATORY THERAPY	84,022	2, 518	0	0		65.0
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	30, 927 107, 647	3, 703 75, 489			0	
	07000 ELECTROENCEPHALOGRAPHY	107, 047	75,489	(		0	
	07001 NEURODI AGNOSTI CS	20, 742	29	C	0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 313, 091	0	C	0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 879, 217	0	0	0	0	
	07300 DRUGS CHARGED TO PATIENTS 07500 ASC (NON-DISTINCT PART)	0 354, 795	17, 624, 491 42, 979	133		0	
	03950 MH ANCI LLARY OUTPATIENT	354,795	42, 979	133		0	
	03951 I NPATI ENT DI ALYSI S	1, 986	5, 576	C			
	OUTPATIENT SERVICE COST CENTERS				1		
		1,675	0	(			
	04950 WOUND CLINIC 09100 EMERGENCY	107, 160 300, 775	19, 452 16, 731	30 135		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	300,775	10, 731	135	, 0		91.00
	OTHER REIMBURSABLE COST CENTERS						]
	09600 DURABLE MEDI CAL EQUI P-RENTED	22, 799	0	C			96. 0
01.00	10100 HOME HEALTH AGENCY	0	0	(	0 0	0	101. 0
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.0
	11600 HOSPI CE	20, 007	487	C	0	n	116.0
118. 00		15, 995, 219	18, 040, 680	677			
	NONREIMBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0		190. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	2, 194, 872	1, 497, 009	0	0		192.0
	19201 FP PETERSBURG 19202 PEDI ATRI CS	24, 683 375, 416	20, 800 344, 276				192. 0 <sup>°</sup> 192. 0
	19202 PEDIATRICS 19203 WASHINGTON PRIMARY CARE	375, 416 142, 522	344, 276 118, 763	r c			192. 0
192 113		112,022					
	07950 COMMUNI TY HEALTH SERVICES	1, 906	0	(	0 0	0	194.00

Health Financial Systems		GOOD SAMARITA				u of Form CMS-:	
COST ALLOCATION - STATISTICAL BASIS			Provider CC		Period:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
Cost Center Description		CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	MENTAL HEALTH	
		SERVICES &	(COSTED	RECORDS &		OH	
		SUPPLY	REQUIS.)	LI BRARY	(NET CHARGES)	(NET CHARGES)	
		(SUPPLIES		(TIME SPENT)			
	_	COST)					
		14.00	15.00	16.00	17.00	17.01	
194. 03 07953 MH RESI DENTI AL		20, 905	312	(	0 0	-	194.03
194. 04 07954 UNUSED SPACE		0	0	(	0 0		194.04
194.05 07955 MOB		0	0	(	0 0		194.05
194.0607956 FOUNDATI ON		0	0	(	0 0		194.06
194.07 07957 KNOX COUNTY HEALTH DEPT		0	0	(	0 0		194.07
194. 08 07958 I NDUSTRI AL HEALTH		0	0	(	0 0		194.08
194. 09 07959 COMMUNI TY MENTAL HEALTH CE	NIER	38, 902	0	(	0 0	8, 355, 158	
200.00 Cross Foot Adjustments							200.00
201.00 Negative Cost Centers						4 007 000	201.00
202.00 Cost to be allocated (per Part I)	WKST. B,	839, 321	4, 764, 517	4, 435, 300	0	1, 227, 830	202.00
203.00 Unit cost multiplier (Wkst	. B, Part I)	0. 044653	0. 237966	6, 551. 403250	0. 000000	0. 073301	203.00
204.00 Cost to be allocated (per Part II)	Wkst. B,	19, 420	252, 920	206, 645	5 0	135, 324	204.00
205.00 Unit cost multiplier (Wkst	. B, Part	0. 001033	0. 012632	305.236337	7 0.000000	0. 008079	205.00
206.00 NAHE adjustment amount to (per Wkst. B-2)	be allocated						206. 00
207.00 NAHE unit cost multiplier Parts III and IV)	(Wkst. D,						207.00

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	GOOD SAMARITA			Period:	u of Form CMS-2552-10 Worksheet B-1
				From 01/01/2019 To 12/31/2019	Date/Time Prepared:
	INTERNS &	RESI DENTS			7/10/2020 2:50 pm
Cost Center Description	SERVI CES-SALAR Y & FRI NGES (ASSI GNED TI ME)	PRGM COSTS (ASSIGNED TIME)	PRGM-RADI OLOG (ASSI GNED TI ME)	(ASSI GNED TI ME)	
GENERAL SERVICE COST CENTERS	21.00	22.00	23.00	23.01	
1.00       00100       CAP       REL       COSTS-BLDG & FIXT         2.00       00200       CAP       REL       COSTS-MVBLE       EQUIP         4.00       00400       EMPLOYEE       BENEFITS       DEPARTMENT         4.01       00401       COMMUNICATIONS         4.02       00402       PURCHASING & RECEIVING         4.03       00403       REGISTRATION         4.04       00404       PATIENT       ACCOUNTS         5.00       00500       ADMINISTRATIVE       & GENERAL         7.00       00700       OPERATION OF       PLANT         8.00       00800       LAUNDRY       & LINEN       SERVICE         9.00       00900       HOUSEKEEPING       001000       DIETARY         11.00       01100       CAFETERIA       3.00       01300       NURSING       ADMINISTRATION         14.00       01400       CENTRAL       SERVICES & SUPPLY       15.00       01500       PHARMACY         16.00       01600       MEDICAL       RECORDS & LI BRARY       17.00       01700       SOCIAL       SERVICE         17.01       01701       MENTAL       HEALTH       OH       21.00       02100       I&R       SE	736	736	10		$\begin{array}{c} 1.\ 00\\ 2.\ 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\\ 13.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 17.\ 00\\ 22.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00\\ 23.\ 00$
23. 01 02301 PARAMED ED PRGM-LAB				100	23. 01
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0 0 368 0 0	0 0 368 0 0		0 0 0 0 0 0 0 0 0 0	30. 00 31. 00 40. 00 41. 00 43. 00
ANCI LLARY SERVICE COST CENTERS					
ANDITIZEAR INGROUND           50.00         05000         OPERATI NG ROOM           51.00         05100         RECOVERY ROOM           51.01         05101         ENDOSCOPY           52.00         05200         DELI VERY ROOM & LABOR ROOM           53.00         05300         ANESTHESI OLOGY           54.00         05400         RADI OLOGY-DI AGNOSTI C           55.00         05500         RADI OLOGY-THERAPEUTI C           60.00         06600         LABORATORY           63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.           65.00         06600         PHYSI CAL THERAPY           66.00         06600         PHYSI CAL THERAPY           69.00         06900         ELECTROCARDI OLOGY           70.00         07000         ELECTROENCEPHALOGRAPHY           70.01         07010         NEUROJI AGNOSTI CS           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS           73.00         07300         RUGS CHARGED TO PATI ENTS           75.00         07500         ASC (NON-DI STI NCT PART)           76.00         03950         M ANCI LLARY OUTPATI ENT				0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0         0       0	50.00 51.01 52.00 53.00 54.00 55.00 60.00 63.00 65.00 66.00 66.00 69.00 70.01 71.00 72.00 73.00 75.00 76.00 76.01 90.00
90.00         04950         WOUND CLINIC           91.00         09100         EMERGENCY           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)           OTHER REIMBURSABLE COST CENTERS	0	0 0 31			90.00 90.01 91.00 92.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS	0	C C		0 0 0 0	96.00 101.00
113. 00 11300   NTEREST EXPENSE 116. 00 11600   HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	399	399		0 0 0 100	113. 00 116. 00 118. 00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 192. 01 19201 FP PETERSBURG 192. 02 19202 PEDI ATRI CS 192. 03 19203 WASHI NGTON PRI MARY CARE	0 337 0 0 0	0 337 0 0 0 0		0 0 0 0 0 0 0 0 0 0	190. 00 192. 00 192. 01 192. 02 192. 03

Health Financial Systems	GOOD SAMARI TA	N HOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2019	Worksheet B-1	
			-	To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
	INTERNS &	RESI DENTS				
Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	PARAMED ED		
	Y & FRINGES		PRGM-RADI OLOG'	Y PRGM-LAB		
	(ASSI GNED	(ASSI GNED		(ASSI GNED		
	TIME)	TIME)	(ASSI GNED	TIME)		
	,	,	TIME)	Í Í		
	21.00	22.00	23.00	23.01		
194.00 07950 COMMUNI TY HEALTH SERVICES	0	0	(	0 0		194.00
194.0207952 MARKETING AND PUBLIC RELATIONS	0	0	(	0 0		194.02
194. 03 07953 MH RESIDENTIAL	0	0	(	0 0		194.03
194.0407954UNUSED SPACE	0	0	(	0 0		194.04
194. 05 07955 MOB	0	0	(	0 0		194.05
194. 06 07956 FOUNDATI ON	0	0	(	0 0		194.06
194.0707957KNOX COUNTY HEALTH DEPT	0	0	(	0 0		194.07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	(	0 0		194.08
194.0907959COMMUNITY MENTAL HEALTH CENTER	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)	470, 409	1, 856, 458	151, 05:	2 326, 290		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	639. 142663	2, 522. 361413	1, 510. 52000	3, 262. 900000		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	135, 703	21, 724	1, 52	5 3, 473		204.00
205.00 Unit cost multiplier (Wkst. B, Part	184. 379076	29. 516304	15. 25000	34. 730000		205.00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2)				0 0		206. 00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)			0.00000	0. 000000		207. 00

Health Financial Systems	GOOD SAMARITA				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 7/10/2020 2:5	pared:
		Title	× XVIII	Hospi tal	PPS	
		11110		Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	1			
30. 00 03000 ADULTS & PEDIATRICS	14, 265, 451		14, 265, 45		14, 265, 451	•
31.00 03100 INTENSIVE CARE UNIT	7, 863, 008		7, 863, 00		7, 863, 008	
40. 00 04000 SUBPROVIDER - IPF	5, 856, 929		5, 856, 92		5, 889, 689	
41. 00 04100 SUBPROVIDER - IRF	4, 428, 427		4, 428, 42		4, 428, 427	•
43. 00 04300 NURSERY	509, 579		509, 57	0 0	509, 579	43.00
ANCI LLARY SERVI CE COST CENTERS	T	I	1			
50. 00 05000 OPERATI NG ROOM	6, 510, 540		6, 510, 54	0 2, 965	6, 513, 505	
51.00 05100 RECOVERY ROOM	0			0 0	0	
51. 01 05101 ENDOSCOPY	3, 050, 597		3, 050, 59		3, 050, 597	
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 582, 545		1, 582, 54	15 0	1, 582, 545	•
53. 00 05300 ANESTHESI OLOGY	0			0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 292, 564		10, 292, 56		10, 292, 564	
55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 022, 008		4, 022, 00		4, 032, 059	
60. 00 06000 LABORATORY	9, 911, 606		9, 911, 60	06 0	9, 911, 606	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	
65. 00 06500 RESPI RATORY THERAPY	3, 565, 824		-,,		3, 565, 824	
66. 00 06600 PHYSI CAL THERAPY	6, 921, 418		6, 921, 41		6, 921, 418	
69. 00 06900 ELECTROCARDI OLOGY	5, 937, 543		5, 937, 54	145, 723	6, 083, 266	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
70. 01 07001 NEURODI AGNOSTI CS	1, 282, 685		1, 282, 68	35 0	1, 282, 685	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 199, 242		5, 199, 24	2 0	5, 199, 242	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	7, 232, 475		7, 232, 47	75 0	7, 232, 475	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 087, 242		24, 087, 24		24, 087, 242	73.00
75.00 07500 ASC (NON-DISTINCT PART)	3, 887, 387		3, 887, 38	37 1, 052	3, 888, 439	75.00
76.00 03950 MH ANCI LLARY OUTPATI ENT	0			0 0	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	922, 173		922, 17	3 5, 835	928, 008	76.01
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	365, 363		365, 36		365, 363	•
90. 01 04950 WOUND CLINIC	1, 749, 458		1, 749, 45		1, 749, 458	
91. 00 09100 EMERGENCY	9, 200, 041		9, 200, 04		9, 201, 576	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 182, 814		3, 182, 81	4	3, 182, 814	92.00
OTHER REIMBURSABLE COST CENTERS	1		1			
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	252, 510		252, 51		252, 510	
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS			1			110.00
113.00 11300 INTEREST EXPENSE	1 700 670		1 700 07		1 700 070	113.00
116.00 11600 HOSPI CE	1, 729, 070		1, 729, 07		1, 729, 070	
200.00 Subtotal (see instructions)	143, 808, 499				144, 008, 420	
201.00 Less Observation Beds	3, 182, 814		3, 182, 81		3, 182, 814	
202.00  Total (see instructions)	140, 625, 685	0	140, 625, 68	35 199, 921	140, 825, 606	J202. 00

COMPUTATI O	ancial Systems N OF RATIO OF COSTS TO CHARGES	GOOD SAMARITA	Provi der C	CN: 15-0042	Peri od:	Worksheet C	2552-10
			i i otraoi o		From 01/01/2019	Part I	
					To 12/31/2019	Date/Time Pre	pared:
					11	7/10/2020 2:5	0 pm
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Inpatient	Charges Outpatient	Total (col	6 Cost or Other	TEFRA	
	cost center bescription	Inpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
					Ratio	Ratio	
		6.00	7.00	8.00	9.00	10.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	0 ADULTS & PEDIATRICS	25, 596, 956		25, 596, 95	56		30.00
31.00 0310	DO INTENSIVE CARE UNIT	17, 439, 101		17, 439, 10	01		31.00
40.00 0400	00 SUBPROVIDER - IPF	8, 395, 319		8, 395, 31	19		40.00
41.00 0410	00 SUBPROVIDER - IRF	7, 646, 926		7, 646, 92	26		41.00
	00 NURSERY	1, 210, 619		1, 210, 61	19		43.00
ANCI	LLARY SERVICE COST CENTERS						
50.00 0500	OO OPERATING ROOM	22, 149, 227	22, 316, 415	44, 465, 64	42 0. 146417	0.000000	50.00
51.00 0510	00 RECOVERY ROOM	0	0		0 0.000000	0.000000	51.00
51.01 0510	1 ENDOSCOPY	1, 330, 173	9, 867, 851	11, 198, 02	0. 272423	0.000000	51.01
	DO DELIVERY ROOM & LABOR ROOM	4, 830, 443	166, 868	4, 997, 31		0.000000	
53.00 0530	00 ANESTHESI OLOGY	0	0		0 0.000000	0.000000	53.00
	00 RADI OLOGY-DI AGNOSTI C	17, 018, 390	77, 164, 746			0.000000	
	00 RADI OLOGY-THERAPEUTI C	658, 518	23, 679, 527			0.000000	
	00 LABORATORY	22, 734, 323	47, 624, 899	70, 359, 22		0.000000	
	00 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0.000000	0.000000	
	00 RESPI RATORY THERAPY	11, 138, 626	3, 148, 948			0.000000	
	00 PHYSI CAL THERAPY	14, 932, 571	10, 292, 466			0.00000	
	00 ELECTROCARDI OLOGY	17, 176, 690	22, 698, 226	39, 874, 91		0.00000	
	00 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0.00000	
	01 NEURODI AGNOSTI CS	104, 999	5, 606, 544			0.00000	
	00 MEDI CAL SUPPLIES CHARGED TO PATIENTS	2, 432, 933	2, 478, 656			0.00000	
	00 I MPL. DEV. CHARGED TO PATIENTS	7, 216, 261	5, 649, 061			0.00000	
	00 DRUGS CHARGED TO PATIENTS	20, 098, 135	66, 821, 217			0.00000	
	00 ASC (NON-DI STI NCT PART)	114, 245	23, 771, 693	23, 885, 93		0.00000	
	O MH ANCI LLARY OUTPATI ENT	1 2/5 055	0	1 1 1 0	0 0.00000	0.00000	
	1 INPATIENT DIALYSIS	1, 365, 855	77, 090	1, 442, 94	0. 639091	0. 000000	76. 01
	PATIENT SERVICE COST CENTERS	0	166, 911	166, 91	2, 188969	0. 000000	90.00
	50 WOUND CLINIC	104, 216	7, 190, 943			0. 000000	
	DO EMERGENCY	10, 880, 148	41, 651, 978			0. 000000	
	00 OBSERVATION BEDS (NON-DISTINCT PART)	1, 598, 678	4, 199, 197			0. 000000	
	R REIMBURSABLE COST CENTERS	1, 370, 070	4, 177, 177	J, 171, 01	0. 546702	0.00000	92.00
	O DURABLE MEDICAL EQUI P-RENTED	0	478, 307	478, 30	0. 527925	0. 000000	96.00
	O HOME HEALTH AGENCY	0	470, 307		0	0.000000	101.00
	TAL PURPOSE COST CENTERS	0	0	1	~		101.00
	00 I NTEREST EXPENSE						113.00
116.001160		0	3, 397, 750	3, 397, 75	50		116.00
200.00	Subtotal (see instructions)	216, 173, 352	378, 449, 293				200.00
201.00	Less Observation Beds		, _ , 0				201.00

	inancial Systems	GOOD SAMARITAN			u of Form CMS-25	<u>552-10</u>
COMPUTAT	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepa 7/10/2020 2:50	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio 11.00				
	NPATIENT ROUTINE SERVICE COST CENTERS	11.00				
	3000 ADULTS & PEDIATRICS					30.00
	3100 I NTENSI VE CARE UNI T					31.00
	4000 SUBPROVIDER - IPF					40.00
	4100 SUBPROVIDER - IRF					41.00
	4300 NURSERY					43.00
	NCILLARY SERVICE COST CENTERS	- <u>I</u> I				
	5000 OPERATI NG ROOM	0. 146484				50.00
51.00 05	5100 RECOVERY ROOM	0.000000				51.00
51.01 05	5101 ENDOSCOPY	0. 272423				51.01
52.00 05	5200 DELIVERY ROOM & LABOR ROOM	0. 316679				52.00
	5300 ANESTHESI OLOGY	0.000000				53.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 109282				54.00
	5500 RADI OLOGY-THERAPEUTI C	0. 165669				55. OC
	6000 LABORATORY	0. 140871				60.00
63.00 06	6300 BLOOD STORING, PROCESSING & TRANS.	0.000000				63.00
	6500 RESPI RATORY THERAPY	0. 249575				65.00
66.00 06	6600 PHYSI CAL THERAPY	0. 274387				66.00
69.00 06	6900 ELECTROCARDI OLOGY	0. 152559				69.00
70.00 07	7000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
70.01 07	7001 NEURODI AGNOSTI CS	0. 224578				70.01
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566				71.00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 562168				72.00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	0. 277122				73.00
75.00 07	7500 ASC (NON-DISTINCT PART)	0. 162792				75.00
76.00 03	3950 MH ANCILLARY OUTPATIENT	0.000000				76.00
	3951 INPATIENT DIALYSIS	0. 643135				76.01
	UTPATIENT SERVICE COST CENTERS					
	9000 CLI NI C	2. 188969				90.00
	4950 WOUND CLINIC	0. 239811				90.01
	9100 EMERGENCY	0. 175161				91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 548962				92.00
	THER REIMBURSABLE COST CENTERS	1 · ·				
	9600 DURABLE MEDI CAL EQUI P-RENTED	0. 527925				96.00
	0100 HOME HEALTH AGENCY				1	01.00
	PECIAL PURPOSE COST CENTERS	1				
	1300 INTEREST EXPENSE					13.00
	1600 HOSPI CE					16.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)				2	202.00

Health Financial Systems	GOOD SAMARI TA	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-0042	Period:	Worksheet C	
				From 01/01/2019	Part I	
				To 12/31/2019	Date/Time Pre	
		T: +1		11	7/10/2020 2:5	U pm
		1  1	e XIX	Hospital	Cost	1
Cost Conton Deserintion	Total Cost	Thorsony Limit	Tatal Casta	Costs RCE	Tatal Casta	
Cost Center Description	(from Wkst. B,	Therapy Limit	Total Costs		Total Costs	
	Part I, col.	Adj .		Di sal I owance		
	26)					
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	5.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRICS	14, 265, 451		14, 265, 45	51 0	14, 265, 451	30.00
31. 00 03100 I NTENSI VE CARE UNI T	7, 863, 008		7, 863, 00		7, 863, 008	
40. 00 04000 SUBPROVIDER - IPF	5, 856, 929		5, 856, 92		5, 889, 689	
41. 00 04100 SUBPROVI DER – I RF	4, 428, 427		4, 428, 42		4, 428, 427	1
43. 00 04300 NURSERY	509, 579		509, 57		509, 579	
ANCI LLARY SERVI CE COST CENTERS	507, 577		507, 51		307, 377	45.00
50. 00 05000 OPERATING ROOM	6, 510, 540		6, 510, 54	10 2, 965	6, 513, 505	50.00
51. 00 05100 RECOVERY ROOM	0,010,010		0,010,0	0 0	0,010,000	1
51. 01 05101 ENDOSCOPY	3, 050, 597		3, 050, 59	97 0	3, 050, 597	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 582, 545		1, 582, 54		1, 582, 545	
53. 00 05300 ANESTHESI OLOGY	0		1,002,0	0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 292, 564		10, 292, 56	54 0	10, 292, 564	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	4, 022, 008		4, 022, 00		4, 032, 059	1
60. 00 06000 LABORATORY	9, 911, 606		9, 911, 60		9, 911, 606	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0 0	0	
65. 00 06500 RESPI RATORY THERAPY	3, 565, 824	0	3, 565, 82	24 0	3, 565, 824	
66. 00 06600 PHYSI CAL THERAPY	6, 921, 418	0	6, 921, 41		6, 921, 418	
69. 00 06900 ELECTROCARDI OLOGY	5, 937, 543	0	5, 937, 54		6, 083, 266	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0,707,010		0,,0,,0	0 0	0,000,200	
70. 01 07001 NEURODI AGNOSTI CS	1, 282, 685		1, 282, 68	35 0	1, 282, 685	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 199, 242		5, 199, 24		5, 199, 242	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	7, 232, 475		7, 232, 47		7, 232, 475	
73. 00 07300 DRUGS CHARGED TO PATIENTS	24, 087, 242		24, 087, 24		24, 087, 242	
75. 00 07500 ASC (NON-DI STI NCT PART)	3, 887, 387		3, 887, 38		3, 888, 439	
76.00 03950 MH ANCI LLARY OUTPATI ENT	0,007,007		0,007,00	0 1,002	0,000,107	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	922, 173		922, 17	73 5,835	928, 008	
OUTPATIENT SERVICE COST CENTERS	,22,110		,22,11	0,000	,20,000	/ 0. 01
90. 00 09000 CLINIC	365, 363		365, 36	53 0	365, 363	90.00
90. 01 04950 WOUND CLINIC	1, 749, 458		1, 749, 45	58 0	1, 749, 458	90.01
91. 00 09100 EMERGENCY	9, 200, 041		9, 200, 04		9, 201, 576	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 182, 814		3, 182, 8		3, 182, 814	1
OTHER REIMBURSABLE COST CENTERS	· · · · · ·				· · ·	1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	252, 510		252, 51	10 0	252, 510	96.00
101.00 10100 HOME HEALTH AGENCY	0			0	0	101.00
SPECIAL PURPOSE COST CENTERS			_			
113.00 11300 INTEREST EXPENSE						113.00
116. 00 11600 HOSPI CE	1, 729, 070		1, 729, 07		1, 729, 070	
200.00 Subtotal (see instructions)	143, 808, 499	0			144, 008, 420	
					0 400 044	1001 00
201.00Less Observation Beds202.00Total (see instructions)	3, 182, 814 140, 625, 685	0	3, 182, 8 <sup>-</sup> 140, 625, 68		3, 182, 814 140, 825, 606	

OMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0042	Period: From 01/01/2019	Worksheet C Part I	
				To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
		Titl	e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpatient	
	( 00	7.00	0.00	0.00	Ratio	
INDATIONT DOUTINE CEDVICE COST CENTEDS	6.00	7.00	8.00	9.00	10.00	
0.00 03000 ADULTS & PEDIATRICS	25, 596, 956		25, 596, 95	4		30. C
1. 00 03100 INTENSIVE CARE UNIT	17, 439, 101					31.0
0. 00 04000 SUBPROVIDER - IPF	8, 395, 319		17, 439, 10 8, 395, 31			40.0
1. 00 04100 SUBPROVIDER - TPF	7, 646, 926		7, 646, 92			40.0
3. 00 04300 NURSERY	1, 210, 619		1, 210, 61			41.0
ANCI LLARY SERVICE COST CENTERS	1,210,019		1,210,0	7		43.0
0. 00 05000 OPERATING ROOM	22, 149, 227	22, 316, 415	44, 465, 64	0. 146417	0. 000000	50. C
1. 00 05100 RECOVERY ROOM	22, 147, 227	22, 310, 413	44, 403, 04	0 0. 000000	0. 000000	
1. 01 05101 ENDOSCOPY	1, 330, 173	9, 867, 851	11, 198, 02		0. 000000	
2.00 05200 DELIVERY ROOM & LABOR ROOM	4, 830, 443	166, 868			0. 000000	
3. 00 05300 ANESTHESI OLOGY	4,030,443	100, 000	4, 777, 3	0 0.000000	0. 000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 018, 390	77, 164, 746	94, 183, 13		0. 000000	
5. 00 05500 RADI OLOGY-THERAPEUTI C	658, 518	23, 679, 527			0. 000000	
0. 00 06000 LABORATORY	22, 734, 323	47, 624, 899			0. 000000	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	22, 701, 020	0,021,07		0 0.000000	0. 000000	
5. 00 06500 RESPIRATORY THERAPY	11, 138, 626	3, 148, 948			0. 000000	
6. 00 06600 PHYSI CAL THERAPY	14, 932, 571	10, 292, 466			0. 000000	
9. 00 06900 ELECTROCARDI OLOGY	17, 176, 690	22, 698, 226			0. 000000	
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0.000000	0.000000	
0. 01 07001 NEURODI AGNOSTI CS	104, 999	5, 606, 544	5, 711, 54		0.000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 432, 933	2, 478, 656			0.000000	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	7, 216, 261	5, 649, 061			0.000000	
3.00 07300 DRUGS CHARGED TO PATIENTS	20, 098, 135	66, 821, 217	86, 919, 35	0. 277122	0.000000	73.0
5.00 07500 ASC (NON-DISTINCT PART)	114, 245	23, 771, 693			0.000000	
6.00 03950 MH ANCI LLARY OUTPATI ENT	0	0		0 0.000000	0.000000	76.
6. 01 03951 I NPATI ENT DI ALYSI S	1, 365, 855	77, 090	1, 442, 94	0. 639091	0.000000	76.
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLI NI C	0	166, 911	166, 91	2. 188969	0.00000	90.
0.01 04950 WOUND CLINIC	104, 216	7, 190, 943	7, 295, 15	0. 239811	0.000000	90.
1.00 09100 EMERGENCY	10, 880, 148	41, 651, 978	52, 532, 12	0. 175132	0.000000	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 598, 678	4, 199, 197	5, 797, 87	0. 548962	0.000000	92.0
OTHER REIMBURSABLE COST CENTERS						
6.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	478, 307	478, 30	0. 527925	0.000000	96.
01.00 10100 HOME HEALTH AGENCY	0	0		0		101. (
SPECIAL PURPOSE COST CENTERS						
13.0011300 INTEREST EXPENSE						113.
16. 00 11600 H0SPI CE	0	3, 397, 750				116.
00.00 Subtotal (see instructions)	216, 173, 352	378, 449, 293	594, 622, 64	15		200.
01.00 Less Observation Beds						201.
02.00 Total (see instructions)	216, 173, 352	378, 449, 293	594, 622, 64	15		202. (

Health Financial Systems	GOOD SAMARI TAN	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0042	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prep 7/10/2020 2:50	
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio 11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 I NTENSI VE CARE UNI T					31.00
40. 00 04000 SUBPROVIDER - IPF					40.00
41. 00 04100 SUBPROVIDER - I RF					41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS					45.00
50. 00 05000 OPERATING ROOM	0.000000				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
51. 01 05101 ENDOSCOPY	0. 000000				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				51.01
53. 00 05300 ANESTHESI OLOGY	0. 000000				52.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000				54.00
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000				55.00
60. 00 06000 LABORATORY	0.000000				60.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0.000000				63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
75. 00 07500 ASC (NON-DI STINCT PART)	0. 000000				75.00
76. 00 03950 MH ANCI LLARY OUTPATI ENT	0. 000000				76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0. 000000				76.01
OUTPATIENT SERVICE COST CENTERS	01000000				/ 0/ 0/
90. 00 09000 CLINIC	0.000000				90.00
90. 01 04950 WOUND CLINIC	0. 000000				90.01
91. 00 09100 EMERGENCY	0, 000000				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
OTHER REI MBURSABLE COST CENTERS					1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000				96.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS	· · · · · ·				1
113. 00 11300 I 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

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPI TAL COSTS	Provider C	F	Period: From 01/01/2019 Fo 12/31/2019		pared: 0 pm
		Title	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 CENTER		-	1	1		
30. 00 ADULTS & PEDIATRICS	2, 709, 042		2, 709, 042			
31.00 INTENSIVE CARE UNIT	1, 063, 797		1, 063, 79			
40. 00 SUBPROVIDER - IPF	587, 168		587, 168			
41.00 SUBPROVIDER - IRF	678, 753		678, 753			
43.00 NURSERY	11, 744		11, 744			
200.00 Total (lines 30 through 199)	5, 050, 504		5, 050, 504	4 33, 675		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTER			1			
30.00 ADULTS & PEDIATRICS	6, 668					30.00
31.00 INTENSIVE CARE UNIT	3, 997		•			31.00
40.00 SUBPROVIDER - IPF	1, 438		1			40.00
41.00 SUBPROVIDER - IRF	5, 957		1			41.00
43.00 NURSERY	0	C				43.00
200.00 Total (lines 30 through 199)	18, 060	2, 636, 283				200.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C	CN: 15-0042	Period: From 01/01/2019 To 12/31/2019		epared: 0 pm
		Title	× XVIII	Hospi tal	PPS	•
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						1
50. 00 05000 OPERATING ROOM	741, 516	44, 465, 642				
51.00 05100 RECOVERY ROOM	0	0	0.0000		0	
51.01 05101 ENDOSCOPY	461, 692					
52. 00 05200 DELIVERY ROOM & LABOR ROOM	29, 210				0	
53. 00 05300 ANESTHESI OLOGY	0	0	010000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 215, 818					
55. 00 05500 RADI OLOGY-THERAPEUTI C	304, 275					
60.00 06000 LABORATORY	373, 176					
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	-	0.0000		Ŭ	
65. 00 06500 RESPI RATORY THERAPY	228, 354					
66. 00 06600 PHYSI CAL THERAPY	822, 386					
69. 00 06900 ELECTROCARDI OLOGY	680, 532					
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	-			-	
70. 01 07001 NEURODI AGNOSTI CS	271, 370					
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	120, 549					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	165, 177					72.00
	332, 229 107, 196					75.00
75.00 07500 ASC (NON-DISTINCT PART) 76.00 03950 MH ANCILLARY OUTPATIENT	107, 198	23, 885, 938	0.000448			
76. 01 03951 INPATIENT DIALYSIS	290, 645	1, 442, 945			190, 520	
OUTPATIENT SERVICE COST CENTERS	290, 045	1, 442, 940	0.20142	940,001	190, 520	70.01
90. 00 09000 CLINIC	96,004	166, 911	0. 57518	31 0	0	90.00
90. 01 04950 WOUND CLINIC	124, 469				-	
90. 01 04930 WOOND CEINIC 91. 00 09100 EMERGENCY	780, 718					
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	604, 423					•
OTHER REIMBURSABLE COST CENTERS	004,423	5, 171, 015	0.10424	042,010	07,003	,2.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	15, 815	478, 307	0. 03300	5 0	0	96.00
200.00 Total (lines 50 through 199)	7, 765, 554			74, 951, 683		
	1,,,00,004	000, 700, 774	I	, , , , , , , , , , , , , , , , , , , ,	1 1,211,047	

