Heal th Financia	al Systems	GOOD SAMARITAN HO	SPI TAI	Inlie	u of Form CMS-2552-10		
This report is	required by law (42 USC 139	25g; 42 CFR 413.20(b)). Failucost reporting period being c	ire to report can r	esult in all interim	<u> </u>		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150042 Period: WE From 01/01/2014 PERIOD: WE Fr							
PART I - COST	REPORT STATUS						
Provi der	1. [ X ] Electronically file			Date: 6/3/201	5 Time: 1:43 pm		
use only	2. [ ] Manually submitted of 3. [ 0 ] If this is an amendod 4. [ F ] Medicare Utilization	cost report ed report enter the number o n. Enter "F" for full or "L"	f times the provide for low.	er resubmitted this c	ost report		
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened		this Provider CCN				

PART II - CERTIFICATION

(5) Amended

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARITAN HOSPITAL (150042) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	71, 453	124, 213	-64, 283	0	1.00
2.00	Subprovi der - IPF	0	4, 334	83		0	2.00
3.00	Subprovi der - IRF	0	38, 560	210		0	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	114, 347	124, 506	-64, 283	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDI CARE.

1100111	AL AND HOSPITAL HEALTH SAME COMPLEX	DENTITION DA		11001	der con.		From 01/01/ To 12/31/	/2014		me Pre 15 1:34	
	1.00	2. (	00		3. 00			4. 00	0/3/20	13 1. 34	pili
	Hospital and Hospital Health Care Co										
1. 00 2. 00	Street: 520 SOUTH 7TH STREET City: VINCENNES	PO Box: State: II	N 7:	p Code	. 47501	Count	W KNOV				1. 00 2. 00
2.00	City: VINCENNES	Component Nai		CCN	CBSA	Provi der	y: KNOX Date	Paymer	nt Syst	em (P	2.00
		Component Na		umber	Number	Type	Certi fi ed		0, or		
						J.		V	XVIII		
		1. 00	2	2. 00	3. 00	4.00	5. 00	6. 00	7. 00	8.00	
	Hospital and Hospital-Based Componer		001.741		00015		07/04/40//				
3.00	Hospi tal	GOOD SAMARITAN HO		50042	99915 99915	1	07/01/1966 01/01/1984		P P	0	3.00
4. 00 5. 00	Subprovider - IPF Subprovider - IRF	GOOD SAMARITAN HO		5S042 5T042	99915	5	01/01/1984	N N	P	0	4. 00 5. 00
6. 00	Subprovider - (Other)	SAWAKI TAN	KEIIAD I IS	1042	77713		0170172001	''	'		6.00
7.00	Swing Beds - SNF			İ							7. 00
8.00	Swing Beds - NF										8. 00
9. 00	Hospi tal -Based SNF										9. 00
10.00	Hospi tal Based NF										10.00
11. 00 12. 00	Hospi tal -Based OLTC Hospi tal -Based HHA	GOOD SAMARITAN HO	ME 1	57432	99915		06/27/1995	N	P	N	11. 00 12. 00
12.00	mospi tai -based min	CARE	, ivic	77432	77713		00/2//1993	l IN	!	"	12.00
13.00	Separately Certified ASC	07.11.12		1							13. 00
14.00	Hospi tal -Based Hospi ce	GOOD SAMARITAN LI	NCOLN 15	51526	99915		01/01/1984				14. 00
		TRAIL HOSPICE									
	Hospital -Based Health Clinic - RHC			-							15.00
17. 00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16. 00 17. 00
	Renal Dialysis										18.00
19. 00	1										19.00
							From:		To	:	
20.00	Cook Books on Books of Cook (dd (cook)						1.00		2. (		20.00
20. 00 21. 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/2	014	12/31	/2014	20.00
21.00	Inpatient PPS Information						_	7			21.00
22. 00	Does this facility qualify and is it	currently receivi	ing paymen	ts for	di sprop	orti onate	Y		N		22. 00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil				2.06(c)(:	2) (Pi ckl e					
22. 01	amendment hospital?) In column 2, en Did this hospital receive interim un				e cost r	anortina	N		N		22. 01
22.01	period? Enter in column 1, "Y" for y						"				22.01
	reporting period occurring prior to										
	for no for the portion of the cost r	eporting period o	ccurring o	n or af	fter Oct	ober 1.					
22.02	(see instructions)										22.02
22. 02	Is this a newly merged hospital that determined at cost report settlement						N N		N		22. 02
	or "N" for no, for the portion of th						3				
	in column 2, "Y" for yes or "N" for						n				
	or after October 1.										
22. 03	Did this hospital receive a geograph						t N		N		22. 03
	of the OMB standards for delineating in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column						e				
	cost reporting period occurring on o										
	hospital contain at least 100 but no		•	unted i	n accord	dance witl	n				
22.00	42 CFR 412.105)? Enter in column 3,			1/ 25	h = 1 = O						22.00
23. 00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i							2	N		23. 00
	method of identifying the days in th	is cost reporting	period di	fferent	t from tl	he method					
	used in the prior cost reporting per	iod? In column 2,	<u>, enter "Y</u>	" for y	yes or "I	N" for no.	.				
			In-State	In-St		ut-of		Medi cai		ther	
			Medi cai d pai d days	Medic eligi		State di cai d   N	State   F Medicaid	HMO day		li cai d	
			paru uays	unpa			eligible			lays	
				day		u uuyo .	unpai d				
			1.00	2. 0		3. 00	4. 00	5. 00	6	. 00	
24. 00	If this provider is an IPPS hospital		1, 535		415	224	512	ç	70	0	24. 00
	in-state Medicaid paid days in colum										
	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai										
	4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in										
25. 00	If this provider is an IRF, enter the		129	'	48	65	30		0		25. 00
	Medicaid paid days in column 1, the Medicaid eligible unpaid days in col										
	out-of-state Medicaid days in column										
	Medicaid eligible unpaid days in col										
	HMO paid and eligible but unpaid day	rs in column 5.					1				

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

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150042 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 6/3/2015 1:34 pm Program Name Program Code Unweighted IME Unwei ghted Direct GME FTE FTE Count Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0.00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 0.00 62.01 62 01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter Ν 63.00 for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions) Unwei ghted Ratio (col. 1/ Unwei ahted **FTES** FTEs in (col . 1 + col Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents 0.000000 64.00 0.00 n the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Unwei ghted Program Name Program Code Unwei ghted Ratio (col. 3/ FTĔs FTEs in (col. 3 + col. Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 0.00 0.00 0.000000 65.00 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of

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

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150042 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 6/3/2015 1:34 pm Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs FTEs in Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 0. 00 66.00 Enter in column 1 the number of unweighted non-primary care resident 0.00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Unwei ghted Ratio (col. 3/ FTEs FTEs in (col. 3 + colNonprovi der Hospi tal 4)) Si te 1.00 2 00 3. 00 4.00 5 00 67.00 Enter in column 1, the program 0. 00 0.00 0.000000 67.00 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) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS 70.00 70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Υ Enter "Y" for yes or "N" for no. If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most 71.00 Ν Ν 0 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 Y" for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section N 85.00 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150042 Peri od: Worksheet S-2 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 6/3/2015 1:34 pm 1. 00 2.00 128.00|If this is a Medicare certified liver transplant center, enter the certification date 128.00 in column 1 and termination date, if applicable, in column 2. 129.00|f this is a Medicare certified lung transplant center, enter the certification date in 129.00 column 1 and termination date, if applicable, in column 2. 130.00 of this is a Medicare certified pancreas transplant center, enter the certification 130.00 date in column 1 and termination date, if applicable, in column 2. 131.00 f this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 If this is a Medicare certified islet transplant center, enter the certification date 132.00 in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter the certification date 133.00 in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (0P0), enter the 0P0 number in column 1 134 00 and termination date, if applicable, in column 2. All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Ν 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)

1.00

2.00 3 00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141. 00 Name: Contractor's Name: Contractor's Number: 141.00 142. 00 Street: 143. 00 Ci ty: PO Box: 142. 00 State: Zip Code: 143. 00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144.00 145.00 If costs for renal services are claimed on Worksheet A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no. N 145.00 1. 00 2.00 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146. 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, § 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147. 00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. 148. 00 Ν 149.00|Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for Ν 149.00 no. Title V Part A 2.00 1.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) N N 155.00 155.00 Hospi tal Ν Ν Ν 156.00 Subprovi der - IPF Ν Ν Ν 156.00 157.00 Subprovi der - IRF Ν 157. 00 N Ν Ν 158. 00 SUBPROVI DER 158 00 159. 00 SNF Ν Ν Ν Ν 159.00 160.00 HOME HEALTH AGENCY Ν Ν Ν N 160. 00 161.00 CMHC 161.00 Ν Ν Ν 1.00 Multicampus 165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no. N 165, 00 Name County State Zip Code CBSA FTE/Campus 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 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) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no. 167.00 168.00| If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions) 169.00|If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.50169.00 transition factor. (see instructions)

Health Financial Systems	GOOD SAMARITAN HO	In Lie	In Lieu of Form CMS-2552-1				
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I DE	E COMPLEX IDENTIFICATION DATA Provider CCN: 150042 Period: From 01/01/201						
			To 12/31/2014				
			Begi nni ng	6/3/2015 1: 34	pm		
	Endi ng						
	2.00						
170.00 Enter in columns 1 and 2 the EHR beginn period respectively (mm/dd/yyyy)	12/31/2014	170. 00					
				1.00			
171.00 If line 167 is "Y", does this provider Medicare cost plans reported on Wkst. S (see instructions)	N	171. 00					

Heal th Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150042 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 6/3/2015 1: 34 pm

					From 01/01/2 To 12/31/2	2014	Part II Date/Time Pr <u>6/3/2015 1:3</u>	repared: 34 pm
				Pa	art A	ľ	Part B	
		Descri pt	tion	Y/N	Date		Y/N	
		0		1.00	2. 00		3. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N			N	21. 00
							1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	TALS ONLY (EXCEPT	CHILDRENS HO	OSPI TALS)				
	Capital Related Cost							
22. 00	Have assets been relifed for Medicare purpose						N	22. 00
23. 00	Have changes occurred in the Medicare depreci reporting period? If yes, see instructions.	·			0		N	23. 00
24. 00	Were new leases and/or amendments to existing If yes, see instructions		o .		0.	od?	Υ	24. 00
25. 00	Have there been new capitalized leases entere instructions.	ed into during th	ne cost repor	ting period?	If yes, see		N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquinstructions.		N	26. 00				
27. 00	Has the provider's capitalization policy char copy.	nged during the c	cost reportin	g period? If	yes, submit		N	27. 00
	Interest Expense							
28. 00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit ente	ered into dur	ing the cost	reporti ng		N	28. 00
29. 00	Did the provider have a funded depreciation a treated as a funded depreciation account? If			bt Service Re	eserve Fund)		N	29. 00
30. 00	Has existing debt been replaced prior to its			debt? If yes,	see		N	30. 00
31. 00	instructions. Has debt been recalled before scheduled matur instructions.	rity without issu	uance of new o	debt? If yes,	see		N	31. 00
	Purchased Services							
32. 00	Have changes or new agreements occurred in pa			d through cor	itractual		N	32. 00
33. 00	arrangements with suppliers of services? If I line 32 is yes, were the requirements of sono, see instructions.			g to competit	ive bidding?	lf		33. 00
	Provi der-Based Physi ci ans							
	Are services furnished at the provider facili	ity under an arra	angement with	provi der-bas	ed physician	is?	Υ	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements			ts with the p	rovi der-base	ed	Υ	35. 00
	physicians during the cost reporting period?	If yes, see inst	ructions.		1			
					Y/N		Date	
	LL 0000				1.00		2. 00	
	Home Office Costs				N.			1, 00
36. 00 37. 00	Were home office costs claimed on the cost re If line 36 is yes, has a home office cost sta		pared by the I	home office?	N			36. 00 37. 00
38. 00	If yes, see instructions. If line 36 is yes , was the fiscal year end o	of the home offic	ce different	from that of				38. 00
39. 00	the provider? If yes, enter in column 2 the If line 36 is yes, did the provider render so	fiscal year end o	of the home o	ffi ce.				39. 00
	see instructions.  If line 36 is yes, did the provider render so		•					40. 00
40.00	instructions.	er vices to the no	ome office?	11 yes, see				40.00
			1. (	00		2. 00	)	
	Cost Report Preparer Contact Information							
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns		Β		BRANDENBURG	G		41.00
42. 00	respectively. Enter the employer/company name of the cost :	report BK	D, LLP					42. 00
43. 00	preparer. Enter the telephone number and email address	of the cost 31	7-383-4000		BBRANDENBUF	RG@BKE	D. COM	43. 00
	report preparer in columns 1 and 2, respective							

позетт	AL AND HUSPITAL HEALTH CARE REIMBURSEMENT QUE.	STI UNIVAL RE	Provider CCN. 150042	From 01/01/2014 To 12/31/2014	Part II Date/Time Prepared: 6/3/2015 1:34 pm
	·	Part B			
		Date			
		4.00			
	PS&R Data				
16.00	Was the cost report prepared using the PS&R	04/15/2014			16. 00
	Report only? If either column 1 or 3 is yes,				
	enter the paid-through date of the PS&R				
	Report used in columns 2 and 4 .(see				
	instructions)				
17. 00	Was the cost report prepared using the PS&R				17. 00
	Report for totals and the provider's records				
	for allocation? If either column 1 or 3 is				
	yes, enter the paid-through date in columns				
40.00	2 and 4. (see instructions)				10.00
18. 00	, , ,				18. 00
	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				
10.00	this cost report? If yes, see instructions.				19. 00
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of				19.00
	other PS&R Report information? If yes, see				
	instructions.				
20. 00	If line 16 or 17 is yes, were adjustments				20.00
20.00	made to PS&R Report data for Other? Describe				20.00
	the other adjustments:				
21 00	Was the cost report prepared only using the				21. 00
21.00	provi der's records? If yes, see				21.00
	instructions.				
			3. 00		
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title		PARTNER		41.00
	held by the cost report preparer in columns 1	, 2, and 3,			
	respecti vel y.				
42.00	Enter the employer/company name of the cost r	report			42.00
	preparer.				
43.00	Enter the telephone number and email address				43. 00
	report preparer in columns 1 and 2, respectiv	∕el y.			

Health Financial Systems GOOD S
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150042

						10 12/31/2014	6/3/2015 1: 34	
							I/P Days / O/P	
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	· · · · ·	Line Number			Avai I abl e			
		1.00		2. 00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		172	62, 78	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO I PF Subprovi der							3. 00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						o	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						Ö	6. 00
7. 00	Total Adults and Peds. (exclude observation			172	62, 780	0.00		7. 00
7.00	beds) (see instructions)			1,72	02, 70	0.00		7.00
8.00	INTENSIVE CARE UNIT	31. 00		20	7, 300	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	011.00		20	,, 55.	0.00		9. 00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)	43.00		192	70, 080	0.00		14. 00
15. 00	CAH visits			172	70,000	0.00		15. 00
16. 00	SUBPROVIDER - IPF	40. 00		22	8, 030	1		16. 00
17. 00	SUBPROVIDER - I RF	41. 00		25				17. 00
18. 00	SUBPROVI DER	41.00		25	7, 12	5	U	18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
	1							
21. 00	OTHER LONG TERM CARE	101 00					0	21. 00
22. 00	HOME HEALTH AGENCY	101. 00					U	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	11/ 00		0				23. 00
24. 00	HOSPI CE	116. 00		U	(	ס		24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			239			_	27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0	(	D		32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33. 00

						6/3/2015 1:34	pm
		I/P Days	/ O/P Visits	/ Trips	Full Time	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	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and	13, 402	1, 311	21, 837			1. 00
	Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	1, 113	2, 074				2. 00
3.00	HMO IPF Subprovider	20	0				3. 00
4.00	HMO IRF Subprovider	73	143				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	C	)		5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	C	)		6. 00
7.00	Total Adults and Peds. (exclude observation	13, 402	1, 311	21, 837	'		7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	1, 706	155	2, 581			8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		64	, , , ,			13. 00
14.00	Total (see instructions)	15, 108	1, 530	25, 488	0.00	1, 555. 68	14. 00
15. 00	CAH visits	0	0	C	)		15. 00
16.00	SUBPROVI DER - I PF	1, 782	1, 156	4, 536	0.00	29. 82	16. 00
17. 00	SUBPROVI DER - I RF	6, 459	129	7, 693	0.00	51.87	17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY	0	0	C	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE	0	0	[ c	0.00	11. 30	24. 00
24. 10	HOSPICE (non-distinct part)	0	0	l c	)		24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	1, 648. 67	27. 00
28. 00			1, 443	2, 427	,		28. 00
29. 00		0	•	·			29. 00
30.00	Employee discount days (see instruction)						30.00
31.00				l			31.00
32. 00		0	52	103	8		32. 00
32. 01	Total ancillary labor & delivery room	٦	02	1 0			32. 01
	outpatient days (see instructions)			]			
33. 00	LTCH non-covered days	0					33. 00

Health Financial Systems GOOD S
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provi der CCN: 150042

				To	12/31/2014	Date/Time Pre   6/3/2015 1:34	
		Full Time	<u> </u>	Di scha	arges	0, 0, 2010 1. 01	Piii
		Equi val ents					
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		776	6, 080	1, 00
1.00	8 exclude Swing Bed, Observation Bed and			3, 104	770	0,000	1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2. 00	HMO and other (see instructions)			209	776		2.00
3. 00	HMO IPF Subprovider			207	,,,		3.00
4. 00	HMO IRF Subprovider						4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0. 00	C	3, 184	776	6, 080	14.00
15. 00	CAH visits					,	15. 00
16.00	SUBPROVI DER - I PF	0. 00	C	250	196	849	16.00
17.00	SUBPROVI DER - I RF	0.00	C	586	8	705	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23. 00
24.00	HOSPI CE	0. 00					24.00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33.00

Provi der CCN: 150042

					Т	o 12/31/2014	Date/Time Pre 6/3/2015 1:34	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from	Adjusted Salaries (col.2 ± col.	Paid Hours Related to Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	Worksheet A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	SALARI ES							1
1. 00	Total salaries (see instructions)	200. 00	95, 604, 183	0	95, 604, 183	3, 473, 493. 00	27. 52	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0. 00	2.00
3. 00	Non-physician anesthetist Part B		0	0	0	0.00	0. 00	3. 00
4.00	Physician-Part A - Administrative		268, 214	0	268, 214	2, 549. 00	105. 22	4.00
4. 01 5. 00	Physicians - Part A - Teaching Physician-Part B		0 3, 983, 052	0	0 3, 983, 052	0. 00 22, 057. 00		
6. 00 7. 00	Non-physician-Part B Interns & residents (in an	21. 00	0	0	0	0. 00 0. 00	l .	1
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0. 00	7. 01
8. 00	programs) Home office personnel		0	0	0	0.00	0. 00	8.00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 30, 027, 523	0 1, 949, 675	0 31, 977, 198	0. 00 932, 399. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		7, 150	0	7, 150			11. 00
12. 00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0. 00	12.00
13. 00	Contract Labor: Physician-Part A - Administrative		204, 450	0	204, 450	2, 873. 00	71. 16	13. 00
14. 00	Home office salaries & wage-related costs		0	0	0	0.00	0. 00	14. 00
15. 00	Home office: Physician Part A - Administrative		0	0	0	0.00	0. 00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0.00	16. 00
17. 00	Wage-related costs (core) (see instructions)		15, 600, 315	0	15, 600, 315	i		17. 00
18. 00	Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		5, 779, 330 0	0	5, 779, 330 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	B Physician Part A -		15, 073	0	15, 073			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0				22. 01
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		137, 808 0	0	137, 808 0			23. 00
25. 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE		0	0	0			25. 00
26. 00		4. 00	4, 210, 844	0	4, 210, 844	268, 145. 00	15. 70	26. 00
27. 00 28. 00	Administrative & General Administrative & General under	5. 00	7, 493, 682 369, 744		8, 115, 919 369, 744			1
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0	0	0	0.00	0. 00	29.00
30. 00	Operation of Plant	7. 00	2, 134, 088			121, 159. 00	18. 64	30.00
31. 00 32. 00	Laundry & Linen Service Housekeeping	8. 00 9. 00	200, 701 1, 831, 085		200, 701 1, 831, 085	147, 643. 00	12. 40	32. 00
33. 00	Housekeeping under contract (see instructions)		0	0	0	0.00		
34. 00 35. 00	Di etary Di etary under contract (see instructions)	10. 00	1, 293, 454 0	-962, 621 0	330, 833 0	25, 152. 00 0. 00	l .	1
36. 00	Cafeteri a	11. 00	0	962, 621	962, 621			36.00
37. 00 38. 00	Maintenance of Personnel Nursing Administration	12. 00 13. 00	0 1, 538, 193	0 41, 482	0 1, 579, 675	0. 00 44, 054. 00		37. 00 38. 00
39. 00 40. 00	Central Services and Supply	14. 00 15. 00	362, 158 3, 039, 837	0	362, 158	28, 715. 00	12. 61	39. 00 40. 00
	1	15.00	5,057,057	1 705, 115	2,575,724	, , , , , , , , , , , , , , , , , , , ,	35. 75	

Health Financial Systems	GOOD SAMARIT	AN HOSPITAL		In Lieu of Form CMS-2552-10			
HOSPITAL WAGE INDEX INFORMATION		Provi der		Peri od:	Worksheet S-3		
				l -	From 01/01/2014 Fo 12/31/2014		nared.
						6/3/2015 1: 34	
	Worksheet A	Amount	Recl assi fi cati			Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col . 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3.00	4. 00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	2, 346, 984	0	2, 346, 98	129, 363. 00	18. 14	41.00
Records Library							
42.00 Social Service	17. 00	4, 148, 245	-2, 737, 841	1, 410, 404	84, 889. 00	16. 61	42.00
43.00 Other General Service	18. 00	0	) o	(	0.00	0.00	43. 00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provider CCN: 150042 Peri od: From 01/01/2014 To 12/31/2014 6/3/2015 1:34 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col.2 ± col. col. 5) (from Salaries in Works<u>heet A-6)</u> 3) col. 4 1.00 5.00 6.00 2.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 91, 990, 875 91, 990, 875 3, 455, 585. 00 1.00 26. 62 instructions) 2.00 30, 027, 523 1, 949, 675 31, 977, 198 932, 399. 00 34. 30 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 61, 963, 352 -1, 949, 675 60, 013, 677 2, 523, 186. 00 23.78 3.00 minus line 2) 4.00 Subtotal other wages & related 211, 600 211,600 3, 542. 00 59.74 4.00 costs (see inst.) Subtotal wage-related costs 5.00 15, 615, 388 Ω 15, 615, 388 0.00 26.02 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 77, 790, 340 -1, 949, 675 75, 840, 665 2, 526, 728. 00 30 02

28, 969, 015

-2, 412, 788

26, 556, 227

1, 298, 771. 00

20. 45

7.00

7.00

Total overhead cost (see

instructions)

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150042	Peri od: Worksheet S-3			
		From 01/01/2014   Part IV			

	To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4, 937, 926	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	11, 105, 183	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	441, 177	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	187, 619	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
13.00	Disability Insurance (If employee is owner or beneficiary)	215, 583	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00	'Workers' Compensation Insurance	308	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumul ative portion)		
	TAXES		
17. 00	FICA-Employers Portion Only	3, 590, 558	17. 00
18. 00	Medicare Taxes - Employers Portion Only	1, 030, 493	18. 00
	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	23, 679	
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	21, 532, 526	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Heal th	Financial Systems	GOOD SAMARITAN HO	SPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150042	Peri od:	Worksheet S-3	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
	Cost Center Description			Contract Labor		Pili
	coot conton boson per on			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				2.00	
	Hospital and Hospital-Based Component Identif	i cati on:				1
1.00	Total facility's contract labor and benefit c			0	0	1.00
2.00	Hospi tal			0	0	2. 00
3.00	Subprovi der - IPF			0	0	3. 00
4.00	Subprovi der - I RF			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	Hospi tal -Based NF					9. 00
10.00	Hospi tal -Based OLTC					10.00
11. 00	Hospital-Based HHA			0	0	11. 00
12.00	Separately Certified ASC					12. 00
	Hospi tal -Based Hospi ce			0	0	1
	Hospital-Based Health Clinic RHC					14. 00
	Hospital-Based Health Clinic FQHC					15. 00
	Hospi tal -Based-CMHC					16. 00
	Renal Dialysis					17. 00
18. 00	Other			0	0	18. 00

Heal th	Financial Systems GOOD SAM	MARITAN HOSPITAL		In lie	u of Form CMS-2	2552-10			
	AL UNCOMPENSATED AND INDIGENT CARE DATA		CCN: 150042	Peri od:	Worksheet S-10				
			30111 100012	From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:			
					6/3/2015 1: 34	pm			
					1. 00				
	Uncompensated and indigent care cost computation								
1.00	Cost to charge ratio (Worksheet C, Part I line 202 col	umn 3 divided by li	ne 202 column	1 8)	0. 309800	1. 00			
	Medicaid (see instructions for each line)								
2.00	Net revenue from Medicaid				15, 949, 903	2. 00			
3.00	Did you receive DSH or supplemental payments from Medi				Υ	3. 00			
4.00									
5.00	If line 4 is "no", then enter DSH or supplemental paym	nents from Medicaid			2, 933, 647	5. 00			
6.00	Medi cai d charges				52, 482, 575	6. 00			
7.00	Medicaid cost (line 1 times line 6)		6.11		16, 259, 102	7. 00			
8. 00	Difference between net revenue and costs for Medicaid < zero then enter zero)			es 2 and 5; if	0	8. 00			
	State Children's Health Insurance Program (SCHIP) (see	instructions for e	ach line)		_				
9.00	Net revenue from stand-alone SCHIP				0				
10.00					0	10.00			
11. 00 12. 00	Stand-alone SCHIP cost (line 1 times line 10)	one CCIIID (Line 11 m	inua lina O.	if . zono thon	0	11. 00 12. 00			
12.00	Difference between net revenue and costs for stand-alo enter zero)	·			U	12.00			
40.00	Other state or local government indigent care program					40.00			
13.00	Net revenue from state or local indigent care program					13.00			
14. 00	Charges for patients covered under state or local indi 10)		Not included	in lines 6 or	0				
15. 00	State or local indigent care program cost (line 1 time	•			0				
16. 00	Difference between net revenue and costs for state or 13; if < zero then enter zero)	local indigent care	program (lir	e 15 minus line	0	16. 00			
	Uncompensated care (see instructions for each line)								
17. 00	Private grants, donations, or endowment income restric	3	,			17. 00			
18. 00	Government grants, appropriations or transfers for sup				0				
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state 8, 12 and 16)	e and local indigent	care progran	is (sum of lines	0	19. 00			
			Uni nsured	Insured	Total (col. 1				
			pati ents	pati ents	+ col . 2)				
			1.00	2. 00	3. 00	20.00			
20. 00	Total initial obligation of patients approved for char		5, 059, 99	7, 872, 410	12, 932, 406	20. 00			
21. 00	charges excluding non-reimbursable cost centers) for t Cost of initial obligation of patients approved for ch		1, 567, 58	2, 438, 873	4, 006, 460	21. 00			
22. 00	times line 20) Partial payment by patients approved for charity care		74, 12	21 414	105, 744	22. 00			
23. 00	Cost of charity care (line 21 minus line 22)		1, 493, 45		3, 900, 716				
23.00	cost of charty care (file 21 millios file 22)		1, 473, 40	2,407,237	3, 400, 710	23.00			
					1. 00				
24. 00	Does the amount in line 20 column 2 include charges fo		nd a Length o	of stay limit	N	24. 00			
25. 00	imposed on patients covered by Medicaid or other indig If line 24 is "yes," charges for patient days beyond		oarom's Longt	h of stay limit	0	25. 00			
26. 00	Total bad debt expense for the entire hospital complex			ii oi Stay IIIII t	18, 842, 659				
26.00	Medicare bad debts for the entire hospital complex (se				18, 842, 659 431, 148				
28. 00	Non-Medicare and non-reimbursable Medicare bad debt ex		s line 27)		18, 411, 511				
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad			28)	5, 703, 886				
30.00			i times tille	. 20)	9, 604, 602				
	Total unreimbursed and uncompensated care cost (line 1				9, 604, 602				
550	1.212. 2 224. 304 4.14 4.135ps//34.54 54. 5 605t (11116 1	- F. 30 50)			,, 55., 662				