Health Financial Systems	GOOD SAMARIT.	AN HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 7/10/2020 2:5	pared: 0 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Post-Stepdown	Nursing School	Post-Stepdow	h Allied Health n Cost	Medi cal	
	Adjustments	1.00	Adjustments	2.00	Education Cost	
	1A	1.00	2A	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			J	0		1 20 00
30. 00 03000 ADULTS & PEDI ATRI CS	0			0 0	0	00.00
31.00 03100 I NTENSI VE CARE UNI T	0	0	)	0 0	0	
40. 00 04000 SUBPROVIDER - IPF	0	0	)	0 0	1, 163, 434	
41.00 04100 SUBPROVIDER - IRF	0	0	)	0 0	0	
43.00 04300 NURSERY	0	0	)	0 0	0	
200.00 Total (lines 30 through 199)	0			0 0	1, 163, 434	200.00
Cost Center Description	Swi ng-Bed	Total Costs		t Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)	( 00	7.00	0.00	
	4.00	5.00	6.00	7.00	8.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0		14.70	0.00	( ( ( )	200.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	0		14,70			
		1 1/2 424	6, 57			
40. 00 04000 SUBPROVI DER - I PF	0	1, 163, 434				
41.00 04100 SUBPROVIDER - IRF	0		7, 05			
43.00 04300 NURSERY		0	84			
200.00 Total (lines 30 through 199)		1, 163, 434	33, 67	5	18,060	200.00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	<u>col. 8)</u> 9.00	-				
INPATIENT ROUTINE SERVICE COST CENTERS	9.00					
						30.00
	0					
31. 00 03100 I NTENSI VE CARE UNI T	0					31.00
40. 00 04000 SUBPROVI DER - I PF	371, 622					40.00
41.00 04100 SUBPROVIDER - IRF	0					41.00
43.00 04300 NURSERY	0					43.00
200.00   Total (lines 30 through 199)	371, 622					200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS         Provider CCN: 15-0042         Period: From 01/01/2019 To 12/31/2019         Port IV Date IV Date Time Part	
Cost Center Description         Non Physician Anesthetist         Nursing School Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments         Allied Health Post-Stepdown Adjustments           50:00         05000 (PERATI NG ROOM 0 00 (OPERATI NG ROOM 0 00 (OPERATI NG ROOM 51:00 (D5100 RECOVERY ROOM 51:01 (D5101 ENDOSCOPY 0 00 (OPERATI NG ROOM 0 00 (OPERATI NG ROOM 51:01 (D5101 ENDOSCOPY 0 00 (OPERATI NG ROOM 0 0 (OPERATI NG ROOM 0 (	
Anesthetist         Post-Stepdown Adjustments         Post-Stepdown Adjustments           ANCILLARY SERVICE COST CENTERS         1.00         2A         2.00         3A         3.00           50.00         05000 OPERATING ROOM         0         0         0         0         0         0         0           51.00         05100 RECOVERY ROOM         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0 <td< td=""><td></td></td<>	
Anesthetist         Post-Stepdown Adjustments         Post-Stepdown Adjustments           ANCILLARY SERVICE COST CENTERS         1.00         2A         2.00         3A         3.00           50.00         05000         0PERATING ROOM         0         0         0         0         0           51.00         05100         RECOVERY ROOM         0         0         0         0         0           52.00         05101         ENDOSCOPY         0         0         0         0         0         0           52.00         05200         DELIVERY ROOM & LABOR ROOM         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	h
I.00         2A         2.00         3A         3.00           ANCILLARY SERVICE COST CENTERS         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	
ANCI LLARY SERVICE COST CENTERS           50.00         05000 OPERATI NG ROOM         0         0         0         0           51.00         05100 RECOVERY ROOM         0         0         0         0         0           51.01         05101 ENDOSCOPY         0         0         0         0         0         0           52.00         05200 DELI VERY ROOM & LABOR ROOM         0         0         0         0         0           53.00         05300 ANESTHESI OLOGY         0         0         0         0         0           54.00         05400 RADI OLOGY-DI AGNOSTI C         0         0         0         0         0           55.00         05500 RADI OLOGY-THERAPEUTI C         0         0         0         0         0           60.00         06000 LABORATORY         0         0         0         0         0         0         326, 25           63.00         06300 BLODD STORI NG, PROCESSI NG & TRANS.         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0         0	
50.00         05000         0PERATI NG ROOM         0         0         0         0           51.00         05100         RECOVERY ROOM         0         0         0         0           51.01         05101         ENDOSCOPY         0         0         0         0           52.00         05200         DELI VERY ROOM & LABOR ROOM         0         0         0         0           53.00         05300         ANESTHESI OLOGY         0         0         0         0           54.00         05400         RADI OLOGY-THERAPEUTI C         0         0         0         0           55.00         05500         RADI OLOGY-THERAPEUTI C         0         0         0         0           60.00         06000         LABORATORY         0         0         0         0           63.00         06300         BLOOD STORI NG, PROCESSI NG & TRANS.         0         0         0         0           65.00         06500         RESPI RATORY THERAPY         0         0         0         0           65.00         06600         PHYSI CAL THERAPY         0         0         0         0           66.00         06600         PHYSI CAL THERAPY <td></td>	
51.00       05100       RECOVERY ROOM       0       0       0         51.01       05101       ENDOSCOPY       0       0       0         52.00       05200       DELI VERY ROOM & LABOR ROOM       0       0       0         53.00       05300       ANESTHESI OLOGY       0       0       0       0         54.00       05400       RADI OLOGY-THERAPEUTI C       0       0       0       0         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0         60.00       06000       LABORATORY       0       0       0       326, 25         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0         65.00       06500       RESPI RATORY THERAPY       0       0       0       0         65.00       06600       PHYSI CAL THERAPY       0       0       0       0         66.00       06600       ELECTROCARDI OLOGY       0       0       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0         71.00       07100       MEDI CAL SU	
51.01       05101       ENDOSCOPY       0       0       0         52.00       05200       DELI VERY ROOM & LABOR ROOM       0       0       0         53.00       05300       ANESTHESI OLOGY       0       0       0       0         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0       151, 05         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0       0         60.00       06000       LABORATORY       0       0       0       0       326, 29         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0       326, 29         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       0         65.00       06600       PHYSI CAL THERAPY       0       0       0       0       0         66.00       06600       ELECTROCARDI OLOGY       0       0       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0         71.00       07100       NEURODI AGNOSTI CS       0 <td>0 50.00</td>	0 50.00
52.00       05200       DELI VERY ROOM & LABOR ROOM       0       0       0         53.00       05300       ANESTHESI OLOGY       0       0       0         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       0         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0         60.00       06000       LABORATORY       0       0       0       326, 29         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       326, 29         65.00       06500       RESPI RATORY THERAPY       0       0       0       0         65.00       06500       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       0         70.01       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0 <t< td=""><td>0 51.00</td></t<>	0 51.00
53.00       05300       ANESTHESI OLOGY       0       0       0         54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       151, 05         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0       0         60.00       06000       LABORATORY       0       0       0       0       326, 29         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0         65.00       06500       RESPI RATORY THERAPY       0       0       0       0         65.00       06600       PHYSI CAL THERAPY       0       0       0       0         69.00       06600       ELECTROCARDI OLOGY       0       0       0       0         70.00       07000       ELECTROCARDI OLOGY       0       0       0       0         70.01       07011       NEURODI AGNOSTI CS       0       0       0       0         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0 <t< td=""><td>0 51.01</td></t<>	0 51.01
54.00       05400       RADI OLOGY-DI AGNOSTI C       0       0       0       151,05         55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0         60.00       06000       LABORATORY       0       0       0       326,29         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0         65.00       06500       RESPI RATORY THERAPY       0       0       0       0         65.00       06600       PHYSI CAL THERAPY       0       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0       0         67.00       06900       ELECTROCARDI OLOGY       0       0       0       0         70.00       07000       ELECTROCARDI OLOGY       0       0       0       0         70.01       07001       NEURODI AGNOSTI CS       0       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0 <td>0 52.00</td>	0 52.00
55.00       05500       RADI OLOGY-THERAPEUTI C       0       0       0       0         60.00       06000       LABORATORY       0       0       0       326, 29         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0       326, 29         63.00       06300       RESPI RATORY THERAPY       0       0       0       0       0         65.00       06600       PHYSI CAL THERAPY       0       0       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0         70.01       NEURODI AGNOSTI CS       0       0       0       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0	0 53.00
60.00       06000       LABORATORY       0       0       326, 29         63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       0         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0         67.00       06900       ELECTROCARDI OLOGY       0       0       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0	52 54.00
63.00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0         65.00       06500       RESPI RATORY THERAPY       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0         67.00       06600       PHYSI CAL THERAPY       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0         70.01       07001       NEURODI AGNOSTI CS       0       0       0         71.00       07100       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0	0 55.00
65.00       06500       RESPI RATORY THERAPY       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0         70.01       07001       NEURODI AGNOSTI CS       0       0       0         71.00       07100       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0	60.00
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         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0	0 63.00
69.00         06900         ELECTROCARDIOLOGY         0         0         0         0           70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0           70.01         07001         NEURODI AGNOSTI CS         0         0         0         0           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         0           72.00         07200         IMPL.         DEV. CHARGED TO PATI ENTS         0         0         0         0	0 65.00
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0           70.01         07001         NEURODI AGNOSTI CS         0         0         0         0           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         0           72.00         07200         IMPL.         DEV. CHARGED TO PATI ENTS         0         0         0         0	0 66.00
70. 01         07001         NEURODI AGNOSTI CS         0         0         0         0           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         0           72. 00         07200         IMPL.         DEV. CHARGED TO PATI ENTS         0         0         0         0	0 69.00
71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         0           72.00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         0         0	0 70.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0	0 70.01
	0 71.00
	0 72.00
	0 73.00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0	0 75.00
76. 00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0	0 76.00
76. 01 03951 I NPATI ENT DI ALYSI S 0 0 0 0	0 76.01
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLINIC 0 0 0	0 90.00
90. 01 04950 WOUND CLINIC 0 0 0	0 90.01
91. 00 09100 EMERGENCY 0 0 0	0 91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0	0 92.00
OTHER REIMBURSABLE COST CENTERS	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0	0 96.00
200.00 Total (lines 50 through 199) 0 0 0 477,34	12 200. 00

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	S Provider C		Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1		L			
50.00 O5000 OPERATING ROOM	0	0		0 44, 465, 642		
51.00 05100 RECOVERY ROOM	0	0		0 0	01000000	
51.01 05101 ENDOSCOPY	0	0		0 11, 198, 024		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 4, 997, 311		
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	151, 052	151, 05			
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 24, 338, 045		
60. 00 06000 LABORATORY	0	326, 290	326, 29	0 70, 359, 222		
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 14, 287, 574		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 25, 225, 037		
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 39, 874, 916		
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0. 000000	
70. 01 07001 NEURODI AGNOSTI CS	0	0		0 5, 711, 543		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 4, 911, 589		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 12, 865, 322		
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 86, 919, 352		
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 23, 885, 938		
76.00 03950 MH ANCI LLARY OUTPATI ENT	0	0		0 0	0.000000	1
76. 01 03951 I NPATI ENT DI ALYSI S	0	0		0 1, 442, 945	0.00000	76.01
OUTPATIENT SERVICE COST CENTERS	1	I			I	
90. 00 09000 CLI NI C	0	-		0 166, 911	0. 000000	
90. 01 04950 WOUND CLINIC	0	0		0 7, 295, 159		
91. 00 09100 EMERGENCY	98, 006					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 5, 797, 875	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS	1			-		
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0 478, 307		
200.00   Total (lines 50 through 199)	98,006	575, 348	575, 34	8 530, 935, 974		200. 00

Health Financial Systems	GOOD SAMARITAN	N HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
			XVIII	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS			1		-	
50. 00 05000 OPERATING ROOM	0. 000000	11, 157, 463		0 9, 197, 955		
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	
51.01 05101 ENDOSCOPY	0.00000	686, 969		0 3, 628, 026		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 6, 474		
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.001604	9, 422, 170				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	431, 805		0 12, 889, 035		
60. 00 06000 LABORATORY	0. 004637	12, 703, 544	58, 90	06 7, 140, 952		•
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 000000	5, 353, 118		0 1, 481, 243		65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 490, 737		0 203, 771		00.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	8, 441, 725		0 11, 815, 611		
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	•	
70. 01 07001 NEURODI AGNOSTI CS	0. 000000	53, 676		0 2, 147, 673		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 393, 510		0 1, 398, 241		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 109, 560		0 2, 804, 021		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	10, 185, 185		0 30, 417, 960		
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	187		0 8, 134, 087		
76.00 03950 MH ANCI LLARY OUTPATI ENT	0. 000000	0		0 0	0	
76. 01 03951 I NPATI ENT DI ALYSI S	0. 000000	945, 861		0 69, 300	0	76.01
OUTPATIENT SERVICE COST CENTERS	· · · · ·				i	
90. 00 09000 CLI NI C	0. 000000	0		0 2,836		
90.01 04950 WOUND CLINIC	0. 000000	35, 004		0 5, 157, 476		
91. 00 09100 EMERGENCY	0. 001866	5, 698, 351				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	842, 818		0 3, 044, 118	0	92.00
OTHER REIMBURSABLE COST CENTERS				- 1	1	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	-	
200.00   Total (lines 50 through 199)		74, 951, 683	84, 65	52 141, 059, 485	102, 491	200. 00

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 7/10/2020 2:5	pared: 0 pm
		Title	e XVIII	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(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	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1	1				
50.00 OPERATING ROOM	0. 146417			0 0	1, 346, 737	
51.00 05100 RECOVERY ROOM	0. 000000			0 0	0	
51. 01 05101 ENDOSCOPY	0. 272423			0 0	988, 358	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 316679			0 0	2, 050	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 109282	30, 914, 510		0 0	3, 378, 399	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 165256	12, 889, 035		0 0	2, 129, 990	55.00
60. 00 06000 LABORATORY	0. 140871	7, 140, 952		0 0	1, 005, 953	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 249575	1, 481, 243		0 0	369, 681	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 274387	203, 771		0 0	55, 912	
69. 00 06900 ELECTROCARDI OLOGY	0. 148904	11, 815, 611		0 0	1, 759, 392	1
70.00 07000 ELECTROENCEPHALOGRAPHY	0.000000			0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 224578			0 0	482, 320	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.058566			0 0	1, 480, 130	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 562168			0 0	1, 576, 331	1
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 277122			0 32, 347	8, 429, 486	1
75.00 07500 ASC (NON-DISTINCT PART)	0. 162748			0 0	1, 323, 806	
76.00 03950 MH ANCI LLARY OUTPATI ENT	0. 000000			0 0	0	1
76. 01 03951 I NPATI ENT DI ALYSI S	0. 639091	69, 300		0 0	44, 289	
OUTPATIENT SERVICE COST CENTERS				- <u>-</u>		
90. 00 09000 CLI NI C	2. 188969	2, 836		0 0	6, 208	90.00
90. 01 04950 WOUND CLINIC	0. 239811	5, 157, 476		0 0	1, 236, 819	90.01
91.00 09100 EMERGENCY	0. 175132	10, 606, 196		0 292	1, 857, 484	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 548962			0 0	1, 671, 105	
OTHER REIMBURSABLE COST CENTERS				<u> </u>		
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 527925	0		0 0	0	96.00
200.00 Subtotal (see instructions)		141, 059, 485		0 32, 639	29, 144, 450	
201.00 Less PBP Clinic Lab. Services-Program	1			0 0		201.00
Only Charges				-		
202.00 Net Charges (line 200 - line 201)		141, 059, 485		0 32, 639	29, 144, 450	202.00

Health Financial Systems	GOOD SAMARITA				u of Form CMS-	-2552-1
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provider C	CN: 15-0042	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pro 7/10/2020 2:5	
		Title	XVIII	Hospi tal	PPS	
		sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins. (see inst.)				
	(see inst.) 6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	I			
50. 00 05000 OPERATI NG ROOM	0	0	)			50.0
51.00 05100 RECOVERY ROOM	0	0	)			51.0
51.01 05101 ENDOSCOPY	0	0				51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.0
53. 00 05300 ANESTHESI OLOGY	0	0				53.0
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.0
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.0
60. 00 06000 LABORATORY	0	0				60.0
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.0
65. 00 06500 RESPI RATORY THERAPY	0	0				65.0
66. 00 06600 PHYSI CAL THERAPY	0	0				66.0
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.0
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.0
70. 01 07001 NEURODI AGNOSTI CS	0	0				70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.0
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0				72.0
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	8, 964	1			73.0
75. 00 07500 ASC (NON-DI STINCT PART)	0	0	1			75.0
76.00 03950 MH ANCILLARY OUTPATIENT 76.01 03951 INPATIENT DIALYSIS		0				76.0
76. 01 03951 I NPATI ENT DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	0	1			_ /0.0
90. 00 09000 CLINIC	0	0				90.0
90. 01 04950 WOUND CLINIC	0	0				90.0
91. 00 09100 EMERGENCY	0	51	1			91.0
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1			92.0
OTHER REIMBURSABLE COST CENTERS			1			1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.0
200.00 Subtotal (see instructions)	0	9, 015				200.0
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	9, 015				202.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0042	Peri od:	Worksheet D	
		Component	CCN: 15-S042	From 01/01/2019 To 12/31/2019		nared
		oomponente	0011. 10 0012		7/10/2020 2:5	
		Title	e XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	(from Wkst. B.	(from Wkst. C,		Program	(column 3 x column 4)	
	Part II, col.	Part I, col. 8)	2)	. Charges	corumn 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
50. 00 05000 OPERATI NG ROOM	741, 516	44, 465, 642	0.0166	76 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0. 00000	0 0	0	51.00
51. 01 05101 ENDOSCOPY	461, 692	11, 198, 024	0.04123	30 O	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	29, 210	4, 997, 311	0.00584	15 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 215, 818	94, 183, 136	0. 01290	52, 238	674	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	304, 275	24, 338, 045	0. 01250	02 0	0	55.00
60. 00 06000 LABORATORY	373, 176	70, 359, 222	0.00530	229, 072	1, 215	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000	0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	228, 354	14, 287, 574	0. 01598	33 179, 306	2, 866	65.00
66. 00 06600 PHYSI CAL THERAPY	822, 386			30, 020	979	66.00
69. 00 06900 ELECTROCARDI OLOGY	680, 532	39, 874, 916			355	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 0	0	
70. 01 07001 NEURODI AGNOSTI CS	271, 370				0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	120, 549				206	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	165, 177				°	
73.00 07300 DRUGS CHARGED TO PATIENTS	332, 229					
75.00 07500 ASC (NON-DISTINCT PART)	107, 196	23, 885, 938			0	
76.00 03950 MH ANCI LLARY OUTPATI ENT	0	0	0.0000		0	
76. 01 03951 I NPATI ENT DI ALYSI S	290, 645	1, 442, 945	0. 20142	25 0	0	76.01
OUTPATIENT SERVICE COST CENTERS				-	-	
90. 00 09000 CLINIC	96, 004				0	
90. 01 04950 WOUND CLINIC	124, 469				0	
91.00 09100 EMERGENCY	780, 718					
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0	5, 797, 875	0.00000	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	15 015	470 207	0.0220	F 0	0	04.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 200.00 Total (lines 50 through 199)	15, 815 7, 161, 131			05 0 1, 084, 537	-	96.00 200.00
200.00   Total (Times 50 through 199)	/, 101, 131	330, 935, 974	1	1, 084, 537	11, 593	I200. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C	CN: 15-0042	Period:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S042	From 01/01/2019 To 12/31/2019		narod
		component	UCIN. 15-5042	10 12/31/2019	7/10/2020 2:5	
		Title	e XVIII	Subprovi der –	PPS	<u> </u>
				I PF		
Cost Center Description				ol Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	<u>Cost</u> 1.00	Adjustments 2A	2.00	Adjustments 3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATI NG ROOM	0	0	1	0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0				0	51.00
51. 01 05101 ENDOSCOPY	0				0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	151,052	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
60. 00 06000 LABORATORY	0	0		0 0	326, 290	60.00
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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	C		0 0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		0 0	0	76.00
76.01 03951 I NPATI ENT DI ALYSI S	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 04950 WOUND CLINIC	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1		1		1	
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 0		
200.00  Total (lines 50 through 199)	0	0	1	0 0	477, 342	200.00

Health Financial Systems	GOOD SAMARITA			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2019 Fo 12/31/2019		norod.
		component	CCN: 15-S042	Fo 12/31/2019	7/10/2020 2:5	
		Title	XVIII	Subprovider -	PPS	
				. I PF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-				
50. 00 05000 OPERATING ROOM	0	0	0	44, 465, 642		
51.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	
51.01 05101 ENDOSCOPY	0	0	(	11, 198, 024		•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(	4, 997, 311	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	151, 052	151, 052			
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		24, 338, 045		
60. 00 06000 LABORATORY	0	326, 290	326, 290	70, 359, 222	0. 004637	•
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	(	0 14, 287, 574	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	(	25, 225, 037		
69. 00 06900 ELECTROCARDI OLOGY	0	0	(	39, 874, 916	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(	0 0	0.000000	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	0	(	5, 711, 543	0.000000	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	4, 911, 589	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	12, 865, 322	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	86, 919, 352	0.000000	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(	23, 885, 938	0. 000000	75.00
76.00 03950 MH ANCI LLARY OUTPATI ENT	0	0		0 0	0. 000000	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0		1, 442, 945	0. 000000	76.01
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0	(	0 166, 911	0. 000000	90.00
90.01 04950 WOUND CLINIC	0	0	(	7, 295, 159	0. 000000	90.01
91.00 09100 EMERGENCY	98, 006	98, 006	98, 000	52, 532, 126	0. 001866	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(	5, 797, 875	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	(	478, 307	0.000000	96.00
200.00 Total (lines 50 through 199)	98, 006	575, 348	575, 348	3 530, 935, 974		200.00

Health Financial Systems	GOOD SAMARI TAM	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C	CN: 15-0042	Peri od:	Worksheet D	
THROUGH COSTS		Component	CON. 15 CO 40	From 01/01/2019 To 12/31/2019		norod.
		component	CCN: 15-S042	10 12/31/2019	7/10/2020 2:5	
		Title	XVIII	Subprovider -	PPS	
	I			I PF		
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
	7) 9.00	10.00	x col. 10)	10.00	x col. 12)	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0.000000	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0.000000	0				51.00
51.00 05100 RECOVERY ROOM 51.01 05101 ENDOSCOPY	0.000000	0		0 0	0	51.00
	0.000000	0		0 0		
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0.000000	0		0 0	0	52.00 53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	52, 238		34 280		53.00
55. 00 05500 RADI OLOGY - DI AGNOSTI C	0.001804	52, 238		0 0	0	54.00
60. 00 06000 LABORATORY	0.000000	229, 072	1, 00		3	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 004837	229,072	1, 00	0 0	3	63.00
65. 00 06500 RESPIRATORY THERAPY	0.000000	179, 306		0 0		65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	30, 020		0 0		66.00
69. 00 106900 ELECTROCARDI OLOGY	0.000000	20, 822		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000	20, 022		0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0.000000	0		0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	8, 393		0 0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0, 373		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.000000	280, 279		0 4, 893	0	73.00
75. 00 07500 ASC (NON-DI STINCT PART)	0.000000	200, 279		0 0	0	75.00
76. 00 03950 MH ANCI LLARY OUTPATI ENT	0.000000	0		0 0	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0. 000000	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS	0.000000	0	I	0 0		70.01
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 04950 WOUND CLINIC	0.000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0.001866	284, 407	53	4, 661	9	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0		92.00
OTHER REIMBURSABLE COST CENTERS			1			
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0.000000	0		0 0	0	96.00
200.00 Total (lines 50 through 199)		1,084,537	1, 6	10, 465	12	200.00

Health Financial Systems	GOOD SAMARI TAN	HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH S	SERVICES AND VACCINE COST	Provider CO	CN: 15-0042	Peri od:	Worksheet D	
		Component (	CCN: 15-S042	From 01/01/2019 To 12/31/2019	Part V Date/Time Pre	nared
		component c	50N. 13 5042	10 12/31/2017	7/10/2020 2:5	0 pm
		Title	XVIII	Subprovider -	PPS	
				I PF		
			Charges	0.1	Costs	
Cost Center Description	Cost to ChargePF Ratio From S	ervices (see	Cost Reimbursed	Cost Reimbursed	PPS Services (see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(see mst.)	
	Part I, col. 9	inst.)	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 OPERATI NG ROOM	0. 146417	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51.01 05101 ENDOSCOPY	0. 272423	0		0 0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 316679	0		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 109282	280		0 0	31	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 165256	0		0 0	0	
60. 00 06000 LABORATORY	0. 140871	631		0 0	89	
63.00 06300 BLOOD STORING, PROCESSING &		0		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 249575	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 274387	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 148904 0. 000000	0		0 0	0	
70. 01 07001 NEURODI AGNOSTI CS	0. 224578	0		0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO		0		0 0	0	
72. 00 07200 IMPL. DEV. CHARGED TO PATIE		0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 277122	4, 893		0 230	1, 356	
75. 00 07500 ASC (NON-DI STI NCT PART)	0. 162748	0,0,0		0 0	0	
76.00 03950 MH ANCI LLARY OUTPATI ENT	0. 000000	0		0 0	0	
76. 01 03951 I NPATI ENT DI ALYSI S	0. 639091	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS		-				
90. 00 09000 CLINIC	2. 188969	0		0 0	0	90.00
90. 01 04950 WOUND CLINIC	0. 239811	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 175132	4, 661		0 0	816	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTI	NCT PART) 0. 548962	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-		
96.00 09600 DURABLE MEDI CAL EQUI P-RENTE	0. 527925	0		0 0	0	
200.00 Subtotal (see instructions)		10, 465		0 230	2, 292	200.00
201.00 Less PBP Clinic Lab. Servic	es-Program			0 0		201.00
Only Charges	- 201)	10 4/5			2	000 00
202.00 Net Charges (line 200 - lin	e 201)	10, 465		0 230	2, 292	202.00

	ncial Systems	GOOD SAMARITA				u of Form CMS-	2552-
PPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider CO	CN: 15-0042 CCN: 15-S042	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 7/10/2020 2:5	epared 50 pm
			Title	XVIII	Subprovider - IPF	PPS	
		Cos					
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.) 6.00	<u>(see inst.)</u> 7.00				
ANCLL	LARY SERVICE COST CENTERS	0.00	7.00				
	OPERATI NG ROOM	0	0				50. (
1.00 05100	RECOVERY ROOM	0	0				51.
1.01 05101	ENDOSCOPY	0	0				51.
2.00 05200	DELIVERY ROOM & LABOR ROOM	0	0				52.
3.00 05300	ANESTHESI OLOGY	0	0				53.
1.00 05400	RADI OLOGY-DI AGNOSTI C	0	0				54.
5.00 05500	RADI OLOGY-THERAPEUTI C	0	0				55.
06000 06000	LABORATORY	0	0				60.
3.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	0				63.
5.00 06500	RESPI RATORY THERAPY	0	0				65.
6.00 06600	PHYSI CAL THERAPY	0	0				66.
9.00 06900	ELECTROCARDI OLOGY	0	0				69.
0.00 07000	ELECTROENCEPHALOGRAPHY	0	0				70.
0. 01 07001	NEURODI AGNOSTI CS	0	0				70.
1.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.
2.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.
3.00 07300	DRUGS CHARGED TO PATIENTS	0	64				73.
5.00 07500	ASC (NON-DISTINCT PART)	0	0				75.
6.00 03950	MH ANCILLARY OUTPATIENT	0	0				76.
	INPATIENT DIALYSIS	0	0				76.
	TIENT SERVICE COST CENTERS						
		0	0				90.
	WOUND CLINIC	0	0				90.
	EMERGENCY	0	0				91.
	OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.
	REIMBURSABLE COST CENTERS						
	DURABLE MEDICAL EQUIP-RENTED	0	0				96.
00.00	Subtotal (see instructions)	0	64				200.
01.00	Less PBP Clinic Lab. Services-Program	0					201.
	Only Charges	1					1

Health Financial Systems	GOOD SAMARI TA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0042	Peri od:	Worksheet D	
		Component (	CCN: 15-T042	From 01/01/2019 To 12/31/2019		nared
		component	00M. 10 1042		7/10/2020 2:5	
		Title	e XVIII	Subprovider -	PPS	•
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B, Part II, col.	Part I, col. 8)	(COI. I ÷ COI 2)	. Charges	column 4)	
	26)	8)	)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 0PERATI NG ROOM	741, 516	44, 465, 642	0.0166	76 89, 561	1, 494	50.00
51.00 05100 RECOVERY ROOM	0	0	0.0000			
51.01 05101 ENDOSCOPY	461, 692	11, 198, 024	0.04123	30 31, 823	1, 312	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	29, 210	4, 997, 311	0.00584		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	1, 215, 818	94, 183, 136	0. 01290	458, 996	5, 925	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	304, 275	24, 338, 045	0. 01250	02 0	0	55.00
60. 00 06000 LABORATORY	373, 176	70, 359, 222	0.00530	1, 140, 022	6, 047	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000	0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	228, 354	14, 287, 574	0. 01598	1, 309, 141	20, 924	65.00
66. 00 06600 PHYSI CAL THERAPY	822, 386					
69. 00 06900 ELECTROCARDI OLOGY	680, 532	39, 874, 916			1, 886	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.0000	0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	271, 370					
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	120, 549					
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	165, 177					
73.00 07300 DRUGS CHARGED TO PATIENTS	332, 229				5, 839	
75.00 07500 ASC (NON-DISTINCT PART)	107, 196	23, 885, 938			0	75.00
76.00 03950 MH ANCI LLARY OUTPATI ENT	0	0	0.0000		0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	290, 645	1, 442, 945	0. 20142	97, 020	19, 542	76.01
OUTPATIENT SERVICE COST CENTERS		1// 0//	0.5754			
90. 00 09000 CLINIC	96, 004				0	90.00
90. 01 04950 WOUND CLINIC	124, 469				0	90.01
91.00 09100 EMERGENCY	780, 718					
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) OTHER REI MBURSABLE COST CENTERS	0	5, 797, 875	0.0000	00 0	0	92.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	15, 815	478, 307	0. 0330	5 0	0	96.00
200.00 Total (lines 50 through 199)	7, 161, 131			13, 234, 381	-	
200.00   TOTAL (TITLES SO THEOUGH 199)	7, 101, 131	030, 930, 974	1	13, 234, 381	330,213	200.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	S Provider C	CN: 15-0042	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T042	From 01/01/2019 To 12/31/2019		narod
		component	CCN. 15-1042	10 12/31/2019	7/10/2020 2:5	
		Title	e XVIII	Subprovider -	PPS	<u> </u>
				I RF		
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	<u>Cost</u> 1.00	Adjustments 2A	2.00	Adjustments 3A	3.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	ZA	2.00	3A	3.00	
50. 00 05000 OPERATING ROOM	0	0	1	0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0			0 0	0	51.00
51. 01 05101 ENDOSCOPY	0				0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0				0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	151,052	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
60. 00 06000 LABORATORY	0	0		0 0	326, 290	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
65. 00 06500 RESPIRATORY 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
70.00 07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	C		0 0	0	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0 0	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0		0 0	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 04950 WOUND CLINIC	0	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS	-	-	1		-	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 0		
200.00  Total (lines 50 through 199)	0	C	1	0 0	477, 342	200.00

Health Financial Systems	GOOD SAMARITA			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS		Component		rom 01/01/2019 0 12/31/2019		norod.
		component	CCN: 15-T042	To 12/31/2019	7/10/2020 2:5	
		Title	XVIII	Subprovider -	PPS	
				' I RF		
Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-	-				
50. 00 05000 OPERATING ROOM	0	0	0	44, 465, 642		
51.00 05100 RECOVERY ROOM	0	0		0 0	0.000000	
51.01 05101 ENDOSCOPY	0	0		11, 198, 024		•
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(	4, 997, 311	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	151, 052	151, 052			
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		24, 338, 045		
60. 00 06000 LABORATORY	0	326, 290	326, 290	70, 359, 222	0. 004637	•
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0	(	14, 287, 574	0.000000	
66. 00 06600 PHYSI CAL THERAPY	0	0	(	25, 225, 037		
69. 00 06900 ELECTROCARDI OLOGY	0	0	(	39, 874, 916	0.000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(	0 0	0.000000	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	0	(	5, 711, 543	0.000000	70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	4, 911, 589	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	12, 865, 322	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	(	86, 919, 352	0.000000	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		23, 885, 938	0. 000000	75.00
76.00 03950 MH ANCI LLARY OUTPATI ENT	0	0		0 0	0. 000000	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0		1, 442, 945	0. 000000	76.01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	(	166, 911	0. 000000	90.00
90. 01 04950 WOUND CLINIC	0	0		7, 295, 159	0.000000	90.01
91.00 09100 EMERGENCY	98,006	98, 006	98, 000	52, 532, 126	0. 001866	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0			0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS	•		•	·		1
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	(	478, 307	0.000000	96.00
200.00 Total (lines 50 through 199)	98, 006	575, 348	575, 348	530, 935, 974		200.00

Health Financial Systems	GOOD SAMARI TAM	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO	CN: 15-0042	Peri od:	Worksheet D	
THROUGH COSTS		Component (	CCN: 15-T042	From 01/01/2019 To 12/31/2019	Part IV Date/Time Pre	nared
		Componente	50N. 15 1042	10 12/31/2017	7/10/2020 2:5	
		Title	XVIII	Subprovider -	PPS	
				I RF		
Cost Center Description	Outpatient	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program Pass-Through	Program	Program Pass-Through	
	to Charges (col. 6 ÷ col.	Charges	Costs (col.		Costs (col. 9	
	7)		x col. 10)	0	x col. 12)	
	9,00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0.000000	89, 561		0 5	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51.01 05101 ENDOSCOPY	0. 000000	31, 823		0 0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 001604	458, 996	73	36 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	0		0 33	0	55.00
60. 00 06000 LABORATORY	0.004637	1, 140, 022	5, 28	36 0	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	1, 309, 141		0 11	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	8, 203, 636		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	110, 478		0 34	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 000000	11, 067		0 5	0	70.01
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0. 000000	153, 178		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0.00000	3, 879		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0.00000	1, 527, 827		0 37	0	73.00
75.00 07500 ASC (NON-DISTINCT PART) 76.00 03950 MH ANCILLARY OUTPATIENT	0.00000	0		0 0	0	75.00
76. 00 03950 MH ANCI LLARY OUTPATI ENT 76. 01 03951 I NPATI ENT DI ALYSI S	0. 000000 0. 000000	0 97, 020		0 0	0	76. 00 76. 01
OUTPATIENT SERVICE COST CENTERS	0.000000	97,020		0 0	0	70.01
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
90. 01 04950 WOUND CLINIC	0.000000	0		0 10	0	90.00
91. 00 09100 EMERGENCY	0.001866	97, 753	18		2	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	0.000000		I	- 0		
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0 0	0	96.00
200.00 Total (lines 50 through 199)		13, 234, 381	6, 20			200.00
						•

Health Financial Systems	GOOD SAMARITA	N HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTI	SERVICES AND VACCINE COST	Provider CC	CN: 15-0042	Period: From 01/01/2019	Worksheet D Part V	
		Component (	CCN: 15-T042	To 12/31/2019	Date/Time Pre 7/10/2020 2:5	pared: 0 pm
		Title	XVIII	Subprovider - IRF	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	0 14(417				1	
	0. 146417	5		0 0	-	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	
51.01 05101 ENDOSCOPY	0. 272423	-		-	0	
52.00 05200 DELIVERY ROOM & LABOR ROO		0		0 0	0	
53.00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 109282	0		0 0	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 165256	33		0 0	5	55.00
60. 00 06000 LABORATORY	0. 140871	0		0 0	0	
63.00 06300 BLOOD STORING, PROCESSING		0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 249575	11		0 0	3	65.00
66.00 06600 PHYSI CAL THERAPY	0. 274387	0		0 0	0	
69.00 06900 ELECTROCARDI OLOGY	0. 148904	34		0 0	5	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
70. 01 07001 NEURODI AGNOSTI CS	0. 224578	5		0 0	1	70.01
71.00 07100 MEDI CAL SUPPLI ES CHARGED		0		0 0	0	
72.00 07200 I MPL. DEV. CHARGED TO PAT		0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS		37		0 721	10	
75.00 07500 ASC (NON-DI STI NCT PART)	0. 162748	0		0 0	0	
76.00 03950 MH ANCI LLARY OUTPATI ENT	0. 000000	0		0 0	0	
76. 01 03951 I NPATI ENT DI ALYSI S	0. 639091	0		0 0	0	76.01
OUTPATIENT SERVICE COST CENTERS		0			0	00.00
90. 00 09000 CLINIC	2. 188969	0		0 0	0	
90. 01 04950 WOUND CLINIC	0. 239811	10		0 0	2	1
91.00 09100 EMERGENCY	0. 175132	876		0 0	153	
92. 00 09200 OBSERVATION BEDS (NON-DIS OTHER REIMBURSABLE COST CENTERS		0		0 0	0	92.00
96. 00 09600 DURABLE MEDICAL EQUIP-REN		0		0 0	0	96.00
200.00 Subtotal (see instruction		1, 011		0 721		200.00
201.00 Less PBP Clinic Lab. Serv		1, 011		0 721	180	200.00
201.00 Less PBP CITTIC Lab. Serv Only Charges				0		201.00
202.00 Net Charges (line 200 - l	ine 201)	1, 011		0 721	180	202.00

Health Financ	cial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-255	52-10
APPORTI ONMEN	T OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC Component (	CN: 15-0042 CCN: 15-T042	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepa 7/10/2020 2:50	ared:
			Title	XVIII	Subprovider - IRF	PPS	
		Cos					
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	ARY SERVICE COST CENTERS	6.00	7.00				
	OPERATING ROOM	0	0			5	50.00
51.000510051.010510152.000520053.0005300	RECOVERY ROOM ENDOSCOPY DELIVERY ROOM & LABOR ROOM ANESTHESI OLOGY		0 0 0 0			5 5 5 5 5	51. 00 51. 01 52. 00 53. 00
	RADI OLOGY-DI AGNOSTI C	0	0				54.00
	RADI OLOGY-THERAPEUTI C LABORATORY	0	0				55.00 60.00
1 1	BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	RESPI RATORY THERAPY	0	0				65.00
	PHYSI CAL THERAPY ELECTROCARDI OLOGY	0	0				66.00 69.00
	ELECTROENCEPHALOGRAPHY	0	0				70.00
	NEURODI AGNOSTI CS	0	0				70. 01
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			7	71.00
	IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	DRUGS CHARGED TO PATIENTS	0	200				73.00
	ASC (NON-DISTINCT PART) MH ANCILLARY OUTPATIENT	0	0				75.0C 76.0C
	INPATIENT DIALYSIS	0					76. 00 76. 01
	I ENT SERVICE COST CENTERS		0			,	/0.01
90.00 09000	CLINIC	0	0			9	90.00
	WOUND CLINIC	0					90. 01
	EMERGENCY	0					91.00
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	0	0	l		9	92.00
	DURABLE MEDICAL EQUIP-RENTED	0	0			q	96.00
	Subtotal (see instructions)	0					00.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	200				01.00
	Net Charges (line 200 - line 201)	0	200			20	02.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	epare
		Title XVIII	Hospi tal	7/10/2020 2:5 PPS	o pm
	Cost Center Description		- noopi tui	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	us oxcluding nowhorn)	1	14, 701	1 1
00	Inpatient days (including private room days, excluding swing-bed days)			14, 701	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	3
0	do not complete this line.			11 401	
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	11, 421 0	
	reporting period	<i>, , , , , , , , , ,</i>			
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
	reporting period	5.		Ū	
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable 1	to the Program (evoluding	swing_bed_and	6, 668	9
0	newborn days) (see instructions)		J Swillig-bed and	0,000	
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10
00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		coom days) after	0	11
00	December 31 of the cost reporting period (if calendar year, e		oom days) arter	0	1 ''
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
00	through December 31 of the cost reporting period	V oply (including privat	a ream day(c)	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 d	of the cost	0.00	17
	reporting period	Ū.			
. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of i	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction			14, 265, 451	
00	Swing-bed cost applicable to SNF type services through Decemb $5 \times 10^{-1}$ x line 17)	per 31 of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	ng period (line 6	0	23
~~	x line 18)			0	
. 00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	er 31 of the cost reporti	ng period (line	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
00	x line 20) Total swing had cost (coo instructions)			^	2/
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 14, 265, 451	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			.,	1 - '
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0. 000000	
00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32
	Average semi-private room per diem charge (line 30 ÷ line 4)	inuc line 22) (coo inctore	stione)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	14, 265, 451	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART IT - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see			970. 37	38
00					
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	-		6, 470, 427 0	

OMPUTATION OF INPATIENT OPERATING COST		Provider CO	CN: 15-0042	Peri od:	Worksheet D-1	1
				From 01/01/2019 To 12/31/2019		epare
		T: +1 -	XX/1.1.1		7/10/2020 2:5	
Cost Center Description	Total	Total	XVIII Average Per	Hospital Program Days	PPS Program Cost	
	Inpatient Costl		Diem (col. 1		(col. 3 x col.	
	1.00	2.00	col. 2)	4.00	4) 5.00	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00 0.0	4.00		) 42.
Intensive Care Type Inpatient Hospit	al Units	0	0.10			
. OO INTENSIVE CARE UNIT	7, 863, 008	6, 570	1, 196. 8	3, 997	4, 783, 610	
OO CORONARY CARE UNIT 5. OO BURN INTENSIVE CARE UNIT						44
0.00 SURGICAL INTENSIVE CARE UNIT						40
. 00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	
.00 Program inpatient ancillary service	cost (Wkst D-3 col 3	Line 200)			1.00 16,991,508	3 48
0.00 Total Program inpatient costs (sum o			ns)		28, 245, 545	
PASS THROUGH COST ADJUSTMENTS					1	
0.00 Pass through costs applicable to Pro	gram inpatient routine s	ervices (from	Wkst. D, sum	of Parts I and	1, 875, 973	3 50
.00 Pass through costs applicable to Pro	oram inpatient ancillarv	services (fr	om Wkst. D. s	um of Parts II	1, 328, 999	51
and IV)						
2.00 Total Program excludable cost (sum o				- 4 ! - 4	3, 204, 972	
3.00 Total Program inpatient operating co medical education costs (line 49 min		ated, non-pny	sician anestr	etist, and	25, 040, 573	3 53
TARGET AMOUNT AND LIMIT COMPUTATION						
00 Program discharges					C	
.00 Target amount per discharge .00 Target amount (line 54 x line 55)					0.00	
. 00 Difference between adjusted inpatien	t operating cost and tar	get amount (l	ine 56 minus	line 53)		
8.00 Bonus payment (see instructions)	<b>3</b>	<u> </u>			C	
0.00 Lesser of lines 53/54 or 55 from the	cost reporting period e	ndi ng 1996, u	pdated and co	mpounded by the	0.00	59
market basket 0.00 Lesser of lines 53/54 or 55 from pri	or vear cost report upd	ated by the m	arket basket		0.00	60
1.00 If line 53/54 is less than the lower				the amount by	C	
which operating costs (line 53) are		(lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter ze 2.00 Relief payment (see instructions)	ro (see instructions)				c c	62
3.00 Allowable Inpatient cost plus incent	ive payment (see instruc	tions)				
PROGRAM INPATIENT ROUTINE SWING BED						
I. 00 Medicare swing-bed SNF inpatient rou instructions)(title XVIII only)	tine costs through Decem	ber 31 of the	cost reporti	ng period (See	C	64.
5.00 Medicare swing-bed SNF inpatient rou	tine costs after Decembe	r 31 of the c	ost reporting	period (See	c c	65
instructions)(title XVIII only)						
5.00 Total Medicare swing-bed SNF inpatie	nt routine costs (line 6	4 plus line 6	5)(title XVII	l only). For	C	66
CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatien	t routine costs through	December 31 o	f the cost re	portina period	c c	67
(line 12 x line 19)	3			51		
3.00 Title V or XIX swing-bed NF inpatien	t routine costs after De	cember 31 of	the cost repo	rting period	C	68
(line 13 x line 20) 9.00  Total title V or XIX swing-bed NF in	patient routine costs ()	ine 67 + line	68)		C	69
PART III - SKILLED NURSING FACILITY,						
0.00 Skilled nursing facility/other nursi	5		• • •			70
.00 Adjusted general inpatient routine s 2.00 Program routine service cost (line 9		ne /0 ÷ line	2)			71
8.00 Medically necessary private room cos	-	(line 14 x li	ne 35)			73
.00 Total Program general inpatient rout			,			74
5.00 Capital-related cost allocated to in	patient routine service	costs (from W	orksheet B, P	art II, column		75
26, line 45) 0.00 Per diem capital-related costs (line	75 ÷ line 2)					76
7.00 Program capital -related costs (line						77
.00 Inpatient routine service cost (line			,			78
.00 Aggregate charges to beneficiaries f .00 Total Program routine service costs				us lina 70)		80
. 00 Inpatient routine service costs	•	st inmitation		us i i i e /7)		81
.00 Inpatient routine service cost limit						82
00 Reasonable inpatient routine service	-	)				83
1.00  Program inpatient ancillary services 5.00  Utilization review - physician compe		c)				84
5.00 Utilization review - physician compe 5.00 Total Program inpatient operating co						85
PART I V - COMPUTATION OF OBSERVATION					· · · · · · · · · · · · · · · · · · ·	
7.00 Total observation bed days (see inst					3, 280	
3.00 Adjusted general inpatient routine c 9.00 Observation bed cost (line 87 x line		line 2)			970. 37 3, 182, 814	
					1 0, 102, 014	. 07

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	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, 709, 042	14, 265, 451	0. 18990	2 3, 182, 814	604, 423	90.00
91.00 Nursing School cost	0	14, 265, 451	0.00000	0 3, 182, 814	0	91.00
92.00 Allied health cost	0	14, 265, 451	0. 00000	0 3, 182, 814	0	92.00
93.00 All other Medical Education	0	14, 265, 451	0. 00000	0 3, 182, 814	0	93.00

/IPUT/	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 7/10/2020 2:5	pare
		Title XVIII	Subprovider -	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				-
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	s excluding newborn)		4, 502	1 1
	Inpatient days (including private room days, excluding swing-			4, 502	2
00	Private room days (excluding swing-bed and observation bed da	ys). If you have only pr	ivate room days,	0	3
	do not complete this line.			4 500	
00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	4, 502 0	4
,0	reporting period	on days) through becchibe	i si oi the cost	0	
00	Total swing-bed SNF type inpatient days (including private ro	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo reporting period	m days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	m davs) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	5.2			
00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	1, 438	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including privato r	oom days)	0	10
00	through December 31 of the cost reporting period (see instruc	tions)	oom uays)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	oom days) after	0	11
~ ~	December 31 of the cost reporting period (if calendar year, e				
00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room davs)	0	13
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lin	e)		
	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	1 10
	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 c	f the cost	0.00	17
~~	reporting period			0.00	1.0
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18
00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19
	reporting period				
00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	he cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instruction	s)		5, 889, 689	21
	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	0	22
	5 x line 17)				
00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23
00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	na period (line	0	24
	7 x line 19)		517		
00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		5, 889, 689	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				1
	General inpatient routine service charges (excluding swing-be	d and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		tions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5, 889, 689	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ		I	1, 308. 24	38
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			1, 308. 24	
	Medically necessary private room cost applicable to the Progr			0	
	Total Program general inpatient routine service cost (line 39	. ,		1, 881, 249	

ealth Financial S OMPUTATION OF IN	Systems PATLENT OPERATING COST	GOOD SAMARITAN		CN: 15-0042	In Lie Period:	eu of Form CMS- Worksheet D-1	
			Component	CCN: 15-SO42	From 01/01/2019 To 12/31/2019	Date/Time Pre	
			Title	e XVIII	Subprovider - IPF	7/10/2020 2:5 PPS	<u>50 pm</u>
Cost	Center Description	Total Inpatient CostIn	Total patient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	<u>col.2)</u> 3.00	4.00	4) 5.00	
	tle V & XIX only)	0	C				) 42.
. 00 INTENSIVE (	Care Type Inpatient Hospital Units			0.	00 0		3 43.
. 00 CORONARY C		0	C	0.	00 0		43
	SIVE CARE UNIT						45.
	NTENSIVE CARE UNIT						46
	AL CARE (SPECIFY) Center Description						47
.00 Program in	patient ancillary service cost (Wk	st D_3 col 3	Line 200)			1.00 230,516	5 48
	ram inpatient costs (sum of lines			ons)		2, 111, 765	
PASS THROUG	COST ADJUSTMENTS	<u> </u>		·			
	gh costs applicable to Program inp	atient routine se	rvices (from	n Wkst. D, su	m of Parts I and	559, 166	5 50
.00 Pass throu	gh costs applicable to Program ing	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	13, 270	51
and IV)		FO and F(1)				F70 101	
	ram excludable cost (sum of lines ram inpatient operating cost exclu		ted non-nh	sician anest	hotist and	572, 436	
medical edu	ucation costs (line 49 minus line					1, 337, 325	
. 00 Program dis	INT AND LIMIT COMPUTATION					0	54
	unt per discharge					0.00	
5	unt (line 54 x line 55)					C	
	between adjusted inpatient operat ent (see instructions)	ing cost and targ	et amount (I	ine 56 minus	line 53)		
	ines 53/54 or 55 from the cost re	porting period en	ding 1996, u	pdated and c	ompounded by the	-	
market bas							
	ines 53/54 or 55 from prior year /54 is less than the lower of line				the amount by	0.00	
	ating costs (line 53) are less that						
	ne 56), otherwise enter zero (see	instructions)			Ū		
	nent (see instructions) Inpatient cost plus incentive paym	ont (coo instruct	ions)				
PROGRAM INF	PATIENT ROUTINE SWING BED COST						
	wing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the	e cost report	ing period (See	C	64
	ns)(title XVIII only) wing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reportin	g period (See	0	65
instructio	ns) (title XVIII only)						
	care swing-bed SNF inpatient routi nstructions)	ne costs (line 64	plus line 6	o5)(title XVI	ll only). For	C	66
	XIX swing-bed NF inpatient routir	e costs through D	ecember 31 c	of the cost r	eporting period	0	67
(line 12 x							
3.00 Title V or (line 13 x	XIX swing-bed NF inpatient routir line 20)	e costs after Dec	ember 31 of	the cost rep	orting period	C	68
9.00 Total title	e V or XIX swing-bed NF inpatient					c	69
	SKILLED NURSING FACILITY, OTHER N rsing facility/other nursing facil				)		70
	eneral inpatient routine service of	5		•			71
U U	utine service cost (line 9 x line			25)			72
	necessary private room cost applic ram general inpatient routine serv	υ,					73
. 00 Capi tal -rel	ated cost allocated to inpatient	•			Part II, column		75
26, line 4 .00 Per diem ca	apital-related costs (line 75 ÷ li	ne 2)					76
	bital-related costs (line 9 x line						77
	routine service cost (line 74 minu charges to beneficiaries for exces		vider record	ls)			78
00 0	ram routine service costs for comp				nus line 79)		80
. 00 Inpatient	outine service cost per diem limi	tation		-	·		81
	routine service cost limitation (l						82
	inpatient routine service costs ( patient ancillary services (see ir						83
5	review - physician compensation		)				85
	ram inpatient operating costs (sun		ugh 85)				86
	COMPUTATION OF OBSERVATION BED PAS rvation bed days (see instructions					C	0 87
	eneral inpatient routine cost per		ine 2)			0.00	
	n bed cost (line 87 x line 88) (se	a instructions)					) 89

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
		Component (		To 12/31/2019		
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	587, 168	5, 889, 689	0. 09969	04 0	0	90.00
91.00 Nursing School cost	0	5, 889, 689	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	5, 889, 689	0. 00000	0 0	0	92.00
93.00 All other Medical Education	1, 163, 434	5, 889, 689	0. 19753	0	0	93.00

/PUT/	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 7/10/2020 2:5	pare
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	vs excluding newborn)		7, 059	1 1
	Inpatient days (including private room days and swing bed day Inpatient days (including private room days, excluding swing-			7,059	2
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	ivate room days,	0	3
	do not complete this line.			7 050	
00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro		or 31 of the cost	7, 059 0	45
,0	reporting period	the ought become	i of the cost	0	
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roo reporting period	om days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private roo	om davs) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
00	Total inpatient days including private room days applicable t	to the Program (excluding	swing-bed and	5, 957	9
00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	nom dave)	0	10
00	through December 31 of the cost reporting period (see instruc		oonii uays)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII o	only (including private r	oom days) after	0	11
~ ~	December 31 of the cost reporting period (if calendar year, e				
00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	X only (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room davs)	0	13
	after December 31 of the cost reporting period (if calendar y	vear, enter O on this lin	ie)		
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	1 10
	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 c	of the cost	0.00	17
00	reporting period			0.00	1.0
00	Medicare rate for swing-bed SNF services applicable to servic reporting period	ces after December 31 of	the cost	0.00	18
00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period	C			
00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instruction	) )		4, 428, 427	21
	Swing-bed cost applicable to SNF type services through Decemb		ing period (line	4, 420, 427	22
	5 x line 17)		5 F		
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 31 of the cost reporti	ng period (line	0	24
00	7 x line 19)		ng period (inne	0	27
00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 428, 427	
1	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			.,,	
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	29
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	30
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
	Average per diem private room charge differential (line 32 mi		tions)	0.00	
	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	4, 428, 427	
	27 minus line 36)			., .20, .27	<i>"</i>
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			107.04	1 20
	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line			627.34 3,737,064	
	Medically necessary private room cost applicable to the Progr			3, 737, 004	
	Total Program general inpatient routine service cost (line 39	. ,		3, 737, 064	

alth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	GOOD SAMARITAN		CN: 15-0042	Peri od:	eu of Form CMS- Worksheet D-1	
			CCN: 15-T042	From 01/01/2019 To 12/31/2019	Date/Time Pre	epare
		Title	e XVIII	Subprovider -	7/10/2020 2:5 PPS	50 pm
			T	I RF		
Cost Center Description	Total Inpatient Costlr	Total npatient Days	col . 2)	÷	Program Cost (col. 3 x col. 4)	
.00 NURSERY (title V & XIX only)	1.00	2.00	3.00 0.	4.00	5.00	42.
Intensive Care Type Inpatient Hospital Ur			0.1	00 0		42
	0	C	0.	00 00	C	43
. OO CORONARY CARE UNIT . OO BURN INTENSIVE CARE UNIT						44
. 00 SURGI CAL I NTENSI VE CARE UNI T						46
. 00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
cost center bescription					1.00	
.00 Program inpatient ancillary service cost	•				3, 496, 827	
.00 Total Program inpatient costs (sum of lin PASS THROUGH COST ADJUSTMENTS	nes 41 through 48)(se	ee instructio	ons)		7, 233, 891	49
. 00 Pass through costs applicable to Program	inpatient routine se	ervices (from	n Wkst. D, su	m of Parts I and	572, 766	50
.00 Pass through costs applicable to Program and IV)	inpatient ancillary	services (fr	OM WKST. D,	sum or Parts II	342, 417	51
.00 Total Program excludable cost (sum of li					915, 183	
8.00 Total Program inpatient operating cost ex medical education costs (line 49 minus li		ated, non-phy	sician anest	netist, and	6, 318, 708	53
TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)				1	
. 00 Program di scharges					C	
.00 Target amount per discharge .00 Target amount (line 54 x line 55)					0.00	
. 00 Difference between adjusted inpatient op	erating cost and tar	get amount (I	ine 56 minus	line 53)		
. 00 Bonus payment (see instructions)					0	
.00 Lesser of lines 53/54 or 55 from the cos market basket	t reporting period e	1αling 1996, ι	ipdated and c	ompounded by the	0.00	59
0.00 Lesser of lines 53/54 or 55 from prior ye					0.00	
I.OO If line 53/54 is less than the lower of which operating costs (line 53) are less					0	61
amount (line 56), otherwise enter zero (		(11163 54 X	00), 01 1% 0	i the target		
2.00 Relief payment (see instructions)					0	
Allowable Inpatient cost plus incentive PROGRAM INPATIENT ROUTINE SWING BED COST	bayment (see Instruc	(i ons)			C	63
.00 Medicare swing-bed SNF inpatient routine	costs through Decem	per 31 of the	e cost report	ng period (See	C	64
instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine	costs after December	- 31 of the c	ost reportin	a period (See	c c	65
instructions) (title XVIII only)	COSTS al tel December	ST OF the c		g period (see		/ 05
0.00 Total Medicare swing-bed SNF inpatient re	outine costs (line 64	1 plus line 6	5)(title XVI	ll only). For	C	66
CAH (see instructions) COO Title V or XIX swing-bed NF inpatient roo	utine costs through	December 31 d	of the cost r	eporting period	0	67
(line 12 x line 19)	-					
8.00 Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	utine costs after De	cember 31 of	the cost rep	orting period	0	68
9.00 Total title V or XIX swing-bed NF inpatio	ent routine costs (li	ne 67 + line	e 68)		0	69
PART III - SKILLED NURSING FACILITY, OTHE				<u>,</u>		
<ul> <li>00 Skilled nursing facility/other nursing facility/other nursing facility/other nursing facility.</li> <li>00 Adjusted general inpatient routine service</li> </ul>				)		70
.00 Program routine service cost (line 9 x li	ne 71)					72
.00 Medically necessary private room cost ap .00 Total Program general inpatient routine	U U	•	,			73
.00 Total Program general inpatient routine s .00 Capital-related cost allocated to inpatic	-			Part II, column		75
26, line 45)		,				
.00  Per diem capital-related costs (line 75 · .00  Program capital-related costs (line 9 x						76
.00 Inpatient routine service cost (line 74 i						78
.00 Aggregate charges to beneficiaries for ex						79
.00  Total Program routine service costs for ( .00  Inpatient routine service cost per diem	•	st limitation	ı (IINE /8 mi)	nus line /9)		80
.00 Inpatient routine service cost limitation	n (line 9 x line 81)					82
.00 Reasonable inpatient routine service cos		1				83
<ul> <li>00 Program inpatient ancillary services (sec</li> <li>00 Utilization review - physician compensation</li> </ul>		5)				84
0.00 Total Program inpatient operating costs	(sum of lines 83 thre					86
PART IV - COMPUTATION OF OBSERVATION BED						
7.00  Total observation bed days (see instruct 3.00  Adjusted general inpatient routine cost	-	ine 2)			0.00	
9.00 Observation bed cost (line 87 x line 88)	-	/				89

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
		Component (	CCN: 15-T042	To 12/31/2019		pared: 0 pm
		Title	XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	678, 753	4, 428, 427	0. 15327	2 0	0	90.00
91.00 Nursing School cost	0	4, 428, 427	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 428, 427	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 428, 427		0 0	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042	Period: From 01/01/2019 To 12/31/2019		par
		Title XIX	Hospi tal	7/10/2020 2:5 Cost	Uр
	Cost Center Description				
_	PART I - ALL PROVIDER COMPONENTS			1.00	-
	INPATIENT DAYS				1
00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			14, 701 14, 701	
00	Private room days (excluding swing-bed and observation bed da		rivate room davs.	14, 701	
	do not complete this line.			-	
00	Semi-private room days (excluding swing-bed and observation k		04 6 11	11, 421	
00	Total swing-bed SNF type inpatient days (including private ro reporting period	oom days) through Decembe	er 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private ro	31 of the cost	0	6	
0	reporting period (if calendar year, enter 0 on this line)	am dava) through December	21 of the east	0	
00	Total swing-bed NF type inpatient days (including private roc reporting period	om days) through December	31 of the cost	0	
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)			0.05	
00	Total inpatient days including private room days applicable t newborn days) (see instructions)	to the Program (excluding	swing-bed and	395	
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10
~~	through December 31 of the cost reporting period (see instruc			0	
00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, et al. 2010)		room days) arter	0	11
00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
~~	through December 31 of the cost reporting period			0	
00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13
00	Medically necessary private room days applicable to the Progr			0	14
00	Total nursery days (title V or XIX only)		-	843	
00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			60	16
00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 d	of the cost	0.00	1 17
	reporting period	C			
00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
	reporting period	5			
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of 1	the cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	าร)		14, 265, 451	21
00	Swing-bed cost applicable to SNF type services through Decemb	per 31 of the cost report	ing period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	a 21 of the cost reportin	a pariod (line 6	0	23
. 00	x line 18)	ST OF the cost reportin	ig period (Trile o	0	2
00	Swing-bed cost applicable to NF type services through December	er 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
. 00	x line 20)		period (The b	0	2
-	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		14, 265, 451	27
00	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	28
00	Private room charges (excluding swing-bed charges)		5 /	0	29
-	Semi-private room charges (excluding swing-bed charges)	Line 29		0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	- IINE 20)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi	, ,	ctions)	0.00	
00 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	14, 265, 451	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ILICTMENTS			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ Adjusted general inpatient routine service cost per diem (see			970. 37	38
	Program general inpatient routine service cost (line 9 x line	•		383, 296	
	Medically necessary private room cost applicable to the Progr			0	
00	Total Program general inpatient routine service cost (line 39	+ IINE 40)		383, 296	41