Health Financial Systems RECLASSIFICATION AND ADJUSTME	NTS OF TRIAL BALANCE O	GOOD SAMARITAN F EXPENSES		CCN: 150042 P	eriod:	u of Form CMS-2  Worksheet A	2552-10
				F	rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
Cost Center Descr	i pti on	Sal ari es	Other	Total (col. 1	Recl assi fi cati	6/3/2015 1: 34 Recl assi fi ed	pm
				+ col . 2)	ons (See A-6)	Trial Balance (col. 3 +-	
						col. 4)	
CENEDAL SERVICE COST OF	INTERC	1. 00	2. 00	3. 00	4. 00	5. 00	
GENERAL SERVICE COST CE 1.00 00100 CAP REL COSTS-BLE			0	С	O	0	1.00
1. 01   00101   NEW CRC - CT EAST	Ī		0	C	,	991, 830	1. 01
1. 02   00102   NEW CRC- CT WEST 1. 03   00103   NEW CRC- MEMORI AL			0	C		1, 165, 706 366, 120	1. 02 1. 03
1. 04   00104   NEW CRC - OUTPATI			Ö	ď		502, 037	1. 04
1. 05   00105   NEW CRD - HEALTH			0	C	.,,	1, 533, 051	1.05
1. 06   00106   NEW CRC - STORAGE 1. 07   00107   NEW CRC - DI AGNOS			0		1, 224 411, 426	1, 224 411, 426	1. 06 1. 07
2. 00 00200 CAP REL COSTS-MVE			5, 181, 269	5, 181, 269		5, 181, 269	2. 00
2. 01   00201   NEW CRC - EQUI PME			0	C	_, _ , ,	2, 817, 555	2. 01
2. 02   00202 NEW CRC - HEALTH 4. 00   00400 EMPLOYEE BENEFITS		688, 120	0 2, 626, 318	0 3, 314, 438	.,,	1, 066, 523 22, 220, 646	2. 02 4. 00
4. 01   00401   COMMUNI CATI ONS	DEI / III III III III III III III III III	244, 275	100, 406			265, 045	4. 01
4. 02 00402 PURCHASING & RECE	EI VI NG	637, 844	274, 541			702, 428	4. 02
4. 03   00403   REGISTRATION 4. 04   00404   PATIENT ACCOUNTS		723, 488 1, 917, 117	385, 871 2, 654, 974	1, 109, 359 4, 572, 091		830, 655 3, 902, 531	4. 03 4. 04
5. 00   00500   ADMI NI STRATI VE &	GENERAL	7, 493, 682	25, 780, 413			29, 763, 365	5. 00
7. 00 00700 OPERATION OF PLAN		2, 134, 088	4, 769, 357			6, 333, 486	7.00
8. 00   00800   LAUNDRY & LI NEN S 9. 00   00900   HOUSEKEEPI NG	SERVI CE	200, 701 1, 831, 085	258, 999 1, 029, 948			309, 193 2, 214, 125	8. 00 9. 00
10. 00   01000 DI ETARY		1, 293, 454	1, 886, 656			758, 209	10.00
11. 00 01100 CAFETERIA	A.T. O.	0	0	0	., ,	1, 961, 692	11.00
13. 00   01300   NURSI NG   ADMINISTE 14. 00   01400   CENTRAL   SERVI CES		1, 538, 193 362, 158	770, 174 364, 196			1, 884, 538 549, 533	13. 00 14. 00
15. 00 01500 PHARMACY	& 3011E1	3, 039, 837	12, 507, 747			2, 975, 743	•
16. 00 01600 MEDICAL RECORDS 8	k LI BRARY	2, 346, 984	1, 655, 288			3, 347, 224	•
17.00   01700   SOCIAL SERVICE 17.01   01701   MENTAL HEALTH OVE	RHEAD	0 4, 148, 245	0 2, 623, 038	·		0 1, 915, 700	17. 00 17. 01
23. 00   02300   PARAMED ED PRGM-(		179, 008	73, 234			208, 773	23. 00
23. 01 02301 PARAMED ED PRGM-L		17, 478	14, 493	31, 971	-2, 157	29, 814	23. 01
30.00 O3000 ADULTS & PEDIATRI		7, 830, 412	4, 841, 235	12, 671, 647	-2, 817, 708	9, 853, 939	30.00
31. 00 03100 I NTENSI VE CARE UN		1, 656, 181	839, 819			1, 917, 461	1
40. 00   04000   SUBPROVI DER -   PF		0	0	4 212 222	0.77,700	619, 785	1
41. 00   04100   SUBPROVI DER - I RF 43. 00   04300   NURSERY	-	2, 571, 119 330, 443	1, 642, 214 145, 048			3, 596, 848 375, 003	41. 00 43. 00
ANCILLARY SERVICE COST	CENTERS			I			
50.00   05000   OPERATING ROOM 51.00   05100   RECOVERY ROOM		4, 094, 519 0	5, 918, 747 0	10, 013, 266	-3, 849, 093	6, 164, 173 0	50. 00 51. 00
51. 01   05101   ENDOSCOPY		962, 868	1, 046, 927	2, 009, 795	-732, 016	1, 277, 779	51. 01
52. 00   05200   DELI VERY ROOM & L	_ABOR ROOM	423, 542	249, 715			507, 515	
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY - DI AGNOS	STLC	0 3, 757, 151	0 5, 004, 737	1		0 5, 649, 803	1
54. 01   05401   RADI OLOGY-NON-CAN	MPUS	825, 260	998, 576	1, 823, 836	-655, 906	1, 167, 930	54. 01
54. 08   05408   RADI OLOGY-GSH   BRE 60. 00   06000   LABORATORY	EAST CENTER	269, 183	111, 963			331, 209 4, 103, 077	54. 08
60. 00   06000   LABORATORY 63. 00   06300   BLOOD   STORI NG, PR	ROCESSING & TRANS.	2, 508, 414	4, 658, 930 0	7, 167, 344 C	954, 012	954, 012	60. 00 63. 00
65. 00 06500 RESPIRATORY THERA		2, 066, 658	1, 026, 210		-680, 709	2, 412, 159	65. 00
66. 00   06600   PHYSI CAL THERAPY	,	2, 449, 752	1, 031, 115			2, 871, 254 5, 232, 541	66.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOG		4, 398, 711	2, 639, 394 0	7, 038, 105 0	-1, 805, 564 0	5, 232, 541	69. 00 70. 00
70. 01   07001   NEURODI AGNOSTI CS		249, 424	261, 775	511, 199		411, 375	70. 01
71. 00 07100 MEDI CAL SUPPLI ES		0	0	O	7, 839, 007	7, 839, 007	71.00
72.00   07200   IMPL. DEV. CHARGE 73.00   07300   DRUGS CHARGED TO			0		2, 456, 432 11, 781, 349	2, 456, 432 11, 781, 349	72. 00 73. 00
75.00 07500 ASC (NON-DISTINCT	PART)	942, 617	3, 048, 497	3, 991, 114		2, 149, 772	75. 00
76. 00   03020 MH ANCILLARY OUTF 76. 01   03950   NPATIENT DIALYSI		0	0 E94 703	E94 703	61 267	0 E2E 424	76.00
76. 01 03950 I NPATI ENT DI ALYSI OUTPATI ENT SERVI CE COST		l U	586, 703	586, 703	-61, 267	525, 436	76. 01
90. 00 09000 CLI NI C		1, 426, 458	1, 094, 849			1, 801, 838	90. 00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS	(NON_DISTINCT DART	2, 730, 481	5, 941, 680	8, 672, 161	-753, 638	7, 918, 523	91. 00 92. 00
OTHER REIMBURSABLE COST							72.00
96. 00 09600 DURABLE MEDICAL E		55, 315	203, 012			213, 739	96.00
101.00 10100 HOME HEALTH AGENCE SPECIAL PURPOSE COST CE		0	0	C	0	0	101. 00
113.00 11300 I NTEREST EXPENSE			1, 257, 903				113. 00
116. 00 11600 HOSPI CE	- LINEC 1 117\	695, 325	727, 562			1, 241, 135	116.00
118.00 SUBTOTALS (SUM OF NONREI MBURSABLE COST CE	·	69, 039, 590	106, 233, 533	175, 273, 123	2, 309, 412	177, 582, 535	1110.00
190. 00 19000 GIFT, FLOWER, COF		0	0	C	0	0	190. 00

Health Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Period: From 01/01/2014	Worksheet A	
				Го 12/31/2014	Date/Time Pre 6/3/2015 1:34	
Cost Center Description	Sal ari es	Other	•	Recl assi fi cati		
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	4 00	0.00	0.00	4.00	col . 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	24, 701, 599					•
194.00 07950 COMMUNITY HEALTH SERVICES	146, 141	109, 554	255, 69	-60, 285	195, 410	194. 00
194. 01 07951 WORK FITNESS	0	0	(	0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	127, 341	585, 475	712, 816	-36, 164	676, 652	194. 02
194.03 07953 MH RESIDENTIAL	779, 461	425, 862	1, 205, 323	-261, 650	943, 673	194. 03
194. 04 07954 UNUSED SPACE	0	0	(	0	0	194. 04
194. 05 07955 MOB	703, 759	419, 518	1, 123, 27	-178, 269	945, 008	194. 05
194. 06 07956 FOUNDATI ON	94, 948	965, 218	1, 060, 166	-14, 765	1, 045, 401	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	90	90	0	90	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	11, 344	6, 072	17, 410	-561	16, 855	194. 08
194. 09 07959 NRCC	o	0	. (	2, 028, 388	2, 028, 388	194. 09
200.00 TOTAL (SUM OF LINES 118-199)	95, 604, 183	119, 894, 700	215, 498, 883	0	215, 498, 883	200. 00

Provi der CCN: 150042

				6/3/2015 1: 34	pm
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation	1	
_	CENEDAL CEDALCE COCT CENTEDO	6.00	7. 00		
1 00	GENERAL SERVICE COST CENTERS			<b>\</b>	1 00
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FLXT 00101 NEW CRC - CT EAST	0	991, 830		1. 00 1. 01
1.01	00101 NEW CRC - CT EAST	0	1, 165, 706		1.01
1.02	00102 NEW CRC- CT WEST		366, 120	1	1. 02
1.03	00103 NEW CRC - WENORIAL		502, 037		1. 03
1.04	00104 NEW CRC - OUTPATTENT		1, 533, 051		1.04
1.05	00106 NEW CRC - STORAGE	0	1, 553, 051		1.05
1.00	00100 NEW CRC - STORAGE		411, 426		1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		5, 181, 269	l e e e e e e e e e e e e e e e e e e e	2.00
2.00	00200 CAF KEE COSTS-WVBEE ECOTF	-372, 142	2, 445, 413		2.00
2. 01	00201 NEW CRC - EGOTFMENT	-26, 044			2.01
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT		1, 040, 479		4.00
4. 00	00400 EMPLOTEE BENEFITS DEPARTMENT	-394, 697 0	21, 825, 949 265, 045		4. 00
4.01	00401 COMMON CATTONS  00402 PURCHASING & RECEIVING	1	481, 019		4. 01
4. 02	00403 REGISTRATION	-221, 409 0	830, 655		4. 02
4.03	00404 PATIENT ACCOUNTS	-202, 137	3, 700, 394		4.03
5.00	00500 ADMINISTRATIVE & GENERAL	-988, 660	28, 774, 705		5.00
7. 00	00700 OPERATION OF PLANT	-70, 113	6, 263, 373		7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	-70, 113	309, 193		8.00
9. 00	00900 HOUSEKEEPI NG		2, 214, 125		9.00
10.00	01000 DI ETARY	-24, 054	734, 155	•	10.00
11. 00	01100 CAFETERI A				
13. 00	01300 NURSI NG ADMI NI STRATI ON	-1, 033, 430	928, 262		11.00
	1	0	1, 884, 538		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	549, 533	•	14. 00
15.00	01500 PHARMACY	0	2, 975, 743		15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	-2, 430	3, 344, 794		16.00
17. 00		0	0		17. 00
17. 01	01701 MENTAL HEALTH OVERHEAD	-832, 127	1, 083, 573		17. 01
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	-58, 811	149, 962		23. 00
23. 01	02301 PARAMED ED PRGM-LAB	0	29, 814		23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS	0	9, 853, 939		30. 00
31. 00	03100 INTENSIVE CARE UNIT	-1, 162	1, 916, 299		31.00
40.00	04000 SUBPROVI DER - I PF	0	619, 785		40. 00
41.00	04100 SUBPROVI DER - I RF	-266	3, 596, 582	2	41.00
43.00	04300 NURSERY	0	375, 003	3	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-1, 647, 112	4, 517, 061		50.00
51.00	05100 RECOVERY ROOM	0	0	1	51.00
51. 01	05101 ENDOSCOPY	0	1, 277, 779		51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	507, 515		52. 00
53.00	05300 ANESTHESI OLOGY	0	0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-366, 983	5, 282, 820		54.00
54.01	05401 RADI OLOGY-NON-CAMPUS	0	1, 167, 930		54. 01
54.08	05408 RADI OLOGY-GSH BREAST CENTER	-151, 215	179, 994		54. 08
60.00	06000 LABORATORY	-60, 157	4, 042, 920		60.00
63.00	1 1	o	954, 012	l e e e e e e e e e e e e e e e e e e e	63. 00
65.00	1 1	-16, 686	2, 395, 473		65. 00
66. 00		-220	2, 871, 034		66.00
69. 00	06900 ELECTROCARDI OLOGY	-2, 423, 247	2, 809, 294		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	_,,		70. 00
70. 01	07001 NEURODI AGNOSTI CS	-4, 171	407, 204		70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	., ., .	7, 839, 007		71.00
72. 00			2, 456, 432		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-430, 331	11, 351, 018		73. 00
75. 00	1	-29	2, 149, 743		75.00
76. 00	03020 MH ANCI LLARY OUTPATIENT	0	2, 147, 743		76.00
76. 00	03950 I NPATI ENT DI ALYSI S	-171, 866	353, 570		76. 00
76.01	OUTPATIENT SERVICE COST CENTERS	-171,000	333, 370	<u>/</u>	76.01
00.00		700 500	1 101 04/	T	00 00
90.00	09000 CLINIC	-700, 592	1, 101, 246		90.00
91.00	1	-4, 621, 419	3, 297, 104	'	91.00
92. 00					92. 00
04 25	OTHER REIMBURSABLE COST CENTERS		040.05=	-	0, 00
96. 00	1	-414	213, 325		96.00
101.00	10100 HOME HEALTH AGENCY	0	0	<u> </u>	101. 00
	SPECIAL PURPOSE COST CENTERS				ļ
	11300 I NTEREST EXPENSE	0	0		113. 00
	11600 H0SPI CE	-748	1, 240, 387		116. 00
118.00		-14, 822, 672	162, 759, 863	3	118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	)	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	32, 064, 871		192. 00
194.00	07950 COMMUNITY HEALTH SERVICES	o	195, 410	)	194. 00
		· · · · · · · · · · · · · · · · · · ·			

Heal th Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 150042 From 01/01/2014 To 12/31/2014 Date/Time Prepared:

				6/3/2015 1: 34	pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8)	For Allocation			
	6.00	7. 00			
194. 01 07951 WORK FITNESS	0	0			194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	676, 652			194. 02
194.03 07953 MH RESIDENTIAL	0	943, 673			194. 03
194. 04 07954 UNUSED SPACE	0	0			194. 04
194. 05 07955 MOB	0	945, 008			194. 05
194. 06 07956 FOUNDATI ON	0	1, 045, 401			194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	90			194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	16, 855			194. 08
194. 09 07959 NRCC	0	2, 028, 388			194. 09
200.00 TOTAL (SUM OF LINES 118-199)	-14, 822, 672	200, 676, 211			200. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Ti me Prepared: 6/3/2015 1: 34 pm Provi der CCN: 150042

					6/3/2015 1: 34	
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2.00	3.00	4. 00	5. 00		
1 00	A - DRUGS CHARGED TO PATIENTS		ما	11, 097, 993		1 00
1. 00	DRUGS CHARGED TO PATIENTS	73.00	0	11, 097, 993		1. 00
	B - MEDICAL SUPPLIES CHARGED	TO DATIENTS	<u> </u>	11,097,993		
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	O	7, 839, 007		1. 00
1.00	PATI ENT	71.00	J	7,007,007		1. 00
2.00	BLOOD STORING, PROCESSING &	63.00	0	954, 012		2.00
	TRANS.					
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
5. 00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10. 00
11. 00		0.00	o	0		11. 00
12. 00		0.00	Ö	0		12. 00
13. 00		0.00	Ö	0		13. 00
14.00		0.00	0	0		14.00
15.00		0.00	O	0		15.00
16. 00		0.00	0	0		16.00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18.00
19. 00		0.00	0	0	l l	19.00
20. 00		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
23. 00		0.00	0	0		23. 00
24. 00		0.00	o	0	l l	24. 00
25. 00		0.00	Ö	0		25. 00
26. 00		0.00	Ö	Ö	l l	26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28.00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0	l l	30.00
31. 00		0.00	0	0		31. 00
32. 00		0.00	0	0		32.00
33. 00		0.00	0	0		33. 00
34. 00		0.00	0	0		34. 00
35. 00 36. 00		0. 00 0. 00	0	0		35. 00 36. 00
37. 00		0.00	0	0		37. 00
37.00	TOTALS — — — —	— <u> </u>	— —	8, 793, 019		37.00
	C - EMPLOYEE BENEFITS		-1	27		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	18, 977, 874		1.00
2.00		0.00	O	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0	l l	8. 00 9. 00
9. 00 10. 00		0.00	0	0		9. 00 10. 00
11. 00		0.00	Ö	0	l l	11. 00
12. 00		0.00	o	Ö		12. 00
13. 00		0.00	Ō	0	l l	13. 00
14.00		0.00	0	0		14.00
15. 00		0.00	0	0	l l	15.00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0	l l	17. 00
18.00		0.00	0	0		18.00
19. 00		0.00	0	0	l l	19.00
20. 00		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
22. 00		0.00	0	0		22.00
24. 00		0.00	0	0		24. 00
25. 00		0.00	Ö	0		25. 00
26. 00		0.00	o	Ö		26. 00
27. 00		0.00	ō	Ō		27. 00
28. 00		0.00	0	0		28. 00
29. 00		0.00	O	0	<u> </u>	29. 00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 150042

						6/3/2015 1: 34 pm	
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3. 00	4. 00	5. 00			
30.00		0.00	C			30.00	
31.00		0.00	C			31.00	
32. 00		0.00	C			32.00	
33. 00		0.00	C			33.00	
34.00		0.00	C			34.00	
35. 00	1	0.00	C			35. 00	
36.00		0.00	C			36.00	
37. 00		0.00	C			37.00	
38. 00		0.00	(			38.00	
39. 00		0. 00 0. 00	C			39. 00 40. 00	
40. 00 41. 00		0.00	C			41. 00	
42. 00		0.00	(			42.00	
43. 00		0.00	(			43.00	
44. 00		0.00	(			44. 00	
45. 00		0.00	C			45. 00	
46. 00		0.00	Č			46. 00	
47. 00		0.00	C			47. 00	
48. 00		0.00	Č			48. 00	
	TOTALS — — — — —						
	D - INTEREST EXPENSE						
1.00	NEW CRC - EQUIPMENT	2. 01	C	1, 252, 853		1. 00	0
2.00	ADMINISTRATIVE & GENERAL	5. 00				2. 00	0
	TOTALS		C	1, 257, 903			
	E - DEPRECIATION EXPENSE						
1.00	NEW CRC - EQUIPMENT	2. 01	C			1.00	
2.00		0.00	C			2. 00	
3.00		0.00	C			3. 00	
4.00		0.00	C			4.00	
5.00		0.00	C			5. 00	
6.00		0.00	(			6.00	
7.00		0. 00 0. 00	C			7.00	
8. 00 9. 00		0.00	C			8. 00 9. 00	
10.00		0.00	(			10.00	
11. 00		0.00	C			11. 00	
12. 00		0.00	(			12. 00	
13. 00		0.00	Č			13. 00	
14. 00		0.00	C			14. 00	
15. 00		0.00	C			15. 00	
16.00		0.00	C	o		16. 00	0
17.00		0.00	C	o		17. 00	0
18.00		0.00	C			18. 00	0
19.00		0.00	C			19.00	
20.00		0.00	C			20.00	
21. 00		0.00	C			21. 00	
22. 00		0.00	C			22. 00	
23. 00		0.00	C			23. 00	
24. 00		0.00	C			24.00	
25. 00		0.00	C			25. 00	
26.00		0.00	C			26. 00	
27. 00		0. 00 0. 00	(			27. 00 28. 00	
28. 00 29. 00		0.00	(			29. 00	
30.00		0.00	C			30.00	
31. 00		0.00	C			31.00	
32. 00		0.00	C			32.00	
33. 00		0.00	C			33.00	
34. 00		0.00	Č			34.00	
35. 00		0.00	Č			35. 00	
36.00		0.00	C	ol		36.00	
37.00		0.00	C			37. 00	
38. 00		0.00	C	0		38.00	0
39. 00		0.00	C	0		39.00	
40.00		0.00	C			40. 00	
41.00		0.00	C			41.00	
42.00		0.00	C			42.00	
43.00		0.00	C			43.00	
44.00		0.00	C			44. 00	
45.00		0.00	C			45. 00	
46. 00	TOTALS — — — —	0.00				46. 00	U
	TOTALS	ı		ار 224, 920			

					To	12/31/2014	Date/Time Prepared: 6/3/2015 1:34 pm
		Increases					07 37 2013 1. 34 piii
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4.00	5. 00			
	G - INSURANCE EXPENSE						
1.00	NEW CRC - EQUIPMENT	2. 01	0	377, 699			1.00
	TOTALS			377, 699			
	H - MENTAL HEALTH OVERHEAD						
1.00	ADMINISTRATIVE & GENERAL	5. 00	622, 237	222, 925			1. 00
2.00	OPERATION OF PLANT	7.00	124, 447	44, 585			2. 00
3.00	NURSING ADMINISTRATION	13. 00	41, 482	14, 862			3.00
4.00	SUBPROVI DER - I PF	40.00	456, 307	163, 478			4. 00
5.00	NRCC	194. 09	1, 493, 368	535, 020			5. 00
	TOTALS		2, 737, 841	980, 870			
	I - IMPL. DEV. CHARGED TO PAT	TENT					
1.00	IMPL. DEV. CHARGED TO	72. 00	0	2, 456, 432			1. 00
	PATI ENTS						
2.00	ADULTS & PEDIATRICS	30.00	0	2, 650			2. 00
3.00		0.00	0	0			3.00
4.00		0.00	0	0			4. 00
5.00		0.00		0			5. 00
	TOTALS		0	2, 459, 082			
	J - ONCOLOGY						
1.00	DRUGS CHARGED TO PATIENTS	7300	<u>463, 1</u> 13	220, 243			1.00
	TOTALS		463, 113	220, 243			
	K - DIETARY						
1.00	CAFETERI A	11. 00	<u>962, 6</u> 21	<u>999, 0</u> 71			1.00
	TOTALS		962, 621	999, 071			
	L - DEPRECIATION EXPENSE				_		
1.00	NEW CRC - CT EAST	1. 01	0	991, 830			1. 00
2.00	NEW CRC- CT WEST	1. 02	0	1, 165, 706			2. 00
3.00	NEW CRC- MEMORIAL	1. 03	0	366, 120			3. 00
4.00	NEW CRC - OUTPATIENT	1. 04	0	502, 037			4. 00
5.00	NEW CRD - HEALTH PAVILION	1. 05	0	1, 533, 051			5. 00
6.00	NEW CRC - STORAGE	1. 06	0	1, 224			6. 00
7.00	NEW CRC - DIAGNOSTIC CENTER	1. 07	0	411, 426			7. 00
8.00	NEW CRC - HEALTH PAVILION		•	<u>1, 066, 523</u>			8. 00
	TOTALS		0	6, 037, 917			
500.00	Grand Total: Increases		4, 163, 575	58, 426, 591			500.00

Health Financial Systems RECLASSIFICATIONS | Peri od: | Worksheet A-6 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provider CCN: 150042

					T	o 12/31/2014 Date/Time Pr 6/3/2015 1:3	
		Decreases	6.1	0.11		, , , , , , , , , , , , , , , , , , , ,	
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - DRUGS CHARGED TO PATIENTS		0.00	7. 00	10.00		
1.00	PHARMACY	<u>15.</u> 00	0	<u>11, 097, 9</u> 93			1. 00
	TOTALS	TO DATIENTS	0	11, 097, 993			
1. 00	B - MEDICAL SUPPLIES CHARGED EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	50, 024	0		1.00
2. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	512			2. 00
3.00	OPERATION OF PLANT	7. 00	0	74	1		3. 00
4. 00 5. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	86 3, 413	1		4. 00 5. 00
6. 00	PHARMACY	15. 00	0	3, 418			6. 00
7. 00	MENTAL HEALTH OVERHEAD	17. 01	0	2, 097			7. 00
8. 00	ADULTS & PEDIATRICS	30.00	0	686, 757	1		8. 00
9. 00 10. 00	INTENSIVE CARE UNIT SUBPROVIDER - IRF	31. 00 41. 00	0	71, 408 17, 005			9. 00
11. 00	NURSERY	43. 00	0	9, 918			11.00
12.00	OPERATING ROOM	50.00	0	818, 123	1		12. 00
13. 00	ENDOSCOPY	51. 01	0	174, 063	1		13. 00
14. 00 15. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52. 00 54. 00	0	43, 366 935, 401	1		14. 00 15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54. 01	0	31, 936	1		16. 00
17. 00	RADI OLOGY-NON-CAMPUS	54. 01	0	31, 931			17. 00
18. 00	RADI OLOGY-GSH BREAST CENTER	54. 08	0	16	1		18. 00
19. 00 20. 00	LABORATORY RESPIRATORY THERAPY	60. 00 65. 00	0	2, 342, 359 167, 919			19. 00 20. 00
21. 00	PHYSICAL THERAPY	66.00	0	66, 720	1		21. 00
22. 00	ELECTROCARDI OLOGY	69.00	0	1, 142, 301	1		22. 00
23. 00	NEURODI AGNOSTI CS	70. 01	0	238	1		23. 00
24. 00	INPATIENT DIALYSIS	76. 01	0	2, 398	1		24. 00
25. 00 26. 00	ASC (NON-DISTINCT PART) CLINIC	75. 00 90. 00	0	776, 925 445, 124	1		25. 00 26. 00
27. 00	EMERGENCY	91.00	0	25, 969	1		27. 00
28. 00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	25, 420	1		28. 00
29. 00 30. 00	HOSPICE PHYSICIANS' PRIVATE OFFICES	116. 00 192. 00	0	34, 008	1		29. 00 30. 00
31. 00	COMMUNITY HEALTH SERVICES	194.00	0	842, 331 18, 022	1		31.00
32. 00	MH RESIDENTIAL	194. 03	0	265	1		32. 00
33.00	MOB	194. 05	0	23, 319	1		33.00
34. 00 35. 00	INDUSTRIAL HEALTH LAUNDRY & LINEN SERVICE	194. 08 8. 00	0	55 20			34. 00 35. 00
36. 00	HOUSEKEEPI NG	9.00	0	41	1		36.00
37. 00	DI ETARY	10.00	0	37			37. 00
	TOTALS		0	8, 793, 019			
1. 00	C - EMPLOYEE BENEFITS COMMUNICATIONS	4. 01	0	78, 762	. 0		1. 00
2. 00	PURCHASING & RECEIVING	4. 02	0	195, 913	1		2. 00
3.00	REGI STRATI ON	4. 03	0	276, 069			3. 00
4.00	PATI ENT ACCOUNTS	4.04	0	626, 193	1		4. 00
5. 00 6. 00	OPERATION OF PLANT	5. 00 7. 00	0	1, 427, 558 508, 020			5. 00 6. 00
7. 00	LAUNDRY & LINEN SERVICE	8.00	0	73, 388			7. 00
8. 00	HOUSEKEEPI NG	9. 00	0	610, 589			8. 00
9.00	DI ETARY	10.00	0	412, 282 288, 829			9.00
10. 00 11. 00	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	13. 00 14. 00	0	133, 261	1		10. 00 11. 00
12. 00	PHARMACY	15. 00	0	603, 412	1		12. 00
13. 00	MEDICAL RECORDS & LIBRARY	16.00	0	645, 127	1		13. 00
14. 00 15. 00	MENTAL HEALTH OVERHEAD PARAMED ED PRGM-(SPECIFY)	17. 01 23. 00	0	1, 088, 159 42, 371			14. 00 15. 00
16. 00	PARAMED ED PRGM-(SPECIFY)	23. 00	0	1, 351	1		16. 00
17. 00	ADULTS & PEDIATRICS	30.00	0	1, 977, 605			17. 00
18. 00	INTENSIVE CARE UNIT	31.00	0	395, 318	1		18. 00
19. 00 20. 00	SUBPROVI DER - I RF NURSERY	41. 00 43. 00	0	575, 032	1		19. 00 20. 00
21. 00	OPERATING ROOM	50.00	0	78, 400 424, 038	1		20.00
22. 00	ENDOSCOPY	51. 01	O	240, 403	- 1		22. 00
23. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	100, 580	1		23. 00
24. 00 25. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	136, 020	1		24. 00 25. 00
26. 00 26. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-NON-CAMPUS	54.00	0	775, 567 12, 583			26. 00
27. 00	RADI OLOGY-NON-CAMPUS	54. 01	0	4, 226	1		27. 00
28. 00	RADI OLOGY-NON-CAMPUS	54. 01	0	93, 703			28. 00
29. 00	RADI OLOGY-NON-CAMPUS RADI OLOGY-NON-CAMPUS	54. 01	0	45, 165 17, 204			29. 00
30. 00 31. 00	RADI OLOGY-NON-CAMPUS RADI OLOGY-GSH BREAST CENTER	54. 01 54. 08	0	17, 204 49, 921			30. 00 31. 00
				,,,,=.			<del></del>