OMPUTA	TION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
					o 12/31/2019	Date/Time Pre	
			Titl	e XIX	Hospi tal	7/10/2020 2:5 Cost	o pi
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	-
	NURSERY (title V & XIX only)	509, 579	843	604.48	8 60		42
	ntensive Care Type Inpatient Hospital Units	7.0(0.000	( 570	1 10( 00			
	INTENSIVE CARE UNIT CORONARY CARE UNIT	7, 863, 008	6, 570	1, 196. 80	0	0	43
	BURN INTENSIVE CARE UNIT						44
	SURGI CAL I NTENSI VE CARE UNI T						46
. 00 0	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description					1.00	
. 00   F	Program inpatient ancillary service cost (Wks	t D-3 col 3	Line 200)			1.00 533,344	48
	Total Program inpatient costs (sum of lines 4			ns)		952, 909	
	PASS THROUGH COST ADJUSTMENTS	9 , (					
	Pass through costs applicable to Program inpa	tient routine	services (from	Wkst. D, sum	of Parts I and	0	50
	III) Pass through costs applicable to Program inpa	tiont ancillar	y sorvicos (fr	om Wkst D si	m of Darte II	0	51
	and IV)		y services (II	UNI WKST. D, SC	m of Faits II		1 51
2. 00   1	Total Program excludable cost (sum of lines 5					0	
	Total Program inpatient operating cost exclud		lated, non-phy	sician anesthe	tist, and	0	53
	medical education costs (line 49 minus line 5	2)					
	ARGET AMOUNT AND LIMIT COMPUTATION Program discharges						54
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	56
	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	
	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	orting poriod	onding 1006 u	ndatod and com	nounded by the	0.00	
	narket basket	or tring period	enurny 1990, u	puateu anu com	pounded by the	0.00	1 37
	Lesser of lines 53/54 or 55 from prior year of	ost report, up	dated by the m	arket basket		0.00	60
	If line 53/54 is less than the lower of lines					0	61
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (lines 54 x	60), or 1% of	the target		
	Relief payment (see instructions)	nstructrons)				0	62
	Allowable Inpatient cost plus incentive payme	nt (see instru	ctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST					1	
	Medicare swing-bed SNF inpatient routine cost	s through Dece	mber 31 of the	cost reportir	g period (See	0	64
	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	s after Decemb	er 31 of the c	ost reporting	period (See	0	65
	instructions)(title XVIII only)			ost reporting			
	Total Medicare swing-bed SNF inpatient routin	e costs (line	64 plus line 6	5)(title XVIII	only). For	0	66
	CAH (see instructions)		D	£ + +			
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	costs through	December 31 0	r the cost rep	orting period	0	67
	Title V or XIX swing-bed NF inpatient routine	costs after D	ecember 31 of	the cost repor	ting period	0	68
(	(line 13 x line 20)						
-	Total title V or XIX swing-bed NF inpatient r	````		/		0	69
	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70
	Adjusted general inpatient routine service co						71
	Program routine service cost (line 9 x line 7	1)		,			72
	Medically necessary private room cost applica			ne 35)			73
	Total Program general inpatient routine servi	•		orkshoot P Po	rt II column		74
	Capital-related cost allocated to inpatient r 26, line 45)	outine service	CUSIS (ITUM W	UNSHEEL B, Pa	ntin, corumn		75
	Per diem capital-related costs (line 75 ÷ lin	e 2)					76
	Program capital-related costs (line 9 x line	,					77
	Inpatient routine service cost (line 74 minus	,	novider r				78
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				s line 70)		80
	Inpatient routine service cost per diem limit				is i i i i e 77)		81
	Inpatient routine service cost limitation (li		)				82
. 00   F	Reasonable inpatient routine service costs (s	ee instruction					83
	Program inpatient ancillary services (see ins		>				84
1	Jtilization review - physician compensation ( Total Program inpatient operating costs (sum						85
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS					1	86
	Total observation bed days (see instructions)					3, 280	87
	Adjusted general inpatient routine cost per d	iem (line 27 ÷	line 2)			970. 37	88
	Observation bed cost (line 87 x line 88) (see					3, 182, 814	1 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider C		Period:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019		pared: 0 pm
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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, 709, 042	14, 265, 451	0. 18990	2 3, 182, 814	604, 423	90.00
91.00 Nursing School cost	0	14, 265, 451	0.00000	0 3, 182, 814	0	91.00
92.00 Allied health cost	0	14, 265, 451	0.00000	0 3, 182, 814	0	92.00
93.00 All other Medical Education	0	14, 265, 451	0. 00000	0 3, 182, 814	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 7/10/2020 2:50	pare
		Title XIX	Subprovider -	Cost	
	Cost Center Description		-	1.00	
	PART I – ALL PROVIDER COMPONENTS				-
00	Inpatient days (including private room days and swing-bed day	vs. excluding newborn)		4, 502	1 1
00	Inpatient days (including private room days, excluding swing-			4, 502	
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	(aveb bec		4, 502	4
20	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	4, 302	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7
00	reporting period			0	<i>'</i>
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable 1	to the Drogram (oveluding	swing_bed and	288	9
50	newborn days) (see instructions)	to the Frogram (excruding	swillig-bed allu	288	'
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		oom days)	0	10
~~~	through December 31 of the cost reporting period (see instruc				
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, et al. )		oom days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
	through December 31 of the cost reporting period				
. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13
. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)	(		843	
. 00	Nursery days (title V or XIX only)			60	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	os through December 21 a	f the cost	0.00	1 17
. 00	reporting period	Les thiough becember 31 0	T the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period	a through December 21 of	the east	0.00	10
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through becember 31 of	the cost	0.00	15
. 00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
~~~	reporting period			F 0F( 000	
. 00 . 00	Total general inpatient routine service cost (see instruction Swing-bed cost applicable to SNF type services through Decemb		ing period (line)	5, 856, 929 0	
. 00	5 x line 17)	bel 31 01 the cost report	ring period (rine	0	
. 00	Swing-bed cost applicable to SNF type services after December	<sup>-</sup> 31 of the cost reportin	g period (line 6	0	23
00	x line 18) Swing had goot appliable to NE type convious through December	an 21 of the east report:	ng pariod (line	0	2
. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er al of the cost reporti	ng period (inne	0	24
. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
~~	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 5, 856, 929	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT			0,000,727	'
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	÷line 28)		0 0. 000000	30
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33
-	Average per diem private room charge differential (line 32 mi	, ,	tions)	0.00	
. 00 . 00	Average per diem private room cost differential (line 34 x li Private room cost differential adjustment (line 3 x line 35)	110 31/		0. 00 0	
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	5, 856, 929	
	27 minus line 36)	•			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ILISTMENTS			
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD. Adjusted general inpatient routine service cost per diem (see			1, 300. 96	38
	Program general inpatient routine service cost (line 9 x line			374, 676	
00	Medically necessary private room cost applicable to the Progr	ram (line 14 x line 35)		0	
00	Total Program general inpatient routine service cost (line 39	∂ + line 40)		374, 676	41

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	GOOD SAMARITAN		CN: 15-0042	Period:	eu of Form CMS- Worksheet D-1	
			CCN: 15-S042	From 01/01/2019 To 12/31/2019	Date/Time Pre	epare
		Titl	e XIX	Subprovider -	7/10/2020 2:5 Cost	50 pm
Cost Conton Deconintion	Tatal			I PF	Disa susan Calat	
Cost Center Description	Total Inpatient CostIr	Total upatient Days	col. 2)	÷	Program Cost (col. 3 x col. 4)	
2.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00 00 0	5.00	) 42.
Intensive Care Type Inpatient Hospital U	ni ts		, <u> </u>		-	
. 00 I NTENSI VE CARE UNI T . 00 CORONARY CARE UNI T	0	C	0.	00 C	C	43
. 00 BURN INTENSIVE CARE UNIT						45
. 00 SURGI CAL I NTENSI VE CARE UNI T						46
Cost Center Description						47
		1: 000)			1.00	- 10
.00 Program inpatient ancillary service cost .00 Total Program inpatient costs (sum of li	-		ons)		21, 886 396, 562	
PASS THROUGH COST ADJUSTMENTS						
.00 Pass through costs applicable to Program	i inpatient routine se	ervices (Tron	N WKST. D, SUI	m of Parts I and	C	50
.00 Pass through costs applicable to Program and IV)	inpatient ancillary	services (fr	rom Wkst. D, s	sum of Parts II	0	51
.00 Total Program excludable cost (sum of li	nes 50 and 51)				c d	52
5.00 Total Program inpatient operating cost e medical education costs (line 49 minus I TARGET AMOUNT AND LIMIT COMPUTATION		ited, non-phy	sician anest	hetist, and	C	) 53
.00 Program di scharges					C	
.00 Target amount per discharge .00 Target amount (line 54 x line 55)					0.00	
. 00 Difference between adjusted inpatient op	erating cost and targ	get amount (I	ine 56 minus	line 53)		
.00 Bonus payment (see instructions)					0	
.00 Lesser of lines 53/54 or 55 from the cos market basket	st reporting period en	1α) ng 1996, ι	ipdated and c	ompounded by the	0.00	) 59
<ul> <li>.00 Lesser of lines 53/54 or 55 from prior 5</li> <li>.00 If line 53/54 is less than the lower of which operating costs (line 53) are less amount (line 56), otherwise enter zero (</li> </ul>	lines 55, 59 or 60 er than expected costs	nter the less	ser of 50% of		0.00 C	
.00Relief payment (see instructions).00Allowable inpatient cost plus incentive	payment (see instruc	i ons)				
.00 Medicare swing-bed SNF inpatient routine		per 31 of the	e cost report	ing period (See	0	) 64
instructions)(title XVIII only)	Ū			01		
.00 Medicare swing-bed SNF inpatient routine instructions)(title XVIII only)	costs after December	31 of the c	cost reporting	g period (see	C	65
.00 Total Medicare swing-bed SNF inpatient r CAH (see instructions)	outine costs (line 64	l plus line 6	5)(title XVI	II only). For	C	66
.00 Title V or XIX swing-bed NF inpatient ro	outine costs through [	ecember 31 o	of the cost r	eporting period	C	67
(line 12 x line 19) 1.00 Title V or XIX swing-bed NF inpatient ro (line 13 x line 20)	outine costs after Dec	cember 31 of	the cost rep	orting period	C	68
0.00 Total title V or XIX swing-bed NF inpati					C	69
.00 Skilled nursing facility/other nursing f				)		70
.00 Adjusted general inpatient routine servi	ce cost per diem (lin					71
.00 Program routine service cost (line 9 x l .00 Medically necessary private room cost ap	,	line 14 x li	ne 35)			72
.00 Total Program general inpatient routine	service costs (line )	, 2 + line 73)	)			74
<ul> <li>.00 Capital-related cost allocated to inpati 26, line 45)</li> <li>.00 Per diem capital-related costs (line 75)</li> </ul>		costs (from V	Vorksheet B, I	Part II, column		75
00 Program capital-related costs (line 9 x	line 76)					77
00 Inpatient routine service cost (line 74 00 Aggregate charges to beneficiaries for e		wider record	1c)			78
.00 Aggregate charges to beneficiaries for e .00 Total Program routine service costs for				nus line 79)		80
.00 Inpatient routine service cost per diem	limitation		•	,		81
<ul> <li>.00 Inpatient routine service cost limitatic</li> <li>.00 Reasonable inpatient routine service cost</li> </ul>	, , ,					82
<ul> <li>00 Reasonable inpatient routine service cos</li> <li>00 Program inpatient ancillary services (set</li> </ul>	•					83
.00 Utilization review - physician compensat	ion (see instructions					85
D. 00 <u>Total Program inpatient operating costs</u> PART IV - COMPUTATION OF OBSERVATION BED		ough 85)				86
7.00 Total observation bed days (see instruct					0	87
3.00 Adjusted general inpatient routine cost	per diem (line 27 ÷ l	ine 2)			0.00	88  0
9.00  Observation bed cost (line 87 x line 88)	(see instructions)				1 0	) 89

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
		Component (		To 12/31/2019		pared: 0 pm
		Titl	e XIX	Subprovider - IPF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	587, 168	5, 856, 929	0. 10025	2 0	0	90.00
91.00 Nursing School cost	0	5, 856, 929	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	5, 856, 929	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	5, 856, 929	0.00000	0 0	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0042 Component CCN: 15-T042	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prep 7/10/2020 2:50	
		Title XIX	Subprovider -	Cost	
	Cost Center Description		-	1.00	
	PART I – ALL PROVIDER COMPONENTS				
00	Inpatient days (including private room days and swing-bed day	/s, excluding newborn)		7, 059	1
00	Inpatient days (including private room days, excluding swing-			7, 059	2
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only pr	ivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	ed days)		7,059	4
00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost	0,007	5
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roc	om davs) through December	31 of the cost	0	7
	reporting period			-	
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable t	to the Program (excluding	swing_bed and	42	9
00	newborn days) (see instructions)		Sinnig bed and	12	ĺ
. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10
. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII of		oom dave) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, e		oom uays) arter	0	''
. 00	Swing-bed NF type inpatient days applicable to titles V or XI		e room days)	0	12
00	through December 31 of the cost reporting period			0	1.0
. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendary			0	13
. 00	Medically necessary private room days applicable to the Progr			0	14
	Total nursery days (title V or XIX only)			843	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			60	16
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 o	f the cost	0.00	17
	reporting period	5			
. 00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period	C			
. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instruction	าร)		4, 428, 427	21
	Swing-bed cost applicable to SNF type services through Decemb	·	ing period (line	0	
	5 x line 17)				
. 00	Swing-bed cost applicable to SNF type services after December x line 18)	- 31 of the cost reportin	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	0	24
	7 x line 19)			_	
. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25
. 00	Total swing-bed cost (see instructions)			0	26
. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 428, 427	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and observation had ab	argos)	0	28
	Private room charges (excluding swing-bed charges)	ed and observation bed ch	arges)	0	20
	Semi -private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0.00 0.00	
1	Average per diem private room cost differential (line 34 x li		/	0.00	
	Private room cost differential adjustment (line 3 x line 35)			0	36
. 00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	tterential (line	4, 428, 427	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
[	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ				
	Adjusted general inpatient routine service cost per diem (see			627.34	
	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr			26, 348 0	
	Total Program general inpatient routine service cost (line 39			26, 348	

	Financial Systems TATION OF INPATIENT OPERATING COST	GOOD SAMARITAN		CN: 15-0042	In Lie Period:	eu of Form CMS- Worksheet D-1	
				CCN: 15-T042	From 01/01/2019 To 12/31/2019	Date/Time Pre	epared
			Titl	e XIX	Subprovider -	7/10/2020 2:5 Cost	50 pm
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient CostIn		col. 2)		(col. 3 x col. 4)	
2.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	) 42. (
	Intensive Care Type Inpatient Hospital Units		-	1		1	
3.00 4.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	0	C	0.	00 00	C	43.
4.00 5.00	BURN INTENSIVE CARE UNIT						44.
6.00	SURGI CAL I NTENSI VE CARE UNI T						46.
7.00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
8.00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			17, 528	48.
9.00	Total Program inpatient costs (sum of lines	41 through 48)(se	e instructio	ons)		43, 876	49.
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine se	rvices (from	n Wkst D su	n of Parts L and	C	50.
0.00	111)						
1.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51.
2.00	and IV) Total Program excludable cost (sum of lines	50 and 51)				C	52.
3.00	Total Program inpatient operating cost exclu		ted, non-phy	sician anest	netist, and	C	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
4.00	Program discharges					C	54.
5.00	Target amount per discharge					0.00	
5.00	Target amount (line 54 x line 55)	ing post and tang	at amount ()	ing E( minug	Line E2)	0	
7.00 3.00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	et amount (i	The so minus	TThe 53)		
9.00	Lesser of lines 53/54 or 55 from the cost re	porting period en	ding 1996, ι	updated and c	ompounded by the	-	
	market basket		<b>.</b>				
0.00 1.00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	
	which operating costs (line 53) are less that	n expected costs					
2 00	amount (line 56), otherwise enter zero (see	instructions)				C C	62.
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instruct	ions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST					1	
4.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Decemb	er 31 of the	e cost report	ng period (See	C	64.
5.00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the d	ost reportin	g period (See	0	65.
	instructions)(title XVIII only)						
6. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	plus line 6	5)(title XVI	ll only). For	C	66.
7.00	Title V or XIX swing-bed NF inpatient routin	e costs through D	ecember 31 d	of the cost r	eporting period	C	67.
0 00	(line 12 x line 19)						
8.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after Dec	ember 31 or	the cost rep	orting period	C	68.
9.00		routine costs (li	ne 67 + line	e 68)		C	69.
0.00	PART III - SKILLED NURSING FACILITY, OTHER N				<u>,</u>		1 70
0.00 1.00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	2			)		70.
2.00	Program routine service cost (line 9 x line		0 / 0 / 11110	_)			72.
3.00	Medically necessary private room cost applic	0,					73.
4.00 5.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			Part II column		74.
2.00	26, line 45)			is respect b,	a.e.r, corumn		,
5.00	Per diem capital -related costs (line 75 ÷ li						76.
7.00 3.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77.
9.00	Aggregate charges to beneficiaries for exces		vider record	ls)			79.
0. 00	Total Program routine service costs for comp		t limitatior	n (line 78 mi	nus line 79)		80.
1.00 2.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 82.
3.00	Reasonable inpatient routine service cost (						83.
4.00	Program inpatient ancillary services (see in	structions)					84.
5.00	Utilization review - physician compensation						85.
6. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		uyii 65)			I	86.
7.00	Total observation bed days (see instructions	)				C	
8.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se		ine 2)			0.00	) 88. ) 89.

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2019	Worksheet D-1	
		Component (	CCN: 15-T042	To 12/31/2019	Date/Time Pre 7/10/2020 2:5	pared: O pm
		Titl	e XIX	Subprovider - IRF	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	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	678, 753	4, 428, 427	0. 15327	2 0	0	90.00
91.00 Nursing School cost	0	4, 428, 427	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 428, 427	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 428, 427	0.00000	0 0	0	93.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL		In Lie	eu of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-0042	Peri od:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
				7/10/2020 2:5	
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	10 717 000		1 20 00
30. 00 03000 ADULTS & PEDIATRICS			12, 717, 803		30.00
31. 00 03100 I NTENSI VE CARE UNI T			9, 954, 663		31.00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF			1, 275		40.00
43. 00 04300 NURSERY			57, 213		
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00 05000 OPERATING ROOM		0. 14648	34 11, 157, 463	1, 634, 390	50,00
51. 00 05100 RECOVERY ROOM		0. 00000		1, 034, 390	51.00
51. 01 05101 ENDOSCOPY		0. 27242			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 3166		0	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 10928		-	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1656		71, 537	
60. 00 06000 LABORATORY		0. 1408		1, 789, 561	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 2495		-	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 27438		957, 813	•
69. 00 06900 ELECTROCARDI OLOGY		0. 15255		1, 287, 861	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.00
70. 01 07001 NEURODI AGNOSTI CS		0. 2245			70.01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1.05850			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 56210			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 27712			•
75.00 07500 ASC (NON-DI STI NCT PART)		0. 16279		30	
76.00 03950 MH ANCI LLARY OUTPATI ENT		0.0000		0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S		0. 64313		608, 316	
OUTPATIENT SERVICE COST CENTERS					1
90. 00 09000 CLI NI C		2. 18890	69 0	0	90.00
90. 01 04950 WOUND CLINIC		0. 2398	35, 004	8, 394	90.01
91.00 09100 EMERGENCY		0. 17516	5, 698, 351	998, 129	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 54896	62 842, 818	462, 675	92.00
OTHER REIMBURSABLE COST CENTERS					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 52792		0	96.00
200.00 Total (sum of lines 50 through 94 and 96			74, 951, 683	16, 991, 508	
201.00 Less PBP Clinic Laboratory Services-Prog	gram only charges (line 61)		0		201.00
202.00 Net charges (line 200 minus line 201)			74, 951, 683		202.00

			Peri od:	Worksheet D-3	,
	Component	CCN: 15-SO42	From 01/01/2019 To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
	Title	e XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	_
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
00 03000 ADULTS & PEDIATRICS			0		3
. 00  03100  ADDETS & PEDIATRICS			0		3
. 00 04000 SUBPROVI DER – I PF			2, 343, 812		4
. 00  04100  SUBPROVI DER - I RF			2, 343, 012		4
. 00 04300 NURSERY			0		4
ANCI LLARY SERVI CE COST CENTERS					`
. 00 O5000 OPERATI NG ROOM		0. 1464	34 0	0	5
00 05100 RECOVERY ROOM		0.0000			
. 01   05101   ENDOSCOPY		0. 27242			
. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 3166		0	
00 05300 ANESTHESI OLOGY		0.0000		0	
. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1092		5, 709	5
. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1656		0	5
. 00 06000 LABORATORY		0. 1408	71 229, 072	32, 270	60
. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000	0 00	0	63
. 00 06500 RESPI RATORY THERAPY		0. 2495	75 179, 306	44, 750	65
. 00 06600 PHYSI CAL THERAPY		0. 2743	30, 020	8, 237	66
. 00 06900 ELECTROCARDI OLOGY		0. 1525	59 20, 822	3, 177	69
. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	0 00	0	70
. 01 07001 NEURODI AGNOSTI CS		0. 2245	78 0	0	70
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1.0585	66 8, 393	8, 885	j 7'
. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 5621	58 0	0	72
. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2771		77, 671	73
. 00 07500 ASC (NON-DI STI NCT PART)		0. 1627		0	) 75
. 00 03950 MH ANCI LLARY OUTPATI ENT		0.0000			
. 01 03951 I NPATI ENT DI ALYSI S		0. 6431	35 0	0	0 70
OUTPATIENT SERVICE COST CENTERS					
. 00 09000 CLINIC		2.1889			
. 01 04950 WOUND CLINIC		0. 2398		0	
00 09100 EMERGENCY		0. 1751		49, 817	
. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 5489	62 0	0	92
		0.5070			
. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 52792		0	
0.00 Total (sum of lines 50 through 94 and 96 through 98)	(1) 20 (1)		1, 084, 537	230, 516	
1.00 Less PBP Clinic Laboratory Services-Program only charges	5 (IINE 61)	1	0		201

INDATIENT ANCLI	I Systems GOOD SAM/ LLARY SERVICE COST APPORTIONMENT	Providor (	CN: 15-0042	Peri od:	u of Form CMS- Worksheet D-3	
INFAILENT ANGL	LART SERVICE COST AFFORTIONWENT	FIOVIDEI C	CN. 13-0042	From 01/01/2019	WOLKSHEEL D-3	2
		Component	CCN: 15-T042	To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
		Titl€	e XVIII	Subprovider - IRF	PPS	•
Co	st Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
			j ő	Charges	(col. 1 x col.	
				3	2)	
			1.00	2.00	3.00	
I NPATI EN	T ROUTINE SERVICE COST CENTERS				_	
30. 00 03000 AD	ULTS & PEDIATRICS			335, 067		30.0
31.00 03100 IN	TENSI VE CARE UNI T			0		31.0
	BPROVIDER – IPF			0		40.0
41.00 04100 SU	BPROVIDER – IRF			6, 294, 034		41.0
43.00 04300 NU						43.0
ANCI LLAR	Y SERVICE COST CENTERS					
	ERATING ROOM		0. 1464	84 89, 561	13, 119	9 50.0
51.00 05100 RE	COVERY ROOM		0.0000		C	51.0
51.01 05101 EN	DOSCOPY		0. 27242	23 31, 823	8, 669	9 51. C
52.00 05200 DE	LIVERY ROOM & LABOR ROOM		0. 3166	79 0	0	52.0
53.00 05300 AN	ESTHESI OLOGY		0.0000	0 00	0	53.0
54.00 05400 RA	DI OLOGY-DI AGNOSTI C		0. 1092	32 458, 996	50, 160	) 54.C
55. 00 05500 RAI	DI OLOGY-THERAPEUTI C		0. 1656	59 0	C	
50.00 06000 LAI	BORATORY		0. 1408	71 1, 140, 022	160, 596	60.0
53.00 06300 BL	OOD STORING, PROCESSING & TRANS.		0.0000	0 00	0	) 63. C
55.00 06500 RE	SPI RATORY THERAPY		0. 2495		326, 729	9 65. C
56.00 06600 PH	YSI CAL THERAPY		0. 2743	8, 203, 636	2, 250, 971	1 66. C
9.00 06900 EL	ECTROCARDI OLOGY		0. 1525	59 110, 478	16, 854	4 69.0
0. 00 07000 EL	ECTROENCEPHALOGRAPHY		0.0000	0 00	0	70.0
0. 01 07001 NE	URODI AGNOSTI CS		0. 2245	78 11, 067	2, 485	5 70.0
	DICAL SUPPLIES CHARGED TO PATIENTS		1.0585	56 153, 178	162, 149	71.0
2.00 07200 IM	PL. DEV. CHARGED TO PATIENTS		0. 5621	58 3, 879	2, 181	1 72.0
	UGS CHARGED TO PATIENTS		0. 2771	22 1, 527, 827	423, 394	1 73.0
	C (NON-DISTINCT PART)		0. 1627	92 0	C	75.0
	ANCI LLARY OUTPATI ENT		0.0000		C	76.0
	PATIENT DIALYSIS		0. 6431	35 97, 020	62, 397	76.0
	NT SERVICE COST CENTERS					
90.00 09000 CL			2. 1889		C	90.0
	UND CLINIC		0. 2398		, s	
91.00 09100 EM			0. 1751		17, 123	3 91. C
	SERVATION BEDS (NON-DISTINCT PART)		0. 5489	62 0	0	92.0
	IMBURSABLE COST CENTERS					
	RABLE MEDICAL EQUIP-RENTED		0. 52792		-	
	tal (sum of lines 50 through 94 and 96 through			13, 234, 381	3, 496, 827	/ 200. 0
201.00 Le:	ss PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201.0
202.00 Ne	t charges (line 200 minus line 201)			13, 234, 381		202.0

Health Financial Systems GOOD SAMARITA	N HOSPI TAL		In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0042	Peri od:	Worksheet D-3	
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre	
	T: +1	e XIX	Hospi tal	7/10/2020 2:5 Cost	<u>o pm</u>
Cost Contor Description	1111	Ratio of Cos		Inpatient	
Cost Center Description		To Charges	Program	Program Costs	
		10 charges	Charges	(col. 1 x col.	
			chai yes	2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	5.00	
30. 00 03000 ADULTS & PEDI ATRI CS			325, 010		30.00
31. 00 03100 I NTENSI VE CARE UNI T			305, 764		31.00
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		40.00
43. 00 04300 NURSERY			99, 964		41.00
ANCI LLARY SERVICE COST CENTERS			77, 704		43.00
50. 00 05000 OPERATI NG ROOM		0. 1464	17 310, 014	45, 391	50.00
51.00 05100 RECOVERY ROOM		0. 0000		43, 371	
51. 01  05101   ENDOSCOPY		0. 2724		4, 566	
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2724		116, 549	
53. 00 05300 ANESTHESI OLOGY		0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1092		32, 056	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1092		1, 010	
60. 00 06000 LABORATORY					
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 1408 0. 0000		62, 883 0	1
65. 00  06500  RESPI RATORY THERAPY 66. 00  06600  PHYSI CAL_THERAPY		0. 2495 0. 2743		51, 753 24, 092	
		0. 2743			
69. 00  06900  ELECTROCARDI OLOGY 70. 00  07000  ELECTROENCEPHALOGRAPHY		0. 1489		37, 779 0	1
		0. 0000			
				414	70.01
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		1.0585		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0.5621		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 2771			
75.00 07500 ASC (NON-DI STI NCT PART)		0. 1627		156	
76.00 03950 MH ANCI LLARY OUTPATIENT		0.0000		0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S		0. 6390	91 13, 783	8, 809	76.01
0UTPATI ENT_SERVICE_COST_CENTERS 90. 00 09000 CLINIC		2 1000	(0) 0	0	00.00
		2.1889		0	
90. 01 04950 WOUND CLINIC		0. 2398		212	
		0. 1751			
92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 5489	62 2,700	1, 482	92.00
		0 5070	25 0	0	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 5279		E22 244	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1)		2, 627, 943	533, 344	
201.00 Less PBP Clinic Laboratory Services-Program only charg 202.00 Net charges (line 200 minus line 201)	jes (ITHE OT)		2 4 27 0 4 2		201.00
202.00  Net charges (line 200 minus line 201)		I	2, 627, 943	l	202.00

NPATIENT ANCI	al Systems GOOD SAMARITA		CN: 15-0042	Peri od:	u of Form CMS- Worksheet D-3	3
				From 01/01/2019		
		Component	CCN: 15-SO42	To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
		Titl	e XIX	Subprovider -	Cost	
				I PF		
Co	ost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2.00	2) 3.00	
ΙΝΡΔΤΙΕΙ	NT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	DULTS & PEDIATRICS		T	0		30.
	VTENSI VE CARE UNI T			0		31. (
	JBPROVIDER - IPF			457, 891		40.0
	JBPROVIDER – IRF			0		41.0
3.00 04300 NI				0		43.
	RY SERVICE COST CENTERS		1			
	PERATING ROOM		0. 1464	17 0	0	50.0
1.00 05100 RE	ECOVERY ROOM		0.0000	0 00	0	51.
1.01 05101 EI	NDOSCOPY		0. 27242		45	51.
2.00 05200 DE	ELIVERY ROOM & LABOR ROOM		0. 3166		0	52.
	NESTHESI OLOGY		0.0000	0 00	0	53.
4.00 05400 R	ADI OLOGY-DI AGNOSTI C		0. 1092		1, 469	54.0
	ADI OLOGY-THERAPEUTI C		0. 1652	56 0	0	55.0
0.00 06000 LA	ABORATORY		0. 1408	71 30, 259	4, 263	60. 0
3. 00  06300  BI	LOOD STORING, PROCESSING & TRANS.		0.0000	0 00	0	63.0
	ESPI RATORY THERAPY		0. 2495			
	HYSI CAL THERAPY		0. 2743		2, 033	
	LECTROCARDI OLOGY		0. 14890			
	LECTROENCEPHALOGRAPHY		0.0000		0	
	EURODI AGNOSTI CS		0. 2245		147	
	EDICAL SUPPLIES CHARGED TO PATIENTS		1.0585		1, 642	
	MPL. DEV. CHARGED TO PATIENTS		0. 5621		0	
	RUGS CHARGED TO PATIENTS		0. 27712		9, 458	
	SC (NON-DI STINCT PART)		0. 1627		0	
	H ANCI LLARY OUTPATI ENT		0.0000		0	
	NPATIENT DIALYSIS		0.6390	91 600	383	76.
0. 00 09000 CI	ENT SERVICE COST CENTERS		2.1889	59 0	0	90.
			0. 2398			
1.00 09100 EN			0. 2398			
	BSERVATION BEDS (NON-DISTINCT PART)		0. 1751.			
OTHER R	EIMBURSABLE COST CENTERS		0. 5469	0	0	72.
	JRABLE MEDICAL EQUIP-RENTED		0. 52792	25 0	0	96.
	otal (sum of lines 50 through 94 and 96 through 98)		0. 5277	98, 911		
	ess PBP Clinic Laboratory Services-Program only charg	es (line 61)		0, 71	21,000	200.
	et charges (line 200 minus line 201)			98, 911		202.

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15 0042	Peri od:	Worksheet D-3	2552-1
INPATTENT ANGILLARY SERVICE CUST APPORTIONMENT	Provider C	CN: 15-0042	From 01/01/2019		6
	Component	CCN: 15-T042	To 12/31/2019	Date/Time Pre	
	Ti +1	e XIX	Subprovider -	7/10/2020 2:5 Cost	o pii
		6 117	IRF	COST	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		-			
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.0
31. 00 03100 I NTENSI VE CARE UNI T			0		31.0
40. 00 04000 SUBPROVIDER - IPF			0		40.0
41. 00 04100 SUBPROVI DER - I RF			52, 755		41.0
43. 00 04300 NURSERY ANCI LLARY SERVICE COST CENTERS			0		43.0
50. 00 05000 OPERATI NG ROOM		0, 1464	17 163	24	50.0
51. 00  05100 RECOVERY ROOM		0. 1484			
51. 00 05100 RECOVERY ROOM 51. 01 05101 ENDOSCOPY		0. 0000			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 2724			
53. 00 05300 ANESTHESI OLOGY		0.3166			
53. 00 105300 ANESTHESTOLOGY 54. 00 105400 RADI OLOGY-DI AGNOSTI C		0. 0000			
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 1092		431	
60. 00  06000  LABORATORY		0. 1852			
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 0000		0	
65. 00 06500 RESPIRATORY THERAPY		0. 2495			
66. 00 06600 PHYSI CAL THERAPY		0. 2743			
69. 00 06900 ELECTROCARDI OLOGY		0. 1489			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000			
70. 01 07001 NEURODI AGNOSTI CS		0. 2245		-	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1.0585			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 5621			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2771			
75. 00 07500 ASC (NON-DI STI NCT PART)		0. 1627			
76.00 03950 MH ANCI LLARY OUTPATI ENT		0.0000			
76. 01 03951 I NPATI ENT DI ALYSI S		0. 6390			
OUTPATIENT SERVICE COST CENTERS				-	1
90. 00 09000 CLI NI C		2. 1889	69 0	0	90.0
90. 01 04950 WOUND CLINIC		0. 2398	11 674	162	90.0
91. 00 09100 EMERGENCY		0. 1751	32 0	0	91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5489	62 0	0	92.0
OTHER REIMBURSABLE COST CENTERS					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 5279	25 0	0	96. C
200.00 Total (sum of lines 50 through 94 and 96 through 98	3)		65, 427	17, 528	200. 0
201.00 Less PBP Clinic Laboratory Services-Program only ch	narges (line 61)		0		201.0
202.00 Net charges (line 200 minus line 201)			65, 427		202.0

.CUL/	Financial Systems GOOD SAMARITAN H ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2019 To 12/31/2019	u of Form CMS-2 Worksheet E Part A Date/Time Pre 7/10/2020 2:50	pared
		Title XVIII	Hospi tal	PPS	0 pili
			MDH	Non MDH	
			1.00	1.01	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
10 11	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	ng prior to October 1	0 6, 985, 700	0 10, 016, 125	1. 0 1. 0
2	(see instructions) DRG amounts other than outlier payments for discharges occurrin	ng on or after October 1	5, 040, 688	0	1.0
3	(see instructions) DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring	0	0	1.0
4	prior to October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	r discharges occurring	0	0	1.0
0	on or after October 1 (see instructions) Outlier payments for discharges. (see instructions)				2.0
1	Outlier reconciliation amount		0	0	2.0
2	Outlier payment for discharges for Model 4 BPCI (see instruction	ons)	0	0	2.0
3	Outlier payments for discharges occurring prior to October 1 (s	see instructions)	29, 567	52, 487	2.0
)4	Outlier payments for discharges occurring on or after October	1 (see instructions)	29, 704	0	2.0
0	Managed Care Simulated Payments		2, 273, 859	1, 221, 352	
0	Bed days available divided by number of days in the cost repor instructions)	ting period (see	88. 57		4.0
0	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting	0.00		5.0
0	period ending on or before 12/31/1996 (see instructions) FTE count for allopathic and osteopathic programs that meet the	e criteria for an add-or	0.00		6.0
	to the cap for new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified u	)	0.00		7.0
	\$412.105(f)(1)(iv)(B)(1) ACA § 5503 reduction amount to the IME cap as specified under		0.00		7.0
	<pre>§412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, : instructions.</pre>				
0	Adjustment (increase or decrease) to the FTE count for allopat programs for affiliated programs in accordance with 42 CFR 413.		0.00		8. 0
	413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069	(August 1, 2002).	0.00		
1	The amount of increase if the hospital was awarded FTE cap slo ACA. If the cost report straddles July 1, 2011, see instruction	ns.	0.00		8.0
12	The amount of increase if the hospital was awarded FTE cap sloteaching hospital under $\S$ 5506 of ACA. (see instructions)		0.00		8.0
0	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (see instructions)		0.00		9.0
00	FTE count for allopathic and osteopathic programs in the curren records	nt year from your	0.00		10.0
	FTE count for residents in dental and podiatric programs.		0.00		11. (
	Current year allowable FTE (see instructions)		0.00		12.0
	Total allowable FTE count for the prior year.		0.00		13.0
00	Total allowable FTE count for the penultimate year if that year September 30, 1997, otherwise enter zero.	r ended on or atter	0.00		14.
	Sum of lines 12 through 14 divided by 3.		0.00		15.
	Adjustment for residents in initial years of the program		0.76		16.
	Adjustment for residents displaced by program or hospital close	ure	0.00		17.
	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).		0. 76 0. 008581		18. 19.
	Prior year resident to bed ratio (see instructions)	•	0.008864		20.
	Enter the lesser of lines 19 or 20 (see instructions)		0. 008581		21.
1	IME payment adjustment (see instructions)		56, 271	46, 865	
1	IME payment adjustment - Managed Care (see instructions)		10, 639	5, 715	
	Indirect Medical Education Adjustment for the Add-on for § 422 Number of additional allopathic and osteopathic IME FTE resider		0.00		23.
	IME FTE Resident Count Over Cap (see instructions)		0.00		23.
	If the amount on line 24 is greater than -O-, then enter the lo	ower of line 23 or line	0.00		24. 25.
00	24 (see instructions) Resident to bed ratio (divide line 25 by line 4)		0. 000000		26.
	IME payments adjustment factor. (see instructions)		0. 000000		27.
	IME add-on adjustment amount (see instructions)		0	0	28.
	IME add-on adjustment amount - Managed Care (see instructions)		0	0	28.
	Total IME payment ( sum of lines 22 and 28)		56, 271	46, 865	29.
01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment	)	10, 639	5, 715	29.
	Percentage of SSI recipient patient days to Medicare Part A par instructions)	tient days (see	4.88		30.
00	Percentage of Medicaid patient days (see instructions)		15.01		31.
00	Sum of Lines 30 and 31		19.89		32.
	Allowable disproportionate share percentage (see instructions)		5.69	5.69	
	Disproportionate share adjustment (see instructions)		171, 076	142, 480	

Heal th	Financial Systems GOOD SAMARITAN	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0042	Peri od:	Worksheet E	
				From 01/01/2019 To 12/31/2019		pared:
		Ti +L c	e XVIII	Hospi tal	7/10/2020 2:50 PPS	0 pm
			MDH Prior to		0n/After 10/1	
			10/1	1.01	0.00	
	Uncompensated Care Adjustment		1.00	1.01	2.00	
35.00	Total uncompensated care amount (see instructions)			0	8, 350, 599, 096	35.00
35.01	Factor 3 (see instructions)		0.0000000		0.000245589	
35. 02	Hospital uncompensated care payment (If line 34 is zero, ente this line) (see instructions)	r zero on	2, 229, 11	8	2, 050, 815	35.02
35.03	Pro rata share of the hospital uncompensated care payment amo	unt (see	1, 667, 25	8	515, 505	35.03
35. 04	instructions) Pro rata share of the hospital uncompensated care payment amo	upt (MDH)	732, 86	.0 934, 398	515, 505	35.04
	Total uncompensated care (sum of columns 1 and 2 on line 35.0	• •	2, 182, 76		515, 505	36.00
	Additional payment for high percentage of ESRD beneficiary di	scharges (li				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	di scharges		0		40.00
	101 MS-DRGS 052, 062, 063, 064 and 065 (See First detroits)		1	MDH	Non MDH	
				1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6 instructions)	83, 684 an 6	985. (see	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 6	82, 683, 684	0	0	41.01
10.00	an 685. (see instructions)					40.00
42.00 43.00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68			0.00		42.00 43.00
101.00	instructions)	2, 000, 001				101 00
44.00	Ratio of average length of stay to one week (line 43 divided days)	by line 41 c	livided by 7	0. 000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions	)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41	. 01)		0		46.00
47.00 48.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	mall rural h	osni tal s	13, 561, 371 14, 899, 248		
40.00	only. (see instructions)			14,077,240	0	40.00
					Amount	
49.00	Total payment for inpatient operating costs (see instructions	)			1.00	49.00
49. 00 50. 00	Total payment for inpatient operating costs (see instructions Payment for inpatient program capital (from Wkst. L, Pt. I an		applicable)			
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.	d Pt. II, as III, see ir	nstructions)		1.00 25,773,488 1,799,889 0	50. 00 51. 00
50. 00 51. 00 52. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii	d Pt. II, as III, see ir	nstructions)		1.00 25,773,488 1,799,889 0 0	50.00 51.00 52.00
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt.	d Pt. II, as III, see ir	nstructions)		1.00 25,773,488 1,799,889 0	50.00 51.00 52.00 53.00
50.00 51.00 52.00 53.00 54.00 54.01	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment	d Pt. II, as III, see ir ne 49 see ir	nstructions)		1.00 25,773,488 1,799,889 0 0 6,748 0 0	50.00 51.00 52.00 53.00 54.00 54.01
50.00 51.00 52.00 53.00 54.00 54.01 55.00	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	d Pt. II, as III, see ir ne 49 see ir 9)	nstructions)		1.00 25,773,488 1,799,889 0 6,748 6,748 0 0	50.00 51.00 52.00 53.00 54.00 54.01 55.00
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr	d Pt. II, as III, see ir ne 49 see ir 9) uctions)	nstructions) nstructions).	rough 35).	1.00 25,773,488 1,799,889 0 0 6,748 0 0	50.00 51.00 52.00 53.00 54.00 54.01 55.00 56.00
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9	nstructions) nstructions). 9, lines 30 th	rough 35).	1.00 25,773,488 1,799,889 0 0 6,748 0 0 0 0 0 0 84,652	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9	nstructions) nstructions). 9, lines 30 th	rough 35).	1.00 25,773,488 1,799,889 0 6,748 0 0 0 0 0 0 84,652 27,664,777	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11	nstructions) nstructions). 9, lines 30 th	rough 35).	1.00 25,773,488 1,799,889 0 6,748 0 0 0 0 0 0 84,652 27,664,777 5,648	50.00 51.00 52.00 53.00 54.01 55.00 56.00 57.00 58.00 59.00 60.00
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11	nstructions) nstructions). 9, lines 30 th	rough 35).	1.00 25,773,488 1,799,889 0 6,748 0 0 0 0 0 0 84,652 27,664,777	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 61.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11	nstructions) nstructions). 9, lines 30 th	rough 35).	1.00 25,773,488 1,799,889 0 6,748 0 0 0 0 0 0 84,652 27,664,777 5,648 27,659,129	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Allowable bad debts (see instructions)	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11	nstructions) nstructions). 9, lines 30 th	rough 35).	1.00 25,773,488 1,799,889 0 0 6,748 0 0 0 0 0 84,652 27,664,777 5,648 27,659,129 2,608,780 43,295 330,957	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 54.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 61.\ 00\\ 63.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60)	nstructions) nstructions). 9, lines 30 th	rough 35).	$\begin{array}{c} 1.\ 00\\ 25,\ 773,\ 488\\ 1,\ 799,\ 889\\ 0\\ 0\\ 6,\ 748\\ 0\\ 0\\ 0\\ 0\\ 0\\ 84,\ 652\\ 27,\ 664,\ 777\\ 5,\ 648\\ 27,\ 659,\ 129\\ 2,\ 608,\ 780\\ 43,\ 295\\ 330,\ 957\\ 215,\ 122\end{array}$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 61.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Allowable bad debts (see instructions)	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60)	nstructions) nstructions). 9, lines 30 th	rough 35).	1.00 25,773,488 1,799,889 0 0 6,748 0 0 0 0 0 84,652 27,664,777 5,648 27,659,129 2,608,780 43,295 330,957	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 68.\ 00\\ 68.\ 00\end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60) ructions) applicable t	onstructions) histructions). (), lines 30 th line 200)	e instructions)	$\begin{array}{c} 1.\ 00\\ 25,\ 773,\ 488\\ 1,\ 799,\ 889\\ 0\\ 0\\ 6,\ 748\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 68.\ 00\\ 68.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. T Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96).	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60) ructions) applicable t	onstructions) histructions). (), lines 30 th line 200)	e instructions)	$\begin{array}{c} 1.\ 00\\ 25,\ 773,\ 488\\ 1,\ 799,\ 889\\ 0\\ 0\\ 6,\ 748\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 54.\ 01\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 61.\ 00\\ 62.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 69.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60) ructions) applicable t (For SCH see	on MS-DRGs (see instructions)	e instructions)	$\begin{array}{c} 1.\ 00\\ 25,\ 773,\ 488\\ 1,\ 799,\ 889\\ 0\\ 0\\ 6,\ 748\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 68.\ 00\\ 68.\ 00\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 54.\ 01\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 70.\ 50\\ 70.\ 50\\ 70.\ 87\end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60) ructions) applicable t (For SCH see	on MS-DRGs (see instructions)	e instructions)	$\begin{array}{c} 1.\ 00\\ 25,\ 773,\ 488\\ 1,\ 799,\ 889\\ 0\\ 0\\ 0\\ 6,\ 748\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 54.\ 01\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 61.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 50\\ 70.\ 87\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 54.\ 01\\ 55.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 87\\ 70.\ 88\end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60) ructions) applicable t (For SCH see ration) adju	on MS-DRGs (see instructions)	e instructions)	$\begin{array}{c} 1.\ 00\\ 25,\ 773,\ 488\\ 1,\ 799,\ 889\\ 0\\ 0\\ 0\\ 6,\ 748\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 70.\ 87\\ 70.\ 88\end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 60.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ 70.\ 88\\ 70.\ 89\end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration OCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60) ructions) applicable t (For SCH see ration) adju	on MS-DRGs (see instructions)	e instructions)	$\begin{array}{c} 1.\ 00\\ 25,\ 773,\ 488\\ 1,\ 799,\ 889\\ 0\\ 0\\ 6,\ 748\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ 70.\ 88\\ 70.\ 89\end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 55.\ 00\\ 57.\ 00\\ 60.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ 70.\ 88\\ 70.\ 89\end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only)	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60) ructions) applicable t (For SCH see ration) adju	on MS-DRGs (see instructions)	e instructions)	$\begin{array}{c} 1.\ 00\\ 25,\ 773,\ 488\\ 1,\ 799,\ 889\\ 0\\ 0\\ 0\\ 6,\ 748\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 59.\ 00\\ 60.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 64.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 87\\ 70.\ 88\\ 70.\ 89\\ 70.\ 90\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 54.\ 01\\ 55.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 61.\ 00\\ 61.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ 70.\ 90\\ 70.\ 91\\ 70.\ 91\\ 70.\ 92\end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, Ii Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60) ructions) applicable t (For SCH see ration) adju	on MS-DRGs (see instructions)	e instructions)	1.00 25,773,488 1,799,889 0 0 6,748 0 0 0 0 0 84,652 27,664,777 5,648 27,669,129 2,668,780 43,295 330,957 215,122 173,169 25,222,176 0 0 0 0 0 0 0 0 939 -4,495 0	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 61.\ 00\\ 61.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ 70.\ 90\\ 70.\ 91\\ 70.\ 92\\ \end{array}$
$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 59.\ 00\\ 61.\ 00\\ 61.\ 00\\ 62.\ 00\\ 61.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ 70.\ 89\\ 70.\ 90\\ 70.\ 91\\ 70.\ 92\\ 70.\ 93\\ \end{array}$	Payment for inpatient program capital (from Wkst. L, Pt. I an Exception payment for inpatient program capital (Wkst. L, Pt. Direct graduate medical education payment (from Wkst. E-4, li Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cost of physicians' services in a teaching hospital (see intr Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58) Primary payer payments Total amount payable for program beneficiaries (line 59 minus Deductibles billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see inst Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst Demonstration payment adjustment amount before sequestration SCH or MDH volume decrease adjustment (contractor use only) Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HRR adjustment amount (see instructions)	d Pt. II, as III, see ir ne 49 see ir 9) uctions) II, column 9 IV, col. 11 line 60) ructions) applicable t (For SCH see ration) adju	on MS-DRGs (see instructions)	e instructions)	$\begin{array}{c} 1.\ 00\\ 25,\ 773,\ 488\\ 1,\ 799,\ 889\\ 0\\ 0\\ 0\\ 6,\ 748\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 84,\ 652\\ 27,\ 664,\ 777\\ 5,\ 648\\ 27,\ 659,\ 129\\ 2,\ 608,\ 780\\ 43,\ 295\\ 330,\ 957\\ 215,\ 122\\ 173,\ 169\\ 25,\ 222,\ 176\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\ 0\\$	$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 53.\ 00\\ 54.\ 01\\ 55.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 61.\ 00\\ 61.\ 00\\ 62.\ 00\\ 61.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ 70.\ 89\\ 70.\ 90\\ 70.\ 91\\ 70.\ 92\\ 70.\ 93\\ \end{array}$

ALCULATION OF REIMBURSEMENT SETTLEMENT	Provider C	CN: 15-0042	Peri od:	Worksheet E	
			From 01/01/2019 To 12/31/2019	Part A Date/Time Prep 7/10/2020 2:50	
	Title	× XVIII	Hospi tal	PPS	o piii
	T.	FFY	(уууу)	Amount	
			0	1.00	
D.96 Low volume adjustment for federal fiscal year (yyyy) (Enter the corresponding federal year for the period prior to 10/1)	in column O		0	0	70.
D. 97 Low volume adjustment for federal fiscal year (yyyy) (Enter	in column O		0	0	70.
the corresponding federal year for the period ending on or a 0.98 Low Volume Payment-3	iiter 10/1)			0	70.
D. 99 HAC adjustment amount (see instructions)				275, 070	
1.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			24, 880, 706	
1.01 Sequestration adjustment (see instructions)				497, 614	71.
1.02 Demonstration payment adjustment amount after sequestration				0	
1.03 Sequestration adjustment-PARHM pass-throughs					71.
2.00 Interim payments				24, 340, 863	
2.01  Interim payments-PARHM 3.00  Tentative settlement (for contractor use only)				0	72.
3. 01 Tentative settlement-PARHM (for contractor use only)				0	73.
4.00 Balance due provider/program (line 71 minus lines 71.01, 71.	02, 72, and			42, 229	
73)					
4.01 Balance due provider/program-PARHM (see instructions)					74.
5.00 Protested amounts (nonallowable cost report items) in accord	lance with			586, 872	75.
CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
0.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2 03			0	90.
plus 2.04 (see instructions)	01 2.00			0	/0.
.00 Capital outlier from Wkst. Ĺ, Pt. I, line 2				0	91.
2.00 Operating outlier reconciliation adjustment amount (see inst				0	
8.00 Capital outlier reconciliation adjustment amount (see instru				0	
4.00 The rate used to calculate the time value of money (see inst 5.00 Time value of money for operating expenses (see instructions	,			0. 00 0	94. 95.
5.00  Time value of money for operating expenses (see instructions 5.00  Time value of money for capital related expenses (see instru				0	
			Prior to 10/1		7.01
			1.00	2.00	
HSP Bonus Payment Amount			E(7.0/7	405 444	1100
00.00 HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			567, 967	435, 441	100.
D1. 00 HVBP adjustment factor (see instructions)			1.0006210634	1.0013449050	101
02.00 HVBP adjustment amount for HSP bonus payment (see instructio	ons)		353		102.
HRR Adjustment for HSP Bonus Payment					
03.00 HRR adjustment factor (see instructions)			0. 9973	0. 9932	103.
04.00 HRR adjustment amount for HSP bonus payment (see instruction			-1, 534	-2, 961	104.
Rural Community Hospital Demonstration Project (§410A Demons					
00.00 Is this the first year of the current 5-year demonstration p Century Cures Act? Enter "Y" for yes or "N" for no.	eriod under t	he 21st			200.
Cost Reimbursement					-
01.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, li	ne 49)				201.
02.00 Medicare discharges (see instructions)	,				202.
03.00 Case-mix adjustment factor (see instructions)					203.
Computation of Demonstration Target Amount Limitation (N/A i	n first year	of the curren	it 5-year demonst	ration	
period) 04.00 Medicare target amount					204
15.00 Case-mix adjusted target amount (line 203 times line 204)					204. 205.
6.00 Medicare inpatient routine cost cap (line 202 times line 205	5)				206.
Adjustment to Medicare Part A Inpatient Reimbursement	·				1
	structions)				207.
5	, line 59)				208.
8.00 Medicare Part A inpatient service costs (from Wkst. È, Pt. A					209.
8.00 Medicare Part A inpatient service costs (from Wkst. È, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions)			1		210.
8.00 Medicare Part A inpatient service costs (from Wkst. È, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use	•)				
8.00 Medicare Part A inpatient service costs (from Wkst. È, Pt. A 9.00 Adjustment to Medicare IPPS payments (see instructions) 0.00 Reserved for future use 1.00 Total adjustment to Medicare IPPS payments (see instructions	3)				211.
<ul> <li>00 Medicare Part A inpatient service costs (from Wkst. È, Pt. A</li> <li>04 Adjustment to Medicare IPPS payments (see instructions)</li> <li>00 Reserved for future use</li> <li>100 Total adjustment to Medicare IPPS payments (see instructions</li> <li>Comparision of PPS versus Cost Reimbursement</li> </ul>	•				211. 212.
<ul> <li>07.00 Program reimbursement under the §410A Demonstration (see ins 88.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A 99.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Reserved for future use</li> <li>1.00 Total adjustment to Medicare IPPS payments (see instructions <u>Comparision of PPS versus Cost Reimbursement</u></li> <li>2.00 Total adjustment to Medicare Part A IPPS payments (from line 3.00 Low-volume adjustment (see instructions)</li> </ul>	•				
<ul> <li>8.00 Medicare Part A inpatient service costs (from Wkst. È, Pt. A</li> <li>9.00 Adjustment to Medicare IPPS payments (see instructions)</li> <li>0.00 Reserved for future use</li> <li>1.00 Total adjustment to Medicare IPPS payments (see instructions</li> <li><u>Comparision of PPS versus Cost Reimbursement</u></li> <li>2.00 Total adjustment to Medicare Part A IPPS payments (from line</li> </ul>	211)	bursement)			212.

VO	Financial Systems LUME CALCULATION EXHIBIT 4			Provider CC	CN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pare
				Title	XVIII	Hospi tal	7/10/2020 2:50 PPS	U pm
				Intro		re 10/01	113	
		W/S E, Part A	Amounts (from	Pre/Post	MDH	Non MDH	Peri od	
		line	E, Part A)	Entitlement	2.00		On/After 10/01	
0	DRG amounts other than outlier	0	1.00	2.00	3.00	<u>3.01</u>	4.00	1.
0	payments	1.00	0	0		0	0	'
1	DRG amounts other than outlier payments for discharges	1.01	17, 001, 825	0	17, 001, 82	25 0		1
2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	5, 040, 688	0			5, 040, 688	1
3	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1.03	0	0		0 0		1
4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0			0	1
0	Outlier payments for	2.00						2
1	discharges (see instructions) Outlier payments for	2. 02	0	0		0 0	0	
2	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to	2.03	82, 054	0	82, 05	54 0		2
3	October 1 (see instructions) Outlier payments for discharges occurring on or after October 1 (see	2.04	29, 704	0			29, 704	2
0	instructions) Operating outlier reconciliation	2. 01	0	0		0 0	0	3
0	Managed care simulated payments Indirect Medical Education Adju	3.00	3, 495, 211	0	2, 439, 45	55 0	1, 055, 756	4
0	Amount from Worksheet E, Part	21.00	0. 008581	0. 008581	0. 00858	0. 008581	0. 008581	5
0	A, line 21 (see instructions) IME payment adjustment (see instructions)	22.00	103, 136					
1	IME payment adjustment for managed care (see	22.01	16, 354	0	11, 41	0	4, 940	6
	instructions) Indirect Medical Education Adju	stmont for the	Add on for So	ction 122 of t	bo MMA			
0	IME payment adjustment factor	27.00	0. 000000			0. 000000	0. 000000	7
0	(see instructions)	27.00	0.000000	0.000000	0.00000	0.000000	0.000000	'
0	IME adjustment (see instructions)	28.00	0	0		0 0	0	8
1	IME payment adjustment add on for managed care (see instructions)	28.01	0	0		0 0	0	8
0	Total IME payment (sum of lines 6 and 8)	29.00	103, 136	0	79, 55	51 0	23, 585	
1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	16, 354	0	11, 41	0	4, 940	9
00	Disproportionate Share Adjustme Allowable disproportionate	33. 00	0. 0569	0. 0569	0.056	59 0. 0569	0. 0569	10
00	share percentage (see instructions)	33.00	0.0304	0.0307	0.030	0.0307	0. 0309	
00	Disproportionate share adjustment (see instructions)	34.00	313, 556	0	241, 85	52 0	71, 704	11
01	Uncompensated care payments	36.00	2, 182, 763		1, 667, 25	58 0	515, 505	11
00	Additional payment for high per Total ESRD additional payment	centage of ESF 46.00	beneficiary 0	di scharges 0		0 0	0	12
00	(see instructions) Subtotal (see instructions) Hospital specific payments	47.00 48.00	24, 753, 726 14, 899, 248	0				
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
00	Total payment for inpatient operating costs (see instructions)	49.00	25, 773, 488	0	20, 087, 36	52 0	5, 686, 126	15
00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 799, 889	0	-407, 99	96 0	2, 207, 885	16

Heal th	Financial Systems		GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-	2552-10
LOW VC	DLUME CALCULATION EXHIBIT 4			Provider C	CN: 15-0042	Period: From 01/01/2019 To 12/31/2019		pared:
				Title	XVIII	Hospi tal	PPS	
					Befo	re 10/01		
			Amounts (from	Pre/Post	MDH	Non MDH	Peri od	
		line	E, Part A)	Entitlement			On/After 10/01	
	1	0	1.00	2.00	3.00	3. 01	4.00	
17.00	Special add-on payments for new technologies	54.00	0	0		0 0	C	
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced	68.00	0	0		0 0	C	17.02
	devices for applicable MS-DRGs							
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0		0 0	C	18.00
19 00	SUBTOTAL			0	19, 679, 3	66 0	7, 894, 011	19 00
17.00		W/S L, line	(Amounts from L)		MDH	Non MDH	1,071,011	17.00
		0	1.00	2.00	3.00	3. 01	4.00	
20.00	Capital DRG other than outlier		1, 765, 397	0				20.00
20. 01	Model 4 BPCI Capital DRG other than outlier		0	0		0 0		
21.00	Capital DRG outlier payments	2.00	26, 901	0	-8, 5	06 0	35, 407	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	C	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0. 0043	0.0043	0.00	43 0. 0043	0. 0043	22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	7, 591	0				23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0.00	00 0. 0000	0. 0000	24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0		0 0	c	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 799, 889	0	-407, 9	96 0	2, 207, 885	26.00
			(Amounts to E,		MDH	Non MDH		
		line	Part A)					
		0	1.00	2.00	3.00	3. 01	4.00	
27.00 28.00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E,	70. 96			0. 0000	00 0. 000000 0 0	0. 000000	27.00 28.00
29.00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				с	) c	29.00
100.00	Pt. A, line) Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

	Financial Systems LUME CALCULATION EXHIBIT 4		GOOD SAMARITAN	Provi der CCN: 15-0042	2 Period: From 01/01/2019	u of Form CMS-255 Worksheet E Part A Exhibit 4	4
					To 12/31/2019	Date/Time Prepar 7/10/2020 2:50 p	red pm
				Title XVIII	Hospi tal	PPS	_
		Total (Col 2 through 4)					
		5.00					
00	DRG amounts other than outlier	0					1. (
)1	payments DRG amounts other than outlier payments for discharges	17, 001, 825					1.
)2	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	5, 040, 688					1.
)3	1 DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	0					1.
)4	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	0					1.
00	October 1 Outlier payments for						2.
)1	discharges (see instructions) Outlier payments for	0					2
)2	discharges for Model 4 BPCI Outlier payments for discharges occurring prior to October 1 (see instructions)	82, 054					2
)3	Outlier payments for discharges occurring on or after October 1 (see	29, 704					2
0	instructions)	~					2
00	Operating outlier reconciliation	0					3
00	Managed care simulated payments	3, 495, 211					4
00	Indirect Medical Education Adju Amount from Worksheet E, Part	Stillent					5
00	A, line 21 (see instructions) IME payment adjustment (see	103, 136					6
)1	instructions) IME payment adjustment for managed care (see instructions)	16, 354					6
	Indirect Medical Education Adju	stment for the	e Add-on for Sect	ion 422 of the MMA			
0	IME payment adjustment factor (see instructions)						7
00	IME adjustment (see instructions)	0					8
)1	IME payment adjustment add on for managed care (see instructions)	0					8
00	Total IME payment (sum of lines 6 and 8)	103, 136					9
)1	Total IME payment for managed care (sum of lines 6.01 and 8.01)	16, 354					9
	Disproportionate Share Adjustme	nt					
00	Allowable disproportionate share percentage (see					1	10
00	instructions) Disproportionate share adjustment (see instructions)	313, 556				1	11
01	Uncompensated care payments	2, 182, 763				1	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	<u>centage of ESR</u> 0	v beneficiary di	scharges		1.	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	24, 753, 726 0				1	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	25, 773, 488				1	15
00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	1, 799, 889				1	16

	Financial Systems		GOOD SAMARI TAN HOSPI TAL		u of Form CMS-255	52-10
LOW VO	LUME CALCULATION EXHIBIT 4		Provider CCN: 15-00	From 01/01/2019 To 12/31/2019		red:
			Title XVIII	Hospi tal	PPS	
		Total (Col 2 through 4) 5,00				
17.00	Special add-on payments for new technologies	0			17	7.00
17.01	Net organ aquisition cost				17	7.0
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	0			17	7.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	0			18	8.00
19.00	SUBTOTAL	27, 573, 377			19	9.00
		5.00				
	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1, 765, 397 0				20. 00 20. 01
21.00	Capital DRG outlier payments	26, 901			21	21.00
	Model 4 BPCI Capital DRG outlier payments	0				21. 0
	Indirect medical education percentage (see instructions)					22.00
	Indirect medical education adjustment (see instructions)	7, 591				23.00
24.00	Allowable disproportionate share percentage (see instructions)				24	24.00
25.00	Disproportionate share adjustment (see instructions)	0			25	25.00
26.00	Total prospective capital payments (see instructions)	1, 799, 889			26	26. 00
		5.00				
27.00	Low volume adjustment factor	5.00			2-	27.00
	Low volume adjustment Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	0				28.00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	0			29	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.				100	00.00

	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2019 To 12/31/2019	Date/Time Prep 7/10/2020 2:50	pared
			Title		Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	MDH	e 10/01 Non MDH	Period on after 10/01	
		0	1.00	2.00	2.01	3.00	
00	DRG amounts other than outlier payments	1.00			_		1.
01 02	DRG amounts other than outlier payments for discharges occurring prior to October 1 DRG amounts other than outlier payments for	1. 01 1. 02	17, 001, 825 5, 040, 688	17, 001, 82	5 0	5, 040, 688	1.
03	discharges occurring on or after October 1 DRG for Federal specific operating payment	1.03	0		0 0	0, 0, 10, 000	1
	for Model 4 BPCI occurring prior to October						
04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after	1.04	0			0	1
00	October 1 Outlier payments for discharges (see instructions)	2.00					2
01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2
02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	82, 054	82, 05	4 0		2
03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	29, 704		0	29, 704 0	2
00 00	Operating outlier reconciliation Managed care simulated payments	2. 01 3. 00	3, 495, 211	2, 439, 45	5 0	1, 055, 756	3
	Indirect Medical Education Adjustment	0100	0,1,0,211	2, 10, 7, 10	<u> </u>	1,000,700	
00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0. 008581	0. 00858		0. 008581	5
00 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22.00 22.01	103, 136 16, 354	79, 55 11, 41		23, 585 4, 940	6 6
	Indirect Medical Education Adjustment for the	e Add-on for Se	ection 422 of th	ne MMA			
00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.00000		0. 000000	7
00 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28.00 28.01	0		0 0 0 0	0	8 8
00 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	29.00 29.01	103, 136 16, 354	79, 55 11, 41		23, 585 4, 940	9 9
	lines 6.01 and 8.01) Disproportionate Share Adjustment		11				
	Allowable disproportionate share percentage (see instructions)	33.00	0. 0569	0. 056	9 0. 0569	0. 0569	10
00	Disproportionate share adjustment (see instructions)	34.00	313, 556	241, 85		71, 704	
. 01	Uncompensated care payments	36.00	2, 182, 763	732, 86	0 934, 398	515, 505	11
. 00	Additional payment for high percentage of ESF Total ESRD additional payment (see instructions)	46.00	0		0 0	0	12
	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	47.00 48.00	24, 753, 726 14, 899, 248	18, 138, 14 8, 726, 81		5, 681, 186 6, 172, 435	
00	Total payment for inpatient operating costs (see instructions)	49.00	25, 773, 488	18, 784, 52	7 934, 398	6, 054, 563	15
	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1, 799, 889	-407, 99	6 0	2, 207, 885	16
. 01	Special add-on payments for new technologies Net organ acquisition cost	54.00	0		0 0	0	17
. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17 18
. 00	Capital outlier reconciliation adjustment	93.00			0 0	0	