Provi der CCN: 150042

Peri od: From 01/01/2014 To 12/31/2014

Date/Time Prepared: 6/3/2015 1:34 pm

		Decreases				6/3/2015 1: 34	+ piii
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9.00	10. 00		
32. 00	LABORATORY	60.00	0.00				32. 00
	RESPI RATORY THERAPY	65. 00	0				33. 00
		•	0				
	PHYSI CAL THERAPY	66.00					34.00
	ELECTROCARDI OLOGY	69.00	0				35. 00
	NEURODI AGNOSTI CS	70. 01	0				36. 00
	ASC (NON-DISTINCT PART)	75. 00	0	,			37. 00
38. 00	CLINIC	90. 00	0	273, 390	0		38. 00
39.00	EMERGENCY	91.00	0	657, 043	0		39. 00
40.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0	18, 790	0		40. 00
41.00	HOSPI CE	116. 00	0	138, 530	o		41.00
42.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	2, 934, 592	o		42.00
	COMMUNITY HEALTH SERVICES	194, 00	0				43.00
	MARKETING AND PUBLIC	194. 02	0				44. 00
11.00	RELATIONS	171.02	J	27,202			11.00
45. 00	MH RESIDENTIAL	194. 03	0	257, 346	0		45. 00
	MOB	194. 05	0				46. 00
	•						1
	FOUNDATION	194.06	0	,			47. 00
48. 00	I NDUSTRI AL HEALTH	1 <u>94.</u> 08	0				48. 00
	TOTALS		0	18, 977, 874			1
	D - INTEREST EXPENSE			T			
1. 00	INTEREST EXPENSE	113. 00	0				1.00
2.00	L		0		0		2. 00
	TOTALS		0	1, 257, 903			]
	E - DEPRECIATION EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	21, 642	9		1.00
2.00	COMMUNI CATI ONS	4. 01	0				2.00
3.00	PURCHASING & RECEIVING	4. 02	0				3.00
4. 00	REGI STRATI ON	4. 03	0				4. 00
5. 00	PATI ENT ACCOUNTS	4. 04	0				5. 00
6. 00	ADMINISTRATIVE & GENERAL	5.00	0				6. 00
7. 00	OPERATION OF PLANT	7. 00	0				7. 00
			_	230, 897			1
	LAUNDRY & LINEN SERVICE	8. 00	0				8. 00
	HOUSEKEEPI NG	9. 00	0				9. 00
	DI ETARY	10. 00	0				10.00
	NURSING ADMINISTRATION	13. 00	0				11. 00
12.00	CENTRAL SERVICES & SUPPLY	14. 00	0	39, 815	9		12.00
13.00	PHARMACY	15. 00	0	183, 662	9		13. 00
14.00	MEDICAL RECORDS & LIBRARY	16. 00	0	9, 921	9		14.00
15.00	MENTAL HEALTH OVERHEAD	17. 01	0	46, 616	9		15. 00
16.00	PARAMED ED PRGM-(SPECIFY)	23. 00	0	1, 098			16.00
	PARAMED ED PRGM-LAB	23. 01	0				17.00
	ADULTS & PEDIATRICS	30.00	0				18. 00
	INTENSIVE CARE UNIT	31.00	0				19. 00
	SUBPROVI DER - I RF	41.00	0				20. 00
	NURSERY	43.00	0	.,			21.00
	OPERATING ROOM	•	0				1
	•	50.00	-				22. 00
	ENDOSCOPY	51. 01	0				23. 00
	DELIVERY ROOM & LABOR ROOM	52. 00	0				24. 00
	RADI OLOGY-DI AGNOSTI C	54. 00	0	1, 3, 0, 01,			25. 00
	RADI OLOGY-NON-CAMPUS	54. 01	0				26. 00
	RADI OLOGY-NON-CAMPUS	54. 01	0				27. 00
	RADI OLOGY-NON-CAMPUS	54. 01	0				28. 00
29. 00	RADI OLOGY-NON-CAMPUS	54. 01	0	1, 972	9		29. 00
30.00	LABORATORY	60.00	0	101, 338	9		30.00
	RESPI RATORY THERAPY	65.00	0	54, 441			31.00
	PHYSI CAL THERAPY	66.00	0	16, 031			32. 00
	ELECTROCARDI OLOGY	69. 00	n	85, 567			33. 00
	NEURODI AGNOSTI CS	70. 01	0	36, 163			34. 00
	INPATIENT DIALYSIS	76. 01 76. 01	0				35. 00
36, 00	ASC (NON-DISTINCT PART)	75. 00	0	456, 233			36.00
	1 1	90.00	0	955			37.00
	CLINIC		0				1
	EMERGENCY	91.00	0	70, 626			38.00
	DURABLE MEDICAL EQUIP-RENTED	96.00	0	378			39.00
	HOSPI CE	116. 00	0	9, 214			40.00
	PHYSICIANS' PRIVATE OFFICES	192. 00	0	9, 183			41.00
	COMMUNITY HEALTH SERVICES	194. 00	0	318			42. 00
43.00	MARKETING AND PUBLIC	194. 02	0	6, 902	9		43. 00
	RELATI ONS						
44.00	MH RESIDENTIAL	194. 03	0	4, 039	9		44. 00
45.00		0.00	0	C	9		45. 00
46.00		0.00	0	c	9		46. 00
	TOTALS — — — —		<sub>0</sub>	7, 224, 920			
	·	ı	ŭ	,, ,20	1		1

RECLAS	SI FI CATI ONS			Provi der	CCN: 150042	Peri od:	Worksheet A-6
						From 01/01/2014 To 12/31/2014	Date/Time Prepared:
						12, 01, 2011	6/3/2015 1: 34 pm
		Decreases				1	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref	<u>-</u>	
	6. 00	7. 00	8. 00	9. 00	10. 00		
	G - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL		•	37 <u>7, 6</u> 99		12	1.00
	TOTALS		0	377, 699			
	H - MENTAL HEALTH OVERHEAD				1		
1.00	MENTAL HEALTH OVERHEAD	17. 01	2, 737, 841	980, 870		0	1. 00
2.00		0.00	0	0		0	2. 00
3.00		0.00	0	0		0	3. 00
4.00		0.00	0	0		0	4. 00
5.00		0.00	0	0		0	5. 00
	TOTALS		2, 737, 841	980, 870			
	I - IMPL. DEV. CHARGED TO PAT		al	205 270	T	al	
1.00	ASC (NON-DISTINCT PART)	75. 00	0	335, 378		0	1. 00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	332		0	2. 00
3.00	OPERATING ROOM	50.00	0	2, 098, 607		0	3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	24, 298		0	4. 00
5.00	INTENSIVE CARE UNIT	31.00		467		익	5. 00
	TOTALS		O	2, 459, 082			
1 00	J - ONCOLOGY	15.00	4/2 112	220 242			1 00
1. 00	PHARMACY	1500	463, 113	220, 243		0	1.00
	K - DIETARY		463, 113	220, 243			
1. 00	DI ETARY	10, 00	962, 621	999, 071		0	1, 00
1.00	TOTALS		962, 621	99 <u>9, 071</u> 999, 071		익	1.00
	L - DEPRECIATION EXPENSE		962, 621	999, 071			
1. 00	NEW CRC - EQUIPMENT	2. 01	ما	6, 037, 917		9	1. 00
2.00	NEW CRC - EQUIPMENT	0.00	0	0, 037, 917		9	2.00
3.00	+	0.00	0	0		9	3.00
4. 00		0.00	0	0		9	4.00
5.00		0.00	0	0		9	5. 00
6. 00		0.00	0	0		o o	6.00
7. 00		0.00	0	0		ó	7.00
8.00		0.00	0	0		ó	8.00
0.00	TOTALS — — — — —		}	<u>6</u> .037.917	<del>                                     </del>	4	3.00
500 00	Grand Total: Decreases		4, 163, 575	58, 426, 591			500.00
300.00	prana rotar. beereases	ı l	4, 100, 575	30, 720, 371	I	I	1 300. 00

					Го 12/31/2014	Date/Time Prep	oared:
						6/3/2015 1: 34	pm
				Acqui si ti ons			
		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 ASSET						
1.00	Land	6, 474, 187	2, 013, 460		2, 013, 460	0	1.00
2.00	Land Improvements	5, 832, 114	270, 719	(	270, 719	0	2.00
3.00	Buildings and Fixtures	0	0	(	0	0	3.00
4.00	Building Improvements	83, 238, 261	5, 105, 354	(	5, 105, 354	0	4.00
5.00	Fixed Equipment	0	0	(	0	0	5.00
6.00	Movable Equipment	190, 723, 302	54, 706, 990	(	54, 706, 990	1, 634, 878	6.00
7.00	HIT designated Assets	0	0	(	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	286, 267, 864	62, 096, 523	(	62, 096, 523	1, 634, 878	8. 00
9.00	Reconciling Items	0	0	(	0	o	9.00
10.00	Total (line 8 minus line 9)	286, 267, 864	62, 096, 523		62, 096, 523	1, 634, 878	10.00
		Ending Balance	Fully				
			Depreciated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	8, 487, 647	0				1.00
2.00	Land Improvements	6, 102, 833	0				2.00
3.00	Buildings and Fixtures	o	0				3.00
4.00	Building Improvements	88, 343, 615	0				4.00
5.00	Fi xed Equipment	o	0				5.00
6.00	Movable Equipment	243, 795, 414	0				6.00
7.00	HIT designated Assets	o	0				7.00
8.00	Subtotal (sum of lines 1-7)	346, 729, 509	0				8.00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	346, 729, 509	0				10. 00
			- 1	1		'	

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS SPITAL In Lieu of Form CMS-2552-10
Provider CCN: 150042 | Period: | Worksheet A-7 | From 01/01/2014 | Part II

					rom 01/01/2014 To 12/31/2014		
			SU	MMARY OF CAPI	ΓAL	0,0,2010 1101	p.iii
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10.00	11. 00	12.00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUMN	2, LINES 1 ar	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0	,	1 1	0	1. 00
1. 01	NEW CRC - CT EAST	0	0	(	0	0	1. 01
1. 02	NEW CRC- CT WEST	0	0	(	0	0	1. 02
1.03	NEW CRC- MEMORIAL	0	0	(	0	0	1. 03
1.04	NEW CRC - OUTPATIENT	0	0	(	0	0	1. 04
1. 05	NEW CRD - HEALTH PAVILION	0	0	(	0	0	1. 05
1.06	NEW CRC - STORAGE	0	0	(	0	0	1. 06
1. 07	NEW CRC - DIAGNOSTIC CENTER	0	0	(	0	0	1. 07
2.00	CAP REL COSTS-MVBLE EQUIP	5, 181, 269	0	(	0	0	2. 00
2. 01	NEW CRC - EQUIPMENT	0	0	(	이	0	2. 01
2. 02	NEW CRC - HEALTH PAVILION	0	0	(	0	0	2. 02
3.00	Total (sum of lines 1-2)	5, 181, 269	0	(	0	0	3. 00
		SUMMARY OF	CAPITAL				
	Coot Conton Decemintion	Other T	otal (1) (sum				
	Cost Center Description	Capi tal -Relate	of cols. 9				
			through 14)				
		instructions)	till ough 14)				
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1. 00
1. 01	NEW CRC - CT EAST	o	o				1. 01
1. 02	NEW CRC- CT WEST	o	o				1. 02
1.03	NEW CRC- MEMORIAL	o	o				1. 03
1.04	NEW CRC - OUTPATIENT	o	o				1. 04
1.05	NEW CRD - HEALTH PAVILION	o	o				1. 05
1.06	NEW CRC - STORAGE	o	o				1. 06
1.07	NEW CRC - DIAGNOSTIC CENTER	o	ol				1. 07
2.00	CAP REL COSTS-MVBLE EQUIP	o	5, 181, 269				2. 00
2.01	NEW CRC - EQUIPMENT	o	o				2. 01
2.02	NEW CRC - HEALTH PAVILION	o	o				2. 02
3.00	Total (sum of lines 1-2)	O	5, 181, 269				3. 00

RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Prep 6/3/2015 1:34	
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	102, 934, 095	C	102, 934, 09		0	1. 00
1.01	NEW CRC - CT EAST	0	0	)	0. 000000	0	1. 01
1. 02	NEW CRC- CT WEST	0	0		0. 000000	0	1. 02
1.03	NEW CRC- MEMORIAL	0	0		0.000000	0	1. 03
1.04	NEW CRC - OUTPATIENT	0	0	1	0.000000	0	1. 04
1.05	NEW CRD - HEALTH PAVILION	0	0	1	0.000000	0	1. 05
1.06	NEW CRC - STORAGE	0		1	0.000000	0	1.06
1. 07	NEW CRC - DIAGNOSTIC CENTER	0		040 705 41	0.000000	0	1. 07
2.00	CAP REL COSTS-MVBLE EQUIP	243, 795, 414	0	, ,		0	2.00
2. 01	NEW CRC - EQUIPMENT	0			0.000000	0	2. 01
2. 02 3. 00	NEW CRC - HEALTH PAVILION Total (sum of lines 1-2)	346, 729, 509	0	346, 729, 50	0. 000000 9 1. 000000		2. 02 3. 00
3.00	Total (Suil of Titles 1-2)		TION OF OTHER (			F CAPITAL	3.00
		ALLOCA				CAFITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		/ 00	d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	6.00	7. 00	8.00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS		ı .	0 0	0	1. 00
1. 00	NEW CRC - CT EAST			1	991, 830		1. 00
1. 01	NEW CRC - CT WEST				1, 165, 706		1. 01
1. 03	NEW CRC- MEMORIAL	0			366, 120		1. 03
1. 04	NEW CRC - OUTPATIENT	0			502, 037	0	1. 04
1. 05	NEW CRD - HEALTH PAVILION	0			1, 533, 051	o	1. 05
1.06	NEW CRC - STORAGE	0	l c	)	1, 224	0	1. 06
1.07	NEW CRC - DIAGNOSTIC CENTER	0	O	)	411, 426	0	1. 07
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	)	5, 181, 269	0	2. 00
2.01	NEW CRC - EQUIPMENT	0	0	)	814, 861	0	2. 01
2.02	NEW CRC - HEALTH PAVILION	0	0	)	1, 040, 479	0	2. 02
3.00	Total (sum of lines 1-2)	0	C	)	12, 008, 003	0	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	<b>'</b>				Capi tal -Relate		
					d Costs (see	through 14)	
					instructions)		
	T	11. 00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		_	1		_	
1.00	CAP REL COSTS-BLDG & FIXT	0	1	1	0		1.00
1.01	NEW CRC - CT EAST	0	0		0		1. 01
1. 02 1. 03	NEW CRC- CT WEST NEW CRC- MEMORIAL					1, 165, 706 366, 120	1.02
1. 03	NEW CRC - OUTPATIENT			1			1. 03 1. 04
1. 04	NEW CRD - HEALTH PAVILION			1			1. 04
1.05	NEW CRC - STORAGE		"	1		1, 333, 031	1. 06
1. 07	NEW CRC - DIAGNOSTIC CENTER		"	1		411, 426	1. 07
2. 00	CAP REL COSTS-MVBLE EQUIP		"			5, 181, 269	2. 00
2. 01	NEW CRC - EQUI PMENT	1, 252, 853	377, 699	1		2, 445, 413	2. 01
2. 02	NEW CRC - HEALTH PAVILION	0	0,,,,,,	1	o o		2. 02
3. 00	Total (sum of lines 1-2)	1, 252, 853	377, 699		0		
		•		•	•		<del>-</del> '

 
 SPITAL
 In Lieu of Form CMS-2552-10

 Provi der CCN: 150042
 Peri od: From 01/01/2014 To 12/31/2014
 Worksheet A-8 Date/Time Prepared: Date/T Health Financial Systems
ADJUSTMENTS TO EXPENSES

				To	12/31/2014	Date/Time Prep 6/3/2015 1:34	
				Expense Classification on		0/3/2015 1.34	piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1.00	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00 0	1. 00
1. 01	COSTS-BLDG & FIXT (chapter 2)		0	NEW CDC CT FAST	1. 01	0	1. 01
1.01	Investment income - NEW CRC - CT EAST (chapter 2)			NEW CRC - CT EAST	1.01		1.01
1. 02	Investment income - NEW CRC- CT WEST (chapter 2)		0	NEW CRC- CT WEST	1. 02	0	1. 02
1.03	Investment income - NEW CRC-		0	NEW CRC- MEMORIAL	1. 03	0	1. 03
1. 04	MEMORIAL (chapter 2) Investment income - NEW CRC -		0	NEW CRC - OUTPATIENT	1. 04	0	1. 04
1. 05	OUTPATIENT (chapter 2) Investment income - NEW CRD -		0	NEW CRD - HEALTH PAVILION	1. 05	0	1. 05
	HEALTH PAVILION (chapter 2)						
1. 06	Investment income - NEW CRC - STORAGE (chapter 2)		0	NEW CRC - STORAGE	1. 06	0	1. 06
1. 07	Investment income - NEW CRC -		0	NEW CRC - DIAGNOSTIC CENTER	1. 07	0	1. 07
2. 00	DIAGNOSTIC CENTER (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2. 01	COSTS-MVBLE EQUIP (chapter 2) Investment income - NEW CRC -		0	NEW CRC - EQUIPMENT	2. 01	0	2. 01
2.01	EQUI PMENT (chapter 2)		O	NEW CRC - EQUIPMENT	2.01		2.01
2. 02	Investment income - NEW CRC - HEALTH PAVILION (chapter 2)		0	NEW CRC - HEALTH PAVILION	2. 02	0	2. 02
3.00	Investment income - other		0		0.00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time	В	-221, 409	PURCHASING & RECEIVING	4. 02	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
5.00	expenses (chapter 8)		0		0.00		5.00
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8.00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provi der-based physician adjustment	A-8-2	-10, 733, 076			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	0			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00		13. 00
	Cafeteria-employees and guests		-1, 033, 430	CAFETERI A	11. 00	0	14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients	В	-430, 331	DRUGS CHARGED TO PATIENTS	73. 00	0	17. 00
18. 00	Sale of medical records and	В	-63, 134	ADMINISTRATIVE & GENERAL	5. 00	О	18. 00
19. 00	abstracts Nursing school (tuition, fees,		Ω		0.00	0	19. 00
	books, etc.)		0			0	
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114. 00		25. 00
	(chapter 21)						

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150042 

Display Continue Transport pit on   Rests (Continue Continue Con						) 12/31/2014	Date/lime Prep   6/3/2015 1:34	
Court Centur Description   Basis/Code (2)   Amount   Court Centur   Line #   Most A.7 Ref.					Expense Classification on	Worksheet A		
1.00   Depreciation - SAP RPL   COMPANIES   COMPANIE					To/From Which the Amount is	to be Adjusted		
1.00   Depreciation - SAP RPL   COMPANIES   COMPANIE								
1.00   Depreciation - SAP RPL   COMPANIES   COMPANIE								
1.00   Depreciation - SAP RPL   COMPANIES   COMPANIE								
Depreciation - APR CRC - CT		Cost Center Description						
COSTS-BLDG & FIXT	24 00	Daniel St. CAD DEL	1.00					24 00
26. 01   Depreciation - NEW CRC - CT   ONEW CRC - CT REST   1. 01   0   26. 01	26.00			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
ABST   Compared at the New Critical Compare	26. 01			0	NEW CRC - CT FAST	1. 01	0	26. 01
VEST				_				
26. 03   Depreciation - NEW CRC -   DIEW CRC - MEMORIAL   1.00   0 26. 03   MEMORIAL   1.00   0 26. 03   MEMORIAL   1.00   0 26. 05   MEMORIAL   1.00   0 27. 02   MEMORIAL   1.00   0 27. 0	26. 02	Depreciation - NEW CRC- CT		0	NEW CRC- CT WEST	1.02	0	26. 02
MEMORIA	0/ 00				NEW ODO MEMODIAL	4 00		0, 00
Depreciation - NEW CRC -   ONEW CRC - OUTPATIENT   1.04   0.20 04	26. 03	·		0	NEW CRC- MEMORIAL	1.03	0	26. 03
0.00   0.00	26. 04	II		0	NEW CRC - OUTPATIENT	1. 04	0	26. 04
HEALTH PAYLLION		1 .						
25.00   Depreciation - NEW CRC -   STORAGE   1.00   25.00	26. 05			0	NEW CRD - HEALTH PAVILION	1. 05	0	26. 05
SIÓNAGE	2/ 0/			0	NEW CDC STODACE	1.04	0	2/ 0/
26. 07 DARFORDIT CENTER   1.07   0 26. 07   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE EQUIP   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS-MABLE COSTS   2.00   0 27. 00   DARFORDIT CENTER   0 CAP REL COSTS   2.00   0 27. 00   DARFORDIT CENTER   2 CAP REL COSTS   2.00   2.00   DARFORDIT CENTER   2 CAP REL CENTER   2.00   2.00   2.00   DARFORDIT CENTER   2 CAP REL CENTER   2.00   2.00   2.00   DARFORDIT CENTER   2 CAP REL CENTER   2.00   2.00   2.00   DARFORDIT CENTER   2 CAP REL CENTER   2.00   2.00   2.00   DARFORDIT CENTER   2 CAP REL CENTER   2.00   2.00   2.00   DARFORDIT CENTER   2 CAP REL CENTER   2.0	20.00	1 .		U	NEW CRC - STURAGE	1.06	0	26.06
DI ARMOSTIC CENTER	26. 07	1		0	NEW CRC - DIAGNOSTIC CENTER	1. 07	0	26. 07
COSTS-IMPRIE COULP CONTROL CON								
27. 01   Depreciation - New CRC -   Depreciation - D	27. 00	1 .		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
EQUIPMENT   COLOR	27 01			0	NEW CDC FOULDMENT	2.01		27 01
27.02   Depreciation - NEW CRC -       DNEW CRC -     HALTH PAVILLON	27.01	·		0	NEW CRC - EQUIPMENT	2.01	0	27.01
HÂLTIR PAYILION	27 02	1		0	NEW CRC - HEALTH PAVILION	2 02	0	27 02
29.00   Physicians' assistant	27.02			· ·	I SHE THE THE SHE SHE	2.02	Ĭ	27.02
30. 00   Adjustment for occupational therapy costs in excess of limitation (chapter 14)   30. 09   Adjustment for speech instructions   30. 00   30. 09   Adjustment for speech pathology costs in excess of limitation (chapter 14)   31. 00   Adjustment for speech pathology costs in excess of limitation (chapter 14)   32. 00   CAH HIT Adjustment for Depreciation and Interest   32. 00   CAH HIT Adjustment for Depreciation and Interest   33. 00   33. 0	28. 00			0	*** Cost Center Deleted ***			
therapy costs in excess of I initiation (chapter 14)				0				
1 inititation (chapter 14)   30.09   Hospice (non-distinct) (see instructions)   31.00   Adjustment for speech pathology costs in excess of instructions)   31.00   Adjustment for speech pathology costs in excess of instructions   31.00   Adjustment for speech pathology costs in excess of instructions   32.00   CAH HIT Adjustment for Depreciation and interest   32.00   CAH HIT Adjustment for Depreciation and interest   33.00   OTHER MISC FEES   B   7-0, 1130 PERATION OF PLANT   75.00   0.33, 01   OTHER MISC FEES   B   7-0, 1130 PERATION OF PLANT   7.00   0.33, 01   OTHER MISC FEES   B   7-0, 1130 PERATION OF PLANT   7.00   0.33, 01   OTHER MISC FEES   B   7-0, 1130 PERATION OF PLANT   7.00   0.33, 01   OTHER MISC FEES   B   7-0, 1130 PERATION OF PLANT   7.00   0.33, 01   OTHER MISC FEES   B   7-0, 1130 PERATION OF PLANT   7.00   0.33, 01   OTHER MISC FEES   B   7-0, 1130 PERATION OF PLANT   7.00   0.33, 01   OTHER MISC FEES   B   7-0, 1130 PERATION OF PLANT   7.00   0.33, 01   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   5.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   5.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   5.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   5.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   5.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   5.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   5.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   7.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   7.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   7.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   7.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   7.00   0.33, 03   OTHER MISC FEES   B   7-0, 124 JAMIN NISTRATIVE & GENERAL   7.00   0.33, 03   OTHER MISC FEES   8   7-0, 124 JAMIN NI	30. 00		A-8-3	0	*** Cost Center Deleted ***	67. 00		30. 00
30.09								
Instructions	30 99			0	ADULTS & PEDLATRICS	30.00		30 99
31.00   Adjustment for speech   A-B-3   0 *** Cost Center Deleted ***   68.00   31.00   Pathology costs in excess of limitation (chapter 14s) of limitation (chapter 14s	00. 77			0	ABOLIS & FLBIAMM 65	00.00		00.77
I imitation (chapter 14)	31.00	1	A-8-3	0	*** Cost Center Deleted ***	68.00		31. 00
22. 00   CAH HIT Adjustment for   0   0.00								
Depreciation and Interest	22.00			0		0.00		22.00
33. 00   OTHER MISC FEES   B   -29/ASC (NON-DISTINCT PART)   75. 00   0   33. 00	32.00	-		0		0.00	0	32.00
33 0   OTHER MISC FEES   B	33 00		В	-29	ASC (NON-DISTINCT PART)	75 00	0	33 00
33 02   OTHER MISC FEES			•		, ,		Ö	
33. 04   OTHER MISC FEES		1	•		i l		0	
33. 05   RENTAL INCOME	33. 03	RENTAL INCOME	В	-377, 241	ADMINISTRATIVE & GENERAL	5.00	0	33. 03
33. 06   OTHER MISC FEES		1			1			
33. 07   OTHER MISC FEES					1			
33. 11   ARESTHESI OLOGY BENEFITS   B   -354,947 EMPLOYEE BENEFITS DEPARTMENT   4,00   0   33, 11     33. 12   RADIOLOGY - SILVER ETC   B   -246,6740  IDOGY-DIAGNOSTIC   54,00   0   33, 13     33. 14   FOOD SERVICE   B   -36,626,8ESPIRATORY THERAPY   65,00   0   33, 13     33. 15   RADIOLOGY - STUDENT TUITION   B   -58,811 PARAMED ED PRGM-(SPECIFY)   23,00   0   33, 14     33. 16   RENTAL INCOME   B   -18,662, MENTAL HEALTH OVERHEAD   17,01   0   33, 16     33. 17   RENTAL INCOME   B   -4,995, RADIOLOGY-DIAGNOSTIC   54,00   0   33, 17     33. 18   PHYSICIAN EMPLOYEE BENEFIT   A   -39,750 EMPLOYEE BENEFITS DEPARTMENT   4,00   0   0   33, 17     33. 19   PHYSICIAN EMPLOYEE BENEFIT   A   -39,750 EMPLOYEE BENEFITS DEPARTMENT   4,00   0   0   33, 19     33. 20   AHA USEFUL LIVES CARRYFORWARD   A   -75,80 EMPLOYEE BENEFITS DEPARTMENT   2,01   9,33, 20     33. 21   HEALTH PAVILION AHA   A   -26,044 NEW CRC - EQUIPMENT   2,01   9,33, 21     33. 22   OTHER MISC FEES   B   -1,162 INTENSIVE CARE UNIT   31,00   0   33, 22     33. 23   ADVANCE EMT TRAINING   A   -13,060 (RESPIRATORY THERAPY   65,00   0   33, 23     33. 24   TOPO ASSETS - AHA LIVES   A   -22,119 NEW CRC - EQUIPMENT   2,01   9,33, 24     33. 33   NEPHROLOGY RENTAL INCOME   B   -157,680 INPATIENT DIALYSIS   76,01   9,33, 28     33. 31   PHYSICIAN BILLING COSTS   A   -180,081 PATIENT DIALYSIS   76,01   9,33, 30     33. 31   PHYSICIAN BILLING COSTS   A   -180,081 PATIENT DIALYSIS   76,01   9,33, 33     33. 33   NEPHROLOGY RENTAL INCOME   B   -157,680 INPATIENT DIALYSIS   76,01   9,33, 33     33. 33   AUSTHESIOLOGY CONTRACT LABOR   A   -180,081 PATIENT DIALYSIS   76,01   9,33, 35     33. 34   ADVERTISING   A   -290,680 IN NISTRATIVE & GENERAL   5,00   0,33, 37     33. 34   ADVERTISING   A   -290,680 IN NISTRATIVE & GENERAL   5,00   0,33, 37     33. 34   ADVERTISING   A   -220,491 PATIENT & GENERAL   5,00   0,33, 37     33. 34   ADVERTISING   A   -220,491 PATIENT & GENERAL   5,00   0,33, 37     33. 34   ADVERTISING   A   -220,491 PATIENT & GENERAL   5,00   0,33,		1	•		1			
33. 12   RADI OLOGY - SILVER ETC   B   -286   RADI OLOGY - DI AGNOSTIC   54. 00   0   33. 12					1		-	
33.13   PT MASSAGE THERAPY   B   -3,626   RESPIRATORY THERAPY   65.00   0   33.13     33.14   FOOD SERVICE   B   -24,054   DIETARY   10.00   0   33.14     33.15   RADI OLOGY - STUDENT TUITION   B   -58,811   PARAMED ED PRGM - (SPECIFY)   23.00   0   33.15     33.16   RENTAL I NCOME   B   -18,662   MENTAL HEALTH OVERHEAD   17.01   0   33.16     33.17   RENTAL I NCOME   B   -4,995   RADI OLOGY - DI AGNOSTI C   54.00   0   33.18     33.18   PHYSI CIAN EMPLOYEE BENEFI T   A   -39,750   EMPLOYEE BENEFI T S DEPARTMENT   4.00   0   33.18     33.19   PHYSI CIAN ON-CALL TIME   A   -161,625   ADMIN INISTRATI VE & GENERAL   5.00   0   33.19     33.20   AHA USEFUL LIVES CARRYFORWARD   A   -26,044   NEW CRC - EQUI PMENT   2.01   9   33.20     33.21   HEALTH PAVILION AHA   A   -26,044   NEW CRC - HEALTH PAVILION   2.02   9   33.21     33.22   ADVANCE EMT TRAINING   A   -13,060   RESPIRATORY THERAPY   65.00   0   33.22     33.24   190 ASSETS - AHA LIVES   A   -2,119   NEW CRC - EQUI PMENT   2.01   9   33.24     33.30   NEPHROLOGY RENTAL I NCOME   B   -369,928   NEW CRC - EQUI PMENT   2.01   9   33.28     33.31   NITEREST I NCOME   B   -369,928   NEW CRC - EQUI PMENT   2.01   9   33.28     33.33   NEPHROLOGY RENTAL I NCOME   B   -157,680   NPATI ENT DI ALYSIS   76.01   0   33.30     33.33   ANESTHESI OLOGY CONTRACT LABOR   A   -180,081   PATI ENT DI ALYSIS   76.01   0   33.31     33.33   ANESTHESI OLOGY CONTRACT LABOR   A   -16,623   OPERATING ROOM   50.00   0   33.35     33.34   ADVERTISING   A   -296   RADIO NIN STRATIVE & GENERAL   5.00   0   33.37     33.34   ADVERTISING   A   -296   RADIO NIN STRATIVE & GENERAL   5.00   0   33.37     33.37   ADVERTISING   A   -296   RADIO NIN STRATIVE & GENERAL   5.00   0   33.37     33.37   ADVERTISING   A   -296   RADIO NIN STRATIVE & GENERAL   5.00   0   33.37     33.37   ADVERTISING   A   -296   RADIO NIN STRATIVE & GENERAL   5.00   0   33.37     33.34   ADVERTISING   A   -296   RADIO NIN STRATIVE & GENERAL   5.00   0   33.37     33.41   ADVERTISING   A   -296   RADIO NIN STRATIVE &								
33. 14   FOOD SERVICE								
33. 16   RENTAL INCOME   B					1			
33. 17   RENTAL I NCOME   B   -4, 995   RADI OLOGY - DI AGNOSTI C   54. 00   0   33. 17     33. 18   PHYSI CI AN EMPLOYEE BENEFI T   COMPENSAT   -39, 750   EMPLOYEE BENEFI TS DEPARTMENT   4. 00   0   33. 18     33. 19   PHYSI CI AN ON-CALL TIME   A   -161, 625   ADMI NI STRATI VE & GENERAL   5. 00   0   33. 19     33. 20   AHA USEFUL LI VES CARRYFORWARD   A   -95 NEW CRC - EQUI PMENT   2. 01   9   33. 20     33. 21   HEALTH PAVI LI ON AHA   A   -26, 044 NEW CRC - HEALTH PAVILI ON   2. 02   9   33. 21     33. 22   OTHER MI SC FEES   B   -1, 162 I INTENSI VE CARE UNI T   31. 00   0   33. 22     33. 23   ADVANCE EMT TRAIN ING   A   -13, 060   RESPIRATORY THERAPY   65. 00   0   33. 23     33. 24   LINTEREST I NCOME   B   -369, 928 NEW CRC - EQUI PMENT   2. 01   9   33. 24     33. 30   NEPHROLOGY RENTAL I INCOME   B   -157, 680 I NPATI ENT DI ALYSIS   76. 01   0   33. 31     33. 33   ANESTHESI OLOGY CONTRACT LABOR   A   -16, 623 OPERATING ROOM   50. 00   0   33. 35     33. 39   ADVERTISI NG   A   -20, 525 ADMI NI STRATI VE & GENERAL   5. 00   0   33. 35     33. 40   ADVERTI SI NG   A   -296   RADI NI STRATI VE & GENERAL   5. 00   0   33. 36     33. 41   ADVERTI SI NG   A   -296   RADI NI STRATI VE & GENERAL   5. 00   0   33. 35     33. 41   ADVERTI SI NG   A   -244   ADVERTI SI NG   A   -414   DURABLE MEDI CAL EQUI P-RENTED   96. 00   0   33. 41     33. 42   ADVERTI SI NG   A   -414   DURABLE MEDI CAL EQUI P-RENTED   96. 00   0   33. 41     33. 42   ADVERTI SI NG   A   -414   DURABLE MEDI CAL EQUI P-RENTED   96. 00   0   33. 41     34. 4   ADVERTI SI NG   A   -414   DURABLE MEDI CAL EQUI P-RENTED   96. 00   0   33. 41     34. 4   ADVERTI SI NG   A   -414   DURABLE MEDI CAL EQUI P-RENTED   96. 00   0   33. 41     34. 4   ADVERTI SI NG   A   -414   DURABLE MEDI CAL EQUI P-RENTED   96. 00   0   33. 41     35. 40   ADVERTI SI NG   A   -414   DURABLE MEDI CAL EQUI P-RENTED   96. 00   0   33. 41     35. 40   ADVERTI SI NG   A   -414   DURABLE MEDI CAL EQUI P-RENTED   96. 00   0   33. 41     35. 40   ADVERTI SI NG   A		RADIOLOGY - STUDENT TUITION						
33. 18   PHYSICIAN EMPLOYEE BENEFIT   A   -39, 750   EMPLOYEE BENEFITS DEPARTMENT   4.00   0   33. 18     33. 19   PHYSICIAN ON-CALL TIME   A   -161, 625 ADMINISTRATIVE & GENERAL   5.00   0   33. 19     33. 20   AHA USEFUL LIVES CARRYFORWARD   A   -26, 044   NEW CRC - EQUIPMENT   2.01   9   33. 20     33. 21   HEALTH PAVILION AHA   A   -26, 044   NEW CRC - HEALTH PAVILION   2.02   9   33. 21     33. 22   OTHER MISC FEES   B   -1, 162   INTENSIVE CARE UNIT   31.00   0   33. 23     33. 24   1990 ASSETS - AHA LIVES   A   -2, 119   NEW CRC - EQUIPMENT   2.01   9   33. 24     33. 28   INTEREST INCOME   B   -369, 928   NEW CRC - EQUIPMENT   2.01   9   33. 28     33. 30   NEPHROLOGY RENTAL INCOME   B   -157, 680   INPATIENT DIALYSIS   76.01   0   33. 30     33. 31   PHYSICIAN BILLING COSTS   A   -180, 081   PATIENT ACCOUNTS   4.04   0   33. 31     33. 33   ANESTHESIOLOGY CONTRACT LABOR   A   -16, 623   OPERATING ROOM   50.00   0   33. 35     33. 37   2004 SURETY BOND EXPENSE   A   -20, 525   ADMINISTRATIVE & GENERAL   5.00   0   33. 37     33. 34   ADVERTISING   A   -296   RADINISTRATIVE & GENERAL   5.00   0   33. 39     33. 40   ADVERTISING   A   -220   PHYSICIAL HERAPY   66.00   0   33. 41     33. 42   ADVERTISING   A   -748   HOSPICE   116.00   0   33. 42	33. 16	RENTAL INCOME	В			17. 01	0	33. 16
COMPENSAT   PHYSI CI AN ON-CALL TI ME		1			1			
33. 19	33. 18		Α	-39, 750	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 18
33. 20	33 10			-161 625	ADMINISTRATIVE & GENERAL	5 00	0	33 10
33. 21 HEALTH PAVILION AHA CARRYFORWARD  33. 22 OTHER MISC FEES B -1, 162 INTENSIVE CARE UNIT 31. 00 33. 22 33. 24 1990 ASSETS - AHA LIVES CARRYFORWARD  33. 28 INTEREST INCOME B -369, 928 NEW CRC - EQUIPMENT 2. 01 9 33. 28 33. 30 NEPHROLOGY RENTAL INCOME B -157, 680 INPATIENT DIALYSIS 76. 01 9 33. 28 33. 31 PHYSICIAN BILLING COSTS A -180, 081 PATIENT ACCOUNTS 4. 04 0 33. 31 33. 33 ANESTHESIOLOGY CONTRACT LABOR A -16, 623 OPERATING ROOM 50. 00 0 33. 35 33. 37 2004 SURETY BOND EXPENSE A -20, 525 ADMINISTRATIVE & GENERAL 5. 00 0 33. 37 33. 39 ADVERTISING A -206 RADIOLOGY-DIAGNOSTIC 54. 00 0 33. 39 33. 41 ADVERTISING A -241 DURABLE MEDICAL EQUIP-RENTED 96. 00 0 33. 41 33. 42 ADVERTISING A -748 HOSPICE		1	1		1			
CARRYFORWARD   OTHER MISC FEES   B		1	1					
33. 23   ADVANCE EMT TRAINING								
33. 24	33. 22	OTHER MISC FEES	В			31.00	0	
CARRYFORWARD     33. 28   INTEREST INCOME   B   -369, 928   NEW CRC - EQUIPMENT   2. 01   9   33. 28   33. 30   NEPHROLOGY RENTAL INCOME   B   -157, 680   NPATIENT DIALYSIS   76. 01   0   33. 30   33. 31   PHYSI CIAN BILLING COSTS   A   -180, 081   PATIENT ACCOUNTS   4. 04   0   33. 31   33. 33   ANESTHESI OLOGY CONTRACT LABOR   A   -16, 623   OPERATING ROOM   50. 00   0   33. 33   33. 35   DONATIONS EXPENSE   A   -66, 118   ADMINISTRATIVE & GENERAL   5. 00   0   33. 35   33. 37   2004   SURETY BOND EXPENSE   A   -20, 525   ADMINISTRATIVE & GENERAL   5. 00   0   33. 37   33. 39   ADVERTISING   A   -296   RADIOLOGY-DIAGNOSTIC   54. 00   0   33. 39   33. 40   ADVERTISING   A   -220   PHYSI CAL THERAPY   66. 00   0   33. 40   33. 41   ADVERTISING   A   -414   DURABLE MEDICAL EQUIP-RENTED   96. 00   0   33. 42   33. 42   ADVERTISING   A   -748   HOSPICE   116. 00   0   33. 42		1	1		ł .			
33. 28 INTEREST INCOME  33. 30 NEPHROLOGY RENTAL INCOME  B -369, 928 NEW CRC - EQUIPMENT  2. 01 9 33. 28  33. 30 NEPHROLOGY RENTAL INCOME  B -157, 680 INPATIENT DIALYSIS  76. 01 0 33. 30  33. 31 PHYSI CIAN BILLING COSTS  A -180, 081 PATIENT ACCOUNTS  4. 04 0 33. 31  33. 33 ANESTHESI OLOGY CONTRACT LABOR  A -16, 623 OPERATING ROOM  50. 00 0 33. 33  30. 33. 35 DONATIONS EXPENSE  A -66, 118 ADMINISTRATIVE & GENERAL  5. 00 0 33. 35  33. 37 2004 SURETY BOND EXPENSE  A -20, 525 ADMINISTRATIVE & GENERAL  5. 00 0 33. 37  33. 39 ADVERTISING  A -296 RADIOLOGY-DIAGNOSTIC  54. 00 0 33. 37  33. 40 ADVERTISING  A -220 PHYSI CAL THERAPY  66. 00 0 33. 40  33. 41 ADVERTISING  A -414 DURABLE MEDICAL EQUIP-RENTED  96. 00 0 33. 41  33. 42 ADVERTISING  A -748 HOSPICE	33. 24		A	-2, 119	NEW CRC - EQUIPMENT	2. 01	9	33. 24
33. 30 NEPHROLOGY RENTAL I NCOME  33. 30 NEPHROLOGY RENTAL I NCOME  33. 31 PHYSI CI AN BI LLI NG COSTS  A -180, 081 PATI ENT ACCOUNTS  4. 04  0 33. 31  33. 33 ANESTHESI OLOGY CONTRACT LABOR  A -16, 623 OPERATI NG ROOM  50. 00  0 33. 33  30. 35 DONATI ONS EXPENSE  A -66, 118 ADMI NI STRATI VE & GENERAL  5. 00  0 33. 35  30. 37 ADVERTI SI NG  A -20, 525 ADMI NI STRATI VE & GENERAL  5. 00  0 33. 37  33. 40 ADVERTI SI NG  A -220 PHYSI CAL THERAPY  66. 00  0 33. 40  33. 41 ADVERTI SI NG  A -414 DURABLE MEDI CAL EQUI P-RENTED  96. 00  0 33. 42	33 20	1	R	-360 030	NEW CRC - FOLLEMENT	2 ∩1	n	33 20
33. 31       PHYSI CI AN BILLING COSTS       A       -180, 081 PATI ENT ACCOUNTS       4. 04       0 33. 31         33. 33       ANESTHESI OLOGY CONTRACT LABOR       A       -16, 623 OPERATI NG ROOM       50. 00       0 33. 33         33. 35       DONATI ONS EXPENSE       A       -66, 118 ADMI NI STRATI VE & GENERAL       5. 00       0 33. 35         33. 37       2004 SURETY BOND EXPENSE       A       -20, 525 ADMI NI STRATI VE & GENERAL       5. 00       0 33. 37         33. 49       ADVERTI SI NG       A       -296 RADI OLOGY-DI AGNOSTI C       54. 00       0 33. 39         33. 41       ADVERTI SI NG       A       -220 PHYSI CAL THERAPY       66. 00       0 33. 41         33. 42       ADVERTI SI NG       A       -414 PDURABLE MEDI CAL EQUI P-RENTED       96. 00       0 33. 41         33. 42       ADVERTI SI NG       A       -748 HOSPI CE       116. 00       0 33. 42		II			1			
33. 33       ANESTHESI OLOGY CONTRACT LABOR       A       -16, 623 OPERATI NG ROOM       50. 00       0       33. 33         33. 35       DONATI ONS EXPENSE       A       -66, 118 ADMI NI STRATI VE & GENERAL       5. 00       0       33. 35         33. 37       2004 SURETY BOND EXPENSE       A       -20, 525 ADMI NI STRATI VE & GENERAL       5. 00       0       33. 37         33. 39       ADVERTI SI NG       A       -296 RADI OLOGY-DI AGNOSTI C       54. 00       0       33. 39         33. 40       ADVERTI SI NG       A       -220 PHYSI CAL THERAPY       66. 00       0       33. 40         33. 41       ADVERTI SI NG       A       -414 PUDRABLE MEDI CAL EQUI P-RENTED       96. 00       0       33. 41         33. 42       ADVERTI SI NG       A       -748 HOSPI CE       116. 00       0       33. 42		II .			1			
33. 35     DONATI ONS EXPENSE     A     -66, 118 ADMI NI STRATI VE & GENERAL     5. 00     0     33. 35       33. 37     2004 SURETY BOND EXPENSE     A     -20, 525 ADMI NI STRATI VE & GENERAL     5. 00     0     33. 37       33. 39     ADVERTI SI NG     A     -296 RADI OLOGY-DI AGNOSTI C     54. 00     0     33. 39       33. 40     ADVERTI SI NG     A     -220 PHYSI CAL THERAPY     66. 00     0     33. 40       33. 41     ADVERTI SI NG     A     -414 DURABLE MEDI CAL EQUI P-RENTED     96. 00     0     33. 41       33. 42     ADVERTI SI NG     A     -748 HOSPI CE     116. 00     0     33. 42		1	1		ł			
33. 39     ADVERTI SI NG     A     -296 RADI OLOGY-DI AGNOSTI C     54. 00     0     33. 39       33. 40     ADVERTI SI NG     A     -220 PHYSI CAL THERAPY     66. 00     0     33. 40       33. 41     ADVERTI SI NG     A     -414 DURABLE MEDI CAL EQUI P-RENTED     96. 00     0     33. 41       33. 42     ADVERTI SI NG     A     -748 HOSPI CE     116. 00     0     33. 42	33. 35	1	Α	-66, 118	ADMINISTRATIVE & GENERAL			33. 35
33. 40   ADVERTI SI NG   A   -220 PHYSI CAL THERAPY   66. 00   0   33. 40   33. 41   ADVERTI SI NG   A   -414 DURABLE MEDI CAL EQUI P-RENTED   96. 00   0   33. 41   33. 42   ADVERTI SI NG   A   -748 HOSPI CE   116. 00   0   33. 42		1	1		1			
33. 41 ADVERTISING A -414 DURABLE MEDICAL EQUIP-RENTED 96. 00 0 33. 41 33. 42 ADVERTISING A -748 HOSPICE 116. 00 0 33. 42		1			1			
33. 42 ADVERTI SI NG A -748 HOSPI CE 116. 00 0 33. 42		1	1		1			
		1	1		ı ı			
- 10,000 point in other the a deficient   0.00  0 00.40		1	1		1			
				75, 655	r Great ve a Selvenne	5.00	1	

					o 12/31/2014	Date/Time Prep 6/3/2015 1:34	
				Expense Classification on	Worksheet A	07 07 2010 1. 01	Pill
				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	
33. 44	IHA LOBBYING OFFSET	В	-3, 032	ADMINISTRATIVE & GENERAL	5. 00	0	33. 44
33. 46	INDIANA CHAMBER LOBBYING	В	-125	ADMINISTRATIVE & GENERAL	5. 00	0	33. 46
	OFFSET						
33. 47	TRADE, QUANTITY, AND TIME	В	-43, 453	ELECTROCARDI OLOGY	69. 00	0	33. 47
	DI SCOUNTS	_					
33. 48		В	-27, 784	ADMINISTRATIVE & GENERAL	5. 00	0	33. 48
	DI SCOUNTS		4.0	WENTAL LIEALTH OVERVIEND	47.04		
33. 49		В	-18	MENTAL HEALTH OVERHEAD	17. 01	O	33. 49
33. 51	DISCOUNTS TRADE, QUANTITY, AND TIME	В	1	  SUBPROVI DER	41. 00		33. 51
33. 31	DI SCOUNTS	D	-1	SUBPROVIDER - IRF	41.00	U	33.31
50. 00			-14, 822, 672				50. 00
30.00	(Transfer to Worksheet A,		-14,022,072				30.00
	column 6, line 200.)						

<sup>(1)</sup> 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.

<sup>(3)</sup> 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 Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT | Peri od: | Worksheet A-8-2 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150042

						o 12/31/2014	Date/lime Pre   6/3/2015 1:34	epared:
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	PIII
		I denti fi er	Remuneration	Component	Component	1102 711104111	ider Component	
							Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	17. 01	MENTAL HEALTH OVERHEAD	968, 253	759, 650	208, 603	159, 800	2, 015	1. 00
2.00		SUBPROVIDER - IRF	265	265	0	0	0	2. 00
3.00	54.00	DR. O	253, 916	251, 155	2, 760	159, 800	106	3. 00
4.00	54.00	DR. P	110, 250	110, 250	0	0	0	4. 00
5.00	54. 08	DR. G	205, 615	150, 615	55, 000	217, 600	520	5. 00
6.00	60.00	DR. Q	123, 108	60, 157		159, 800	1, 476	6. 00
7.00	65. 00	DR. R	18, 000	0	18, 000	159, 800	300	7. 00
8.00	69. 00	ELECTROCARDI OLOGY	2, 376, 805	2, 372, 195	4, 610	159, 800	14	8. 00
9.00	70. 01	NEURODI AGNOSTI CS	18, 000	0	18, 000	159, 800	180	9. 00
10.00	76. 01		40, 000	0	40, 000	159, 800	336	10.00
11. 00	75. 00	ASC (NON-DISTINCT PART)	11, 000	0	11, 000	159, 800	144	11. 00
12.00	90. 00	DR. L	700, 592	700, 592	0	0	0	12. 00
13.00	91.00	EMERGENCY	4, 646, 849	4, 595, 111	51, 738	159, 800	331	13. 00
14.00	50. 00	OPERATING ROOM	1, 630, 489		0	0	0	14. 00
200.00			11, 103, 142	10, 630, 479	472, 662		5, 422	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		l denti fi er	Limit	Unadjusted RCE	Memberships &	Component	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		MENTAL HEALTH OVERHEAD	154, 806			0	0	
2.00		SUBPROVIDER - IRF	0	0	_	0	0	
3.00	54. 00		8, 144	•	0	0	0	
4.00	54.00		0	0 700	_	0	0	
5.00	54. 08		54, 400			0	0	5. 00
6.00	60.00		113, 396			0	0	
7.00	65. 00		23, 048			0	0	7. 00
8.00		ELECTROCARDI OLOGY NEURODI AGNOSTI CS	1, 076		-	0	0	8. 00
9.00	70. 01 76. 01		13, 829	691	0	0	0	9.00
10.00		ASC (NON-DISTINCT PART)	25, 814		0	0	0	
11. 00	90.00		11, 063	553	_	0	_	11.00
12. 00 13. 00			0	0	_	0	0	12. 00 13. 00
		EMERGENCY OPERATING ROOM	25, 430	1, 272	0	0	0	
14. 00 200. 00	50.00	UPERATING ROOM	431, 006	1	_	0	0	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
	WKSt. A LITTE #	I denti fi er	Component	Limit	Di sal I owance	Auj us tillerit		
		ruciiti i i ci	Share of col.		Di Sai i Owance			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00	17. 01	MENTAL HEALTH OVERHEAD	0	154, 806	53, 797	813, 447		1. 00
2.00	41.00	SUBPROVIDER - IRF	0	0	0	265		2. 00
3.00	54.00	DR. O	0	8, 144	0	251, 156		3. 00
4.00	54.00	DR. P	0	0	0	110, 250		4. 00
5.00	54. 08	DR. G	0	54, 400	600	151, 215		5. 00
6.00	60.00	DR. Q	0	113, 396	0	60, 157		6. 00
7.00	65. 00		0			0		7. 00
8.00		ELECTROCARDI OLOGY	0	1, 076	3, 534	2, 375, 729		8. 00
9.00		NEURODI AGNOSTI CS	0	13, 829	4, 171	4, 171		9. 00
10.00	76. 01		0	25, 814		14, 186		10. 00
11. 00		ASC (NON-DISTINCT PART)	0	11, 063	0	0		11. 00
12.00	90. 00		0	0	0	700, 592		12. 00
13.00		EMERGENCY	0		26, 308	4, 621, 419		13. 00
14.00	50. 00	OPERATING ROOM	0		0	1, 630, 489		14. 00
200.00			0	431, 006	102, 596	10, 733, 076		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150042

Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

6/3/2015 1:34 pm CAPITAL RELATED COSTS NEW CRC-Cost Center Description Net Expenses BLDG & FIXT NEW CRC - CT NEW CRC- CT for Cost FAST WEST MEMORI AL All ocation (from Wkst A col. 7) 1.00 1. 01 1. 02 1. 03 GENERAL SERVICE COST CENTERS 1 00 1 00 00100 CAP REL COSTS-BLDG & FLXT 0 1.01 00101 NEW CRC - CT EAST 991, 830 0 991, 830 1.01 1.02 00102 NEW CRC- CT WEST 1, 165, 706 1, 165, 706 1.02 00103 NEW CRC- MEMORIAL 00104 NEW CRC - OUTPATIENT 1 03 Ω O 366, 120 1 03 366, 120 0 1.04 502,037 C 0 0 1.04 1.05 00105 NEW CRD - HEALTH PAVILION 1, 533, 051 0 0 1.05 00106 NEW CRC - STORAGE 00107 NEW CRC - DIAGNOSTIC CENTER 1, 224 0 0 0 1.06 1.06 411, 426 0 1 07 1 07 0 2.00 00200 CAP REL COSTS-MVBLE EQUIP 5, 181, 269 2.00 00201 NEW CRC - EQUI PMENT 2, 445, 413 2.01 2.01 00202 NEW CRC - HEALTH PAVILION 1,040,479 2.02 2.02 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 21, 825, 949 0 17, 100 4 00 4.01 00401 COMMUNI CATI ONS 265, 045 0 4.01 0 00402 PURCHASING & RECEIVING 4.02 481, 019 83, 672 599 4.02 00403 REGI STRATI ON 4, 988 4.03 830, 655 4.03 C n 4.04 00404 PATIENT ACCOUNTS 3, 700, 394 0 22.847 4 04 5.00 00500 ADMINISTRATIVE & GENERAL 28, 774, 705 20, 495 96, 843 5.00 63, 662 7.00 00700 OPERATION OF PLANT 6, 263, 373 95, 982 139, 288 115, 457 7 00 00800 LAUNDRY & LINEN SERVICE 22, 248 8.00 309.193 8.00 00900 HOUSEKEEPI NG 9.00 2, 214, 125 6, 207 23, 320 12, 227 9 00 01000 DI ETARY 734, 155 10.00 10.00 0 11.00 01100 CAFETERI A 928, 262 73, 787 0 11.00 13.00 01300 NURSING ADMINISTRATION 1,884,538 13.00 29, 927 0 01400 CENTRAL SERVICES & SUPPLY 14.00 549, 533 2, 944 14.00 01500 PHARMACY 2, 975, 743 15.00 34.304 15.00 3, 344, 794 16.00 01600 MEDICAL RECORDS & LIBRARY 3, 297 1, 058 16.00 01700 SOCIAL SERVICE 17.00 C Ω 17.00 C 0 01701 MENTAL HEALTH OVERHEAD 1,083,573 17.01 17.01 22, 253 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 149, 962 0 C 0 O 23.00 02301 PARAMED ED PRGM-LAB 0 23.01 29,814 Ω Λ 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 9, 853, 939 30.00 03000 ADULTS & PEDIATRICS 247, 320 242, 494 30.00 03100 INTENSIVE CARE UNIT 1, 916, 299 131, 955 31.00 31.00 0 0 04000 SUBPROVIDER - IPF 619, 785 0 85, 683 40.00 Λ 40.00 41.00 04100 SUBPROVI DER - I RF 3, 596, 582 0 17, 553 0 54,843 41.00 43.00 04300 NURSERY 375,003 0 0 43.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 517, 061 0 122, 224 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 51.00 05101 ENDOSCOPY 51.01 1, 277, 779 0 0 0 0 51.01 05200 DELIVERY ROOM & LABOR ROOM 507, 515 Ω 52 00 52 00 0 0 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 5, 282, 820 64, 704 3, 384 54.00 54.00 0 1, 167, 930 54.01 05401 RADI OLOGY-NON-CAMPUS 2.883 0 54.01 05408 RADI OLOGY-GSH BREAST CENTER 179, 994 54.08 Ω 0 0 54 08 60.00 06000 LABORATORY 4, 042, 920 0 45, 295 0 0 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 954, 012 63.00 63.00 06500 RESPIRATORY THERAPY 2, 395, 473 65.00 996 102, 466 0 65.00 06600 PHYSI CAL THERAPY 66.00 2.871.034 2.302 113, 641 0 66.00 69.00 06900 ELECTROCARDI OLOGY 2, 809, 294 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70 00 0 70.00 07001 NEURODI AGNOSTI CS 70 01 407, 204 9, 206 70 01 4, 248 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 7, 839, 007 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 2, 456, 432 72.00 72.00 0 0 0 07300 DRUGS CHARGED TO PATIENTS 11, 351, 018 73.00 0 0 0 0 73.00 07500 ASC (NON-DISTINCT PART) 0 75.00 2, 149, 743 Ω 0 0 75.00 76.00 03020 MH ANCILLARY OUTPATIENT 0 0 0 76.00 03950 INPATIENT DIALYSIS 76.01 353, 570 0 0 3, 102 0 76.01 OUTPATIENT SERVICE COST CENTERS 90 00 90.00 09000 CLI NI C 1, 101, 246 Ω 0 0 91.00 09100 EMERGENCY 3, 297, 104 0 291, 180 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 213, 325 Ω 996 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | I NTEREST EXPENSE 113.00 0 116. 00 11600 HOSPI CE 1, 240, 387 0 0 0 116.00

			10	5 12/31/2014	6/3/2015 1:34	
			CAPITAL REI	_ATED_COSTS		
Cost Center Description	Net Expenses	BLDG & FIXT	NEW CRC - CT	NEW CRC- CT	NEW CRC-	
	for Cost		EAST	WEST	MEMORI AL	
	Allocation					
	(from Wkst A					
	col . 7)					
	0	1. 00	1. 01	1. 02	1. 03	
118.00 SUBTOTALS (SUM OF LINES 1-117)	162, 759, 863	0	969, 086	1, 160, 911	308, 983	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	32, 064, 871	0	4, 603	0	1, 945	192. 00
194.00 07950 COMMUNITY HEALTH SERVICES	195, 410	0	0	0	0	194. 00
194. 01 07951 WORK FITNESS	0	0	0	0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	676, 652	0	0	0	4, 365	194. 02
194.03 07953 MH RESIDENTIAL	943, 673	0	0	0	0	194. 03
194. 04 07954 UNUSED SPACE	0	0	18, 141	0	35, 667	194. 04
194. 05 07955 MOB	945, 008	0	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	1, 045, 401	0	0	0	2, 165	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	90	0	0	0	12, 995	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	16, 855	0	0	0	0	194. 08
194. 09 07959 NRCC	2, 028, 388	0	0	4, 795	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 118-201)	200, 676, 211	0	991, 830	1, 165, 706	366, 120	202. 00

	CAPITAL RELATED COSTS					
Cost Center Description	NEW CRC -	NEW CRD -	NEW CRC -	NEW CRC -	MVBLE EQUIP	
cost center bescription	OUTPATI ENT	HEALTH	STORAGE	DI AGNOSTI C	WVDLL LQUIF	
	1.04	PAVI LI ON 1. 05	1.06	1. 07	2. 00	
GENERAL SERVICE COST CENTERS		00		07	2, 33	
1.00   00100   CAP REL COSTS-BLDG & FIXT 1.01   00101   NEW CRC - CT EAST						1. 00 1. 01
1. 02   00102   NEW CRC- CT WEST						1. 02
1. 03 O0103 NEW CRC- MEMORI AL						1. 03
1.04   OO104 NEW CRC - OUTPATIENT 1.05   OO105 NEW CRD - HEALTH PAVILION	502, 037 0	1, 533, 051				1. 04 1. 05
1.06   00106   NEW CRC - STORAGE	O	0	1, 224			1.06
1. 07 00107 NEW CRC - DIAGNOSTIC CENTER	0	0	0	411, 426		1. 07
2. 00   00200   CAP REL COSTS-MVBLE EQUI P 2. 01   00201   NEW CRC - EQUI PMENT					5, 181, 269 0	2. 00 2. 01
2. 02   OO202   NEW CRC - HEALTH PAVILION					0	2. 02
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	1, 894	0	0	0	0	4. 00
4. 01   00401   COMMUNI CATI ONS 4. 02   00402   PURCHASI NG & RECEI VI NG	0 3, 194	0	0	0	0 437, 100	4. 01 4. 02
4. 03   00403   REGI STRATI ON	0	15, 740	o	0	0	4. 03
4.04   OO404   PATI ENT ACCOUNTS	21, 549	0	0	0	0	4. 04
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	13, 841 49, 598	52, 495 282, 114	0 1, 224	0 128, 004	107, 063 501, 406	5. 00 7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE	9, 936	202, 114	0	120, 004	0	8.00
9. 00 00900 HOUSEKEEPI NG	7, 296	6, 024	0	0	32, 423	9. 00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A	0	0 3, 369	0	0	0 385, 460	10. 00 11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	1, 034	0, 307	0	0	156, 339	13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	O	1, 531	0	0	0	14. 00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	0 343	0 3, 659	0	0	179, 204 17, 225	15. 00 16. 00
17. 00   01700   SOCIAL SERVICE	0	3, 659	0	0	17, 225	17. 00
17.01 01701 MENTAL HEALTH OVERHEAD	0	o	0	0	116, 249	17. 01
23. 00   02300   PARAMED ED   PRGM-(SPECIFY)	0	0	0	0	0	23. 00
23. 01   02301   PARAMED ED PRGM-LAB   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J U	U	0	U	0	23. 01
30. 00 03000 ADULTS & PEDIATRICS	14, 383	322, 848	0	0	1, 291, 982	30. 00
31. 00   03100   I NTENSI VE CARE UNI T 40. 00   04000   SUBPROVI DER - I PF	0	0	0	0	0	31.00
40. 00   04000   SUBPROVI DER -   1 PF 41. 00   04100   SUBPROVI DER -   1 RF		ol Ol	0	0	447, 604 91, 696	40. 00 41. 00
43. 00 04300 NURSERY	0	0	0	0	0	43. 00
ANCILLARY SERVICE COST CENTERS  50. 00   O5000   OPERATING ROOM	l ol	ol	ol	0	638, 493	50.00
51. 00   05100   RECOVERY ROOM	0	o	0	0	030, 473	51.00
51. 01   05101   ENDOSCOPY	O	208, 229	0	0	0	51. 01
52. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	52. 00 53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	3, 494	75, 672	0	198, 486	_	
54. 01 05401 RADI OLOGY-NON-CAMPUS	1, 730	2, 382	0	84, 936	15, 063	54. 01
54. 08   05408   RADI OLOGY-GSH   BREAST CENTER 60. 00   06000   LABORATORY	3, 326	0 6, 977	0	0	0 236, 619	54. 08 60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0, 320	0, 777	0	0	230, 017	63.00
65. 00 06500 RESPIRATORY THERAPY	O	o	0	0	5, 201	65. 00
66. 00   06600   PHYSI CAL THERAPY 69. 00   06900   ELECTROCARDI OLOGY	2, 274	1, 600 175, 881	0	0	12, 023 0	66. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	O	125, 989	0	0	48, 094	70. 01
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS		ol	0	0	0	72. 00 73. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	O	0	0	0	75. 00
76. 00   03020 MH ANCILLARY OUTPATIENT 76. 01   03950   NPATIENT DIALYSIS	14 711	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS	14, 711	<u> </u>	U	0	0	76. 01
90. 00 09000 CLI NI C	5, 034	0	0	0	0	90. 00
91. 00 09100 EMERGENCY	0	0	0	0	0	91.00
92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	743	0	0	0	5, 201	96. 00
101. 00 10100 HOME HEALTH AGENCY	0	o	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	9, 172	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	163, 552	1, 284, 510	1, 224	411, 426	5, 062, 453	118. 00