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-:	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 7/10/2020 2:5	pared:
			Title	XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)	MDH	Non MDH		
		0	1.00	2.00	2. 01	3.00	
20.00	Capital DRG other than outlier	1.00	1, 765, 397	-397, 7	30 0	2, 163, 177	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	26, 901	-8, 5	0 0	35, 407	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	
	Indirect medical education percentage (see instructions)	5.00	0.0043	0.00	43 0.0043	0.0043	
23.00	Indirect medical education adjustment (see	6.00	7, 591	-1, 7	10 0	9, 301	23.00
24.00	instructions) Allowable disproportionate share percentage	10.00	0.0000	0.00	0.0000	0. 0000	24.00
25.00	(see instructions) Disproportionate share adjustment (see	11.00	0		0 0	0	25.00
26.00	instructions) Total prospective capital payments (see instructions)	12.00	1, 799, 889	-407, 9	96 0	2, 207, 885	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)	MDH	Non MDH		
		0	1.00	2.00	2. 01	3.00	
27.00		-					27.00
28.00	Low volume adjustment prior to October 1	70, 96	0		0 0		28.00
29.00	Low volume adjustment on or after October 1	70.97	0		о 0	0	
30.00	HVBP payment adjustment (see instructions)	70, 93	17, 337	10, 5	58 0	6.779	
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	939		53 0	586	
31.00	HRR adjustment (see instructions)	70.94	-80, 181	-45,9	04	-34, 277	31.00
31.00	HRR adjustment for HSP bonus payment (see instructions)	70. 91	-4, 495			-2, 961	
				MDH	Non MDH		
		0	1.00	2.00	2.01	3, 00	
32.00	HAC Reduction Program adjustment (see	70.99	1.00	183, 4			32.00
100.00	instructions) Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100. 00

	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	GOOD SAMARITAN	Provi der CCN: 15-0042	Period:	u of Form CMS-255 Worksheet E	<u>52-1(</u>
				From 01/01/2019 To 12/31/2019	Part A Exhi bi t Date/Time Prepa 7/10/2020 2:50	red:
			Title XVIII	Hospi tal	PPS	
		Total (cols. 2 <u>and 3)</u> 4.00				
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	17, 001, 825				1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	5, 040, 688				1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	0				1. 03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	0				1. 04
2.00	Outlier payments for discharges (see instructions)					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	0				2. 01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	82,054				2.02
2.03 3.00	Outlier payments for discharges occurring on or after October 1 (see instructions) Operating outlier reconciliation	29, 704 0				2.03 3.00
4.00	Managed care simulated payments Indirect Medical Education Adjustment	3, 495, 211				4.00
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)					5.00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	103, 136 16, 354				6.00 6.0
7.00	Indirect Medical Education Adjustment for the IME payment adjustment factor (see instructions)	e Add-on for Sect	ion 422 of the MMA			7.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed Care (see instructions)	0 0				8.00 8.01
9. 00 9. 01	Total IME payment (sum of lines 6 and 8) Total IME payment for managed care (sum of	103, 136 16, 354				9.00 9.0
	lines 6.01 and 8.01) Disproportionate Share Adjustment					
10. 00	Allowable disproportionate share percentage (see instructions)				1	10. 00
11. 00	Disproportionate share adjustment (see instructions)	313, 556				11.00
11.01	Uncompensated care payments Additional payment for high percentage of ESR Tatel CODP additional payment (acc		scharges			11. 01
12.00	Total ESRD additional payment (see instructions) Subtotal (see instructions)	0 24, 753, 726				12.00 13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	14, 899, 248				14. 00
15. 00	Total payment for inpatient operating costs (see instructions)	25, 773, 488			1	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	1, 799, 889				16.00
17.00 17.01 17.02	Special add-on payments for new technologies Net organ acquisition cost Credits received from manufacturers for	0			1	17.00 17.01 17.02
18.00	replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment	0				17.02
	amount (see instructions) SUBTOTAL	27, 573, 377				19.00

Health Financial Systems	GOOD SAMARITAN	HOSPI TAL	In Lie	u of Form CMS-	-2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provider CCN: 15-0042	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Exhibi Date/Time Pro 7/10/2020 2:	epared:
		Title XVIII	Hospi tal	PPS	
	4.00				
20.00 Capital DRG other than outlier	1, 765, 397				20.00
20.01 Model 4 BPCI Capital DRG other than outlier	0				20. 01
21.00 Capital DRG outlier payments	26, 901				21.00
21.01 Model 4 BPCI Capital DRG outlier payments	0				21.01
22.00 Indirect medical education percentage (see					22.00
instructions)					
23.00 Indirect medical education adjustment (see	7, 591				23.00
instructions)					
24.00 Allowable disproportionate share percentage					24.00
(see instructions)					
25.00 Disproportionate share adjustment (see	0				25.00
instructions)					
26.00 Total prospective capital payments (see	1, 799, 889				26.00
instructions)					
	4.00				07.00
27.00					27.00
28.00 Low volume adjustment prior to October 1	0				28.00
29.00 Low volume adjustment on or after October 1	0				29.00
30.00 HVBP payment adjustment (see instructions)	17, 337				30.00
30.01 HVBP payment adjustment for HSP bonus	939				30. 01
payment (see instructions)					
31.00 HRR adjustment (see instructions)	-80, 181				31.00
31.01 HRR adjustment for HSP bonus payment (see	-4, 495				31.01
instructions)	• •				
	(Amt. to Wkst.				
	<u>E, Pt. A)</u>				
	4.00				
32.00 HAC Reduction Program adjustment (see	275, 070				32.00
instructions)					100.07
100.00 Transfer HAC Reduction Program adjustment to					100.00
Wkst. E, Pt. A.					

	Financial Systems GOOD SAMARITAN HO ATION OF REIMBURSEMENT SETTLEMENT F	OSPITAL Provider CCN: 15-0042	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
0/12002			From 01/01/2019 To 12/31/2019	Part B Date/Time Pre	
		Title XVIII	Hospi tal	7/10/2020 2:5 PPS	0 pm
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	ons)		9, 015 29, 041, 959	
3.00	OPPS payments			27, 422, 318	
4.00	Outlier payment (see instructions)			80, 035	4.00
4.01 5.00	Outlier reconciliation amount (see instructions) Enter the hospital specific payment to cost ratio (see instruction)	ions)		0.000	4.01 5.00
6.00	Line 2 times line 5			0	6.00
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	7.00
8.00 9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	, col. 13, line 200		102, 491	
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			9, 015	11.00
	Reasonable charges				
12.00	Ancillary service charges			32, 639	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line Total reasonable charges (sum of lines 12 and 13)	e 69)		0 32, 639	13.00 14.00
14.00	Customary charges			52,057	14.00
15.00	Aggregate amount actually collected from patients liable for pay			0	
16.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(e)	payment for services of	on a chargebasi s	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)		11) (	32, 639	
19.00	Excess of customary charges over reasonable cost (complete only instructions)	IT TINE 18 exceeds TI	ne II) (see	23, 624	19.00
20.00	Excess of reasonable cost over customary charges (complete only	ifline 11 exceeds li	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			9, 015	21.00
22.00	Interns and residents (see instructions)			0	
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, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			27, 604, 844	24.00
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25.00
26.00 27.00	Deductibles and Coinsurance amounts relating to amount on line 2 Subtatal [((inser 21 and 24 minus the sum of lines 25 and 2() all	-		5, 342, 462	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pluinstructions)	us the sum of times 22		22, 271, 397	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line	e 50)		0	28.00
29.00 30.00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 22, 271, 397	
31.00	Primary payer payments			11, 297	
32.00	Subtotal (line 30 minus line 31)	2)		22, 260, 100	32.00
33.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES Composite rate ESRD (from Wkst. 1-5, line 11)	5)		0	33.00
	Allowable bad debts (see instructions)			804, 850	
35.00	Adjusted reimbursable bad debts (see instructions)	-+:>		523, 153	
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	ctions)		542, 150 22, 783, 253	
38.00	MSP-LCC reconciliation amount from PS&R			-96	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.97 39.98	Partial or full credits received from manufacturers for replaced	d devices (see instruc	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40. 00 40. 01	Subtotal (see instructions)			22, 783, 349 455, 667	
40. 01 40. 02	Sequestration adjustment (see instructions) Demonstration payment adjustment amount after sequestration			455, 667	
40.03	Sequestration adjustment-PARHM pass-throughs				40. 03
	Interim payments			22, 113, 348	
41. 01 42. 00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43. 00 43. 01	Balance due provider/program (see instructions)			214, 334	
43.01 44.00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance §115.2	e with CMS Pub. 15-2,	chapter 1,	0	43.01 44.00
00.00	TO BE COMPLETED BY CONTRACTOR				
90.00 91.00	Original outlier amount (see instructions) 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	Time Value of Money (see instructions)			0	93.00
94.00	Total (sum of lines 91 and 93)			0	94.00

	Financial Systems GOOD SAMARITAN ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	Peri od: From 01/01/2019	u of Form CMS-2 Worksheet E	_002
		Component CCN: 15-S042	To 12/31/2019	Part B Date/Time Pre	
		Title XVIII	Subprovider -	7/10/2020 2:5 PPS	o pin
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00 . 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	ctions)		64 2, 280	
. 00	OPPS payments			2, 521	3.
. 00 . 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
. 00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
.00	Line 2 times line 5			0	
. 00 . 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		12	
0.00	Organ acqui si ti ons			0	
1. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			64	11.
2 00	Reasonable charges			220	112
2.00 3.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, 1	line 69)		230	12.
<ul> <li>14.00 Total reasonable charges (sum of lines 12 and 13)</li> <li>Customary charges</li> <li>15.00 Aggregate amount actually collected from patients liable for payment for services on a charge basi</li> </ul>					14
	Aggregate amount actually collected from patients liable for			0	
6. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13		on a chargebasis	0	16
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	(e)		0.000000	17
8.00	Total customary charges (see instructions)			230	
9.00	Excess of customary charges over reasonable cost (complete or instructions)	nly if line 18 exceeds li	ne 11) (see	166	19
0. 00	Excess of reasonable cost over customary charges (complete or instructions)	nlyifline 11 exceeds li	ne 18) (see	0	20
1. 00	Lesser of cost or charges (see instructions)			64	21
2.00	Interns and residents (see instructions)	•		0	
3.00 4.00	Cost of physicians' services in a teaching hospital (see ins Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	tructions)		0 2, 533	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
5.00 6.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	-	ructions)	0 437	
7.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			2, 160	
	instructions) Direct graduate modical education normante (from What 5.4.1	line EQ)		0	20
3.00 9.00	Direct graduate medical education payments (from Wkst. E-4, ESRD direct medical education costs (from Wkst. E-4, line 36			0	
0.00	Subtotal (sum of lines 27 through 29)			2, 160	30
1.00	Primary payer payments			0	
2.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		2, 160	32
3. 00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	
4.00 5.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			425 276	
5.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		425	
7.00	Subtotal (see instructions)			2, 436	37
3.00 9.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.00 9.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39
9. 97	Demonstration payment adjustment amount before sequestration			0	
9.98 9.99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instruc	tions)	0	
5. 99 D. 00	Subtotal (see instructions)			2, 436	
D. 01	Sequestration adjustment (see instructions)			49	
). 02 ). 03	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40
1.00	Interim payments			2, 109	
I. 01	Interim payments-PARHM				41
2.00 2.01	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42
3.00	Balance due provider/program (see instructions)			278	42
3. 01	Balance due provider/program-PARHM (see instructions)				43
4. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	44
0. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90
1.00	Outlier reconciliation adjustment amount (see instructions)			0	91
2.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	
3.00	LINE VALUE OF MODEV (SEE INSTELETIONS)			0	93

	Financial Systems GOOD SAMARITAN ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	Peri od: From 01/01/2019	u of Form CMS-2 Worksheet E	
		Component CCN: 15-T042	To 12/31/2019	Part B Date/Time Pre 7/10/2020 2:50	
		Title XVIII	Subprovider -	PPS	io piii
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				1.
. 00 . 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruc	ctions)		200 178	
. 00	OPPS payments			508	
. 00 . 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
. 00	Enter the hospital specific payment to cost ratio (see instru	uctions)		0.000	
. 00	Line 2 times line 5	,		0	
. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	
. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		2	
0.00	Organ acqui si ti ons			0	
1. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			200	11.
2.00	Reasonable charges			721	12.
2.00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	line 69)		0	1
4.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			721	
5.00	Aggregate amount actually collected from patients liable for			0	
6.00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13		on a chargebasi's	0	16.
7.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17.
8.00	Total customary charges (see instructions)		11) (	721	
9.00	Excess of customary charges over reasonable cost (complete or instructions)	niy it line 18 exceeds li	ne II) (see	521	19.
0. 00	Excess of reasonable cost over customary charges (complete or instructions)	nlyifline 11 exceeds li	ne 18) (see	0	20.
1.00	Lesser of cost or charges (see instructions)			200	
2.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see inst	tructions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			510	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	)			1 25
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instruction Deductibles and Coinsurance amounts relating to amount on lin	-	ructions)	0 21	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)			689	27.
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, I	line 50)		0	28.
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			689	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			0 689	
2.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	I CES)		007	52.
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
4.00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			0	
6.00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		0	
7.00	Subtotal (see instructions)			689	
38.00 39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instruction	ns)		0	39.
39. 97	Demonstration payment adjustment amount before sequestration			0	
39.98 39.99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	aced devices (see instruc	ctions)	0	
10.00	Subtotal (see instructions)			689	
0. 01	Sequestration adjustment (see instructions)			14	
0.02	Demonstration payment adjustment amount after sequestration Sequestration adjustment-PARHM pass-throughs			0	40. 40.
1.00	Interim payments			690	
1. 01	Interim payments-PARHM				41.
2.00	Tentative settlement (for contractors use only) Tentative settlement-PARHM (for contractor use only)			0	42. 42.
3.00	Balance due provider/program (see instructions)			-15	
13.01	Balance due provider/program-PARHM (see instructions)				43.
4. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	ance with CMS Pub. 15-2,	chapter 1,	0	44.
0. 00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.
1. 00	Outlier reconciliation adjustment amount (see instructions)			0	91.
~ ~~	The rate used to calculate the Time Value of Money			0.00	92.
92.00 93.00	Time Value of Money (see instructions)			0	93.

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet E-1 Part I Date/Time Prep 7/10/2020 2:50	pared
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	tВ	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 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 List separately each retroactive lump sum adjustment		24, 143, 19	0	21, 708, 859 0	1. ( 2. ( 3. (
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					
. 01	ADJUSTMENTS TO PROVIDER	12/31/2019	197, 67	/2 12/31/2019	368, 589	3. (
. 02				0 05/08/2019	35, 900	3.
. 03				0	0	3.
. 04 . 05				0	0	3. 3.
. 05	Provider to Program				0	J. J.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		197, 67	-	404, 489	3.
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)		24, 340, 86	93	22, 113, 348	4.
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
	Provider to Program					
50 51	TENTATI VE TO PROGRAM			0	0	5. 5.
51 52				0	0	5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		42, 22		214, 334	6.
02	SETTLEMENT TO PROGRAM		24 202 00	0	0	6. 7.
00	Total Medicare program liability (see instructions)		24, 383, 09	Contractor	22, 327, 682 NPR Date	1.
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

VALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent	CN: 15-0042 CCN: 15-S042	Period: From 01/01/2019 To 12/31/2019		
		Title	e XVIII	Subprovider - IPF	PPS	
		I npati en	it Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00 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		984, 5	0	2, 109 0	1. ( 2. (
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. (
01	ADJUSTMENTS TO PROVIDER			0	0	3. (
02				0	0	3.
03 04				0	0	3. 3.
04				0	0	3.
	Provider to Program		1	-1		
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)			0	0	3.
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)		984, 5	00	2, 109	4.
	TO BE COMPLETED BY CONTRACTOR		1	- 1	1	
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.
01	Program to Provider TENTATIVE TO PROVIDER			0		
01 02	TENTATIVE TO PROVIDER			0	0	5. 5.
03				0	0	
	Provider to Program			- 1		
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
)0	5.50-5.98) Determined net settlement amount (balance due) based on			0	0	6
	the cost report. (1)					
01	SETTLEMENT TO PROVI DER		426, 4	78	278	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		1, 410, 9		2, 387	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
			о С	1.00	2.00	-

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CO	CN: 15-0042 CCN: 15-T042	Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Subprovider - IRF	PPS	
		I npati en	t Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 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		8, 227, 9	99 0	690 0	1.0 2.0
. 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. (
. 01	ADJUSTMENTS TO PROVIDER			0	0	3.0
. 02				0	0	3. (
. 03				0	0	3.
. 04				0	0	3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 3.
77	3. 50-3. 98)			0	0	3.
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)		8, 227, 9	99	690	4.
	TO BE COMPLETED BY CONTRACTOR					
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.
	Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03	Provider to Program			0	0	5.
50	TENTATI VE TO PROGRAM			0	0	5.
51				0	0	5.
52				0	0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5.
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		25, 2	93	0	6.
02	SETTLEMENT TO PROGRAM			0	15	6.
00	Total Medicare program liability (see instructions)		8, 253, 2		675	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
			)	1. 00	2.00	

Heal th	Financial Systems GOOD SAMARI	TAN HOSPI TAL	In Lie	u of Form CMS	-2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0042 Period: From 01/01/2019 To 12/31/2019 To 12/3100 To 12/3100 To 12/3100 To 12/3100 To 1					
		Title XVIII	Hospi tal	PPS		
				1.00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULAT	I ON				
1.00	.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14					
2.00	00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12					
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2					
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1	, 8-12			4.00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1			5.00	
6.00	Total hospital charity care charges from Wkst. S-10, col.	3 line 20			6.00	
7.00	CAH only - The reasonable cost incurred for the purchase on the first $168$	f certified HIT technology	Wkst. S-2, Pt. I		7.00	
8.00	Calculation of the HIT incentive payment (see instructions	5)			8.00	
9.00	Sequestration adjustment amount (see instructions)				9.00	
10.00	Calculation of the HIT incentive payment after sequestrati	on (see instructions)			10.00	
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
32.00	Balance due provider (line 8 (or line 10) minus line 30 an	d line 31) (see instruction	ns)		32.00	

	Financial Systems GOOD SAMARIT ATLON OF RELMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet E-3	
LOOL		Component CCN: 15-S042	From 01/01/2019 To 12/31/2019	Part II Date/Time Pre	pare
		Title XVIII	Subprovider -	7/10/2020 2:5 PPS	<u>o pm</u>
				1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			1.00	
	Net Federal IPF PPS Payments (excluding outlier, ECT, and	medical education payments)		1, 231, 444	
00	Net IPF PPS Outlier Payments			20, 281	2
00 00	Net IPF PPS ECT Payments Unweighted intern and resident FTE count in the most recen	t cost report filed on or b	efore November	0 0.00	
	15, 2004. (see instructions)				
01	Cap increases for the unweighted intern and resident FTE corpogram or hospital closure, that would not be counted with CFR s412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	4
00	New Teaching program adjustment. (see instructions)			0.00	5
00	Current year's unweighted FTE count of I&R excluding FTEs	in the new program growth p	eriod of a "new	0.00	6
	teaching program" (see instuctions)				
00	Current year's unweighted I&R FTE count for residents with	in the new program growth p	eriod of a "new	1.01	
00	teaching program" (see instuctions) Intern and resident count for IPF PPS medical education ad	iustment (see instructions)		1.01	6
	Average Daily Census (see instructions)			12. 334247	
	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised	to the power of .5150 -1}.		0.041366	
	Teaching Adjustment (line 1 multiplied by line 10).			50, 940	1
	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 1			1, 302, 665	
	Nursing and Allied Health Managed Care payment (see instru-	ction)		0	
	Organ acquisition (DO NOT USE THIS LINE)			0	14
	Cost of physicians' services in a teaching hospital (see in Subtotal (see instructions)	nstructions)		0 1, 302, 665	
	Primary payer payments			3, 636	
	Subtotal (line 16 less line 17).			1, 299, 029	
	Deductibles			167, 724	
	Subtotal (line 18 minus line 19)			1, 131, 305	
	Coinsurance			75, 702	
	Subtotal (line 20 minus line 21)	ruisse) (see instructions)		1, 055, 603	
	Allowable bad debts (exclude bad debts for professional se Adjusted reimbursable bad debts (see instructions)	rvices) (see instructions)		16, 725 10, 871	
	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		12, 705	
	Subtotal (sum of lines 22 and 24)			1, 066, 474	
	Direct graduate medical education payments (see instruction	ns)		0	
	Other pass through costs (see instructions)			373, 299	2
	Outlier payments reconciliation			0	2
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	:>		0	
	Pioneer ACO demonstration payment adjustment (see instruct			0	
	Demonstration payment adjustment amount before sequestration Total amount payable to the provider (see instructions)	UII		0 1, 439, 773	
	Sequestration adjustment (see instructions)			28, 795	
	Demonstration payment adjustment amount after sequestration	n		0	
00	Interim payments			984, 500	32
	Tentative settlement (for contractor use only)			0	33
	Balance due provider/program (line 31 minus lines 31.01, 3			426, 478	
. 00	Protested amounts (nonallowable cost report items) in acco §115.2	rdance with CMS Pub. 15-2,	cnapter 1,	0	35
	TO BE COMPLETED BY CONTRACTOR	-			
	Original outlier amount from Worksheet E-3, Part II, line :			20, 281	
-	Outlier reconciliation adjustment amount (see instructions)	)		0	
	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	52 53

	Financial Systems GOOD SAMAR ATION OF RELMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Peri od:	u of Form CMS-2 Worksheet E-3	
LOOL			From 01/01/2019	Part III	
		Component CCN: 15-T042	To 12/31/2019	Date/Time Prep 7/10/2020 2:50	
		Title XVIII	Subprovider - IRF	PPS	
				1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
00	Net Federal PPS Payment (see instructions)			8, 188, 370	-
00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0351	
00	Inpatient Rehabilitation LIP Payments (see instructions)			153, 941	
00	Outlier Payments			176, 814	4
00	Unweighted intern and resident FTE count in the most received to November 15, 2004 (see instructions)		5 1	0.00	
01	Cap increases for the unweighted intern and resident FTE program or hospital closure, that would not be counted with CFR \$412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00	1
00	New Teaching program adjustment. (see instructions)			0.00	
00	Current year's unweighted FTE count of I&R excluding FTEs	s in the new program growth p	eriod of a "new	0.00	-
	teaching program" (see instructions)				
00	Current year's unweighted I&R FTE count for residents with teaching program" (see instructions)	thin the new program growth p	eriod of a "new	0.00	8
00	Intern and resident count for IRF PPS medical education a	adjustment (see instructions)		0.00	
. 00	Average Daily Census (see instructions)			19. 339726	
. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
. 00	Teaching Adjustment (see instructions)			0	
. 00	Total PPS Payment (see instructions)			8, 519, 125	
. 00	Nursing and Allied Health Managed Care payments (see inst	truction)		0	
. 00	Organ acquisition (DO NOT USE THIS LINE)				1
. 00	Cost of physicians' services in a teaching hospital (see	instructions)			1
. 00	Subtotal (see instructions)			8, 519, 125 0	
. 00	Primary payer payments Subtotal (line 17 less line 18).			8, 519, 125	
. 00	Deductibles			8, 519, 125 106, 344	
. 00	Subtotal (line 19 minus line 20)			8, 412, 781	
. 00	Coi nsurance			7, 843	
. 00	Subtotal (line 21 minus line 22)			8, 404, 938	
. 00	Allowable bad debts (exclude bad debts for professional s	services) (see instructions)		16, 285	
. 00	Adjusted reimbursable bad debts (see instructions)			10, 585	
b. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		12, 910	
. 00	Subtotal (sum of lines 23 and 25)	,		8, 415, 523	
. 00	Direct graduate medical education payments (from Wkst. E-	-4, line 49)		0	
. 00	Other pass through costs (see instructions)			6, 204	2
. 00	Outlier payments reconciliation			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	3
. 50	Pioneer ACO demonstration payment adjustment (see instruc	ctions)		0	3
. 99	Demonstration payment adjustment amount before sequestra	tion		0	3
. 00	Total amount payable to the provider (see instructions)			8, 421, 727	
. 01	Sequestration adjustment (see instructions)			168, 435	
. 02	Demonstration payment adjustment amount after sequestrati	i on			3
. 00	Interim payments			8, 227, 999	
. 00	Tentative settlement (for contractor use only)			0	
6.00	Balance due provider/program (line 32 minus lines 32.01,			25, 293	
o. 00	Protested amounts (nonallowable cost report items) in acc §115.2	cordance with CMS Pub. 15-2,	chapter 1,	0	3
	TO BE COMPLETED BY CONTRACTOR			474 014	-
0.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	<b>`</b>		176, 814	
. 00	Outlier reconciliation adjustment amount (see instruction	ns)		0	
	The rate used to calculate the Time Value of Money			0.00	15

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Pre 7/10/2020 2:50	pared:
		Title XIX	Hospi tal	Cost	<u>o p</u>
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	ICES FOR TITLES V OR X	I X SERVICES		1
	COMPUTATION OF NET COST OF COVERED SERVICES				-
1.00	Inpatient hospital/SNF/NF services		952, 909		1.00
2.00	Medical and other services			0	2.00
3.00 1.00	Organ acquisition (certified transplant centers only)		052,000	0	3.00
F. 00 5. 00	Subtotal (sum of lines 1, 2 and 3) Inpatient primary payer payments		952, 909 0	0	5.00
5.00	Outpatient primary payer payments		0	0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		952, 909	0	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES		702,707		,
	Reasonabl e Charges				1
3. 00	Routine service charges		730, 738		8.00
9.00	Ancillary service charges		2, 627, 943	0	9.00
0.00	Organ acquisition charges, net of revenue		0		10.00
1.00	Incentive from target amount computation		0		11.00
2.00	Total reasonable charges (sum of lines 8 through 11)		3, 358, 681	0	12.00
	CUSTOMARY CHARGES				
3.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basi s			_	
4.00	Amounts that would have been realized from patients liable for		n O	0	14.00
	a charge basis had such payment been made in accordance with 42 Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0.000000	15 00	
15.00 16.00	Total customary charges (see instructions)		3, 358, 681	0.000000	16.00
17.00	Excess of customary charges over reasonable cost (complete only	2, 405, 772	0		
17.00	line 4) (see instructions)	IT THE TO EXCEEDS	2,403,772	0	17.00
8.00	Excess of reasonable cost over customary charges (complete only	/ifline 4 exceeds lin	ie 0	0	18.00
	16) (see instructions)		-	-	
9.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instru	ıcti ons)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 10	<b>b</b> )	952, 909	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be o	completed for PPS provi	ders.		
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27.00 28.00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	27.00
28.00	Titles V or XIX (sum of lines 21 and 27)		952, 909	0	
29.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		732, 707	0	29.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		952, 909	0	31.00
32.00	Deducti bl es		0	0	•
33.00			0	0	
34.00	Allowable bad debts (see instructions)		0	0	
35.00	Utilization review				35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)			0	36.0
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.0
38.00	Subtotal (line 36 ± line 37)		952, 909	0	38.0
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.0
10.00	Total amount payable to the provider (sum of lines 38 and 39)		952, 909	0	40.0
1.00	Interim payments		1, 558, 430	0	41.0
12.00	Balance due provider/program (line 40 minus line 41)		-605, 521	0	
13.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15_2	0	0	43.0

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042 Component CCN: 15-S042	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part VII Date/Time Pre	
				7/10/2020 2:5	par 0 p
		Title XIX	Subprovider - IPF	Cost	
			Inpatient	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEF	RVICES FOR TITIES V OR X	1.00	2.00	-
	COMPUTATION OF NET COST OF COVERED SERVICES		TX SERVICES		1
00	Inpatient hospital/SNF/NF services		396, 562		1 1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3
00	Subtotal (sum of lines 1, 2 and 3)		396, 562	0	
00	Inpatient primary payer payments		0	0	
00 00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		204 542	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		396, 562	0	1 1
	Reasonabl e Charges				1
00	Routi ne servi ce charges		457, 891		1 8
00	Ancillary service charges		98, 911	0	
. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		11
. 00	Total reasonable charges (sum of lines 8 through 11)		556, 802	0	12
00	CUSTOMARY CHARGES			0	4
. 00	Amount actually collected from patients liable for payment for basis	r services on a charge	0	0	13
. 00	Amounts that would have been realized from patients liable for	r navment for services o	n O	0	14
. 00	a charge basis had such payment been made in accordance with			0	1.
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	1!
. 00	Total customary charges (see instructions)	556, 802	0	10	
. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds		160, 240	0	1
	line 4) (see instructions)			_	
. 00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds lin	e 0	0	18
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line 1		396, 562	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			-	1
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0	0	25
. 00 . 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services only)		0	0	
	Titles V or XIX (sum of lines 21 and 27)		396, 562	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0,0,002		1 -
. 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	)	396, 562	0	3
	Deducti bl es		0	0	
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	0	
. 00	Utilization review Subtotal (sum of lines 21, 24 and 25 minus sum of lines 22 and	4 22)	204 542	0	3!
. 00 . 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	u 33)	396, 562	0	
. 00	Subtotal (line 36 ± line 37)		396, 562	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0	0	30
. 00	Total amount payable to the provider (sum of lines 38 and 39)		396, 562	0	
. 00	Interim payments		213, 564	0	
. 00	Balance due provider/program (line 40 minus line 41)		182, 998	0	
		nce with CMS Pub 15-2,		0	43