			10	0 12/31/2014	6/3/2015 1:34	
		CAPI	TAL RELATED CO	STS		
Cost Center Description	NEW CRC - OUTPATIENT	NEW CRD - HEALTH PAVILION	NEW CRC - STORAGE	NEW CRC - DI AGNOSTI C CENTER	MVBLE EQUIP	
	1.04	1. 05	1.06	1. 07	2. 00	
NONREI MBURSABLE COST CENTERS			,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	193, 097	81, 883	0	0	24, 047	192. 00
194. 00 07950 COMMUNITY HEALTH SERVICES	4, 785	0	0	0	0	194. 00
194. 01 07951 WORK FITNESS	0	0	0	0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	0	0	0	194. 02
194. 03 07953 MH RESIDENTIAL	38, 226	0	0	0	0	194. 03
194. 04 07954 UNUSED SPACE	68	0	0	0	94, 769	194. 04
194. 05 07955 MOB	43, 958	166, 658	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	0	0	0	0	0	194. 06
194.07 07957 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. 09 07959 NRCC	58, 351	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 118-201)	502, 037	1, 533, 051	1, 224	411, 426	5, 181, 269	202. 00

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

					0 12/31/2014	6/3/2015 1: 34	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW CRC -	NEW CRC -	EMPLOYEE	COMMUNI CATI ONS	PURCHASING &	
	cost center bescription	EQUI PMENT	HEALTH	BENEFITS	COMMUNICATIONS	RECEI VI NG	
			PAVI LI ON	DEPARTMENT			
		2. 01	2. 02	4. 00	4. 01	4. 02	
4 00	GENERAL SERVICE COST CENTERS	1			T		4 00
1. 00 1. 01	O0100 CAP REL COSTS-BLDG & FLXT						1. 00 1. 01
1.01	00102 NEW CRC - CT WEST						1. 01
1. 02	00103 NEW CRC- MEMORI AL						1. 02
1. 04	00104 NEW CRC - OUTPATIENT						1. 04
1.05	00105 NEW CRD - HEALTH PAVILION						1. 05
1.06	00106 NEW CRC - STORAGE						1. 06
1. 07	00107 NEW CRC - DIAGNOSTIC CENTER						1. 07
2.00	00200 CAP REL COSTS-MVBLE EQUI P	0 445 440					2.00
2. 01 2. 02	OO201   NEW CRC - EQUIPMENT   OO202   NEW CRC - HEALTH PAVILION	2, 445, 413	1, 040, 479				2. 01 2. 02
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	15, 988	1, 040, 479	21, 860, 931			4. 00
4. 01	00401 COMMUNI CATI ONS	13, 700	0	56, 261			4. 01
4. 02	00402 PURCHASING & RECEIVING	53, 226	0	146, 908		1, 209, 198	4. 02
4.03	00403 REGI STRATI ON	4, 358	10, 683	166, 633	3, 190	727	4. 03
4.04	00404 PATIENT ACCOUNTS	57, 721	0	441, 548	14, 644	2, 545	4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	114, 883	35, 628	1, 869, 250		15, 560	5. 00
7.00	00700 OPERATION OF PLANT	390, 076	191, 470	520, 184		18, 870	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	35, 085	4 000	46, 225		3, 419	8. 00
10. 00	00900  HOUSEKEEPI NG   01000  DI ETARY	32, 304	4, 088	421, 734 76, 197		9, 870 49, 070	9. 00 10. 00
11. 00	ł I	41, 885	2, 287	221, 710		49,070	11. 00
13. 00	ł I	18, 675	2, 20,	363, 829			13. 00
14. 00	· · · · · · · · · · · · · · · · · · ·	927	1, 039	83, 412		4, 009	14.00
15. 00	01500 PHARMACY	19, 141	0	593, 468	5, 800	463, 805	15. 00
16. 00	· · · · · · · · · · · · · · · · · · ·	3, 488	2, 483	540, 555	11, 744	756	16. 00
17. 00	I I	0	0	C	-	0	17. 00
17. 01		12, 416	0	324, 843		5, 013	17. 01
23. 00 23. 01		0	0	41, 229 4, 026		11 151	23. 00 23. 01
23.01	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	)	<u> </u>	4, 020	ı o	131	23.01
30.00		283, 562	219, 119	1, 803, 493	66, 839	47, 400	30. 00
31. 00	03100 INTENSIVE CARE UNIT	27, 005	0	381, 450	5, 510	6, 944	31.00
40. 00		47, 808	0	105, 096		0	40.00
41. 00		49, 453	0	592, 178		3, 847	41.00
43. 00	04300  NURSERY   ANCI LLARY SERVI CE COST CENTERS	0	0	76, 107	0	1, 372	43. 00
50. 00		68, 197	0	943, 046	11, 020	68, 798	50. 00
51. 00	05100 RECOVERY ROOM	0	0	· O		0	51.00
51. 01	05101 ENDOSCOPY	44, 143	141, 324	221, 767	3, 335	12, 342	51. 01
52. 00		0	0	97, 550	0	3, 391	52.00
53. 00	l l	0	0	0	0	0	53. 00
54. 00	l l	83, 990	51, 358	865, 343 190, 073		44, 785	54.00
54. 01 54. 08	ł I	15, 894 0	1, 617	61, 998		5, 122 256	54. 01 54. 08
60.00	ł I	33, 112	4, 735	577, 735		105, 339	60.00
63.00		0	0	C	0	0	63.00
65.00		21, 525	0	475, 991	3, 915	10, 514	65.00
66. 00		29, 227	1, 086	564, 224		4, 220	66. 00
69. 00	I I	37, 285	119, 370	1, 013, 107	6, 380	48, 768	69. 00
70.00		0	05 500	C 57 447	0	0	70.00
70. 01 71. 00	I I	32, 715	85, 508	57, 447	3, 335	1, 780 0	70. 01 71. 00
71.00		0	0	0	0	101, 446	71.00
73. 00		0	Ö	106, 664	o	0	73. 00
75. 00		0	0	217, 103		53, 599	75. 00
76.00		0	0	C	0	0	76. 00
76. 01		28, 761	0	C	1, 305	173	76. 01
	OUTPATIENT SERVICE COST CENTERS		ما	000 540	1	10.555	
90. 00 91. 00		9, 624 59, 590	0	328, 540		19, 555	90. 00 91. 00
91.00		59, 590	U	628, 882	6, 960	10, 975	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
96. 00		1, 977	0	12, 740	0	3, 184	96. 00
101.0	O 10100 HOME HEALTH AGENCY	0	0	C			101. 00
440 -	SPECIAL PURPOSE COST CENTERS						440.00
	0	17, 535		160, 147	435	2 205	113. 00 116. 00
118.0		1, 691, 576	871, 795				
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	,, -, 0	2, . , 9	., , . , . ,		,,	

				1	0 12/31/2014	6/3/2015 1:34	
		CAPITAL REL	ATED COSTS			07 07 2010 1. 01	Pili
	Cost Center Description	NEW CRC - EQUI PMENT	NEW CRC - HEALTH PAVILION	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	PURCHASI NG & RECEI VI NG	
		2. 01	2. 02	4. 00	4. 01	4. 02	
NONRE	MBURSABLE COST CENTERS						
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	390, 509	55, 574	5, 689, 204	62, 492	60, 419	192. 00
194. 00 07950	COMMUNITY HEALTH SERVICES	9, 148	0	33, 659	5, 365	963	194. 00
194. 01 07951	WORK FITNESS	0	0	0	0	0	194. 01
194. 02 07952	MARKETING AND PUBLIC RELATIONS	3, 156	0	29, 329	0	9, 732	194. 02
194. 03 07953	MH RESIDENTIAL	73, 085	0	179, 525	0	2, 462	194. 03
194. 04 07954	UNUSED SPACE	36, 045	0	0	0	0	194. 04
194. 05 07955	MOB	119, 374	113, 110	162, 089	435	1, 344	194. 05
194. 06 07956	FOUNDATI ON	1, 566	0	21, 868	0	2, 804	194. 06
194. 07 07957	KNOX COUNTY HEALTH DEPT	9, 397	0	0	2, 030	0	194. 07
194. 08 07958	INDUSTRIAL HEALTH	0	0	2, 613	0	2	194. 08
194. 09 07959	NRCC	111, 557	0	343, 951	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 118-201)	2, 445, 413	1, 040, 479	21, 860, 931	321, 306	1, 209, 198	202. 00

					0 12/31/2014	6/3/2015 1:34	
	Cost Center Description	REGI STRATI ON	PATI ENT	Subtotal	ADMI NI STRATI VE		
		4.03	ACCOUNTS 4. 04	4A. 04	& GENERAL 5.00	PLANT 7. 00	
	GENERAL SERVICE COST CENTERS	4.03	4.04	4A. 04	5. 00	7.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 NEW CRC - CT EAST						1. 01
1.02	00102 NEW CRC- CT WEST						1. 02
1.03	00103 NEW CRC- MEMORI AL						1. 03
1. 04 1. 05	OO104   NEW CRC - OUTPATIENT   OO105   NEW CRD - HEALTH PAVILION						1. 04 1. 05
1.05	00105 NEW CRD - HEALTH PAVILION  00106 NEW CRC - STORAGE					ļ	1.05
1. 07	00107 NEW CRC - DIAGNOSTIC CENTER						1. 07
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 NEW CRC - EQUI PMENT						2. 01
2.02	00202 NEW CRC - HEALTH PAVILION						2. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01	00401 COMMUNI CATI ONS						4. 01
4. 02	00402 PURCHASING & RECEIVING	4 00/ 07/					4. 02
4. 03	00403 REGISTRATION	1, 036, 974	4 2/1 240				4. 03
4. 04 5. 00	OO4O4  PATIENT ACCOUNTS   OO5O0  ADMINISTRATIVE & GENERAL	0	4, 261, 248	31, 195, 889	31, 195, 889		4. 04 5. 00
7. 00	00700 OPERATION OF PLANT		0	8, 697, 046	1, 600, 848	10, 297, 894	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE		Ö	426, 106	78, 432	199, 707	8. 00
9. 00	00900 HOUSEKEEPI NG	o	ol	2, 772, 373	510, 305	183, 876	9. 00
10.00	01000 DI ETARY	o	O	862, 032	158, 673	0	1
11. 00	01100 CAFETERI A	o	O	1, 656, 760	304, 956	238, 412	11. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	2, 460, 823	452, 959	106, 301	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	0	644, 555	118, 642	5, 277	14. 00
15.00	01500 PHARMACY	0	0	4, 271, 465	786, 240	108, 950	1
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	3, 929, 402 0	723, 277	19, 856	1
17. 00 17. 01	O1700   SOCIAL SERVICE   O1701   MENTAL HEALTH OVERHEAD	0	0	1, 581, 601	0 291, 122	0 70, 676	17. 00 17. 01
23. 00	02300 PARAMED ED PRGM-(SPECIFY)		0	1, 381, 001	35, 194	70, 070	23. 00
23. 01	02301 PARAMED ED PRGM-LAB		Ö	33, 991	6, 257	Ö	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS		-1		5/ = 5 · [	-	
30.00	03000 ADULTS & PEDIATRICS	89, 853	369, 225	14, 852, 457	2, 733, 862	1, 614, 060	30. 00
31.00	03100 INTENSIVE CARE UNIT	14, 592	59, 960	2, 543, 715	468, 217	153, 712	31. 00
40. 00	04000 SUBPROVI DER - I PF	11, 821	48, 574	1, 367, 241	251, 665	272, 128	1
41. 00	04100 SUBPROVI DER - I RF	15, 911	65, 384	4, 498, 467	828, 024	281, 491	41. 00
43. 00	04300 NURSERY	2, 367	9, 727	464, 576	85, 514	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS    05000   OPERATING ROOM	68, 185	280, 186	6, 717, 210	1, 236, 423	388, 182	50.00
51. 00	05100 RECOVERY ROOM	00, 103	200, 100	0, 717, 210	1, 230, 423	0	51.00
51. 01	05101 ENDOSCOPY	24, 927	102, 430	2, 036, 276	374, 813	251, 266	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 695	35, 729	652, 880	120, 174	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	172, 076	707, 192	7, 905, 666	1, 455, 180	478, 076	
54. 01	05401 RADI OLOGY-NON-CAMPUS	40, 882	167, 991	1, 696, 503	312, 272	90, 470	
54. 08	O5408   RADI OLOGY-GSH BREAST CENTER	854	3, 508	246, 610	45, 393	100 475	54. 08
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	107, 178 5, 895	440, 420 24, 225	5, 610, 326 984, 132		188, 475 0	1
65. 00	06500 RESPIRATORY THERAPY	21, 476	88, 248	3, 125, 805	181, 147 575, 361	122, 522	
66. 00	06600 PHYSI CAL THERAPY	57, 624	236, 791	3, 896, 771	717, 271	166, 361	66. 00
69. 00	06900 ELECTROCARDI OLOGY	67, 546	277, 560	4, 555, 191	838, 465	212, 232	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	13, 265	54, 510	843, 301	155, 225	186, 216	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	18, 823	77, 347	7, 935, 177	1, 460, 612	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	27, 668	113, 693	2, 699, 239	496, 844	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	124, 997	513, 641	12, 096, 320		0	73. 00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03020 MH ANCILLARY OUTPATIENT	48, 192 0	198, 032	2, 675, 949 0	492, 557 0	0	75. 00 76. 00
	03950 I NPATI ENT DI ALYSI S	2,770	11, 384	415, 776	76, 531	163, 712	76. 00 76. 01
70.01	OUTPATIENT SERVICE COST CENTERS	2,770	11, 304	413,770	70, 331	103, 712	70.01
90.00	09000 CLI NI C	8, 056	33, 103	1, 505, 158	277, 051	54, 783	90.00
91. 00	09100 EMERGENCY	75, 703	311, 082	4, 681, 476		339, 189	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART			0	·		92. 00
	OTHER REIMBURSABLE COST CENTERS	,					
	09600 DURABLE MEDICAL EQUIP-RENTED	1, 472	6, 050	245, 688		11, 252	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
110.00	SPECIAL PURPOSE COST CENTERS				ı		112 00
	11300 INTEREST EXPENSE  11600 HOSPICE	6, 146	25, 256	1, 461, 383	268, 994	99, 812	113.00
118.00		1, 036, 974	4, 261, 248	154, 436, 538		6, 006, 994	1
110.00	NONREI MBURSABLE COST CENTERS	1,030,714	7, 201, 240	137, 430, 330	22, 004, 004	5, 500, 774	1.10.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	ol	0	190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	Ō	38, 628, 644	7, 110, 282	2, 222, 809	192. 00
	07950 COMMUNITY HEALTH SERVICES	o	o	249, 330		52, 072	

In Lieu of Form CMS-2552-10 Health Financial Systems GOOD SAMARITAN HOSPITAL COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150042 Worksheet B Peri od:

From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 6/3/2015 1:34 pm Cost Center Description REGI STRATI ON PATI ENT Subtotal ADMINISTRATIVE OPERATION OF ACCOUNTS & GENERAL PLANT 4. 03 4. 04 4A. 04 5.00 7.00 194. 01 07951 WORK FITNESS 0 194. 01 0 0 0 0 0 0 0 194.02 07952 MARKETING AND PUBLIC RELATIONS 17, 967 194. 02 0 723, 234 133, 124 194. 03 07953 MH RESIDENTIAL 0 1, 236, 971 227, 687 416, 004 194. 03 184, 690 194. 04 07954 UNUSED SPACE 33, 996 205, 169 194. 04 0 194. 05 07955 MOB 194. 06 07956 FOUNDATION 0 1, 551, 976 679, 487 194. 05 285, 669 0 8, 911 194. 06 1, 073, 804 197, 653 194. 07 07957 KNOX COUNTY HEALTH DEPT 24, 512 4, 512 53, 489 194. 07

1, 036, 974

0

4, 261, 248

19, 470

0

2, 547, 042

200, 676, 211

3, 584

468, 829

31, 195, 889

0 194. 08

200. 00

0 201. 00

634, 992 194. 09

10, 297, 894 202. 00

194. 08 07958 I NDUSTRI AL HEALTH

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

194. 09 07959 NRCC

200.00

201.00

202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: | 6/3/2015 1:34 pm

			1				6/3/2015 1: 34	pm
		Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
			LINEN SERVICE 8.00	9. 00	10.00	11.00	ADMI NI STRATI ON 13. 00	
	GENER	AL SERVICE COST CENTERS	0.00	7.00	10.00	11.00	13.00	
1.00		CAP REL COSTS-BLDG & FIXT						1. 00
1.01	00101	NEW CRC - CT EAST						1. 01
1.02		NEW CRC- CT WEST						1. 02
1.03		NEW CRC- MEMORIAL						1. 03
1.04		NEW CRC - OUTPATIENT						1.04
1.05		NEW CRD - HEALTH PAVILION						1. 05
1.06		NEW CRC - STORAGE						1.06
1. 07 2. 00	1	NEW CRC - DIAGNOSTIC CENTER   CAP REL COSTS-MVBLE EQUIP						1. 07 2. 00
2.00		NEW CRC - EQUIPMENT						2.00
2. 02		NEW CRC - HEALTH PAVILION						2. 02
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01	1	COMMUNI CATI ONS						4. 01
4.02		PURCHASING & RECEIVING						4. 02
4.03	00403	REGI STRATI ON						4. 03
4.04	00404	PATIENT ACCOUNTS						4. 04
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
7. 00	1	OPERATION OF PLANT						7. 00
8.00		LAUNDRY & LINEN SERVICE	704, 245	0.504.404				8. 00
9.00		HOUSEKEEPI NG	37, 640	3, 504, 194				9.00
10. 00 11. 00		DI ETARY CAFETERI A	6, 380	107, 578 18, 899		2, 219, 027		10. 00 11. 00
13.00		NURSING ADMINISTRATION		10, 699	1	36, 343	1	
14. 00		CENTRAL SERVICES & SUPPLY	5, 492	42, 859		25, 112		14. 00
15. 00	1	PHARMACY	0, 1,2	34, 944		78, 158	l I	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	o	24, 175	1	113, 132	l	16. 00
17. 00	01700	SOCIAL SERVICE	0	0	1	. 0	l .	17. 00
17. 01	01701	MENTAL HEALTH OVERHEAD	12, 598	101, 978	0	132, 632	0	17. 01
23. 00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	5, 747	0	23. 00
23. 01		PARAMED ED PRGM-LAB	0	0	0	0	0	23. 01
		IENT ROUTINE SERVICE COST CENTERS						
30. 00	1	ADULTS & PEDI ATRI CS	285, 830	1, 160, 096		329, 282		
31. 00	1	INTENSIVE CARE UNIT	37, 321	114, 093		55, 641		
40.00	1	SUBPROVIDER - I PF	0	170.027		54, 112		
41. 00 43. 00	1	SUBPROVIDER - IRF  NURSERY	43, 660 4, 920	179, 027 12, 276		115, 224 10, 835		41. 00 43. 00
43.00		LARY SERVICE COST CENTERS	4, 920	12, 270	32, 102	10, 633	43, 114	43.00
50. 00		OPERATI NG ROOM	28, 128	265, 445	0	60, 870	242, 198	50. 00
51. 00		RECOVERY ROOM	0	0		0	0	51.00
51. 01		ENDOSCOPY	19, 168	57, 289	0	32, 744	0	51. 01
52.00	05200	DELIVERY ROOM & LABOR ROOM	8, 399	15, 184	0	14, 055	55, 926	52. 00
53.00	05300	ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	59, 063	173, 535	0	127, 247		54.00
54. 01		RADI OLOGY-NON-CAMPUS	0	0	1	26, 583	l	54. 01
54. 08		RADIOLOGY-GSH BREAST CENTER	0	0		0	0	54. 08
60.00	1	LABORATORY	0	55, 297		109, 912	0	60.00
63. 00 65. 00		BLOOD STORING, PROCESSING & TRANS.   RESPIRATORY THERAPY	280	0 32, 413		0 63, 081		63. 00 65. 00
66. 00		PHYSICAL THERAPY	24, 277	76, 080		70, 770		66. 00
69. 00		ELECTROCARDI OLOGY	10, 848	88, 194		77, 893		69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0	00, 171	1	0	Ö	70.00
70. 01		NEURODI AGNOSTI CS	19, 546	69, 349	0	11, 480	o	70. 01
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	o	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
75. 00		ASC (NON-DISTINCT PART)	25, 314	167, 774		0	0	75. 00
76. 00		MH ANCILLARY OUTPATIENT	0	0	0	0	0	76. 00
76. 01		I NPATI ENT DI ALYSI S	0	0	0	0	0	76. 01
00 00		TIENT SERVICE COST CENTERS	105	24 220		24 220		00 00
90. 00 91. 00		CLINIC EMERGENCY	195 56, 321	24, 229 166, 589		26, 329 101, 457		90. 00 91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART	30, 321	100, 369	U	101, 437	403, 092	91.00
92.00		REIMBURSABLE COST CENTERS						72.00
96. 00		DURABLE MEDICAL EQUIP-RENTED	O	0	0	2, 683	0	96. 00
		HOME HEALTH AGENCY	l o	0		0		101. 00
		AL PURPOSE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
113.00		INTEREST EXPENSE						113. 00
	1	HOSPI CE	0	41, 190		26, 671		
118.00		SUBTOTALS (SUM OF LINES 1-117)	685, 380	3, 028, 493	1, 134, 663	1, 707, 993	3, 056, 426	118. 00
		I MBURSABLE COST CENTERS	1		1			
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
		PHYSICIANS' PRIVATE OFFICES	18, 865	434, 888		424, 094	l I	192.00
194.00	10195C	COMMUNITY HEALTH SERVICES	<u> </u>	16, 530	0	6, 191	1 0	194. 00

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

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150042 Period: Worksheet B From 01/01/2014 Part I

Part I Date/Time Prepared: 6/3/2015 1:34 pm 12/31/2014 LAUNDRY & HOUSEKEEPI NG Cost Center Description DI ETARY CAFETERI A NURSI NG LINEN SERVICE ADMI NI STRATI ON 8. 00 9.00 10.00 11.00 13.00 194. 01 07951 WORK FITNESS 0 0 0 194. 01 0 0 0 0 0 0 0 0 194. 02 194.02 07952 MARKETING AND PUBLIC RELATIONS 6, 946 6, 407 194. 03 07953 MH RESIDENTIAL 0 0 194. 03 47, 037 194. 04 07954 UNUSED SPACE 0 0 194. 04 194. 05 07955 MOB 194. 06 07956 FOUNDATION 0 194. 05 0 23, 122 0 0 194. 06 3,644 194. 07 07957 KNOX COUNTY HEALTH DEPT 17,876 0 0 194. 07 194. 08 07958 I NDUSTRI AL HEALTH 0 0 0 194. 08 194. 09 07959 NRCC 0 0 194. 09 0 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201. 00 3, 504, 194 1, 134, 663 2, 219, 027 3, 056, 426 202. 00 202.00 TOTAL (sum lines 118-201) 704, 245

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared:

			1	0 12/31/2014	Date/lime Pre 6/3/2015 1:34	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	SERVICES & SUPPLY		RECORDS & LI BRARY		OVERHEAD	
	14. 00	15. 00	16. 00	17. 00	17. 01	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
1.01   00101   NEW CRC - CT EAST 1.02   00102   NEW CRC- CT WEST						1. 01 1. 02
1. 03   00103   NEW CRC-   CT   WEST   1. 03   00103   NEW CRC-   MEMORI AL						1. 02
1. 04   00104 NEW CRC - OUTPATIENT						1. 03
1. 05 00105 NEW CRD - HEALTH PAVILION						1. 05
1. 06 O0106 NEW CRC - STORAGE						1. 06
1.07   OO107 NEW CRC - DIAGNOSTIC CENTER						1. 07
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01   00201   NEW CRC - EQUI PMENT						2. 01
2. 02   00202   NEW CRC - HEALTH PAVILION						2. 02
4.00   00400 EMPLOYEE BENEFITS DEPARTMENT 4.01   00401 COMMUNI CATIONS						4.00
4. 01						4. 01 4. 02
4. 03   00403   REGI STRATI ON						4. 02
4. 04   00404 PATIENT ACCOUNTS						4. 04
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7.00
8.00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00   01100   CAFETERI A						11.00
13. 00   01300   NURSI NG ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	841, 937					13. 00 14. 00
15. 00   01500   PHARMACY	353, 843	5, 633, 600				15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	577	0, 033, 000	4, 810, 419			16. 00
17. 00 01700 SOCI AL SERVI CE	0	o	0,010,117	0		17. 00
17. 01 01701 MENTAL HEALTH OVERHEAD	3, 825	663	0	0	2, 195, 095	17. 01
23.00 02300 PARAMED ED PRGM-(SPECIFY)	9	О	0	0	0	23.00
23. 01 O2301 PARAMED ED PRGM-LAB	116	0	0	0	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	36, 162	9, 992	1, 880, 947	0	1, 007, 443	30.00
31. 00 03100 I NTENSI VE CARE UNI T	5, 298	2, 424	356, 179		105.040	31.00
40. 00   04000   SUBPROVI DER -   PF 41. 00   04100   SUBPROVI DER -   RF	2, 935	3, 279	268, 135 320, 161	0	195, 940 0	40. 00 41. 00
43. 00   04300   NURSERY	1, 046	235	32, 016	0	0	43.00
ANCI LLARY SERVI CE COST CENTERS	1,010	200	02,010	<u> </u>	0	10.00
50. 00 05000 OPERATI NG ROOM	52, 487	22, 489	328, 165	0	0	50.00
51.00   O5100   RECOVERY ROOM	0	O	0	0	0	51.00
51. 01   05101   ENDOSCOPY	9, 416	1, 350	132, 066	0	0	51. 01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	2, 587	268	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   RADI OLOGY-NON-CAMPUS	34, 167	68, 929	0	0	0	54. 00 54. 01
54. 01   03401 RADI OLOGY-NON-CAMPOS 54. 08   05408 RADI OLOGY-GSH BREAST CENTER	3, 908 195	14, 590	0	0	0	54. 01
60. 00   06000   LABORATORY	80, 365	1, 663	0	_	0	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	8, 021	1, 800	20, 010	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	3, 219	6, 815	0	0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	37, 206	457	144, 072	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
70. 01 07001 NEURODI AGNOSTI CS	1, 358	14	100, 050	0	0	70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	77 205	0	0	0	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	77, 395 0	4, 886, 599	0	0	0	72. 00 73. 00
75. 00   07500   DROGS CHARGED TO PATTENTS  75. 00   07500   ASC (NON-DISTINCT PART)	40, 892	5, 655	316, 159	0	798, 840	75. 00 75. 00
76. 00 03020 MH ANCI LLARY OUTPATIENT	10, 072	0, 039	310, 137	0	7 70, 040	76. 00
76. 01 03950 I NPATIENT DI ALYSI S	132	1, 163	0	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	14, 919	3, 953	0	0	0	90. 00
91. 00   09100   EMERGENCY	8, 373	5, 545	912, 459	0	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS	2 420	ما	0		0	07.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	2, 429 0	0	0		0	96. 00 101. 00
101. 00 10100 HOME HEALTH AGENCY SPECI AL PURPOSE COST CENTERS	U <sub>I</sub>	U	0	U	0	101.00
113. 00 11300 I NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	1, 758	14, 910	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	782, 638	5, 052, 793	4, 810, 419	0	2, 002, 223	
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	46, 095	571, 718	0	0	192, 872	192. 00

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

| Period: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 6/3/2015 1:34 pm

					6/3/2015 1:34	_pm
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	MENTAL HEALTH	
	SERVICES &		RECORDS &		OVERHEAD	
	SUPPLY		LI BRARY			
	14. 00	15. 00	16.00	17. 00	17. 01	
194. 00 07950 COMMUNITY HEALTH SERVICES	735	9, 089	0	0	0	194. 00
194. 01 07951 WORK FITNESS	0	0	0	0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	7, 424	0	0	0	0	194. 02
194.03 07953 MH RESIDENTIAL	1, 879	0	0	0	0	194. 03
194. 04 07954 UNUSED SPACE	0	0	0	0	0	194. 04
194. 05 07955 MOB	1, 025	0	0	0	0	194. 05
194. 06 07956 FOUNDATI ON	2, 139	0	0	0	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	2	0	0	0	0	194. 08
194. 09 07959 NRCC	0	0	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 118-201)	841, 937	5, 633, 600	4, 810, 419	0	2, 195, 095	202. 00