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2019	Worksheet E-3 Part VII	
		Component CCN: 15-TO42	To 12/31/2019	Date/Time Prep 7/10/2020 2:50	
		Title XIX	Subprovider - IRF	Cost	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEI	RVICES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		43, 876		1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)		0		3
00 00	Subtotal (sum of lines 1, 2 and 3)		43, 876	0	2
00	Inpatient primary payer payments Outpatient primary payer payments		0	0	
00	Subtotal (line 4 less sum of lines 5 and 6)		43, 876	0	
00	COMPUTATION OF LESSER OF COST OR CHARGES		43, 070	0	i í
	Reasonable Charges				1
00	Routi ne servi ce charges		52, 755		1 8
00	Ancillary service charges		65, 427	0	
0. 00	Organ acquisition charges, net of revenue		0		10
. 00	Incentive from target amount computation		0		1
. 00	Total reasonable charges (sum of lines 8 through 11)		118, 182	0	1:
00	CUSTOMARY CHARGES				1 .
. 00	Amount actually collected from patients liable for payment fo basis	i services on a charge	0	0	1:
. 00	Amounts that would have been realized from patients liable fo	r payment for services o	n 0	0	1
. 00	a charge basis had such payment been made in accordance with			Ű	Ι.
. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)			0. 000000	1!
. 00	Total customary charges (see instructions)			0	
. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds			0	1
	line 4) (see instructions)				
. 00	Excess of reasonable cost over customary charges (complete on	ly if line 4 exceeds lin	e 0	0	18
. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19
0.00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
. 00	Cost of covered services (enter the lesser of line 4 or line		43, 876	0	
. 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	1
. 00	Other than outlier payments		0	0	22
. 00	Outlier payments		0	0	23
. 00	Program capital payments		0		24
. 00	Capital exception payments (see instructions)		0		2!
. 00	Routine and Ancillary service other pass through costs		0	0	
. 00	Subtotal (sum of lines 22 through 26)		0	0	
. 00	Customary charges (title V or XIX PPS covered services only)		0	0	
. 00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		43, 876	0	29
). 00	Excess of reasonable cost (from line 18)		0	0	30
. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6	)	43, 876	0	
	Deductiblies	/	43, 070	0	
. 00	Coinsurance		0	0	
. 00	Allowable bad debts (see instructions)		0	Ő	
. 00	Utilization review		0		3!
. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 an	d 33)	43, 876	0	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
. 00	Subtotal (line 36 ± line 37)		43, 876	0	
. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39
. 00	Total amount payable to the provider (sum of lines 38 and 39)		43, 876	0	
. 00	Interim payments		74, 451	0	
. 00 . 00	Balance due provider/program (line 40 minus line 41)	nco with CMS Dub 15 0	-30, 575	0	
	Protested amounts (nonallowable cost report items) in accorda	NGE WITH OWS PUD 15-2,	0	0	43

nd-ty	E SHEET (If you are nonproprietary and do not maintain /pe accounting records, complete the General Fund column	Provider C	F	eriod: rom 01/01/2019 o 12/31/2019	Worksheet G Date/Time Pre	naroo
ly)		General Fund	Speci fi c	Endowment Fund	7/10/2020 2:50 Pl ant Fund	
	-	1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS	04 004 740				
	Cash on hand in banks Temporary investments	26, 806, 742		0	0	1.0
	Notes receivable	0	0	0	0	3. (
	Accounts receivable	80, 326, 635	0	0	0	4.
00	Other recei vabl e	6, 700, 168	0	0	0	
	Allowances for uncollectible notes and accounts receivable	-49, 925, 885		0	0	
	Inventory Prepaid expenses	1, 892, 688 4, 605, 388		0	0	
	Other current assets	4, 805, 388 399, 010	-	0	0	
	Due from other funds	1, 011, 491	0	0	0	10.
	Total current assets (sum of lines 1-10)	71, 816, 237	0	0	0	11.
	FIXED ASSETS		1	· · · · · ·		
	Land	6, 581, 448	0	0	0	12.
	Land improvements Accumulated depreciation	4, 198, 345	0	0	0	13. 14.
	Buildings	163, 818, 192		0	0	15.
	Accumulated depreciation	-72, 255, 913	0	0	0	16.
. 00	Leasehold improvements	850, 562	0	0	0	17.
	Accumulated depreciation	0	0	0	0	18.
	Fixed equipment	0	0	0	0	19.
	Accumulated depreciation Automobiles and trucks	0		0	0	20.
	Accumulated depreciation	0		0	0	
	Major movable equipment	218, 400, 469	-	0	0	23.
	Accumulated depreciation	-145, 531, 622	0	0	0	24.
	Minor equipment depreciable	0	0	0	0	25
	Accumulated depreciation	0	0	0	0	26
	HIT designated Assets Accumulated depreciation	0	0	0	0	27. 28.
	Mi nor equipment-nondepreciable	0		0	0	28.
	Total fixed assets (sum of lines 12-29)	176, 061, 481	0		0	
	OTHER ASSETS					
	Investments	59, 025, 081	0	-	0	31.
	Deposits on Leases	0	0	0	0	32.
	Due from owners/officers	(22.01)	0	0	0	33. 34.
	Other assets Total other assets (sum of lines 31-34)	632, 816 59, 657, 897		0	0	34.
	Total assets (sum of lines 11, 30, and 35)	307, 535, 615		-	0	
	CURRENT LI ABI LI TI ES					
	Accounts payable	4, 312, 575			0	37.
	Salaries, wages, and fees payable	2, 437, 202	0		0	
	Payroll taxes payable Notes and Loans payable (short term)	11, 127, 062 2, 786, 498	0	0	0	39. 40.
	Deferred income	2, 780, 498 68, 276		0	0	
	Accel erated payments	00,270		0	0	42.
	Due to other funds	0	0	0	0	43.
	Other current liabilities	1, 480, 101	0		0	
. 00	Total current liabilities (sum of lines 37 thru 44)	22, 211, 714	0	0	0	45.
. 00	LONG TERM LIABILITIES Mortgage payable	109, 060, 586	0	0	0	46.
	Notes payable	107, 000, 380 N		0	0	40.
	Unsecured Loans	0	0	0	0	
. 00	Other long term liabilities	439, 115	0	0	0	49
	Total long term liabilities (sum of lines 46 thru 49)	109, 499, 701	0		0	50
	Total liabilities (sum of lines 45 and 50)	131, 711, 415	0	0	0	51
	CAPITAL ACCOUNTS General fund balance	175, 824, 200				52
	Specific purpose fund	175, 624, 200	0			52
	Donor created - endowment fund balance - restricted		ĺ	о		54
	Donor created - endowment fund balance - unrestricted			Ő		55
. 00	Governing body created - endowment fund balance			0		56
	Plant fund balance - invested in plant				0	57
. 00	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	175, 824, 200	0	0	0	59
00					()	1 37

Heal th	Financial Systems	GOOD SAMARI TAN	N HOSPI TAL		In Li	eu of Form CMS-2	2552-10
	IENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0042	Period: From 01/01/201 To 12/31/201	9 Worksheet G-1	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		165, 847, 567 9, 976, 632 175, 824, 199 0 175, 824, 199 0 175, 824, 199				10. 00 11. 00 12. 00 13. 00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CCI	N: 15-0042	Period: From 01/ To 12/	/01/2019 /31/2019		
				10 12/	517 201 9	7/10/2020 2:5	0 pm
	Cost Center Description	_	Inpati ent		atient	Total	
			1.00	2.	00	3.00	
	PART I - PATIENT REVENUES						-
00	General Inpatient Routine Services		26, 807, 5	75		26, 807, 575	1 1.0
. 00 . 00	Hospi tal SUBPROVI DER – I PF		26, 807, 5 8, 395, 3			8, 395, 319	
. 00	SUBPROVIDER - IRF		6, 393, 3 7, 646, 92			7, 646, 926	
. 00	SUBPROVI DER		7,040,9.	20		7,040,920	4.0
. 00	Swing bed - SNF			0		0	
. 00	Swing bed - NF			0		0	
. 00	SKILLED NURSING FACILITY			-		-	7.0
. 00	NURSING FACILITY						8.0
. 00	OTHER LONG TERM CARE						9.0
0.00	Total general inpatient care services (sum of lines 1-9)		42, 849, 82	20		42, 849, 820	10.0
	Intensive Care Type Inpatient Hospital Services						1
1.00	INTENSIVE CARE UNIT		17, 439, 10	01		17, 439, 101	11.0
2.00	CORONARY CARE UNI T						12.0
3.00	BURN INTENSIVE CARE UNIT						13.0
4.00	SURGI CAL INTENSI VE CARE UNI T						14.0
5.00	OTHER SPECIAL CARE (SPECIFY)						15.0
6.00	Total intensive care type inpatient hospital services (sum of	lines	17, 439, 10	01		17, 439, 101	16.0
	11-15)		(				17.0
7.00	Total inpatient routine care services (sum of lines 10 and 16	)	60, 288, 92			60, 288, 921	
8.00	Ancillary services		143, 301, 39		364, 206	464, 665, 596	
9.00 0.00	Outpatient services RURAL HEALTH CLINIC		12, 583, 0 <sup>,</sup>	+1 53, 0	209, 162	65, 792, 203 0	19.0 20.0
1.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
2.00	HOME HEALTH AGENCY			0	0	0	21.0
3.00	AMBULANCE SERVICES				0	0	23.0
4.00	CMHC						24.0
5.00	AMBULATORY SURGICAL CENTER (D. P. )						25.0
6.00	HOSPI CE			0 3,	397, 750	3, 397, 750	
7.00	DME			0	478, 307	478, 307	27.0
7.01	PHYSICIAN OFFICE		7, 666, 0	20 65,	598, 204	73, 264, 224	27.0
7.02	PROFESSIONAL FEES			0 10,	738, 321	10, 738, 321	27.0
8.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	223, 839, 3	72 454,	785, 950	678, 625, 322	28.0
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
9.00	Operating expenses (per Wkst. A, column 3, line 200)				016, 427		29.0
0.00	ADD (SPECI FY)			0			30.0
2.00				0			31. C
3.00				0			33.0
4.00				0			34.0
5.00				0			35.0
6.00	Total additions (sum of lines 30-35)			Ŭ	0		36.0
7.00	DEDUCT (SPECIFY)			0	Ű		37.0
8.00				0			38.0
9.00				0			39.0
0.00				0			40.0
1.00				0			41.0
2.00	Total deductions (sum of lines 37-41)				0		42.0
3.00	Total operating expenses (sum of lines 29 and 36 minus line 4	(1)		244	016, 427		43.0

Health Fi	nancial Systems	GOOD SAMARITAN H	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
	T OF REVENUES AND EXPENSES		Provider CCN: 15-0042	Peri od:	Worksheet G-3	
				From 01/01/2019		
				To 12/31/2019	Date/Time Prep 7/10/2020 2:50	
	· · · · · · · · · · · · · · · · · · ·				//10/2020 2:50	J pin
				-	1.00	
1.00 To	otal patient revenues (from Wkst. G-2, Part	L column 3 line	28)		678, 625, 322	1.00
	ess contractual allowances and discounts on				444, 385, 444	2.00
	et patient revenues (line 1 minus line 2)				234, 239, 878	3.00
	ess total operating expenses (from Wkst. G-2,	. Part II. line 4	3)		244, 016, 427	4.00
	et income from service to patients (line 3 mi				-9, 776, 549	5.00
	THER I NCOME			1	.,	
6.00 Co	ontributions, donations, bequests, etc				0	6.00
7.00 In	ncome from investments				0	7.00
8.00 Re	evenues from telephone and other miscellaneou	us communication	servi ces		0	8.00
9.00 Re	evenue from television and radio service				0	9.00
10. 00 Pu	urchase di scounts				0	10.00
11.00 Re	ebates and refunds of expenses				0	11.00
	arking lot receipts				0	12.00
13.00 Re	evenue from laundry and linen service				0	13.00
14.00 Re	evenue from meals sold to employees and gues	ts			0	14.00
	evenue from rental of living quarters				0	15.00
16.00 Re	evenue from sale of medical and surgical supp	plies to other th	nan patients		0	16.00
17.00 Re	evenue from sale of drugs to other than patio	ents			0	17.00
	evenue from sale of medical records and abst				0	18.00
19.00 Tu	uition (fees, sale of textbooks, uniforms, e	tc.)			0	19.00
	evenue from gifts, flowers, coffee shops, and	d canteen			0	20.00
	ental of vending machines				0	21.00
22.00 Re	ental of hospital space				0	22.00
	overnmental appropriations				4, 151, 848	23.00
	THER REVENUE				4, 334, 671	24.00
	VVESTMENT INCOME				6, 246, 114	24.01
	NTEREST EXPENSE				0	24.02
	THER NONOPERATING				1, 747, 525	24.03
	NTERCOMPANY TRANSFERS				2, 605, 371	24.04
24.05 UP					25, 492	
	ETARY REVENUE				642, 160	24.06
	THER (SPECIFY)				0	24.07
	otal other income (sum of lines 6-24)				19, 753, 181	25.00
	otal (line 5 plus line 25)				9, 976, 632	26.00
	THER EXPENSES (SPECIFY)				0	27.00
	otal other expenses (sum of line 27 and subsections of the subsection of the subsect				0	28.00
29.00 Ne	et income (or loss) for the period (line 26 m	minus line 28)			9, 976, 632	29.00

Health Financial Sys		GOOD SAMARITAN				u of Form CMS-	2552-10
ANALYSIS OF HOSPITAL	-BASED HOSPICE COSTS		Provider C	CN: 15-0042	Period: From 01/01/2019	Worksheet 0	
_			Hospi ce CC	N: 15-1526	To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
		SALARI ES	OTHER	SUBTOTAL (co	Hospi ce I	SUBTOTAL	
		1.00	2.00	1 plus col. 3.00	2) CATLONS 4.00	5.00	
GENERAL SERVI	CE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
1.00 CAP REL COSTS			C	D	0 0	0	1.00
2.00 CAP REL COSTS	-MVBLE EQUIP*		C	D	0 0	0	2.00
3.00 EMPLOYEE BENE	FITS DEPARTMENT*	0	C	D	0 0	0	3.00
4.00 ADMI NI STRATI V	E & GENERAL*	94, 607	709, 519			701, 350	4.00
5.00 PLANT OPERATI	ON & MAINTENANCE*	0	3, 020	3,0	20 0	3, 020	5.00
6.00 LAUNDRY & LIN	EN SERVICE*	0	C	D	0 0	0	
7.00 HOUSEKEEPI NG*		0	C	D	0 0	0	
8.00 DI ETARY*		0	C	D	0 0	0	
9.00 NURSING ADMIN	I STRATI ON*	0	C	D	0 0	0	9.00
10.00 ROUTINE MEDIC	AL SUPPLIES*	0	3, 404	1 3, 4	.04 0	3, 404	10.00
11.00 MEDICAL RECOR	DS*	0	C	D	0 0	0	11.00
12.00 STAFF TRANSPO	RTATI ON*	0	C	D	0 0	0	12.00
13.00 VOLUNTEER SER	VICE COORDINATION*	0	C	D	0 0	0	13.00
14.00 PHARMACY*		0	487	7 4	.87 0	487	14.00
	INISTRATIVE SERVICES*	0	C	D	0 0	0	15.00
16.00 OTHER GENERAL		0	C	D	0 0	0	16.00
17.00 PATIENT/RESID	ENTIAL CARE SERVICES						17.00
	T CARE SERVICE COST CENTERS						
25.00 INPATIENT CAR	E-CONTRACTED**		C	D	0 0	0	25.00
26.00 PHYSICIAN SER		11, 623	2, 706			14, 329	
27.00 NURSE PRACTIT		385	90		75 0	475	1
28.00 REGISTERED NU	RSE**	231, 867	53, 983	3 285, 8	50 0	285, 850	28.00
29.00 LPN/LVN**		0	C	D	0 0	0	
30.00 PHYSICAL THER		0	C	D	0 0	0	
31.00 OCCUPATIONAL		0	C	D	0 0	0	
	GE PATHOLOGY**	0	C	D	0 0	0	
33.00 MEDICAL SOCIA		45, 443	10, 580	56, 0	023 0	56, 023	
34.00 SPIRITUAL COU		0	C	D	0 0	0	
35.00 DI ETARY COUNS		0	C	D	0 0	0	
36.00 COUNSELING -		0	C		0 0	0	
	& HOMEMAKER SERVICES**	56, 932	13, 255	5 70, 1	87 0	70, 187	
	AL EQUIPMENT/OXYGEN**	0	C	D	0 0	0	
39.00 PATIENT TRANS		0	C		0 0	0	
40.00 I MAGI NG SERVI		0	C		0 0	0	
41.00 LABS & DI AGNO		0	C	)	0 0	0	
	I ES-NON-ROUTI NE**	0	C	)	0 0	0	
	TO PATIENTS**	0	C		0 0	0	
43.00 OUTPATIENT SE		0	C		0 0	0	
	DIATION THERAPY**	0	C		0 0	0	
45.00 PALLIATIVE CH		0	(		0 0	0	
	CARE SERVICES (SPECIFY)**	594	139	/	33 0	733	46.00
	LE COST CENTERS				0		10.00
60.00 BEREAVEMENT P		0	C	1	0 0	0	
61.00 VOLUNTEER PRO	UKAW	0		2		0	
62.00 FUNDRAI SI NG*		0		2		0	
1	ATIVE MEDICINE FELLOWS*	0	C	1	0 0	0	1
64.00 PALLIATIVE CA		0		2		0	
65.00 OTHER PHYSICI		0		2		0	
66.00 RESIDENTIAL C	AKE "	0	()		0 0	0	
67.00 ADVERTI SI NG*		0	438	4	.38 0	438	1
68.00 TELEHEALTH/TE		0		2		0	
69.00 THRI FT STORE*		0	C	1	0 0	0	
	ITY ROOM & BOARD*	0	C	1	0 0	0	1
	BURSABLE (SPECIFY)*	441, 451	797, 621	) 1, 239, 0	0 0 072 -102, 776	0 1, 136, 296	
100.00 TOTAL		///////////////////////////////////////			//6		

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

VALYS	SIS OF HOSPITAL-BASED HOSPICE COSTS		Provider CC		Period: From 01/01/2019	Worksheet C	
			Hospi ce CCN:	15-1526	To 12/31/2019 Hospi ce I	Date/Time F 7/10/2020 2	
		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)		nospi ce i		
	1	6.00	7.00				
~~	GENERAL SERVICE COST CENTERS		0				
00 00	CAP REL COSTS-BLDG & FIXT* CAP REL COSTS-MVBLE EQUIP*	0	0				1
00	EMPLOYEE BENEFITS DEPARTMENT*	0	0				2
00	ADMI NI STRATI VE & GENERAL*	0	701, 350				4
00	PLANT OPERATION & MAINTENANCE*	0	3, 020				5
00	LAUNDRY & LINEN SERVICE*	0	0				6
00	HOUSEKEEPI NG*	0	0				7
00	DI ETARY*	0	0				8
00	NURSING ADMINISTRATION*	0	0				9
. 00	ROUTINE MEDICAL SUPPLIES*	0	3, 404				10
. 00	MEDI CAL RECORDS*	0	0				11
. 00	STAFF TRANSPORTATION*	0	0				12
. 00	VOLUNTEER SERVICE COORDINATION*	0	0				13
. 00	PHARMACY* PHYSI CI AN ADMI NI STRATI VE SERVI CES*	0	487				14
. 00	OTHER GENERAL SERVICE*	0	0				15
. 00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	U				17
. 00	DI RECT PATI ENT CARE SERVICE COST CENTERS						- ''
. 00	INPATIENT CARE-CONTRACTED**	0	0				25
. 00	PHYSI CI AN SERVI CES**	0	14, 329				26
. 00	NURSE PRACTITIONER**	0	475				27
. 00	REGI STERED NURSE**	0	285, 850				28
. 00	LPN/LVN**	0	0				29
. 00	PHYSICAL THERAPY**	0	0				30
. 00	OCCUPATIONAL THERAPY**	0	0				31
. 00	SPEECH/LANGUAGE PATHOLOGY**	0	0				32
8.00	MEDICAL SOCIAL SERVICES**	0	56, 023				33
. 00	SPIRITUAL COUNSELING**	0	0				34
. 00	DI ETARY COUNSELING**	0	0				35
. 00	COUNSELING - OTHER** HOSPICE AIDE & HOMEMAKER SERVICES**	0	70, 187				30
. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	/0, 18/				38
. 00	PATI ENT TRANSPORTATI ON**	0	0				39
. 00	I MAGI NG SERVI CES**	0	0				40
. 00	LABS & DI AGNOSTI CS**	0	0				41
. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0				42
. 50	DRUGS CHARGED TO PATI ENTS**	0	0				42
. 00	OUTPATI ENT SERVI CES**	0	0				43
. 00	PALLIATIVE RADIATION THERAPY**	0	0				44
. 00	PALLIATIVE CHEMOTHERAPY**	0	0				45
. 00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	733				46
	NONREI MBURSABLE COST CENTERS		a				
. 00	BEREAVEMENT PROGRAM *	0	0				60
. 00 . 00	VOLUNTEER PROGRAM * FUNDRAI SI NG*	0	0				61
. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0				63
. 00	PALLIATIVE CARE PROGRAM*	0	0				64
. 00	OTHER PHYSI CI AN SERVI CES*	0	o				65
. 00	RESI DENTI AL CARE*	0	0				66
. 00	ADVERTI SI NG*	0	438				67
. 00	TELEHEALTH/TELEMONI TORI NG*	0	0				68
. 00	THRI FT STORE*	0	Ō				69
. 00	NURSING FACILITY ROOM & BOARD*	0	o				70
	OTHER NONREIMBURSABLE (SPECIFY)*	0	O				71
0 00	TOTAL		1, 136, 296				100

\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

	Financial Systems	GOOD SAMARITA			In Lie	eu of Form CMS-2	
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E ROUTINE HOME	Provider C	CN: 15-0042	Peri od:	Worksheet 0-2	
CARE			Hospi ce CC	N: 15-1526	From 01/01/2019 To 12/31/2019		narod
			nospi ce cc	N. 15-1520	10 12/31/2019	7/10/2020 2:5	
					Hospi ce I		-
		SALARI ES	OTHER	SUBTOTAL (co	I. RECLASSI FI -	SUBTOTAL	
				1 + col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25.00
26.00	PHYSI CLAN SERVI CES	10, 726	2, 497	13, 2	23 0	13, 223	26.00
27.00	NURSE PRACTITIONER	355	83	4	38 0	438	27.00
28.00	REGI STERED NURSE	213, 958	49, 813	263, 7	71 0	263, 771	28.00
29.00	LPN/LVN	0	0		0 0	0	29.00
30.00	PHYSI CAL THERAPY	0	0		0 0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	41, 933	9, 763	51, 6	96 0	51, 696	33.00
34.00	SPI RI TUAL COUNSELI NG	0	C		0 0	0	34.00
35.00	DI ETARY COUNSELI NG	0	C		0 0	0	35.00
36.00	COUNSELING - OTHER	0	0		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	52, 535	12, 231	64, 7	66 0	64, 766	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		0 0	0	39.00
40.00	I MAGI NG SERVI CES	0	0		0 0	0	10100
41.00	LABS & DI AGNOSTI CS	0	C		0 0	0	41.00
	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	C		0 0	0	12.00
	DRUGS CHARGED TO PATIENTS	0	C		0 0	0	12.00
	OUTPATI ENT SERVICES	0	C		0 0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	)	0 0	0	44.00

36.00 COUNSELING - OTHER	0	0	0	0	0 36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	52, 535	12, 231	64, 766	0	64, 766 37. 00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0 38.00
39.00 PATIENT TRANSPORTATION	0	0	0	0	0 39.00
40. 00 I MAGI NG SERVI CES	0	0	0	0	0 40.00
41.00 LABS & DIAGNOSTICS	0	0	0	0	0 41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	0	0	0 42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0	0	0	0 42.50
43.00 OUTPATI ENT SERVI CES	0	0	0	0	0 43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	0	0 44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	0	0 45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	548	128	676	0	676 46.00
100.00 TOTAL *	320, 055	74, 515	394, 570	0	394, 570 100. 00
* Transfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 51.				
	ADJUSTMENTS	TOTAL (col. 5			
		± col. 6)			
	6.00	7.00			
DIRECT PATIENT CARE SERVICE COST CENTERS					
25.00 INPATIENT CARE-CONTRACTED					25.00
26.00 PHYSI CI AN SERVI CES	0	13, 223			26.00
27.00 NURSE PRACTITIONER	0	438			27.00
28.00 REGI STERED NURSE	0	263, 771			28.00
29.00 LPN/LVN	0	0			29.00
30. 00 PHYSI CAL THERAPY	0	0			30.00
31.00 OCCUPATIONAL THERAPY	0	0			31.00
32.00 SPEECH/LANGUAGE PATHOLOGY	0	0			32.00
33.00 MEDI CAL SOCI AL SERVI CES	0	51, 696			33.00
34.00 SPI RI TUAL COUNSELI NG	0	0			34.00
35.00 DI ETARY COUNSELI NG	0	0			35.00
36.00 COUNSELING - OTHER	0	0			36.00
37.00 HOSPICE AIDE & HOMEMAKER SERVICES	0	64, 766			37.00
38.00 DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0			38.00
39.00 PATIENT TRANSPORTATION	0	0			39.00
40.00 I MAGI NG SERVI CES	0	0			40.00
41.00 LABS & DIAGNOSTICS	0	0			41.00
42.00 MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0			42.00
42.50 DRUGS CHARGED TO PATIENTS	0	0			42.50
43.00 OUTPATI ENT SERVICES	0	0			43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0			44.00
45.00 PALLI ATI VE CHEMOTHERAPY	0	0			45.00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	676			46.00
100.00 TOTAL *	0	394, 570			100.00
		· · · · · · · · · · · · · · · · · · ·			

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

Heal th	Financial Systems	GOOD SAMARITAN	HOSPI TAL		In Lie	u of Form CMS-	2552-10
	IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	E INPATI ENT	Provider C	CN: 15-0042	Period:	Worksheet 0-3	
RESPI T	E CARE		Hospice CC	N: 15-1526	From 01/01/2019 To 12/31/2019	Date/Time Pre	nared
			110301 00 00	N. 15 1520	10 12/31/2017	7/10/2020 2:5	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (co		SUBTOTAL	
				1 + col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			1			
25.00	INPATIENT CARE-CONTRACTED		C		0 0	0	25.00
26.00	PHYSI CI AN SERVI CES	89	21	1	10 0	110	
27.00	NURSE PRACTITIONER	3	1		4 0	4	27.00
28.00	REGI STERED NURSE	1, 781	415	2, 1	96 0	2, 196	
29.00	LPN/LVN	0	C		0 0	0	29.00
30.00	PHYSI CAL THERAPY	0	C		0 0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	C		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	C		0 0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	349	81	4	30 0	430	
34.00	SPI RI TUAL COUNSELI NG	0	C		0 0	0	34.00
35.00	DI ETARY COUNSELI NG	0	C		0 0	0	35.00
36.00	COUNSELING - OTHER	0	C		0 0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	437	102	5	39 0	539	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	C		0 0	0	38.00
39.00	PATI ENT TRANSPORTATI ON	0	C		0 0	0	39.00
40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00	LABS & DI AGNOSTI CS	0	0		0 0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0 0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	C		0 0	0	42.50
43.00	OUTPATIENT SERVICES	0	0		0 0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	1	0 0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	1	0 0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	5	1		6 0	6	46.00
100.00	TOTAL *	2, 664	621	3, 2	35 0	3, 285	100.00

 100.00
 Total \*
 2,664

 \* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5	
		6, 00	<u>± col. 6)</u> 7.00	
DII	RECT PATIENT CARE SERVICE COST CENTERS			
25.00 IN	NPATIENT CARE-CONTRACTED	0	0	25.0
26.00 PH	HYSI CI AN SERVI CES	0	110	26.0
27.00 NU	JRSE PRACTI TI ONER	0	4	27.0
28.00 RE	EGI STERED NURSE	0	2, 196	28.0
29.00 LP	PN/LVN	0	0	29.0
30.00 PH	HYSI CAL THERAPY	0	0	30. 0
31.00 OC	CCUPATIONAL THERAPY	0	0	31.0
32.00 SP	PEECH/LANGUAGE PATHOLOGY	0	0	32.0
33.00 ME	EDICAL SOCIAL SERVICES	0	430	33. 0
34.00 SP	PERETUAL COUNSELING	0	0	34.0
35.00 DI	ETARY COUNSELING	0	0	35. 0
	DUNSELING - OTHER	0	0	36.0
37.00 HO	OSPICE AIDE & HOMEMAKER SERVICES	0	539	37.0
	JRABLE MEDI CAL EQUI PMENT/OXYGEN	0	0	38.0
39.00 PA	ATIENT TRANSPORTATION	0	0	39. C
40.00 IM	AGI NG SERVI CES	0	0	40. C
41.00 LA	ABS & DIAGNOSTICS	0	0	41. C
42.00 ME	EDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.0
42.50 DR	RUGS CHARGED TO PATIENTS	0	0	42.5
	JTPATI ENT SERVI CES	0	0	43.0
	ALLIATIVE RADIATION THERAPY	0	0	44. C
45.00 PA	ALLIATIVE CHEMOTHERAPY	0	0	45. C
46.00 OT	THER PATIENT CARE SERVICES (SPECIFY)	0	6	46.0
100.00 TO	DTAL *	0	3, 285	100. C
* Transfe	er the amount in column 7 to Wkst. 0-5, colu	umn 1, line 52.		

ANAL YS	Financial Systems IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC	GOOD SAMARITAI	Provider CC	N· 15-0042	Peri od:	u of Form CMS-2 Worksheet 0-4	
	ENT CARE				From 01/01/2019		
			Hospi ce cui	N: 15-1526	To 12/31/2019	Date/Time Pre 7/10/2020 2:5	pared: O pm
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col		SUBTOTAL	
				1 + col. 2)	CATIONS		
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS		_		-1 -1		
25.00	INPATIENT CARE-CONTRACTED		0		0 0	0	25.00
	PHYSI CI AN SERVI CES	808	188	99		996	26.00
	NURSE PRACTITIONER	27	6		0	33	27.00
	REGI STERED NURSE	16, 128	3, 755	19, 88	33 0	19, 883	•
	LPN/LVN	0	0		0 0	0	29.00
	PHYSI CAL THERAPY	0	0		0 0	0	30.00
	OCCUPATIONAL THERAPY	0	0		0 0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0.00	0 0	0	32.00
	MEDICAL SOCIAL SERVICES	3, 161	736	3, 89	0	3, 897	33.00
	SPIRITUAL COUNSELING	0	0		0 0	0	34.00
	DI ETARY COUNSELI NG	0	0		0 0	0	35.00
	COUNSELING - OTHER	0	0		0 0	0	36.00
	HOSPICE AIDE & HOMEMAKER SERVICES	3, 960	922	4, 88	32 0	4, 882	37.00
	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0 0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0		0 0	0	39.00
40.00	I MAGI NG SERVI CES	0	0		0 0	0	40.00
41.00	LABS & DIAGNOSTICS MEDICAL SUPPLIES-NON-ROUTINE	0	0		0 0	0	41.00
		0	0		0 0	0	42.00
	DRUGS CHARGED TO PATIENTS OUTPATIENT SERVICES	0	0		0 0	0	42.50
	PALLIATIVE RADIATION THERAPY	0	0			0	43.00
	PALLIATIVE RADIATION THERAPY PALLIATIVE CHEMOTHERAPY	0	0			0	44.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	41	10	-	51 0	51	45.00
40.00	UTILK FATILINI VARE SERVICES (SPECIFY)	41 24, 125	10		0	51	40.00

\* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
		6,00	<u>± col. 6)</u> 7.00	-	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00		
25.00	INPATIENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	996		26.00
27.00	NURSE PRACTITIONER	0	33		27.00
28.00	REGI STERED NURSE	0	19, 883		28.00
29.00	LPN/LVN	0	0		29.00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATIONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	3, 897		33.00
34.00	SPI RI TUAL COUNSELI NG	0	0		34.00
35.00	DI ETARY COUNSELI NG	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	4, 882		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		38.00
39.00	PATI ENT TRANSPORTATI ON	0	0		39.00
40.00	I MAGI NG SERVI CES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		42.50
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	0	51		46.00
100.00	TOTAL *	0	29, 742		100.00
* Tran	sfer the amount in column 7 to Wkst. 0-5, colu	umn 1, line 53.			