Heal th	Finar	ncial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST A	ALLOCA	TION - GENERAL SERVICE COSTS		Provi der	CCN: 150042	Peri od: From 01/01/2014		
						To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
		Cost Center Description	PARAMED ED	PARAMED ED	Subtotal	Intern &	Total	
			PRGM	PRGM-LAB		Residents Cost & Post		
						Stepdown		
			23. 00	23. 01	24. 00	Adjustments 25.00	26. 00	
		AL SERVICE COST CENTERS	20.00	20.01	211.00	20.00	20.00	
1.00		CAP REL COSTS-BLDG & FIXT NEW CRC - CT EAST						1.00
1. 01 1. 02	1	NEW CRC - CT EAST						1. 01 1. 02
1.03	00103	NEW CRC- MEMORIAL	] [					1. 03
1. 04 1. 05		NEW CRC - OUTPATIENT   NEW CRD - HEALTH PAVILION						1. 04 1. 05
1.05	1	NEW CRD - HEALTH PAVILION NEW CRC - STORAGE						1.05
1.07		NEW CRC - DIAGNOSTIC CENTER						1. 07
2. 00 2. 01	1	CAP REL COSTS-MVBLE EQUIP NEW CRC - EQUIPMENT						2. 00 2. 01
2. 02		NEW CRC - HEALTH PAVILION						2. 02
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01 4. 02	1	COMMUNI CATI ONS   PURCHASI NG & RECEI VI NG						4. 01 4. 02
4. 03		REGI STRATI ON						4. 03
4.04		PATIENT ACCOUNTS						4. 04
5. 00 7. 00	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT						5. 00 7. 00
8. 00	00800	LAUNDRY & LINEN SERVICE	1					8. 00
9.00	1	HOUSEKEEPI NG DI ETARY						9. 00 10. 00
10. 00 11. 00	1	CAFETERIA						11.00
13. 00	1	NURSING ADMINISTRATION	]					13. 00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY   PHARMACY						14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY						16. 00
17. 00	1	SOCIAL SERVICE						17. 00
17. 01 23. 00		MENTAL HEALTH OVERHEAD   PARAMED ED PRGM-(SPECIFY)	232, 152					17. 01 23. 00
23. 01	02301	PARAMED ED PRGM-LAB	0	40, 364				23. 01
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	l ol	0	25, 878, 56	55 0	25, 878, 565	30.00
31. 00		INTENSIVE CARE UNIT	0	0	4, 035, 42		4, 035, 427	
40.00		SUBPROVIDER - I PF	0	0	2, 760, 62		2, 760, 620	
41. 00 43. 00	1	SUBPROVI DER - I RF   NURSERY	0	0	6, 961, 54 686, 63		6, 961, 544 686, 634	
<b>50.00</b>		LARY SERVICE COST CENTERS			2 244 54			
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	0	0		97 0 0 0		1
		ENDOSCOPY	0	0			l .	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM   ANESTHESIOLOGY	0	0	869, 47	73 0	869, 473 0	52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	232, 152	0	10, 534, 0°		10, 534, 015	
54. 01	1	RADI OLOGY-NON-CAMPUS	0	0	2, 144, 32	26 0	2, 144, 326	54. 01
54. 08 60. 00	1	RADIOLOGY-GSH BREAST CENTER LABORATORY	0	0 40, 364	292, 19 7, 119, 08		292, 198 7, 119, 083	
63. 00		BLOOD STORING, PROCESSING & TRANS.	0	40, 304	1, 165, 27		1, 165, 279	
65.00		RESPI RATORY THERAPY	0	0	3, 949, 29		3, 949, 293	1
66. 00 69. 00	1	PHYSI CAL THERAPY   ELECTROCARDI OLOGY	0	0	4, 961, 56 5, 964, 55		4, 961, 564 5, 964, 558	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
70. 01 71. 00		NEURODI AGNOSTI CS   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	1, 386, 53 9, 395, 78		1, 386, 539 9, 395, 789	
71.00		IMPL. DEV. CHARGED TO PATIENTS	0	0	3, 273, 47		3, 273, 478	1
73. 00		DRUGS CHARGED TO PATIENTS	0	0	19, 209, 46		19, 209, 464	
75. 00 76. 00		ASC (NON-DISTINCT PART) MH ANCILLARY OUTPATIENT	0	0	4, 523, 14	10 0 0 0	4, 523, 140 0	75. 00 76. 00
76. 01		INPATIENT DIALYSIS	0	0	657, 3°	-	657, 314	
00 00		TIENT SERVICE COST CENTERS		0	1 004 41	17	1 004 417	00.00
90. 00 91. 00		CLINIC EMERGENCY	0	0	1, 906, 6´ 7, 536, 8´		1, 906, 617 7, 536, 811	
92. 00	09200	OBSERVATION BEDS (NON-DISTINCT PART			,	0	, , , , ,	92. 00
96 NN		REIMBURSABLE COST CENTERS DURABLE MEDICAL EQUIP-RENTED	l ol	0	307, 27	75 0	307, 275	96 00
	10100	HOME HEALTH AGENCY	0	0		0 0	1	101. 00
112 00		AL PURPOSE COST CENTERS						112 00
		I NTEREST EXPENSE   HOSPI CE	О	0	2, 020, 83	39 0	2, 020, 839	113. 00 116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	232, 152	40, 364				

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150042 Peri od: Worksheet B From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 6/3/2015 1:34 pm Cost Center Description PARAMED ED PARAMED ED Subtotal Intern & Total PRGM PRGM-LAB Residents Cost & Post Stepdown Adjustments 23.00 23. 01 24.00 25.00 26.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 190. 00 0 0 0 0 0 0 0 0 0 0 49, 650, 267 0 0 0 0 0 0 0 0 0 0 0 49, 650, 267 192. 00 0 194. 00 07950 COMMUNITY HEALTH SERVICES 379, 841 194. 00 0 379, 841 194. 01 07951 WORK FITNESS 0 194. 01 895, 102 194. 02 07952 MARKETING AND PUBLIC RELATIONS 895, 102 194. 02 194. 03 07953 MH RESIDENTIAL 1, 929, 578 1, 929, 578 194. 03 194. 04 07954 UNUSED SPACE 423, 855 423, 855 194. 04 194. 05 07955 MOB 2, 541, 279 2, 541, 279 194. 05 194. 06 07956 FOUNDATION 0 1, 286, 151 1, 286, 151 194. 06 194.07 07957 KNOX COUNTY HEALTH DEPT 0 100, 389 100, 389 194. 07 194. 08 07958 I NDUSTRI AL HEALTH 23, 056 23, 056 194. 08 194. 09 07959 NRCC 3, 650, 863 3, 650, 863 194. 09 200.00 Cross Foot Adjustments 0 200. 00 Ω 0

0

40, 364

232, 152

0

200, 676, 211

0 201.00

200, 676, 211 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

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

						6/3/2015 1: 34	
				CAPITAL REI	LATED COSTS		
	Cost Center Description	Di rectly	BLDG & FIXT	NEW CRC - CT	NEW CRC- CT	NEW CRC-	
	'	Assi gned New		EAST	WEST	MEMORI AL	
		Capital Related Costs					
		0	1.00	1. 01	1. 02	1. 03	
	GENERAL SERVI CE COST CENTERS		Г				
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FLXT 00101 NEW CRC - CT EAST						1. 00 1. 01
1. 01	00101 NEW CRC - CT EAST						1. 01
1. 03	00103 NEW CRC- MEMORIAL						1. 03
1.04	00104 NEW CRC - OUTPATIENT						1. 04
1.05	00105 NEW CRD - HEALTH PAVILION						1.05
1. 06 1. 07	00106 NEW CRC - STORAGE 00107 NEW CRC - DIAGNOSTIC CENTER						1. 06 1. 07
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01	00201 NEW CRC - EQUI PMENT						2. 01
2. 02	00202 NEW CRC - HEALTH PAVILION						2. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	_	0	17, 100	4. 00
4. 01 4. 02	00401 COMMUNI CATI ONS 00402 PURCHASI NG & RECEI VI NG	0		0 83, 672	0	0 599	4. 01 4. 02
4. 03	00403 REGI STRATI ON	0	Ö	00,072	4, 988	0	4. 03
4.04	00404 PATIENT ACCOUNTS	0	0	0	0	22, 847	4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	0	0	20, 495	96, 843	63, 662	5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	0	95, 982 0	139, 288	115, 457 22, 248	7. 00 8. 00
9. 00	00900 HOUSEKEEPING	0		6, 207	23, 320	12, 227	9. 00
10.00	01000 DI ETARY	0	Ö	0	0	0	10.00
11. 00	01100 CAFETERI A	0	0	73, 787	0	0	11. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON	0	0	29, 927	0	0	13.00
15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0		0 34, 304	2, 944	0	14. 00 15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	Ö	3, 297	1, 058	0	16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
17. 01	01701 MENTAL HEALTH OVERHEAD	0	0	22, 253	0	0	17. 01
23. 00 23. 01	O2300   PARAMED ED   PRGM-(SPECIFY)   O2301   PARAMED ED   PRGM-LAB	0	0		0	0	23. 00 23. 01
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	0		0	- υ <sub>Ι</sub>	0	23.01
30.00	03000 ADULTS & PEDIATRICS	0	0	247, 320	242, 494	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	131, 955	0	31. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0	85, 683 17, 553	0	0 54, 843	40. 00 41. 00
43. 00	04300 NURSERY	0			0	0 0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	50.00
51. 00 51. 01	05100   RECOVERY   ROOM   05101   ENDOSCOPY	0	0	0	0	0	51. 00 51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	o	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		3, 384	0	
54. 01 54. 08	O5401   RADI OLOGY-NON-CAMPUS   O5408   RADI OLOGY-GSH   BREAST CENTER	0	0	2, 883 0	0	0	54. 01 54. 08
60.00	06000 LABORATORY	0		45, 295	0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö	0	ō	0	63.00
65. 00	06500 RESPIRATORY THERAPY	0	0	996	102, 466	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	2, 302	113, 641	0	66.00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY			[ 0	0	0	69. 00 70. 00
70. 01	07001 NEURODI AGNOSTI CS		0	9, 206	4, 248	0	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 DRUCS 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	73. 00 75. 00
76. 00	03020 MH ANCI LLARY OUTPATIENT	0	Ö	Ö	ő	0	76.00
76. 01	03950 INPATIENT DIALYSIS	0	0	0	3, 102	0	76. 01
00.00	OUTPATIENT SERVICE COST CENTERS				ما		00.00
90.00	09000 CLI NI C 09100 EMERGENCY	0	0		0 291, 180	0	90. 00 91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				271, 100	O	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	
101.00	10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
113.00	11300 INTEREST EXPENSE						113. 00
116.00	11600 HOSPI CE	0	0		O	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	969, 086	1, 160, 911	308, 983	118. 00

			1	0 12/31/2014	Date/IIme Pre   6/3/2015 1:34	
		<u>'</u>	CAPITAL RE	LATED COSTS		
Cost Center Description	Di rectly Assigned New Capital	BLDG & FIXT	NEW CRC - CT EAST	NEW CRC- CT WEST	NEW CRC- MEMORIAL	
	Related Costs	4 00	1 01	4 00	4 00	
NONDEL MOUDEARLE, COCT, CENTERS	0	1. 00	1. 01	1. 02	1. 03	
NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		٥	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	4, 603			192.00
194. 00 07950 COMMUNITY HEALTH SERVICES	o o	0	0	o		194. 00
194. 01 07951 WORK FITNESS	0	0	0	0		194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	0	0	4, 365	194. 02
194. 03 07953 MH RESI DENTI AL	0	0	0	0		194. 03
194. 04 07954 UNUSED SPACE	0	0	18, 141	0	· ·	194. 04
194. 05 07955 MOB	0	0	0	0		194. 05
194. 06 07956  FOUNDATION	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 194. 09 07959  NRCC	0	0	0	4, 795		194. 08
200.00 Cross Foot Adjustments	U	Ü	0	4, 795	U	194. 09 200. 00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	o	0	991, 830	1, 165, 706	366, 120	1

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150042

Peri od: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared:

6/3/2015 1:34 pm CAPITAL RELATED COSTS NEW CRC -NEW CRD -NEW CRC -NEW CRC -MVBLE EQUIP Cost Center Description DI AGNOSTI C **OUTPATIENT** HEALTH STORAGE PAVI LI ON CENTER 1.04 1.05 1.06 1.07 2.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 NEW CRC - CT EAST 1.01 1.01 1.02 00102 NEW CRC- CT WEST 1.02 00103 NEW CRC- MEMORIAL 1.03 1.03 00104 NEW CRC - OUTPATIENT 1.04 1.04 00105 NEW CRD - HEALTH PAVILION 1.05 1.05 1.06 00106 NEW CRC - STORAGE 1.06 1.07 00107 NEW CRC - DIAGNOSTIC CENTER 1.07 00200 CAP REL COSTS-MVBLE EQUIP 2 00 2 00 00201 NEW CRC - EQUIPMENT 2.01 2.01 2.02 00202 NEW CRC - HEALTH PAVILION 2.02 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1,894 4.00 0 00401 COMMUNI CATI ONS 0 4 01 4 01 0 4.02 00402 PURCHASING & RECEIVING 3, 194 0 437, 100 4.02 00403 REGI STRATI ON 4.03 15, 740 0 0 4.03 0 00404 PATIENT ACCOUNTS 4 04 21 549 0 0 4 04 0 5.00 00500 ADMINISTRATIVE & GENERAL 13,841 52, 495 Ω 107, 063 5.00 7.00 00700 OPERATION OF PLANT 49, 598 282, 114 1, 224 128, 004 501, 406 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 9,936 8.00 C 00900 HOUSEKEEPING 0 7, 296 6,024 O 9 00 32.423 9 00 10.00 01000 DI ETARY 0 0 0 10.00 01100 CAFETERI A 0 385, 460 11.00 3, 369 11.00 0 156, 339 13.00 01300 NURSING ADMINISTRATION 1.034 0 13.00 01400 CENTRAL SERVICES & SUPPLY 0 14 00 0 1, 531 0 14 00 0 15.00 01500 PHARMACY 0 179, 204 15.00 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 343 3, 659 17, 225 16.00 0 01700 SOCIAL SERVICE 17.00 0 0 17.00 n 0 01701 MENTAL HEALTH OVERHEAD 0 17.01 C 116, 249 17.01 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23.00 23.00 C 0 02301 PARAMED ED PRGM-LAB 23.01 0 23 01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 14, 383 322, 848 0 0 1, 291, 982 30.00 03100 INTENSIVE CARE UNIT 0 31.00 31.00 04000 SUBPROVIDER - IPF 0 0 40.00 0 C 447, 604 40.00 04100 SUBPROVIDER - IRF 0 0 41.00 0 41.00 C 91, 696 04300 NURSERY 0 43.00 0 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM C 638, 493 50.00 51.00 05100 RECOVERY ROOM 0 0 0 Λ 51.00 51.01 05101 ENDOSCOPY 0 208, 229 0 0 51.01 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 o 52.00 05300 ANESTHESI OLOGY 53.00 0 0 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 3.494 75, 672 198, 486 338,008 54.00 54.01 05401 RADI OLOGY-NON-CAMPUS 1,730 2, 382 84.936 15,063 54.01 05408 RADI OLOGY-GSH BREAST CENTER 0 54.08 0 54.08 0 06000 LABORATORY 60.00 3, 326 6, 977 0 236, 619 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 06500 RESPIRATORY THERAPY 0 0 65.00 5, 201 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 2.274 1,600 12.023 66.00 69.00 06900 ELECTROCARDI OLOGY 175, 881 0 Λ 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70.00 70.01 07001 NEURODI AGNOSTI CS 0 125, 989 0 48,094 70.01 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 C 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 C 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 0 03020 MH ANCILLARY OUTPATIENT 76 00 0 76 00 Ω 0 03950 INPATIENT DIALYSIS 0 76.01 14, 711 0 0 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 5.034 0 0 90.00 O 91.00 09100 EMERGENCY 91.00 C 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 96, 00 09600 DURABLE MEDICAL EQUIP-RENTED C 5, 201 96.00 743 0 101.00 10100 HOME HEALTH AGENCY C 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 9.172 nl116, 00 0 0 118.00 SUBTOTALS (SUM OF LINES 1-117) 163, 552 1, 284, 510 1, 224 411, 426 5, 062, 453 118. 00 ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150042

Worksheet B Peri od: From 01/01/2014 Part II Date/Time Prepared: То 12/31/2014

6/3/2015 1:34 pm CAPITAL RELATED COSTS NEW CRC -NEW CRD -NEW CRC -NEW CRC -MVBLE EQUIP Cost Center Description **OUTPATIENT** HEALTH STORAGE DI AGNOSTI C PAVI LI ON CENTER 2.00 1.04 1.06 1.05 1.07 NONREI MBURSABLE COST CENTERS

190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 190. 00 0 0 0 0 0 0 0 0 0 0 24, 047 192. 00 193, 097 81,883 194. 00 07950 COMMUNITY HEALTH SERVICES 0 194. 00 4, 785 194.01 07951 WORK FITNESS 194.02 07952 MARKETING AND PUBLIC RELATIONS 0 0 194. 01 0 0 0 194. 02 194. 03 07953 MH RESI DENTI AL 194. 04 07954 UNUSED SPACE 0 0 194. 03 38, 226 68 94, 769 194. 04 194. 05 07955 MOB 43, 958 166, 658 0 0 194. 05 194. 06 07956 FOUNDATION 0 0 194. 06 0 C 194. 07 07957 KNOX COUNTY HEALTH DEPT 0 0 194. 07 0 C 194. 08 07958 I NDUSTRI AL HEALTH 0 0 194. 08 194. 09 07959 NRCC 0 0 0 0 194. 09 58, 351 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201. 00 202.00 TOTAL (sum lines 118-201) 502, 037 1, 533, 051 1, 224 411, 426 5, 181, 269 202. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150042

				10	12/31/2014	Date/lime Prep 6/3/2015 1:34	
		CAPITAL REL	ATED COSTS				
	Cost Center Description	NEW CRC - EQUI PMENT	NEW CRC - HEALTH PAVILION	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ONS	
		2. 01	2. 02	2A	4. 00	4. 01	
1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06	GENERAL SERVICE COST CENTERS  O0100 CAP REL COSTS-BLDG & FIXT  O0101 NEW CRC - CT EAST  O0102 NEW CRC- CT WEST  O0103 NEW CRC- MEMORI AL  O0104 NEW CRC - OUTPATIENT  O0105 NEW CRD - HEALTH PAVILION  O0106 NEW CRC - STORAGE  O0107 NEW CRC - DI AGNOSTIC CENTER						1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07
2. 00 2. 01 2. 02 4. 00 4. 01 4. 02 4. 03 4. 04 5. 00 7. 00	00200 CAP REL COSTS-MVBLE EQUIP 00201 NEW CRC - EQUIPMENT 00202 NEW CRC - HEALTH PAVILION 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS 00402 PURCHASING & RECEIVING 00403 REGISTRATION 00404 PATIENT ACCOUNTS 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	15, 988 0 53, 226 4, 358 57, 721 114, 883 390, 076	0 0 0 10, 683 0 35, 628 191, 470	34, 982 0 577, 791 35, 769 102, 117 504, 910 1, 894, 619	34, 982 90 235 267 707 2, 995 833	90 1 1 4 9	2. 00 2. 01 2. 02 4. 00 4. 01 4. 02 4. 03 4. 04 5. 00 7. 00
8. 00 9. 00 10. 00 11. 00 13. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION	35, 085 32, 304 0 41, 885 18, 675	4, 088 0 2, 287	67, 269 123, 889 0 506, 788 205, 975	74 676 122 355 583	0 1 1 0	8. 00 9. 00 10. 00 11. 00 13. 00
14. 00 15. 00 16. 00 17. 00 17. 01	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 MENTAL HEALTH OVERHEAD	927 19, 141 3, 488 0 12, 416	1, 039 0 2, 483 0 0	6, 441 232, 649 31, 553 0 150, 918	134 951 866 0 520	0 2 3 0 5	14. 00 15. 00 16. 00 17. 00 17. 01
23. 00 23. 01	02300 PARAMED ED PRGM-(SPECIFY) 02301 PARAMED ED PRGM-LAB INPATIENT ROUTINE SERVICE COST CENTERS	0 0	0	0 0	66	0	23. 00 23. 01
30. 00 31. 00 40. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY	283, 562 27, 005 47, 808 49, 453 0	219, 119 0 0 0 0	2, 621, 708 158, 960 581, 095 213, 545 0	2, 889 611 168 949 122	2 0 3	30. 00 31. 00 40. 00 41. 00 43. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	49 107	0	929 014	1 E11	2	EO 00
50. 00 51. 00 51. 01 52. 00 53. 00	05100 RECOVERY ROOM 05101 ENDOSCOPY 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	68, 197 0 44, 143 0 0	0 0 141, 324 0 0	828, 914 0 393, 696 0 0	1, 511 0 355 156 0	1 0	50. 00 51. 00 51. 01 52. 00 53. 00
54. 00 54. 01 54. 08 60. 00	05400 RADI OLOGY-DI AGNOSTI C 05401 RADI OLOGY-NON-CAMPUS 05408 RADI OLOGY-GSH BREAST CENTER 06000 LABORATORY	83, 990 15, 894 0 33, 112	51, 358 1, 617 0 4, 735	819, 096 124, 505 0 330, 064	1, 386 305 99 926	0 0 2	60. 00
63. 00 65. 00 66. 00 69. 00 70. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY	21, 525 29, 227 37, 285 0	0 0 1, 086 119, 370 0	130, 188 162, 153 332, 536 0	0 763 904 1, 623 0	1 0 2 0	63. 00 65. 00 66. 00 69. 00 70. 00
70. 01 71. 00 72. 00 73. 00 75. 00 76. 00	07001 NEURODI AGNOSTICS 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07500 ASC (NON-DISTINCT PART) 03020 MH ANCILLARY OUTPATIENT	32, 715 0 0 0 0 0	85, 508 0 0 0 0 0	305, 760 0 0 0 0 0	92 0 0 171 348 0	0 0 0 3	70. 01 71. 00 72. 00 73. 00 75. 00 76. 00
76. 01 90. 00	03950 I NPATI ENT DI ALYSI S  OUTPATI ENT SERVI CE COST CENTERS  09000 CLI NI C	9, 624	0	14, 658	526		76. 01 90. 00
91. 00 92. 00 96. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	59, 590 1, 977	0	350, 770 0 8, 917	1, 008		91. 00 92. 00 96. 00
101.00	11300   HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 11300   INTEREST EXPENSE	0	0	0, 417	0	0	101. 00 113. 00
	11600 H0SPI CE	17, 535 1, 691, 576	0 871, 795		257 24, 669	0	116. 00 118. 00

| Peri od: | Worksheet B | From 01/01/2014 | Part II | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 150042

					6/3/2015 1: 34	
	CAPITAL RELATED COSTS					
	NEW ODG	NEW ODG		ENDLOVEE		
Cost Center Description	NEW CRC -	NEW CRC -	Subtotal		COMMUNI CATI ONS	
	EQUI PMENT	HEALTH		BENEFITS		
	2. 01	PAVI LI ON 2. 02	2A	DEPARTMENT 4. 00	4. 01	
NONREI MBURSABLE COST CENTERS	2.01	2.02	ZA	4.00	4.01	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		Λ	0	0	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	390, 509	55, 574	751, 658	9, 074		192. 00
194. 00 07950 COMMUNITY HEALTH SERVICES	9, 148	00, 07	13, 933	•		194. 00
194. 01 07951 WORK FITNESS	7, 1.10	0	0	0		194. 01
194.0207952 MARKETING AND PUBLIC RELATIONS	3, 156	0	7, 521	47	-	194. 02
194. 03 07953 MH RESIDENTIAL	73, 085	0	111, 311	288		194. 03
194. 04 07954 UNUSED SPACE	36, 045	o	184, 690	0	0	194. 04
194. 05 07955 MOB	119, 374	113, 110	443, 100	260	0	194. 05
194. 06 07956 FOUNDATI ON	1, 566	0	3, 731	35	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	9, 397	0	22, 392	0	1	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	4	0	194. 08
194. 09 07959 NRCC	111, 557	0	174, 703	551	0	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 118-201)	2, 445, 413	1, 040, 479	13, 638, 555	34, 982	90	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150042

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2014	Part II
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				<b>'</b>	0 12/31/2014	6/3/2015 1:34	
	Cost Center Description	PURCHASING & RECEIVING	REGI STRATI ON	PATI ENT ACCOUNTS	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	
		4. 02	4. 03	4. 04	5. 00	7. 00	
	GENERAL SERVI CE COST CENTERS				1		
1.00	00100 CAP REL COSTS-BLDG & FIXT 00101 NEW CRC - CT EAST						1.00
1. 01 1. 02	00101 NEW CRC - CT EAST						1. 01 1. 02
1. 02	00103 NEW CRC- MEMORIAL						1. 02
1. 04	00104 NEW CRC - OUTPATIENT						1. 04
1.05	00105 NEW CRD - HEALTH PAVILION						1. 05
1.06	00106 NEW CRC - STORAGE						1. 06
1. 07	00107 NEW CRC - DIAGNOSTIC CENTER						1. 07
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
2. 01	00201 NEW CRC - EQUI PMENT						2. 01
2. 02 4. 00	00202 NEW CRC - HEALTH PAVILION 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 02 4. 00
4. 01	00401 COMMUNI CATI ONS						4. 00
4. 02	00402 PURCHASING & RECEIVING	578, 027					4. 02
4.03	00403 REGI STRATI ON	347	36, 384				4. 03
4.04	00404 PATIENT ACCOUNTS	1, 217	0	104, 045			4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	7, 438	0	C			5. 00
7.00	00700 OPERATION OF PLANT	9, 020	0	C	,	1, 930, 920	7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	1, 634	0	0	1,72,0	37, 446	8.00
9. 00 10. 00	01000 DI ETARY	4, 718 23, 457	0	C	-,	34, 478 0	9. 00 10. 00
11. 00	01100 CAFETERI A	23, 437	0	0		44, 704	11. 00
13. 00	01300 NURSING ADMINISTRATION	741	o	Ö		19, 932	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 916	o	C	1	989	14.00
15.00	01500 PHARMACY	221, 702	o	C	12, 990	20, 429	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	362	0	C	11, 949	3, 723	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	C	1	0	17. 00
17. 01	01701 MENTAL HEALTH OVERHEAD	2, 396	0	0		13, 252	17. 01
23. 00 23. 01	O2300   PARAMED ED   PRGM-(SPECIFY)   O2301   PARAMED ED   PRGM-LAB	5 72	0 0	C		0	23. 00 23. 01
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	12	υ		103	0	23.01
30. 00	03000 ADULTS & PEDI ATRI CS	22, 659	3, 167	9, 032	45, 166	302, 646	30. 00
31.00	03100 INTENSIVE CARE UNIT	3, 320	514	1, 467		28, 822	31. 00
40.00	04000 SUBPROVI DER - I PF	0	417	1, 188	4, 158	51, 026	40. 00
41. 00	04100 SUBPROVI DER - I RF	1, 839	561	1, 599		52, 781	41. 00
43. 00	04300 NURSERY	656	83	238	1, 413	0	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	32, 888	2, 403	6, 854	20, 427	72, 787	50.00
51.00	05100 RECOVERY ROOM	32,000	2, 403	0, 034		72, 787	51.00
51. 01	05101 ENDOSCOPY	5, 900	879	2, 506		47, 114	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 621	306	874		0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	C	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	21, 409	5, 898	17, 104		89, 642	54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS	2, 449	1, 441	4, 109		16, 964	54. 01
54. 08 60. 00	05408 RADI OLOGY-GSH BREAST CENTER	122	30	10 774	1	0 35 340	54. 08 60. 00
63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	50, 356	3, 778 208	10, 774 593		35, 340 0	63.00
65. 00	06500 RESPIRATORY THERAPY	5, 026	757	2, 159		22, 974	
66. 00	06600 PHYSI CAL THERAPY	2,017	2, 031	5, 793		31, 194	66. 00
69. 00	06900 ELECTROCARDI OLOGY	23, 313	2, 381	6, 790		39, 795	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	T -	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	851	468	1, 333		34, 917	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	663	1, 892		0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	48, 495 0	975 4, 406	2, 781		0	72. 00 73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	25, 623	1, 699	12, 565 4, 844		0	75.00
76. 00	03020 MH ANCI LLARY OUTPATIENT	25, 025	1, 077	4, 044		0	76. 00
76. 01	03950 I NPATI ENT DI ALYSI S	83	98	278	1	30, 697	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	9, 348	284	810		10, 272	90. 00
91. 00	09100 EMERGENCY	5, 247	2, 668	7, 610	14, 236	63, 600	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
96. 00	OTHER REIMBURSABLE COST CENTERS O9600 DURABLE MEDICAL EQUIP-RENTED	1, 522	E 2	148	747	2, 110	96. 00
	10100 HOME HEALTH AGENCY	1, 522	52 0	140			101. 00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>	<u></u>		1 0		101.00
113.00	11300   NTEREST EXPENSE						113. 00
116.00	11600 H0SPI CE	1, 102	217	618		18, 715	116. 00
118. 00	,	540, 871	36, 384	104, 045	374, 772	1, 126, 349	118. 00
466 -	NONREI MBURSABLE COST CENTERS		=1				100.00
190.00	) 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN ) 19200 PHYSICIANS' PRIVATE OFFICES	0 28, 883	0	0	1	0 416, 791	190.00
	0/07950 COMMUNITY HEALTH SERVICES	28, 883	0	0			192.00
174.00	5/07/20/ COMMON TI HEALTH SERVICES	1 401	·		130	7, 704	1.74.00

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

Cost Center Description	PURCHASING &	REGI STRATI ON	PATI ENT	ADMI NI STRATI VE	OPERATION OF	
	RECEI VI NG		ACCOUNTS	& GENERAL	PLANT	
	4. 02	4. 03	4. 04	5. 00	7. 00	
194. 01 07951 WORK FITNESS	0	0	0	0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	4, 652	0	0	2, 199	3, 369	194. 02
194. 03 07953 MH RESI DENTI AL	1, 177	0	0	3, 762	78, 003	194. 03
194. 04 07954 UNUSED SPACE	0	0	0	562	38, 470	194. 04
194. 05 07955 MOB	642	0	0	4, 720	127, 408	194. 05
194. 06 07956 FOUNDATI ON	1, 340	0	0	3, 265	1, 671	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	75	10, 030	194. 07
194.08 07958 INDUSTRIAL HEALTH	1	0	0	59	0	194. 08
194. 09 07959 NRCC	0	0	0	7, 746	119, 065	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 118-201)	578, 027	36, 384	104, 045	515, 352	1, 930, 920	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150042

	Cost Contar Description	LAUNDDY 0	HOUSEKEEPI NG	DIETADY		6/3/2015 1: 34 NURSI NG	
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	CAFETERI A	ADMI NI STRATI ON	
	GENERAL SERVICE COST CENTERS	8.00	9. 00	10.00	11.00	13. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01	00101 NEW CRC - CT EAST						1. 01
1. 02 1. 03	00102 NEW CRC- CT WEST 00103 NEW CRC- MEMORIAL						1. 02 1. 03
1. 03	00103 NEW CRC - WEWORLAL						1. 03
1. 05	00105 NEW CRD - HEALTH PAVILION						1. 05
1.06	00106 NEW CRC - STORAGE						1. 06
1. 07 2. 00	00107 NEW CRC - DIAGNOSTIC CENTER 00200 CAP REL COSTS-MVBLE EQUIP						1. 07 2. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 02	00202 NEW CRC - HEALTH PAVILION						2. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01 4. 02	OO401   COMMUNI CATI ONS   OO402   PURCHASI NG & RECEI VI NG						4. 01 4. 02
4. 02	00403 REGI STRATI ON						4. 02
4.04	00404 PATIENT ACCOUNTS						4. 04
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	107, 719					7. 00 8. 00
9. 00	00900 HOUSEKEEPING	5, 757	177, 950				9. 00
10.00	01000 DI ETARY	976	5, 463	32, 640			10. 00
11.00	01100 CAFETERI A	0	960		557, 845	0.40, 054	11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	840	0 2, 176		9, 136 6, 313	243, 851 0	13. 00 14. 00
15. 00	01500 PHARMACY	0	1, 775		19, 648	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	1, 228	0	28, 440	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0	0	17. 00
17. 01 23. 00	01701 MENTAL HEALTH OVERHEAD 02300 PARAMED ED PRGM-(SPECIFY)	1, 927	5, 179 0		33, 343 1, 445	0	17. 01 23. 00
23. 01	02301 PARAMED ED PRGM-LAB	l o	0		0	0	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	43, 719		·	82, 779	104, 532	30.00
31. 00 40. 00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF	5, 708	5, 794 0		13, 988 13, 603	17, 663 17, 178	
41. 00	04100 SUBPROVI DER - I RF	6, 678	_	-,	28, 966	36, 578	41. 00
43.00	04300 NURSERY	753	623	923	2, 724	3, 440	43. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	4 202	12 490	O	15 202	19, 323	50. 00
50. 00 51. 00	05100 RECOVERY ROOM	4, 302	13, 480 0		15, 302 0	19, 323	50.00
51. 01	05101 ENDOSCOPY	2, 932	2, 909		8, 232	0	51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 285	771	0	3, 533	4, 462	52. 00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	9, 034	0 8, 812		0 31, 989	0	53. 00 54. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	9,034	0, 612	i	6, 683	0	54. 00
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0	0	0	0	0	54. 08
60.00	06000 LABORATORY	0	2, 808		27, 631	0	60.00
63. 00 65. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	43	0 1, 646	_	0 15, 858	0	63. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 713			17, 791	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 659		0	19, 582	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS	0	0		0	0	70.00
70. 01 71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2, 990	3, 522 0		2, 886 0	0	70. 01 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	O	Ō		Ö	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
75. 00 76. 00	O7500   ASC (NON-DISTINCT PART)   O3020   MH   ANCILLARY OUTPATIENT	3, 872	8, 520		0	0	75. 00 76. 00
76. 00 76. 01	03950 INPATIENT DIALYSIS	0	0		0	0	76. 00 76. 01
70.01	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		, 0. 0.
90.00	09000 CLI NI C	30			6, 619	0	90. 00
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	8, 615	8, 460	0	25, 505	32, 208	91. 00 92. 00
92. 00	OTHER REIMBURSABLE COST CENTERS						72. UU
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	674	0	96. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113 00	SPECIAL PURPOSE COST CENTERS   11300   INTEREST EXPENSE						113. 00
	11600 HOSPI CE	o	2, 092	0	6, 705		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	104, 833	153, 794		429, 375	243, 851	
100 5	NONREI MBURSABLE COST CENTERS		=	1	1		100.00
190.00	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN  1920 PHYSICIANS' PRIVATE OFFICES	2, 886	0 22, 084		0 106, 614		190. 00 192. 00
	07950 COMMUNITY HEALTH SERVICES	2,880			1, 556		194. 00
				1			·

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ALLOCATION OF CAPITAL RELATED COSTS GOOD SAMARITAN HOSPITAL Provi der CCN: 150042

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Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
	LINEN SERVICE				ADMI NI STRATI ON	
	8. 00	9. 00	10.00	11.00	13.00	
194. 01 07951 WORK FITNESS	0	0	C	0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	325	C	1, 746	0	194. 02
194.03 07953 MH RESIDENTIAL	0	0	C	11, 825	0	194. 03
194. 04 07954 UNUSED SPACE	0	0	C	0	0	194. 04
194. 05 07955 MOB	0	0	C	5, 813	0	194. 05
194. 06 07956 FOUNDATI ON	0	0	C	916	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	908	C	0	0	194. 07
194.08 07958 INDUSTRIAL HEALTH	0	0	C	0	0	194. 08
194. 09 07959 NRCC	0	0	C	0	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 118-201)	107, 719	177, 950	32, 640	557, 845	243, 851	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

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In Lieu of Form CMS-2552-10

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			'	0 12/31/2014	6/3/2015 1: 34	
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
	SERVICES & SUPPLY		RECORDS & LI BRARY		OVERHEAD	
	14. 00	15. 00	16. 00	17. 00	17. 01	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01   00101   NEW CRC - CT EAST						1. 01
1. 02   00102   NEW CRC- CT WEST						1. 02
1.03 O0103 NEW CRC- MEMORIAL						1.03
1.04   O0104 NEW CRC - OUTPATIENT 1.05   O0105 NEW CRD - HEALTH PAVILION						1. 04 1. 05
1.06   00106   NEW CRC - STORAGE						1. 05
1. 07   00107   NEW CRC - DI AGNOSTI C CENTER						1. 07
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01 00201 NEW CRC - EQUI PMENT						2. 01
2.02   OO2O2   NEW CRC - HEALTH PAVILION						2. 02
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. 03 4. 04
5. 00   00500   ADMI NI STRATI VE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00   01000   DI ETARY						10. 00
11. 00   01100   CAFETERI A						11. 00
13. 00   01300   NURSI NG ADMINISTRATI ON						13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	20, 769	F10, 000				14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL RECORDS & LI BRARY	8, 734	518, 880	70 120			15. 00 16. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY 17. 00   01700   SOCI AL SERVI CE	14	0	78, 138	0		17. 00
17. 01   01700   SOCTAL SERVICE	94	61	0	0	212, 505	17. 00
23. 00   02300   PARAMED ED   PRGM- (SPECIFY)	0	0	0	_	0	23. 00
23. 01   02301   PARAMED ED   PRGM-LAB	3	Ō	C		0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDIATRICS	892	920	30, 552		97, 518	30. 00
31. 00 03100 INTENSIVE CARE UNIT	131	223	5, 786		0	31. 00
40. 00   04000   SUBPROVI DER -   PF	0	0	4, 355	1	18, 971	40.00
41. 00   04100   SUBPROVI DER - I RF	72	302	5, 201	0	0	41.00
43. 00 O4300 NURSERY ANCI LLARY SERVICE COST CENTERS	26	22	520	U	0	43. 00
50. 00 05000 OPERATING ROOM	1, 294	2, 071	5, 331	0	0	50. 00
51. 00 05100 RECOVERY ROOM	0	0	C	0	0	51. 00
51. 01   05101   ENDOSCOPY	232	124	2, 145	0	0	51. 01
52.00   05200   DELIVERY ROOM & LABOR ROOM	64	25	C	0	0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	C	0	0	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	843	6, 349	C	0	0	54.00
54. 01   05401   RADI OLOGY-NON-CAMPUS	96 5	1, 344	0	0	0	54. 01
54. 08   05408   RADI OLOGY-GSH   BREAST CENTER 60. 00   06000   LABORATORY	1, 982	0 153	0		0	54. 08 60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	1, 702	0	0	0	0	63. 00
65. 00 06500 RESPIRATORY THERAPY	198	166	325	o	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	79	628	C	0	0	66. 00
69. 00 06900 ELECTROCARDI OLOGY	918	42	2, 340	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70. 00
70. 01 07001 NEURODI AGNOSTI CS	33	1	1, 625	0	0	70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 909	450 070	0	0	0	72.00
73. 00   07300   DRUGS CHARGED TO PATLENTS 75. 00   07500   ASC (NON-DISTINCT PART)	1, 008	450, 079 521	5, 136		77, 342	73. 00 75. 00
76. 00 03020 MH ANCI LLARY OUTPATIENT	1,008	0	5, 130	0	77, 342	76.00
76. 01   03950   NPATIENT DIALYSIS	3	107	Ö	0	Ö	76. 01
OUTPATIENT SERVICE COST CENTERS	-,			-1		
90. 00 09000 CLI NI C	368	364	C	0	0	90. 00
91. 00   09100   EMERGENCY	206	511	14, 822	0	0	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS	1					
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	60	0	O		0	96.00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE		I				113. 00
116. 00 11600 HOSPI CE	43	1, 373	C	0	n	116. 00
118.00   SUBTOTALS (SUM OF LINES 1-117)	19, 307	465, 386	_		193, 831	
NONREI MBURSABLE COST CENTERS		,				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C			190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	1, 137	52, 657	C	0	18, 674	192. 00

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

| Peri od: | Worksheet B | From 01/01/2014 | Part II | To | 12/31/2014 | Date/Time Prepared: | 6/3/2015 | 1: 34 pm

					6/3/2015 1:34	_pm
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	MENTAL HEALTH	
	SERVICES &		RECORDS &		OVERHEAD	
	SUPPLY		LI BRARY			
	14.00	15. 00	16. 00	17. 00	17. 01	
194.00 07950 COMMUNITY HEALTH SERVICES	18	837	C	0	0	194. 00
194. 01 07951 WORK FITNESS	0	0	C	0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	183	0	C	0	0	194. 02
194. 03 07953 MH RESIDENTIAL	46	0	C	0	0	194. 03
194. 04 07954 UNUSED SPACE	0	0	C	0	0	194. 04
194. 05 07955 MOB	25	0	C	0	0	194. 05
194. 06 07956 FOUNDATI ON	53	0	C	0	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	C	0	0	194. 07
194.08 07958 INDUSTRIAL HEALTH	0	0	C	0	0	194. 08
194. 09 07959 NRCC	0	0	C	0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	C	0	0	201.00
202.00 TOTAL (sum lines 118-201)	20, 769	518, 880	78, 138	0	212, 505	202. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CCN: 150042	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II	pared:
Cost Center Description	PARAMED ED PRGM	PARAMED ED PRGM-LAB	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	piii
	23. 00	23. 01	24. 00	25. 00	26. 00	
GENERAL SERVICE COST CENTERS	23. 00	23. 01	24.00	25.00	26.00	1. 00 1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 2. 00 2. 01 2. 02 4. 00 4. 01 4. 02 4. 03 4. 04 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 14. 00 15. 00 16. 00 17. 00
17. 01   01701   MENTAL HEALTH OVERHEAD 23. 00   02300   PARAMED ED   PRGM-(SPECIFY) 23. 01   02301   PARAMED ED   PRGM-LAB	2, 097	184	Į.			17. 01 23. 00 23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T			3, 446, 04 252, 95		3, 446, 045 252, 951	•
40. 00   04000   SUBPROVI DER - I PF			696, 07		696, 074	1
41. 00   04100   SUBPROVI DER -   I RF			378, 48		378, 484	•
43. 00 04300 NURSERY			11, 54	13 0	11, 543	43.00
ANCILLARY SERVICE COST CENTERS				al al	1 00/ 000	
50. 00   05000   OPERATING ROOM 51. 00   05100   RECOVERY ROOM			1, 026, 89	0 0	1, 026, 890 0	
51. 01   05101   ENDOSCOPY			473, 21		473, 217	
52.00   05200   DELIVERY ROOM & LABOR ROOM			15, 08		15, 082	
53. 00   05300   ANESTHESI OLOGY				0 0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   RADI OLOGY-NON-CAMPUS			1, 035, 60 163, 05		1, 035, 607 163, 055	1
54. 08   05408   RADI OLOGY - GSH   BREAST CENTER			1, 09		1, 092	1
60. 00   06000   LABORATORY			480, 87		480, 875	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			3, 79		3, 794	1
65. 00   06500   RESPI RATORY   THERAPY 66. 00   06600   PHYSI CAL   THERAPY			189, 61 242, 01		189, 610 242, 016	1
69. 00 06900 ELECTROCARDI OLOGY			449, 31		449, 312	
70.00 07000 ELECTROENCEPHALOGRAPHY				0 0	0	1
70. 01   07001   NEURODI AGNOSTI CS 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT			357, 04		357, 043	1
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS			26, 68 62, 36		26, 686 62, 368	1
73.00 07300 DRUGS CHARGED TO PATIENTS			504, 00		504, 006	1
75.00 07500 ASC (NON-DISTINCT PART)			137, 05		137, 054	•
76. 00   03020 MH ANCI LLARY OUTPATI ENT 76. 01   03950 I NPATI ENT DI ALYSI S			79, 10	0 0	79, 104	1
90. 00 O9000 CLINIC COST CENTERS			49, 08	36 0	49, 086	90.00
91.00   09100   EMERGENCY 92.00   09200   OBSERVATION   BEDS   (NON-DISTINCT   PART			535, 46		535, 468	1
OTHER REIMBURSABLE COST CENTERS  96. 00			14, 25	0 0		96. 00 101. 00
SPECIAL PURPOSE COST CENTERS  113. 00 11300   INTEREST EXPENSE					0	113. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0	C	70, 74 10, 701, 45			116. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B
				From 01/01/2014	Part II
				To 12/31/2014	Date/Time Prepared: 6/3/2015 1:34 pm
Cost Center Description	PARAMED ED	PARAMED ED	Subtotal	Intern &	Total
oost denter beserretten	PRGM	PRGM-LAB	Jubrotai	Residents Cost	10141
	1 Itom	TROM END		& Post	
				Stepdown	
				Adjustments	
	23. 00	23. 01	24.00	25. 00	26.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN				0 0	0 190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES			1, 527, 91	ol ol	1, 527, 910 192. 00
194.00 07950 COMMUNITY HEALTH SERVICES			28, 22	2 0	28, 222 194. 00
194. 01 07951 WORK FITNESS				0 0	0 194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS			20, 04	2 0	20, 042 194. 02
194. 03 07953 MH RESIDENTIAL			206, 41	2 0	206, 412 194. 03
194. 04 07954 UNUSED SPACE			223, 72	2 0	223, 722 194. 04
194. 05 07955 MOB			581, 96	8 0	581, 968 194. 05
194. 06 07956 FOUNDATI ON			11, 01	1 0	11, 011 194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT			33, 40	6 0	33, 406 194. 07
194. 08 07958 I NDUSTRI AL HEALTH			6	4 0	64 194. 08
194. 09 07959 NRCC			302, 06	5 0	302, 065 194. 09
200.00 Cross Foot Adjustments	2, 097	184	2, 28	1 0	2, 281 200. 00
201.00 Negative Cost Centers	o	0		o  o	0 201. 00
202.00 TOTAL (sum lines 118-201)	2, 097	184	13, 638, 55	5 0	13, 638, 555 202. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
				rom 01/01/2014 o 12/31/2014		pared:
		CAD	TITAL RELATED CO	nete	6/3/2015 1: 34	pm
		CAP	TIAL RELATED CO	J313		
Cost Center Description	BLDG & FIXT	NEW CRC - CT	NEW CRC- CT	NEW CRC-	NEW CRC -	
	(SQUARE FEET)	EAST	WEST	MEMORI AL	OUTPATI ENT	
	1.00	(SQUARE FEET) 1.01	(SQUARE FEET) 1.02	(SQUARE FEET) 1.03	(SQUARE FEET) 1.04	
GENERAL SERVICE COST CENTERS	1.00	1.01	1.02	1.00	1.04	
1.00 O0100 CAP REL COSTS-BLDG & FLXT	0					1. 00
1.01   00101   NEW CRC - CT EAST 1.02   00102   NEW CRC- CT WEST	0	153, 411	1			1. 01
1. 02   00102   NEW CRC- CT WEST 1. 03   00103   NEW CRC- MEMORI AL	0		66, 132	73, 394		1. 02 1. 03
1. 04 O0104 NEW CRC - OUTPATIENT	0	Ö	Ö	0	266, 080	1. 04
1.05 O0105 NEW CRD - HEALTH PAVILION	0	0	0	0	0	1. 05
1.06   OO106 NEW CRC - STORAGE 1.07   OO107 NEW CRC - DIAGNOSTIC CENTER	0	0	0	0	0	1. 06 1. 07
2. 00   OO200   CAP   REL   COSTS-MVBLE   EQUI   P			,	0		2.00
2. 01   00201   NEW CRC - EQUI PMENT						2. 01
2. 02 00202 NEW CRC - HEALTH PAVILION						2. 02
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 4. 01   00401   COMMUNI CATLONS	0	0	0	3, 428	1, 004 0	4. 00 4. 01
4. 02   00402   PURCHASI NG & RECEI VI NG		12, 942	0	120	1, 693	4. 02
4. 03   00403   REGI STRATI ON	0	O	283	0	0	4. 03
4. 04   00404   PATI ENT ACCOUNTS	0	0	0	4, 580		4. 04
5.00   00500   ADMINISTRATIVE & GENERAL 7.00   00700   OPERATION OF PLANT	0	3, 170 14, 846			7, 336 26, 287	5. 00 7. 00
8. 00   00800   LAUNDRY & LINEN SERVICE		14, 840	0	4, 460		8.00
9. 00   00900   HOUSEKEEPI NG	0	960	1, 323		3, 867	9. 00
10. 00 01000 DI ETARY	0	0	0	0	0	10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	0	11, 413 4, 629		0	0 548	11. 00 13. 00
14. 00   01400   CENTRAL SERVICES & SUPPLY		4, 027	1	0	0	14. 00
15. 00 01500 PHARMACY	0	-,		_	0	15. 00
16. 00   01600   MEDI CAL RECORDS & LI BRARY	0	510	60	0	182	16.00
17. 00   01700   SOCIAL SERVICE 17. 01   01701   MENTAL HEALTH OVERHEAD	0	3, 442	0	0	0 0	17. 00 17. 01
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0, 112	0	0	Ö	23. 00
23. 01 O2301 PARAMED ED PRGM-LAB	0	0	0	0	0	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS  30. 00 03000 ADULTS & PEDI ATRI CS	1 0	38, 254	13, 757	0	7, 623	30.00
31. 00   03100   NTENSI VE CARE UNI T			1		7,023	31.00
40. 00   04000   SUBPROVI DER - I PF	0			_	0	40. 00
41. 00   04100   SUBPROVI DER -   RF	0				0 0	41. 00 43. 00
43. 00   04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	0		<u> </u>	0	0	43.00
50. 00 05000 OPERATING ROOM	0	18, 905	0	0	0	50. 00
51. 00   05100   RECOVERY ROOM	0	0	0	0	0	51.00
51. 01   05101   ENDOSCOPY 52. 00   05200   DELIVERY ROOM & LABOR ROOM	0			0	0	51. 01 52. 00
53. 00   05300   ANESTHESI OLOGY			Ö	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	10, 008	192	0	1, 852	54.00
54. 01   05401   RADI OLOGY-NON-CAMPUS	0	446	0	0	917	54. 01
54. 08   05408   RADI OLOGY-GSH BREAST CENTER 60. 00   06000   LABORATORY	0	7, 006		0	0 1, 763	54. 08 60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	Ö	0	0	63.00
65. 00 06500 RESPI RATORY THERAPY	0	154	1	0	0	65. 00
66. 00   06600   PHYSI CAL THERAPY 69. 00   06900   ELECTROCARDI OLOGY	0	356	6, 447	0	1, 205 0	66. 00 69. 00
70. 00 07000 ELECTROCARD GEOGRAPHY			Ö	0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	1, 424	241	0	0	70. 01
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	0			0	0 0	72. 00 73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	Ö	Ö	0	Ö	75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0	-	0	0	0	76. 00
76. 01 03950 I NPATI ENT DI ALYSI S	0	0	176	0	7, 797	76. 01
90. 00 O9000 CLI NI C	1 0		) 0	0	2, 668	90.00
91. 00 09100 EMERGENCY	0					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS  96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	T 0	154	. 0	0	394	96. 00
101. 00 109600 DURABLE MEDICAL EQUIP-RENTED						101.00
SPECIAL PURPOSE COST CENTERS					, and the second	
113. 00 11300 I NTEREST EXPENSE				_		113.00
116.00   11600   HOSPI CE 118.00   SUBTOTALS (SUM OF LINES 1-117)	0		65, 860	61, 940		116. 00 118. 00
1000.00.120 (0011 01 211120 1 111)		1 17, 373	00,000	01,740	35, 504	1

| Peri od: | Worksheet B-1 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

				0 12/31/2014	6/3/2015 1: 34	
		CAP	ITAL RELATED CO	OSTS		
Cost Center Description	BLDG & FIXT	NEW CRC - CT	NEW CRC- CT	NEW CRC-	NEW CRC -	
	(SQUARE FEET)	EAST	WEST	MEMORI AL	OUTPATI ENT	
	1.00	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	(SQUARE FEET)	
NONDEL NOUDCARL E COCT CENTERS	1.00	1. 01	1. 02	1. 03	1. 04	
NONREI MBURSABLE COST CENTERS						400 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	712	0	390		
194. 00 07950 COMMUNI TY HEALTH SERVI CES	0	0	0	0		194. 00
194. 01 07951 WORK FITNESS	0	0	0	0	-	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	0	875		194. 02
194. 03 07953 MH RESI DENTI AL	0	0	0	0	20, 260	
194. 04 07954 UNUSED SPACE	0	2, 806	0	7, 150		194. 04
194. 05 07955 MOB	0	0	0	0	23, 298	
194. 06 07956 FOUNDATI ON	0	0	0	434	-	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	0	2, 605		194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	0		194. 08
194. 09 07959  NRCC	0	0	272	0	30, 926	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,	0	991, 830	1, 165, 706	366, 120	502, 037	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	6. 465182	17. 626958	4. 988419	1. 886790	203. 00
204.00 Cost to be allocated (per Wkst. B,						204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part						205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2014 To 12/31/2014 Worksheet B-1 Date/Ti me Prepared: 6/3/2015 1: 34 pm Provi der CCN: 150042

	CAPITAL RELATED COSTS							
			NEW ODD				NEW ODO	
		Cost Center Description	NEW CRD - HEALTH	NEW CRC - STORAGE	NEW CRC - DIAGNOSTIC	MVBLE EQUIP (SQUARE FEET)	NEW CRC - EQUIPMENT	
			PAVILION	(SQUARE FEET)	CENTER		(SQUARE FEET)	
			(SQUARE FEET) 1.05	1.06	(SQUARE FEET) 1.07	2. 00	2. 01	
1 00		AL SERVICE COST CENTERS		I				1 00
1. 00 1. 01		CAP REL COSTS-BLDG & FIXT NEW CRC - CT EAST						1. 00 1. 01
1.02	00102	NEW CRC- CT WEST						1. 02
1.03		NEW CRC- MEMORIAL						1. 03
1. 04 1. 05		NEW CRC - OUTPATIENT NEW CRD - HEALTH PAVILION	90, 093					1. 04 1. 05
1. 06		NEW CRC - STORAGE	0	15, 000				1. 06
1.07		NEW CRC - DIAGNOSTIC CENTER	0	0	14, 062	450 444		1. 07
2. 00 2. 01		CAP REL COSTS-MVBLE EQUIP NEW CRC - EQUIPMENT				153, 411 0	677, 899	2. 00 2. 01
2. 02	1	NEW CRC - HEALTH PAVILION				0	0,7,0,7	2. 02
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	4, 432	4. 00
4. 01 4. 02	1	COMMUNI CATIONS PURCHASING & RECEIVING	0	0	0	0 12, 942	0 14, 755	4. 01 4. 02
4. 02		REGISTRATION	925	Ö	0	12, 742	1, 208	4. 03
4.04	1	PATIENT ACCOUNTS	0	0	0	0	16, 001	4. 04
5. 00 7. 00	1	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	3, 085 16, 579	B .	0 4, 375	3, 170 14, 846	31, 847 108, 134	5. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	10, 5/9	15,000	4, 3/3	14, 640	9, 726	8.00
9. 00	00900	HOUSEKEEPI NG	354	0	0	960	8, 955	9. 00
10.00		DIETARY	0	-	0	11 412	0	10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMINI STRATI ON	198	0	0	11, 413 4, 629	11, 611 5, 177	11. 00 13. 00
14. 00	01400	CENTRAL SERVICES & SUPPLY	90	0	0	0	257	14. 00
15. 00	1	PHARMACY	0	0	0	5, 306	5, 306	
16. 00 17. 00	1	MEDICAL RECORDS & LIBRARY  SOCIAL SERVICE	215		0	510 0	967 0	16. 00 17. 00
17. 01	01701	MENTAL HEALTH OVERHEAD	0	0	0	3, 442	3, 442	17. 01
23. 00 23. 01	1	PARAMED ED PRGM-(SPECIFY) PARAMED ED PRGM-LAB	0	0		0	0	23. 00 23. 01
23.01		I ENT ROUTI NE SERVI CE COST CENTERS			0	0	0	23.01
30. 00	1	ADULTS & PEDI ATRI CS	18, 973	•	0	38, 254	78, 607	30. 00
31. 00 40. 00	1	INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	0	0	0 13, 253	7, 486 13, 253	31. 00 40. 00
41. 00	1	SUBPROVI DER - I RF	0	Ö	Ö	2, 715	13, 709	
43. 00		NURSERY	0	0	0	0	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	0	0	18, 905	18, 905	50. 00
51.00		RECOVERY ROOM	0	0	0	0	0	51. 00
51. 01 52. 00	1	ENDOSCOPY DELIVERY ROOM & LABOR ROOM	12, 237	0	0	0	12, 237 0	51. 01 52. 00
53. 00		ANESTHESI OLOGY	0		0	0	0	
54.00	1	RADI OLOGY-DI AGNOSTI C	4, 447	0		10, 008	23, 283	
54. 01 54. 08		RADIOLOGY-NON-CAMPUS  RADIOLOGY-GSH BREAST CENTER	140		2, 903	446	4, 406 0	•
60.00	1	LABORATORY	410	1	0	7, 006	9, 179	60.00
63.00		BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	. 0	63. 00
65. 00		RESPIRATORY THERAPY	0	0	0	154	5, 967	65. 00
66. 00 69. 00		PHYSI CAL THERAPY ELECTROCARDI OLOGY	94 10, 336		0	356 0	8, 102 10, 336	
70. 00	1	ELECTROENCEPHALOGRAPHY	0	Ö	0	0	0	70. 00
70. 01		NEURODI AGNOSTI CS	7, 404	0	0	1, 424	9, 069	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0	Ö	Ö	0	0	73. 00
75.00		ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00 76. 01		MH ANCILLARY OUTPATIENT INPATIENT DIALYSIS	0	0	0	0	0 7, 973	76. 00 76. 01
70.01		TIENT SERVICE COST CENTERS					7,770	70.01
90.00		CLINIC	0	1		0	2, 668	90.00
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	16, 519	91. 00 92. 00
	OTHER	REIMBURSABLE COST CENTERS						
96.00		DURABLE MEDICAL EQUIP-RENTED HOME HEALTH AGENCY	0	1		154 0	548	96. 00 101. 00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS			0	0	0	101.00
	11300	INTEREST EXPENSE						113. 00
116. 00 118. 00		HOSPICE  SUBTOTALS (SUM OF LINES 1-117)	75, 487	0 15, 000	0 14, 062	0 149, 893	4, 861 468, 926	116. 00 118. 00
- 10.00	-1	1	, 5, 407	15,000	17,002	1 17, 075	100, 720	1

			T	o 12/31/2014	Date/Time Pre 6/3/2015 1:34	
		CAP	TAL RELATED CO	OSTS	10,0,2010 1101	T
Cost Center Description	NEW CRD -	NEW CRC -	NEW CRC -	MVBLE EQUIP	NEW CRC -	
	HEALTH	STORAGE	DI AGNOSTI C	(SQUARE FEET)	EQUI PMENT	
	PAVI LI ON	(SQUARE FEET)	CENTER		(SQUARE FEET)	
	(SQUARE FEET)		(SQUARE FEET)			
	1. 05	1. 06	1. 07	2. 00	2. 01	
NONREI MBURSABLE COST CENTERS		Г		T		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	4, 812	0	0	712	108, 254	
194. 00 07950 COMMUNITY HEALTH SERVICES	0	0	0	0		194. 00
194. 01 07951 WORK FITNESS	0	0	0	0		194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	0	0		194. 02
194. 03 07953 MH RESIDENTIAL	0	0	0	0		194. 03
194. 04 07954 UNUSED SPACE	0	0	0	2, 806		194. 04
194. 05 07955 MOB	9, 794	0	0	0		194. 05
194. 06 07956 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 NRCC	0	0	0	0	30, 925	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,	1, 533, 051	1, 224	411, 426	5, 181, 269	2, 445, 413	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	17. 016316	0. 081600	29. 258000	33. 773778	3. 607341	
204.00 Cost to be allocated (per Wkst. B,						204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part						205. 00
11)						I