Heal th	Financial Systems GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0042	Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION	Hospi ce CC	N: 15-1526	From 01/01/2019 To 12/31/2019		
				Hospi ce I	771072020 2.3	
	Descriptions		HOSPICE DIRE		TOTAL EXPENSES	
			EXPENSES (se		(sum of cols.	
			i nstructi ons			
				WKST B PART I	, í	
				(see		
				instructions)		
			1.00	2.00	3.00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT			0 110, 375		1.00
2.00	CAP REL COSTS-MVBLE EQUIP			0 99		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT			0 160, 033		3.00
4.00	ADMINISTRATIVE & GENERAL		701, 3			4.00
5.00	PLANT OPERATION & MAINTENANCE		3, 0			5.00
6.00	LAUNDRY & LINEN SERVICE			0 0	-	6.00
7.00	HOUSEKEEPING			0 46, 811	46, 811	7.00
8.00	DI ETARY			0 0	0	8.00
9.00	NURSI NG ADMI NI STRATI ON			0 46, 928		9.00
10.00	ROUTINE MEDICAL SUPPLIES		3, 4	94 893	4, 297	10.00
11.00	MEDI CAL RECORDS			0 0	0	11.00
12.00	STAFF TRANSPORTATION			0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0	13.00
14.00	PHARMACY		4			14.00
15.00	PHYSI CI AN ADMI NI STRATI VE SERVI CES			0	0	15.00
16.00	OTHER GENERAL SERVICE			0 0		16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES			0	0	17.00
	LEVEL OF CARE		1			
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE		394, 5		394, 570	1
52.00	HOSPICE INPATIENT RESPITE CARE		3, 2		3, 285	52.00
53.00	HOSPICE GENERAL INPATIENT CARE		29, 7	2	29, 742	53.00
(0.00	NONREI MBURSABLE COST CENTERS			0	0	(0.00
60.00 61.00	BEREAVEMENT PROGRAM			0	0	60.00 61.00
62.00	VOLUNTEER PROGRAM FUNDRAI SI NG			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	65.00
66.00	RESIDENTIAL CARE			0	0	66.00
67.00	ADVERTI SI NG		1	8	438	67.00
68.00	TELEHEALTH/TELEMONI TORI NG			0	430	68.00
69.00	THRIFT STORE			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
70.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	70.00
99.00	NEGATI VE COST CENTER			0	0	99.00
	TOTAL		1, 136, 2	592, 774		
100.00	1.0		1 1,100,2	0,2,7,4	1, 12, 010	1.00.00

	Financial Systems	GOOD SAMARITA				eu of Form CMS-	
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CC Hospice CC		Period: From 01/01/2019 To 12/31/2019	9 Date/Time Pre	pared:
						7/10/2020 2:5	0 pm
	Descriptions	TOTAL EXPENSES		CAD DEL MVBI	Hospice I	SUBTOTAL	
	bescriptions		FIX	EQUI P	BENEFI TS DEPARTMENT	SUBTUTAL	
		0	1.00	2.00	3.00	3A	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	110, 375	110, 375				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	99			99		2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	160, 033	0		0 160, 033	3	3.00
4.00	ADMI NI STRATI VE & GENERAL	862, 105	0		0 (	862, 105	4.00
5.00	PLANT OPERATION & MAINTENANCE	69, 784	0		0 (	69, 784	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0 0	6.00
7.00	HOUSEKEEPING	46, 811	0		0 0	46, 811	7.00
8.00	DI ETARY	0	0		0 0	0 0	8.00
9.00	NURSING ADMINISTRATION	46, 928	0		0 0	46, 928	9.00
10.00	ROUTINE MEDICAL SUPPLIES	4, 297	0		0 0	4, 297	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	0 0	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	o o	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	o o	13.00
14.00	PHARMACY	603	0		0 (	603	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 (	0 0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0	0 0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0			(	0 0	50.00
51.00	HOSPICE ROUTINE HOME CARE	394, 570			147, 673	542, 243	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3, 285	10, 941		10 1, 229	15, 465	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	29, 742	99, 434		89 11, 13		
	NONREIMBURSABLE COST CENTERS						1
60.00	BEREAVEMENT PROGRAM	0	0		0 (	0 0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0	0 0	61.00
62.00	FUNDRAI SI NG	0	0		0	0 0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0 0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0	o o	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0	0 0	65.00
66.00	RESI DENTI AL CARE	0	0		0	0 0	66.00
67.00	ADVERTI SI NG	438	0		0	438	•
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0 0	•
69.00	THRI FT STORE	0	0		0		•
70.00	NURSING FACILITY ROOM & BOARD	0	-			0	
71.00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0	ol o	
99.00	NEGATIVE COST CENTER	0	0		0		99.00
	TOTAL	1, 729, 070	110, 375		99 160, 03	1	100.00

	Financial Systems	GOOD SAMARITA		01 45 0040			u of Form CMS		552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	_ SERVICE COSIS	Provider C Hospice CC	CN: 15-0042 N: 15-1526		eriod: rom 01/01/2019 o 12/31/2019	Worksheet 0- Part I Date/Time Pr 7/10/2020 2:	гер	ared: pm
				_		Hospi ce I			
	Descriptions	ADMI NI STRATI VE & GENERAL	PLANT OPERATI ON & MAI NTENANCE	LAUNDRY & LINEN SERVIO		HOUSEKEEPI NG	DI ETARY		
		4.00	5.00	6.00		7.00	8.00		
	GENERAL SERVICE COST CENTERS			·					
1.00	CAP REL COSTS-BLDG & FIXT								1.00
2.00	CAP REL COSTS-MVBLE EQUIP								2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT								3.00
4.00	ADMI NI STRATI VE & GENERAL	862, 105							4.00
5.00	PLANT OPERATION & MAINTENANCE	69, 393	139, 177						5.00
6.00	LAUNDRY & LINEN SERVICE	0	C		0				6.00
7.00	HOUSEKEEPING	46, 549	C	)		93, 360			7.00
8.00	DI ETARY	0	C	)		0		0	8.00
9.00	NURSING ADMINISTRATION	46, 665	C			0			9.00
10.00	ROUTINE MEDICAL SUPPLIES	4, 273	C			0			10.00
11.00	MEDICAL RECORDS	0	C	)		0			11.00
12.00	STAFF TRANSPORTATION	0	C	)		0			12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	C	)		0			13.00
14.00	PHARMACY	600	C	)		0			14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	C	)		0			15.00
16.00	OTHER GENERAL SERVICE	0	C	)		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	C	)		0			17.00
	LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	0							50.00
51.00	HOSPICE ROUTINE HOME CARE	539, 202							51.00
52.00	HOSPICE INPATIENT RESPITE CARE	15, 378	13, 796	,	0	9, 254		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	139, 609	125, 381		0	84, 106		0	53.00
	NONREIMBURSABLE COST CENTERS			·					
60.00	BEREAVEMENT PROGRAM	0	C	)		0			60.00
61.00	VOLUNTEER PROGRAM	0	C			0			61.00
62.00	FUNDRAI SI NG	0	C			0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	C			0			63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0			64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0			65.00
66.00	RESI DENTI AL CARE	0	C		0	0		0	66.00
67.00	ADVERTI SI NG	436	0			0			67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	C			0			68.00
69.00	THRI FT STORE	0	C	)		0			69.00
70.00	NURSING FACILITY ROOM & BOARD								70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	C		0	0		0	71.00
99.00	NEGATI VE COST CENTER	0	C		0	0		0	99.00
	TOTAL	862, 105	139, 177		0	93, 360			00.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS       Provider CCN: 15-0042 Hospice CCN: 15-1526       Period: From 01/01/2019 To 12/31/2019       Worksheet Part I Date/Time 7/10/2020         Descriptions       NURSING ADMINISTRATION       ROUTINE MEDICAL SUPPLIES       MEDICAL RECORDS       STAFF TRANSPORTATION       VOLUNTEER SERVICE COORDINATION         0       CAP REL COSTS-BLDG & FIXT 2.00       0       10.00       11.00       12.00       13.00         1.00       CAP REL COSTS-MVBLE EQUIP 3.00       ENPLOYEE BENEFITS DEPARTMENT 4.00       ADMINISTRATIVE & GENERAL 5.00       PLANT OPERATION & MAINTENANCE 6.00       HANDRY & LINEN SERVICE 7.00       HOUSEKEEPING 8.00       HOUSEKEEPING 8.00       93, 593	Prepared: 2:50 pm
Descriptions     NURSING ADMINISTRATION     ROUTINE MEDICAL SUPPLIES     MEDICAL RECORDS     STAFF TRANSPORTATION     VOLUNTEER SERVICE COORDINATION       1.00     GENERAL SERVICE COST CENTERS     9.00     10.00     11.00     12.00     13.00       2.00     CAP REL COSTS-BLDG & FIXT     0     0     11.00     12.00     13.00       3.00     EMPLOYEE BENEFITS DEPARTMENT     0     ADMINISTRATIVE & GENERAL     0     0     0       4.00     ADMINISTRATIVE & GENERAL     0     0     0     0     0     0       5.00     PLANT OPERATION & MAINTENANCE     0     0     0     0     0     0       6.00     LAUNDRY & LINEN SERVICE     0     0     0     0     0     0       8.00     DI ETARY     0     0     0     0     0     0	1.00 2.00 3.00 4.00 5.00 6.00
ADMI NI STRATI ON MEDI CAL SUPPLI ES RECORDS TRANSPORTATI ON SERVI CE COORDI NATI ( 9.00 10.00 11.00 12.00 13.00 10.00 10.00 11.00 12.00 13.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 1	1.00 2.00 3.00 4.00 5.00 6.00
GENERAL SERVICE COST CENTERS9.0010.0011.0012.0013.001.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP10.0010.0011.0012.0013.003.00CAP REL COSTS-MVBLE EQUIP10.00CAP REL COSTS-MVBLE EQUIP10.0010.0010.0011.0012.0013.003.00CAP REL COSTS-MVBLE EQUIP10.00CAP REL COSTS-MVBLE EQUIP10.0010.0010.0010.0011.0012.0013.003.00EMPLOYEE BENEFITS DEPARTMENT10.00CAP REL COSTS-MVBLE & GENERAL10.0010.0010.0010.0010.005.00PLANT OPERATION & MAI NTENANCE10.0010.0010.0010.0010.0010.0010.006.00LAUNDRY & LI NEN SERVI CE10.0010.0010.0010.0010.0010.0010.007.00HOUSEKEEPI NG10.0010.0010.0010.0010.0010.0010.008.00DI ETARY10.0010.0010.0010.0010.0010.0010.00	1.00 2.00 3.00 4.00 5.00 6.00
1.00       CAP REL COSTS-BLDG & FIXT         2.00       CAP REL COSTS-MVBLE EQUIP         3.00       EMPLOYEE BENEFITS DEPARTMENT         4.00       ADMI NI STRATI VE & GENERAL         5.00       PLANT OPERATION & MAI NTENANCE         6.00       LAUNDRY & LI NEN SERVI CE         7.00       HOUSEKEEPI NG         8.00       DI ETARY	2.00 3.00 4.00 5.00 6.00
1.00       CAP REL COSTS-BLDG & FIXT         2.00       CAP REL COSTS-MVBLE EQUIP         3.00       EMPLOYEE BENEFITS DEPARTMENT         4.00       ADMI NI STRATI VE & GENERAL         5.00       PLANT OPERATION & MAI NTENANCE         6.00       LAUNDRY & LI NEN SERVI CE         7.00       HOUSEKEEPI NG         8.00       DI ETARY	2.00 3.00 4.00 5.00 6.00
2. 00       CAP REL COSTS-MVBLE EQUIP         3. 00       EMPLOYEE BENEFITS DEPARTMENT         4. 00       ADMI NI STRATI VE & GENERAL         5. 00       PLANT OPERATI ON & MAI NTENANCE         6. 00       LAUNDRY & LI NEN SERVI CE         7. 00       HOUSEKEEPI NG         8. 00       DI ETARY	2.00 3.00 4.00 5.00 6.00
3. 00EMPLOYEE BENEFITS DEPARTMENT4. 00ADMI NI STRATI VE & GENERAL5. 00PLANT OPERATI ON & MAI NTENANCE6. 00LAUNDRY & LI NEN SERVI CE7. 00HOUSEKEEPI NG8. 00DI ETARY	3.00 4.00 5.00 6.00
4. 00ADMI NI STRATI VE & GENERAL5. 00PLANT OPERATI ON & MAI NTENANCE6. 00LAUNDRY & LI NEN SERVI CE7. 00HOUSEKEEPI NG8. 00DI ETARY	4.00 5.00 6.00
5.00       PLANT OPERATION & MAINTENANCE         6.00       LAUNDRY & LINEN SERVICE         7.00       HOUSEKEEPING         8.00       DIETARY	5.00 6.00
6. 00       LAUNDRY & LI NEN SERVI CE         7. 00       HOUSEKEEPI NG         8. 00       DI ETARY	6.00
7. 00 HOUSEKEEPI NG 8. 00 DI ETARY	
8.00 DI ETARY	1 7.00
	8.00
9. 00 NURSI NG ADMI NI STRATI ON 93, 593	9,00
10. 00 ROUTINE MEDICAL SUPPLIES 0 8, 570	10.00
11. 00 MEDICAL SUPPLIES 0 8, 570	11.00
	12.00
	0 13.00
13. 00 VOLUNTEER SERVICE COORDINATION 0 0 14. 00 PHARMACY 0 0	
	0 14.00
15. 00 PHYSI CI AN ADMI NI STRATI VE SERVI CES 0 0 0	0 15.00
	0 16.00
17. 00 PATI ENT/RESI DENTI AL CARE SERVI CES	17.00
LEVEL OF CARE	
50. 00 HOSPICE CONTINUOUS HOME CARE 0 0 0 0	0 50.00
51. 00 HOSPICE ROUTINE HOME CARE 86, 364 7, 908 0 0	0 51.00
52. 00 HOSPICE INPATIENT RESPITE CARE 719 66 0 0	0 52.00
53. 00 HOSPICE GENERAL I NPATI ENT CARE 6, 510 596 0 0	0 53.00
NONREI MBURSABLE COST CENTERS	
60. 00     BEREAVEMENT     PROGRAM     0     0       (1. 00)     MULLINITEER     PROGRAM     0     0	0 60.00
61. 00 VOLUNTEER PROGRAM 0 0	0 61.00
62. 00 FUNDRALSING 0 0	0 62.00
63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 0	0 63.00
64. 00 PALLIATIVE CARE PROGRAM 0 0	0 64.00
65. 00 OTHER PHYSICIAN SERVICES 0 0	0 65.00
66. 00 RESI DENTIAL CARE 0 0	0 66.00
67. 00 ADVERTI SI NG 0 0	0 67.00
68. 00 TELEHEALTH/TELEMONI TORI NG 0 0	0 68.00
69. 00 THRI FT STORE 0 0	0 69.00
70. 00 NURSING FACILITY ROOM & BOARD	70.00
71.00 OTHER NONREIMBURSABLE (SPECIFY) 0 0	0 71.00
99.00 NEGATIVE COST CENTER 0 0 0 0	0 99.00
100.00 TOTAL   93,593  8,570  0  0	0 100. 00

0001 A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provider CO Hospice CCI		Period: From 01/01/2019 To 12/31/2019	Worksheet 0-6 Part I Date/Time Pre 7/10/2020 2:5	epared:
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN ADMI NI STRATI VE SERVI CES	OTHER GENERA SERVI CE		TOTAL	
		14.00	15.00	16.00	17.00	18.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE					l .	5.00
6.00	LAUNDRY & LINEN SERVICE					l	6.00
7.00	HOUSEKEEPING					l	7.00
8.00	DI ETARY					l	8.00
9.00	NURSING ADMINISTRATION					l	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES					l	10.00
	MEDI CAL RECORDS					l	11.00
	STAFF TRANSPORTATION					l	12.00
	VOLUNTEER SERVICE COORDINATION					l	13.00
	PHARMACY	1, 203				l	14.00
	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
	OTHER GENERAL SERVICE	0			0	1	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0	L	17.00
	LEVEL OF CARE						
	HOSPICE CONTINUOUS HOME CARE	0	0		0	C	
	HOSPICE ROUTINE HOME CARE	1, 111	0		0	1, 176, 828	1
	HOSPICE INPATIENT RESPITE CARE	9	0		0 0	54, 687	1
53.00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	83	0		0 0	496, 681	1 53.00
60, 00	BEREAVEMENT PROGRAM	0			0	C	60, 00
61.00	VOLUNTEER PROGRAM	0			0		
62.00	FUNDRAI SI NG	0			0		
	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0		
	PALLIATIVE CARE PROGRAM	0			0	i c	
	OTHER PHYSICIAN SERVICES	0			0		
66.00	RESI DENTI AL CARE	0	0		0 0		
	ADVERTI SI NG	0			0	874	
	TELEHEALTH/TELEMONI TORI NG	0			0	0/4	
	THRI FT STORE	0			0		
	NURSING FACILITY ROOM & BOARD				Ŭ		
, 0. 00	OTHER NONREI MBURSABLE (SPECIFY)	0	0		0 0		
71 00							
	NEGATI VE COST CENTER	0	0		0 0	C	

Heal th	Financial Systems	GOOD SAMARI TAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENER	RAL SERVICE COSTS	Provider CC		Peri od:	Worksheet 0-6	
STATI S	TI CAL BASI S		lloopi oo CCN		From 01/01/2019	Part II	norod.
			Hospi ce CCN	l: 15-1526	To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
-					Hospi ce I	77 107 2020 2.3	
	Cost Center Descriptions	CAP REL BLDG & C	AP REL MVBLE	EMPLOYEE	RECONCI LI ATI ON	ADMI NI STRATI VE	
		FIX	EQUI P	BENEFITS		& GENERAL	
		(SQUARE FEET) (D	OLLAR VALUE)	DEPARTMENT		(ACCUMULATED	
				(GROSS		COSTS)	
				SALARI ES)			
		1.00	2.00	3.00	4A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	686					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		686				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	160, 03	6		3.00
4.00	ADMI NI STRATI VE & GENERAL	0	0		0 -862, 105	866, 965	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0		0 0	69, 784	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0 0	0	6.00
7.00	HOUSEKEEPING	0	0		0 0	46, 811	7.00
8.00	DI ETARY	0	0		0 0	0	8.00
9.00	NURSING ADMINISTRATION	0	0		0 0	46, 928	9.00
10.00	ROUTI NE MEDI CAL SUPPLI ES	0	0		0 0	4, 297	10.00
11.00	MEDI CAL RECORDS	0	0		0 0	0	11.00
12.00	STAFF TRANSPORTATION	0	0		0 0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0		0 0	0	13.00
14.00	PHARMACY	0	0		0 0	603	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0		0 0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0		0 0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0	0	17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE				0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE			147, 67		542, 243	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	68	68	1, 22		15, 465	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	618	618	11, 13	0	140, 396	53.00
	NONREI MBURSABLE COST CENTERS		1				
60.00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0		0 0	0	61.00
62.00	FUNDRAI SI NG	0	0		0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0		0 0	0	65.00
66.00	RESIDENTIAL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	438	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0 0	0	68.00
69.00	THRIFT STORE	0	0		0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD		_		0	_	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0 0	0	71.00
	NEGATIVE COST CENTER			4/6 55		0/0 105	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Pa		99	160, 03		862, 105	
101.00	UNIT COST MULTIPLIER	160. 896501	0. 144315	0. 99998	) I	0. 994394	101.00

	n Financial Systems	GOOD SAMARITA	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL STICAL BASIS	SERVICE COSTS	Provider CO Hospice CCI		Period: From 01/01/2019 To 12/31/2019		pared:
					Hospi ce I		
	Cost Center Descriptions	PLANT OPERATI ON & MAI NTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET	G DI ETARY	NURSI NG ADMI NI STRATI ON (DI RECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	5.00	0.00	7.00	0.00	7.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL PLANT OPERATION & MAINTENANCE LAUNDRY & LINEN SERVICE HOUSEKEEPING DIETARY NURSING ADMINISTRATION ROUTINE MEDICAL SUPPLIES MEDICAL RECORDS STAFF TRANSPORTATION VOLUNTEER SERVICE COORDINATION PHARMACY PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE	686 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0		36 0 0 0 0 0 0 0 0 0 0 0 0	123, 648 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\end{array}$
	LEVEL OF CARE						
50.00 51.00 52.00 53.00	HOSPI CE ROUTI NE HOME CARE HOSPI CE I NPATI ENT RESPI TE CARE	68 618	0		58 O 18 O		50.00 51.00 52.00 53.00
100.0	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM FUNDRAI SI NG HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS PALLI ATI VE CARE PROGRAM OTHER PHYSI CI AN SERVI CES RESI DENTI AL CARE ADVERTI SI NG TELEHEALTH/TELEMONI TORI NG THRI FT STORE NURSI NG FACI LI TY ROOM & BOARD	<ul> <li>0</li> <li>139, 177</li> <li>202. 881924</li> </ul>	0 0 0.000000	93, 30		0 0 0 93, 593	

Heal th	Financial Systems	GOOD SAMARITA	N HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provider C	CN: 15-0042	Peri od:	Worksheet 0-6	
STATI S	TICAL BASIS			45 4504	From 01/01/2019	Part II	
			Hospi ce CC	N: 15-1526	To 12/31/2019	Date/Time Pre 7/10/2020 2:5	
					Hospi ce I	771072020 2.3	
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDICAL	RECORDS	TRANSPORTATIO		(CHARGES)	
			(PATIENT DAYS)		COORDI NATI ON	(	
		(PATIENT DAYS)	````	(MI LEAGE)	(HOURS OF		
		ľ í			SERVICE)		
		10.00	11.00	12.00	13.00	14.00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMI NI STRATI VE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DI ETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES	6, 901					10.00
11.00	MEDI CAL RECORDS		0				11.00
12.00	STAFF TRANSPORTATION				0		12.00
13.00	VOLUNTEER SERVICE COORDINATION				0 0		13.00
14.00	PHARMACY				0 0	1, 571	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES				0 0	0	15.00
16.00	OTHER GENERAL SERVICE				0 0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
	LEVEL OF CARE	· · · · · · · · · · · · · · · · · · ·					
50.00	HOSPI CE CONTI NUOUS HOME CARE	0	0		0 0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	6, 368	0		0 0	1, 450	1
52.00	HOSPICE INPATIENT RESPITE CARE	53	0		0 0	12	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	480	0		0 0	109	53.00
	NONREI MBURSABLE COST CENTERS	1 1		1	- 1		
60.00	BEREAVEMENT PROGRAM				0 0	0	60.00
61.00	VOLUNTEER PROGRAM				0 0	0	61.00
62.00	FUNDRAI SI NG				0 0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0 0	0	63.00
64.00	PALLIATIVE CARE PROGRAM				0 0	0	64.00
65.00	OTHER PHYSI CI AN SERVI CES				0 0	0	65.00
66.00	RESI DENTI AL CARE				0 0	0	66.00
67.00	ADVERTI SI NG				0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG				0 0	0	68.00
69.00	THRI FT STORE				0 0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD				-	-	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0	0	
	NEGATIVE COST CENTER	0.570	-			4	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	8, 570	0	0.0000			100.00
101.00	UNIT COST MULTIPLIER	1. 241849	0. 000000	0.0000	0. 000000	0. 765754	101.00

	Financial Systems LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	GOOD SAMARITA	Provider C	CN: 15-0042	Peri od:	u of Form CMS Worksheet O-	
	TICAL BASIS		Hospi ce CC		From 01/01/2019 To 12/31/2019	Part II Date/Time Pr 7/10/2020 2:	epared:
					Hospi ce I		<u></u>
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
		ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)	BASIS)	(IN-FACILIT	Y		
				DAYS)			
		15.00	16.00	17.00			
1 00	GENERAL SERVICE COST CENTERS	1		1			1 00
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00 4.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
	ADMINISTRATIVE & GENERAL						4.00
5.00 6.00	PLANT OPERATION & MAINTENANCE						5.00
8.00 7.00	LAUNDRY & LINEN SERVICE						6.00
7.00 8.00	HOUSEKEEPI NG DI ETARY						7.00
8.00 9.00	NURSI NG ADMI NI STRATI ON						9.00
9.00 10.00	ROUTINE MEDICAL SUPPLIES						10.00
10.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
12.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY						14.00
14.00	PHYSICIAN ADMINISTRATIVE SERVICES	0					15.00
16.00	OTHER GENERAL SERVICE	0	0				16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			·	0		17.00
17.00	LEVEL OF CARE						- 17.00
50.00	HOSPICE CONTINUOUS HOME CARE	0	C				50.00
51.00	HOSPICE ROUTINE HOME CARE	0					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0			0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0			0		53.00
	NONREIMBURSABLE COST CENTERS		· · ·				
60.00	BEREAVEMENT PROGRAM		0	)			60.00
61.00	VOLUNTEER PROGRAM		0	)			61.00
62.00	FUNDRAI SI NG		0	)			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	)			63.00
64.00	PALLIATIVE CARE PROGRAM		C	)			64.00
65.00	OTHER PHYSICIAN SERVICES		0				65.00
66.00	RESIDENTIAL CARE	0	0		0		66.00
67.00	ADVERTI SI NG		0				67.00
68.00	TELEHEALTH/TELEMONI TORI NG		0				68.00
69.00	THRI FT STORE		0				69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0		71.00
99.00	NEGATIVE COST CENTER						99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)		0		0		100.00
101.00	UNIT COST MULTIPLIER	0. 000000	0. 000000	0.0000	00		101.00

Heal th	Financial Systems	GOOD SAMARI TAN	N HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	IONMENT OF HOSPITAL-BASED HOSPICE SHARED SERV	ICE COSTS BY	Provider CC	CN: 15-0042	Peri od:	Worksheet 0-7	
LEVEL	OF CARE		Hospice CCN	l: 15-1526	From 01/01/2019 To 12/31/2019	Date/Time Prep 7/10/2020 2:50	pared: 0 pm
					Hospi ce I	11 10/ 2020 210	<u> </u>
				Charges by	LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C, C Part I, Col. 9 line	ost to Charge Ratio	НСНС	HRHC	HI RC	
		0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS	· ·					
1.00 2.00 3.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY SPEECH PATHOLOGY	66.00 67.00 68.00	0. 274387		0 0	0	1.00 2.00 3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 277122		0 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0. 527925		0 0	0	5.00
6.00	LABORATORY	60.00	0. 140871		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	1. 058566		0 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93.00					8.00
9.00	RADI OLOGY-THERAPEUTI C	55.00	0. 165256		0 0	0	9.00
	MH ANCILLARY OUTPATIENT	76.00	0. 000000		0 0	0	10.00
10. 01	INPATIENT DIALYSIS	76. 01	0. 639091		0 0	0	10.01
11.00	Totals (sum of lines 1–11)						11.00
		Charges by LOC (from Provider Records)		Shared Servi	ice Costs by LOC		
	Cost Center Descriptions		CHC (col. 1 x	HRHC (col. 1	xHIRC (col. 1 x	HGLP (col. 1 x	
			col. 2)	col. 3)	col. 4)	col. 5)	
		5.00	6.00	7.00	8.00	9.00	
	ANCI LLARY SERVI CE COST CENTERS	<u>_</u>					
1.00	PHYSI CAL THERAPY	0	0		0 0	0	1.00
2.00	OCCUPATIONAL THERAPY						2.00
3.00	SPEECH PATHOLOGY						3.00
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	5.00
6.00	LABORATORY	0	0		0 0	0	6.00
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
10.00	MH ANCILLARY OUTPATIENT	0	0		0 0	0	
	INPATIENT DIALYSIS	0	0		0 0	0	10101
11.00	Totals (sum of lines 1–11)		0		0 0	0	11.00

	Financial Systems TION OF HOSPITAL-BASED HOSPICE PER DIEM COS <sup>-</sup>	GOOD SAMARITAN	Provider C	NI 15 0042	Period:	u of Form CMS-2 Worksheet 0-8	
ALCULAI	TION OF HUSPITAL-BASED HUSPICE PER DIEM CUS	I	Provider C	JN: 15-0042	From 01/01/2019	worksneet 0-8	
			Hospi ce CCI	N: 15-1526	To 12/31/2019	Date/Time Pre	pared
						7/10/2020 2:5	
					Hospi ce I		
				TITLE XVIII	TITLE XIX	TOTAL	
				MEDI CARE	MEDI CAI D		
				1.00	2.00	3.00	
	IOSPICE CONTINUOUS HOME CARE						
	Total cost (Wkst. 0-6, Part I, col. 18, line	e 50 plus Wkst. O-	7, col. 6,			0	1. (
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4,					0	2.0
	Total average cost per diem (line 1 divided					0.00	3.
	Unduplicated program days (Wkst. S-9 col. as	s appropriate, lin	e 10)		0 0		4.
.00 P	Program cost (line 3 times line 4)				0 0		5.
	HOSPICE ROUTINE HOME CARE						
.00 T	Total cost (Wkst. 0-6, Part I, col. 18, line	e 51 plus Wkst. O-	7, col. 7,			1, 176, 828	6.
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4,					6, 368	7.
	Total average cost per diem (line 6 divided					184.80	8.
. 00 U	Unduplicated program days (Wkst. S-9, col. a	as appropriate, li	ne 11)	6, 0	77 129		9.
	Program cost (line 8 times line 9)			1, 123, 0	30 23, 839		10.
	HOSPICE INPATIENT RESPITE CARE						
1.00 T	Total cost (Wkst. 0-6, Part I, col. 18, line	e 52 plus Wkst. O-	7, col. 8,			54, 687	11.
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4,						12.
	Total average cost per diem (line 11 divideo					1, 031. 83	13.
	Unduplicated program days (Wkst. S-9, col. a	as appropriate, li	ne 12)		22 0		14.
	Program cost (line 13 times line 14)			22, 7	00 00		15.
	HOSPICE GENERAL INPATIENT CARE						
5.00 T	Total cost (Wkst. 0-6, Part I, col. 18, line	e 53 plus Wkst. O-	7, col. 9,			496, 681	16.
	line 11)						
	Total unduplicated days (Wkst. S-9, col. 4,					480	17.
3.00 T	Total average cost per diem (line 16 dividec	d by line 17)				1,034.75	18.
	Unduplicated program days (Wkst. S-9, col. a	as appropriate, li	ne 13)		84 10		19.
	Program cost (line 18 times line 19)			397, 3	44 10, 348		20.
	TOTAL HOSPICE CARE						
I. 00 T	Total cost (sum of line 1 + line 6 + line 11	l + line 16)				1, 728, 196	21.
	Total unduplicated days (Wkst. S-9, col. 4,					6, 901	22.
2 00 1	Average cost per diem (line 21 divided by li	ne 22)				250.43	22

ALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0042	Period: From 01/01/2019 To 12/31/2019	Worksheet L Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	7/10/2020 2:5 PPS	0 pm
			nospi tui	115	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
. 00	Capital DRG other than outlier			1, 765, 397	1.
. 01	Model 4 BPCI Capital DRG other than outlier			0	
00	Capital DRG outlier payments			26, 901	
01	Model 4 BPCI Capital DRG outlier payments			0	
00	Total inpatient days divided by number of days in the c	ost reporting period (see inst	ructions)	49.63	
00	Number of interns & residents (see instructions)			0.76	
00	Indirect medical education percentage (see instructions			0.43	
00	Indirect medical education adjustment (multiply line 5 1.01)(see instructions)	-		7, 591	
00	Percentage of SSI recipient patient days to Medicare Pa 30) (see instructions)		E, part A line	0.00	
00	Percentage of Medicaid patient days to total days (see	instructions)		0.00	
00	Sum of lines 7 and 8			0.00	
. 00		ctions)		0.00	
	Disproportionate share adjustment (see instructions)			0	
2.00	Total prospective capital payments (see instructions)			1, 799, 889	12.
				1.00	<u> </u>
	PART II – PAYMENT UNDER REASONABLE COST			1.00	-
00	Program inpatient routine capital cost (see instruction	s)		0	1 1.
00	Program inpatient ancillary capital cost (see instructi			0	1
00	Total inpatient program capital cost (line 1 plus line	-		0	
00	Capital cost payment factor (see instructions)	,		0	
00	Total inpatient program capital cost (line 3 x line 4)			0	5.
				1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
00	Program inpatient capital costs (see instructions)			0	1 1
00	Program inpatient capital costs for extraordinary circu	mstances (see instructions)		0	2
00	Net program inpatient capital costs (line 1 minus line	2)		0	-
00	Applicable exception percentage (see instructions)			0.00	
00	Capital cost for comparison to payments (line 3 x line			0	-
00	Percentage adjustment for extraordinary circumstances (			0.00	
00	Adjustment to capital minimum payment level for extraor	dinary circumstances (line 2 >	(line 6)	0	
00	Capital minimum payment level (line 5 plus line 7)			0	
00	Current year capital payments (from Part I, line 12, as			0	
. 00	Current year comparison of capital minimum payment leve			0	1
. 00	Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14)		5	0	
. 00			,	0	1
	Current year exception payment (if line 12 is positive,			0	
	Carryover of accumulated capital minimum payment level		ollowing period	0	14.
	$(1 \neq 1)$ no nonotive onton the employer $++!-1!$				
1. 00	(if line 12 is negative, enter the amount on this line)			^	10
3.00 4.00 5.00 5.00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (s Current year operating and capital costs (see instructi	ee instructions)		0	