	Financial Systems LLOCATION - STATISTICAL BASIS	GOOD SAMARITA		CCN: 150042 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
					rom 01/01/2014 o 12/31/2014	Date/Time Pre 6/3/2015 1:34	
	Cost Center Description	CAPITAL RELATED COSTS NEW CRC - HEALTH PAVILION (SQUARE FEET)	EMPLOYEE BENEFI TS DEPARTMENT (GROSS SALARI ES)	COMMUNI CATI ONS  (NUMBER OF PHONES)	PURCHASI NG & RECEI VI NG (SUPPLI ES C OST)	REGI STRATI ON (GROSS CHAR GES)	
	CENEDAL SERVICE COST CENTERS	2.02	4. 00	4. 01	4. 02	4. 03	
1. 00	GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 2. 00 2. 01 2. 02 4. 00 4. 01 4. 02 4. 03 4. 04 5. 00 7. 00 8. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 00 23. 00 23. 01	00101 NEW CRC - CT EAST 00102 NEW CRC- CT WEST 00103 NEW CRC- MEMORI AL 00104 NEW CRC - OUTPATIENT 00105 NEW CRD - HEALTH PAVILION 00106 NEW CRC - STORAGE 00107 NEW CRC - DIAGNOSTIC CENTER 00200 CAP REL COSTS-MVBLE EQUIP 00201 NEW CRC - EQUIPMENT 00202 NEW CRC - HEALTH PAVILION 00400 EMPLOYEE BENEFITS DEPARTMENT 00401 COMMUNICATIONS 00402 PURCHASING & RECEIVING 00403 REGISTRATION 00404 PATIENT ACCOUNTS 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01701 MENTAL HEALTH OVERHEAD 02300 PARAMED ED PRGM-LAB	90, 093 0 0 0 925 0 3, 085 16, 579 0 354 0 198 0 90 0 215 0	94, 916, 063 244, 275 637, 844 723, 488 1, 917, 117 8, 115, 919 2, 258, 535 200, 701 1, 831, 085 330, 833 962, 621 1, 579, 675 362, 158 2, 576, 724 2, 346, 984 0 1, 410, 404 179, 008 17, 478	2, 216 24 22 101 217 0 0 19 18 0 34 8 40 81 0 119	29, 279, 587 17, 593 61, 621 376, 784 456, 919 82, 778 238, 988 1, 188, 192 0 37, 545 97, 072 11, 230, 515 18, 312 0 121, 389 276	451, 245, 669 0 0 0 0 0 0 0 0 0 0	1. 01 1. 02 1. 03 1. 04 1. 05 1. 06 1. 07 2. 00 2. 01 2. 02 4. 00 4. 01 4. 02 4. 03 4. 04 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 17. 00 17. 00 17. 00 17. 00 17. 00 17. 01 23. 00 23. 01
30. 00 31. 00	INPATIENT ROUTINE SERVICE COST CENTERS   03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT	18, 973	7, 830, 412 1, 656, 181	38		39, 100, 373 6, 349, 700	31. 00
40. 00 41. 00 43. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY	0 0 0	456, 307 2, 571, 119 330, 443	76	93, 145	5, 143, 872 6, 924, 045 1, 030, 098	41. 00
F0 00	ANCI LLARY SERVI CE COST CENTERS		4 004 510	7/	1 // 5 000	20 (71 220	   FO 00
	05000   OPERATI NG ROOM   05100   RECOVERY ROOM	0	4, 094, 519 0	l .		29, 671, 320 0	
51. 01 52. 00	05101   ENDOSCOPY   05200   DELI VERY ROOM & LABOR ROOM	12, 237 0	962, 868 423, 542	23 0	298, 860 82, 100	10, 847, 143 3, 783, 627	51. 01 52. 00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	0 4, 447	0 3, 757, 151	0 99		0 74, 876, 268	
54. 00	05401 RADI OLOGY - NON-CAMPUS	140	825, 260	l .		17, 790, 040	
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0	269, 183	0	-,	371, 533	
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	410	2, 508, 414	46		46, 639, 858 2, 565, 383	
65. 00	06500 RESPIRATORY THERAPY	0	2, 066, 658			9, 345, 346	
66. 00	06600 PHYSI CAL THERAPY	94	2, 449, 752	l .		25, 075, 778	66. 00
69. 00 70. 00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	10, 336	4, 398, 711	44	1, 180, 882	29, 393, 176 0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	7, 404	249, 424	23	43, 090	5, 772, 488	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		8, 190, 955	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0		12, 039, 954	•
73. 00 75. 00	O7300   DRUGS CHARGED TO PATIENTS   O7500   ASC (NON-DISTINCT PART)	0	463, 113 942, 617	1	-	54, 393, 860 20, 971, 332	
76. 00	03020 MH ANCI LLARY OUTPATIENT	0	017	0		20, 771, 332	
76. 01	03950 INPATIENT DIALYSIS	0	0	9	4, 181	1, 205, 589	
90. 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	0	1 404 450		473, 504	2 EOE E10	00.00
91. 00	09100 EMERGENCY	0	1, 426, 458 2, 730, 481	1		3, 505, 519 32, 943, 170	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	0	55, 315 0			640, 718 0	96. 00 101. 00
110 00	SPECIAL PURPOSE COST CENTERS						110 00
	11300  NTEREST EXPENSE  11600 HOSPICE	0	695, 325	3	55, 802	2, 674, 524	113. 00 116. 00
		<u> </u>					

Health Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150042	Period: From 01/01/2014	Worksheet B-1	
				To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
	CAPI TAL					
<u>+</u>	RELATED COSTS					
Cost Center Description	NEW CRC -		COMMUNICATION	S PURCHASING &	REGI STRATI ON	
	HEALTH	BENEFITS		RECEI VI NG	(GROSS CHAR	

			To	o 12/31/2014	Date/Time Pre 6/3/2015 1:34	
	CAPI TAL	<u> </u>			, =	
	RELATED COSTS					
Cost Center Description	NEW CRC -	EMPLOYEE	COMMUNI CATI ONS	PURCHASING &	REGI STRATI ON	
	HEALTH	BENEFITS		RECEI VI NG	(GROSS CHAR	
	PAVI LI ON	DEPARTMENT	(NUMBER OF	(SUPPLIES C	GES)	
	(SQUARE FEET)	(GROSS	PHONES)	OST)		
		SALARI ES)				
	2. 02	4. 00	4. 01	4. 02	4. 03	
118.00 SUBTOTALS (SUM OF LINES 1-117)	75, 487	66, 858, 102	1, 731	27, 397, 512	451, 245, 669	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	-		190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	4, 812	24, 701, 599	431	1, 463, 004		192. 00
194.00 07950 COMMUNITY HEALTH SERVICES	0	146, 141	37	23, 328		194. 00
194. 01 07951 WORK FITNESS	0	0	0	0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	127, 341	0	235, 643	0	194. 02
194. 03 07953 MH RESI DENTI AL	0	779, 461	0	59, 623	0	194. 03
194. 04 07954 UNUSED SPACE	0	0	0	0		194. 04
194. 05 07955 MOB	9, 794	703, 759	3	32, 537	0	194. 05
194. 06 07956 FOUNDATI ON	0	94, 948	0	67, 885	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	14	0	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	11, 344	0	55	0	194. 08
194. 09 07959 NRCC	0	1, 493, 368	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,	1, 040, 479	21, 860, 931	321, 306	1, 209, 198	1, 036, 974	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	11. 548944	0. 230319	144. 993682	0. 041298	0. 002298	203. 00
204.00 Cost to be allocated (per Wkst. B,		34, 982	90	578, 027	36, 384	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part		0. 000369	0. 040614	0. 019742	0. 000081	205. 00
11)						

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

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150042 | Period: From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

					1	0 12/31/2014	Date/lime Prep 6/3/2015 1:34	
		Cost Center Description	PATI ENT	Reconciliation	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	
			ACCOUNTS		& GENERAL	PLANT	LINEN SERVICE	
			(GROSS CHAR GES)		(ACCUM. COST)	(SQUARE FEET)	(LBS OF LAU NDRY)	
			4. 04	5A	5. 00	7. 00	8. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT						1. 00
1. 01 1. 02		NEW CRC - CT EAST   NEW CRC- CT WEST						1. 01 1. 02
1.02	1	NEW CRC- CT WEST						1. 02
1. 04		NEW CRC - OUTPATIENT						1. 04
1.05		NEW CRD - HEALTH PAVILION						1. 05
1.06		NEW CRC - STORAGE						1. 06
1.07		NEW CRC - DIAGNOSTIC CENTER						1. 07
2. 00 2. 01	1	CAP REL COSTS-MVBLE EQUIP NEW CRC - EQUIPMENT						2. 00 2. 01
2. 02	1	NEW CRC - LEGITIMENT						2. 02
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01		COMMUNI CATI ONS						4. 01
4. 02		PURCHASING & RECEIVING						4. 02
4. 03 4. 04	1	REGISTRATION PATIENT ACCOUNTS	451, 245, 669					4. 03 4. 04
5.00		ADMINISTRATIVE & GENERAL	431, 243, 009	-31, 195, 889	169, 480, 322			5. 00
7. 00		OPERATION OF PLANT	Ö	0				7. 00
8.00		LAUNDRY & LINEN SERVICE	0	0	426, 106		1, 163, 718	8. 00
9.00	1	HOUSEKEEPI NG	0	0	2, 772, 373		62, 198	9. 00
10.00	1	DIETARY	0	0	862, 032		10, 542	10.00
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION	0	0	1, 656, 760 2, 460, 823		0	11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY	Ö	0	644, 555		9, 075	14. 00
15. 00	1	PHARMACY	o	0	4, 271, 465		0	15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	0	0	3, 929, 402	967	0	16. 00
17. 00	1	SOCIAL SERVICE	0	0	0	0	0	17. 00
17. 01 23. 00		MENTAL HEALTH OVERHEAD  PARAMED ED PRGM-(SPECIFY)	0	0		3, 442	20, 817 0	17. 01 23. 00
23. 00		PARAMED ED PRGM-LAB	0	0	' '	0	0	23. 00
20.0.		TENT ROUTINE SERVICE COST CENTERS			00,771			20.0.
30. 00		ADULTS & PEDIATRICS	39, 100, 373	0	14, 852, 457		472, 318	30.00
31. 00		INTENSIVE CARE UNIT	6, 349, 700	0			61, 670	
40.00	1	SUBPROVIDER - I PF	5, 143, 872	0			72 145	40.00
41. 00 43. 00		SUBPROVIDER - IRF  NURSERY	6, 924, 045 1, 030, 098	0			72, 145 8, 130	
10.00		LARY SERVICE COST CENTERS	1,000,070		101, 070	<u> </u>	0, 100	10.00
50.00		OPERATING ROOM	29, 671, 320	0	6, 717, 210	18, 905	46, 479	50.00
51.00		RECOVERY ROOM	0	0		0	0	51.00
51. 01 52. 00	1	ENDOSCOPY  DELIVERY ROOM & LABOR ROOM	10, 847, 143 3, 783, 627	0	2, 036, 276 652, 880		31, 674 13, 878	51. 01 52. 00
53. 00		ANESTHESI OLOGY	3, 763, 627	0	052, 860	0	13, 676	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	74, 876, 268	0	7, 905, 666	23, 283	97, 598	54. 00
54. 01		RADI OLOGY-NON-CAMPUS	17, 790, 040	0			0	
		RADIOLOGY-GSH BREAST CENTER	371, 533	0	2.0,0.0		0	
60.00	1	LABORATORY	46, 639, 858	0				60.00
63. 00 65. 00	1	BLOOD STORING, PROCESSING & TRANS.   RESPIRATORY THERAPY	2, 565, 383 9, 345, 346	0	984, 132 3, 125, 805		0 463	63. 00 65. 00
66. 00		PHYSI CAL THERAPY	25, 075, 778	0	3, 123, 303	8, 102	40, 116	
69. 00	1	ELECTROCARDI OLOGY	29, 393, 176	0	4, 555, 191		17, 925	
70. 00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
70. 01		NEURODI AGNOSTI CS	5, 772, 488	0	843, 301	9, 069	32, 299	
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	8, 190, 955 12, 039, 954	0	7, 935, 177 2, 699, 239		0	71. 00 72. 00
73. 00	1	DRUGS CHARGED TO PATTENTS	54, 393, 860	0	12, 096, 320		0	73. 00
75. 00		ASC (NON-DISTINCT PART)	20, 971, 332	0	2, 675, 949		41, 829	
76. 00		MH ANCILLARY OUTPATIENT	O	0	0	0	0	76.00
76. 01		I NPATI ENT DI ALYSI S	1, 205, 589	0	415, 776	7, 973	0	76. 01
00 00		TIENT SERVICE COST CENTERS	2 505 510	0	1 505 150	2.770	222	00.00
90. 00 91. 00		CLI NI C   EMERGENCY	3, 505, 519 32, 943, 170	0			322 93, 067	90. 00 91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	32, 743, 170	0	1, 001, 470	10, 317	75, 007	92. 00
	OTHER	REIMBURSABLE COST CENTERS						
		DURABLE MEDICAL EQUIP-RENTED	640, 718	0				96. 00
101. 00		HOME HEALTH AGENCY	0	0	0	0	0	101. 00
113 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
		HOSPI CE	2, 674, 524	0	1, 461, 383	4, 861		116. 00
118. 00	)	SUBTOTALS (SUM OF LINES 1-117)	451, 245, 669	-31, 195, 889			1, 132, 545	
400.5		I MBURSABLE COST CENTERS			-		-	400 00
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00

Peri od: From 01/01/2014 To 12/31/2014 Worksheet B-1 Date/Ti me Prepared: 6/3/2015 1: 34 pm Provi der CCN: 150042

					6/3/2015 1: 34	pm
Cost Center Description	PATI ENT	Reconciliation	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	
	ACCOUNTS		& GENERAL	PLANT	LINEN SERVICE	
	(GROSS CHAR		(ACCUM. COST)	(SQUARE FEET)	(LBS OF LAU	
	GES)				NDRY)	
	4. 04	5A	5. 00	7. 00	8. 00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	38, 628, 644	108, 254	31, 173	192. 00
194.00 07950 COMMUNITY HEALTH SERVICES	0	0	249, 330	2, 536	0	194. 00
194. 01 07951 WORK FITNESS	0	0	0	0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0	723, 234	875	0	194. 02
194. 03 07953 MH RESI DENTI AL	0	0	1, 236, 971	20, 260	0	194. 03
194. 04 07954 UNUSED SPACE	0	0	184, 690	9, 992	0	194. 04
194. 05 07955 MOB	0	0	1, 551, 976	33, 092	0	194. 05
194. 06 07956 FOUNDATI ON	0	0	1, 073, 804	434	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0	24, 512	2, 605	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	19, 470	0	0	194. 08
194. 09 07959 NRCC	0	0	2, 547, 042	30, 925	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,	4, 261, 248		31, 195, 889	10, 297, 894	704, 245	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 009443		0. 184068	20. 533285	0. 605168	203. 00
204.00 Cost to be allocated (per Wkst. B,	104, 045		515, 352	1, 930, 920	107, 719	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 000231		0. 003041	3. 850120	0. 092565	205. 00

JST AL	LOCATION - STATISTICAL BASIS		Provider	F	reriod: from 01/01/2014 fo 12/31/2014	Worksheet B-1 Date/Time Pre	pare
	Cost Center Description	HOUSEKEEPING (TIME SPENT)	DIETARY (PATIENT DA YS)	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI ON	6/3/2015 1: 34 CENTRAL SERVI CES & SUPPLY	pm
					(DI RECT NUR SI NG)	(SUPPLIES C OST)	
		9. 00	10.00	11.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS				1		1
00	DO1010 CAP REL COSTS-BLDG & FIXT  D0102 NEW CRC - CT EAST  D0103 NEW CRC - CT WEST  D0103 NEW CRC - MEMORIAL  D0104 NEW CRC - OUTPATIENT  D0105 NEW CRC - HEALTH PAVILION  D0106 NEW CRC - STORAGE  D0107 NEW CRC - DIAGNOSTIC CENTER  D0200 CAP REL COSTS-MVBLE EQUIP  D0200 EMPLOYEE BENEFITS DEPARTMENT  D0400 EMPLOYEE BENEFITS DEPARTMENT  D0400 PURCHASING & RECEIVING  D0401 COMMUNICATIONS  D0402 PURCHASING & RECEIVING  D0403 REGISTRATION  D0404 PATIENT ACCOUNTS  D0500 ADMINISTRATIVE & GENERAL  D0700 OPERATION OF PLANT  D0800 LAUNDRY & LINEN SERVICE  D0900 HOUSEKEEPING  D1000 DIETARY  D1100 CAFETERIA  D1300 NURSING ADMINISTRATION  D1400 CENTRAL SERVICES & SUPPLY  D1500 PHARMACY  D1600 MEDICAL RECORDS & LIBRARY  D1701 MENTAL HEALTH OVERHEAD  D2300 PARAMED ED PRGM-LAB  NPATIENT ROUTINE SERVICE COST CENTERS	65, 082 1, 998 351 0 796 649 449 0 1, 894	37, 820 0 0 0 0 0 0 0	2, 537, 396 41, 557 28, 715 89, 371 129, 363 0 151, 661 6, 572	878, 356 0 0 0 0 0 0	26, 722, 095 11, 230, 515 18, 312 0 121, 389 276 3, 666	15. 16. 17. 17. 23.
	03000 ADULTS & PEDIATRICS	21, 546	21, 940	376, 525	376, 525	1, 147, 756	30.
	03100 INTENSIVE CARE UNIT	2, 119	2, 581	63, 624		168, 149	1
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0 3, 325	4, 536 7, 693	61, 876 131, 756		0 93, 145	
	04300 NURSERY	228	1, 070	12, 390		33, 210	
	NCILLARY SERVICE COST CENTERS						
	D5000 OPERATING ROOM D5100 RECOVERY ROOM	4, 930 0	0	69, 603	I I	1, 665, 890 0	
	D5101 ENDOSCOPY	1, 064	0	37, 442	٦	298, 860	
00 0	D5200 DELIVERY ROOM & LABOR ROOM	282	0		l l	82, 100	
	05300 ANESTHESI OLOGY	0	0	0	0	0	
	D5400 RADI OLOGY-DI AGNOSTI C D5401 RADI OLOGY-NON-CAMPUS	3, 223	0	145, 504 30, 397	l l	1, 084, 427 124, 034	
	05408 RADI OLOGY-GSH BREAST CENTER	ő	0	00, 07,		6, 200	
00 0	06000 LABORATORY	1, 027	0	125, 681	0	2, 550, 709	
1	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
1	06500 RESPI RATORY THERAPY	602	0	72, 131	l l	254, 577	6
- 1	06600  PHYSI CAL THERAPY 06900  ELECTROCARDI OLOGY	1, 413 1, 638	0	80, 924 89, 069	l l	102, 181 1, 180, 882	
	07000 ELECTROEARD OLOGI 07000 ELECTROENCEPHALOGRAPHY	1,030	0	07,007	1	1, 100, 002	
01 0	07001 NEURODI AGNOSTI CS	1, 288	o	13, 127		43, 090	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		0	7
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0		2, 456, 432 0	
	07500 ASC (NON-DISTINCT PART)	3, 116	0	1 0		1, 297, 871	7:
- 1	03020 MH ANCILLARY OUTPATIENT	0,110	0	ď	Ö	0	
01 0	03950 INPATIENT DIALYSIS	0	0	C	0	4, 181	7
	OUTPATIENT SERVICE COST CENTERS						ļ.,
	09000 CLINIC	450	0	30, 106		473, 504	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 094	0	116, 013	116, 013	265, 754	9:
	OTHER REIMBURSABLE COST CENTERS						1
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	3, 068	0	77, 108	9
- 1	10100 HOME HEALTH AGENCY	0	0	C	1		10
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE		_			== 0	113
6. 00 1 8. 00	11600 HOSPICE   SUBTOTALS (SUM OF LINES 1-117)	765 56, 247	0 37, 820		I I	55, 802 24, 840, 020	
	JUDICIALS (JUNIOI LINES I-II/)	1 30, 24/	31,020	ı, 700, 044	0/0,300	44, 04U, UZU	1116

Health Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014	D-+- /T: D	
				To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
Cost Center Description	HOUSEKEEPI NG	DIETARY	CAFETERI A	NURSI NG	CENTRAL	Pili
oost denter beserretten	(TIME SPENT)	(PATIENT DA	(MAN HOURS)	ADMI NI STRATI ON	SERVICES &	
	(112 0. 2.11)	YS)	(		SUPPLY	
		/		(DI RECT NUR	(SUPPLIES C	
				SING)	OST)	
	9. 00	10.00	11.00	13.00	14.00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	8, 077	0	484, 93	9 0	1, 463, 004	
194.00 07950 COMMUNITY HEALTH SERVICES	307	0	7, 07	9 0	23, 328	194. 00
194. 01 07951 WORK FITNESS	0	0		0 0	0	194. 01
194.02 07952 MARKETING AND PUBLIC RELATIONS	119	0	7, 94	2 0	235, 643	194. 02
194. 03 07953 MH RESIDENTIAL	0	0	53, 78	6 0	59, 623	194. 03
194. 04 07954 UNUSED SPACE	0	0		0 0	0	194. 04
194. 05 07955 MOB	0	0	26, 43	9 0	32, 537	194. 05
194. 06 07956 FOUNDATI ON	0	0	4, 16	7 0		194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	332	0		0 0		194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0 0		194. 08
194. 09 07959 NRCC	0	0		0 0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	3, 504, 194	1, 134, 663	2, 219, 02	7 3, 056, 426	841, 937	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	53. 842752	30. 001666			0. 031507	1
204.00 Cost to be allocated (per Wkst. B,	177, 950	32, 640	557, 84	5 243, 851	20, 769	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	2. 734243	0. 863035	0. 21984	9 0. 277622	0. 000777	205. 00
11)						I

	ALLOCATION - STATISTICAL BASIS	GOOD SAWART IA			Peri od:	Worksheet B-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
	Cost Contor Docorintian	PHARMACY	MEDICAL	SOCIAL SERVIC	E MENTAL HEALTH	6/3/2015 1: 34	
	Cost Center Description	(COSTED REC	MEDICAL RECORDS &	SUCTAL SERVIC	OVERHEAD	PARAMED ED PRGM	
		QUIS)	LI BRARY	(TIME SPENT)	(CHARGES)	(ASSI GNED	
		15. 00	(TIME SPENT) 16.00	17.00	17. 01	TI ME) 23. 00	
	GENERAL SERVICE COST CENTERS	10.00	10.00		17.01	20.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT					l	1.00
1. 01 1. 02	00101 NEW CRC - CT EAST 00102 NEW CRC- CT WEST					I	1. 01
1. 03	00103 NEW CRC- MEMORI AL					I	1. 03
1.04	00104 NEW CRC - OUTPATIENT					1	1. 04
1. 05 1. 06	OO105 NEW CRD - HEALTH PAVILION   OO106 NEW CRC - STORAGE						1. 05 1. 06
1. 07	00107 NEW CRC - DIAGNOSTIC CENTER						1. 07
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
2. 01 2. 02	OO201 NEW CRC - EQUIPMENT   OO202 NEW CRC - HEALTH PAVILION						2. 01 2. 02
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4.01	00401 COMMUNI CATI ONS						4. 01
4. 02 4. 03	00402 PURCHASING & RECEIVING 00403 REGISTRATION						4. 02 4. 03
4. 04	00404 PATIENT ACCOUNTS						4. 04
5.00	00500 ADMINISTRATIVE & GENERAL	1				l	5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					I	7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG					I	9. 00
10.00	01000 DI ETARY					l	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON						11.00
	01400 CENTRAL SERVICES & SUPPLY					I	14. 00
	01500 PHARMACY	11, 618, 102				I	15. 00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	1, 202	1	0	I	16. 00 17. 00
17. 00	01701 MENTAL HEALTH OVERHEAD	1, 368	O	1	57, 626, 171	I	17. 01
	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0		23. 00
23. 01	O2301   PARAMED ED PRGM-LAB     I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	)	0 0	0	23. 01
30. 00	03000 ADULTS & PEDIATRICS	20, 607	470		0 26, 447, 640	0	30.00
	03100 I NTENSI VE CARE UNI T	5, 000	89	1	0 0	0	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0 6, 762	67 80	1	0 5, 143, 872 0 0	0	
	04300 NURSERY	484	8		0 0		
	ANCILLARY SERVICE COST CENTERS						1
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	46, 379 0	82		0 0	0	
51. 00	05101 ENDOSCOPY	2, 784	33	•	0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	553	O		0	0	
	05300   ANESTHESI OLOGY   05400   RADI OLOGY - DI AGNOSTI C	0 142, 151	0		0	0 100	
54. 01	05401 RADI OLOGY-NON-CAMPUS	30, 089	O		0 0	0	
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0	0		0	0	
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	3, 430	0		0	0	60.00
65. 00	06500 RESPIRATORY THERAPY	3, 712	5		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	14, 055	O	1	0 0	0	66. 00
69. 00 70. 00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	942	36		0	0	69. 00 70. 00
70. 00	07000 ELECTROENCEPHALOGRAPHI	29	25		0 0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	O		0 0	0	71. 00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 10, 077, 569	0		0	0	72. 00 73. 00
	07500 ASC (NON-DISTINCT PART)	11, 662	79		0 20, 971, 332	1 0	75. 00
76. 00	03020 MH ANCILLARY OUTPATIENT	0	O		0	0	
76. 01	03950   I NPATI ENT DI ALYSI S   OUTPATI ENT SERVI CE COST CENTERS	2, 398	0	)	0 0	0	76. 01
90. 00		8, 152	O		0 0	0	90.00
91.00	09100 EMERGENCY	11, 435	228	•	0		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	o o	O		0 0		101. 00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
	11300 INTEREST EXPENSE  11600 HOSPICE	30, 749	n		0 0	n	113. 00 116. 00
118.00		10, 420, 310		1	52, 562, 844		118. 00
100 -	NONREI MBURSABLE COST CENTERS						100.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	ין	0 0	0	190. 00

Provi der CCN: 150042

			11	0 12/31/2014	6/3/2015 1: 34	
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	MENTAL HEALTH	PARAMED ED	Pili
·	(COSTED REC	RECORDS &		OVERHEAD	PRGM	
	QUIS)	LI BRARY	(TIME SPENT)	(CHARGES)	(ASSI GNED	
		(TIME SPENT)			TIME)	
	15. 00	16. 00	17. 00	17. 01	23. 00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 179, 047	0	0	5, 063, 327	0	192. 00
194.00 07950 COMMUNITY HEALTH SERVICES	18, 745	0	0	0	0	194. 00
194. 01 07951 WORK FITNESS	0	0	0	0	0	194. 01
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
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
194.07 07957 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. 09 07959 NRCC	0	0	0	0	0	194. 09
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	5, 633, 600	4, 810, 419	0	2, 195, 095	232, 152	202. 00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I	0. 484898	4, 002. 012479	0.000000	0. 038092	2, 321. 520000	203. 00
204.00 Cost to be allocated (per Wkst. B,	518, 880	78, 138	0	212, 505	2, 097	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 044661	65. 006656	0.000000	0. 003688	20. 970000	205. 00
						[

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

From 01/01/2014 12/31/2014 Date/Time Prepared: 6/3/2015 1:34 pm Cost Center Description PARAMED ED PRGM-LAB (ASSI GNED TIME) 23.01 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 1.01 00101 NEW CRC - CT EAST 1.01 00102 NEW CRC- CT WEST 1.02 1 02 1.03 00103 NEW CRC- MEMORIAL 1.03 00104 NEW CRC - OUTPATIENT 1.04 1.04 00105 NEW CRD - HEALTH PAVILION 1.05 1.05 00106 NEW CRC - STORAGE 1.06 1.06 00107 NEW CRC - DIAGNOSTIC CENTER 1.07 1.07 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00201 NEW CRC - EQUI PMENT 00202 NEW CRC - HEALTH PAVI LI ON 2.01 2. 01 2.02 2.02 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.01 00401 COMMUNI CATI ONS 4.01 00402 PURCHASING & RECEIVING 4.02 4.02 4.03 00403 REGI STRATI ON 4.03 00404 PATIENT ACCOUNTS 4.04 4.04 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14 00 01500 PHARMACY 15.00 15.00 16.00 |01600 | MEDI CAL RECORDS & LI BRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01701 MENTAL HEALTH OVERHEAD 17 01 17 01 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 02301 PARAMED ED PRGM-LAB 100 23.01 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 0 0 31.00 03100 INTENSIVE CARE UNIT 31.00 04000 SUBPROVI DER - I PF 40.00 40.00 04100 SUBPROVI DER - I RF 0 41.00 41.00 04300 NURSERY 43.00 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 05100 RECOVERY ROOM 00000 51.00 51.00 05101 ENDOSCOPY 51.01 51.01 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 53.00 05300 ANESTHESI OLOGY 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 54.00 05401 RADI OLOGY-NON-CAMPUS 54.01 54.01 54.08 05408 RADI OLOGY-GSH BREAST CENTER 0 54.08 60.00 06000 LABORATORY 100 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63 00 06500 RESPIRATORY THERAPY 0000000000 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06900 ELECTROCARDI OLOGY 69.00 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 70.00 07001 NEURODI AGNOSTI CS 70.01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 07500 ASC (NON-DISTINCT PART) 75.00 75.00 03020 MH ANCILLARY OUTPATIENT 76.00 76.00 03950 INPATIENT DIALYSIS 76. 01 0 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY 0 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 101.00 10100 HOME HEALTH AGENCY 0 101. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 116. 00 11600 HOSPI CE 0 116, 00 SUBTOTALS (SUM OF LINES 1-117) 100 118, 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00

Health Financial Syste	ems	GOOD SAMARITA	N HOSPITAL				In Lieu	of Form C	MS-25	52-10
COST ALLOCATION - STA	TISTICAL BASIS		Provi	der CCN:	150042		d: 01/01/2014	Worksheet	B-1	
						То	12/31/2014	Date/Time 6/3/2015 1		
Coot Cont	or Decemintion	DADAMED ED								

				6/3/2015 1:34 pm
Cost	Center Description	PARAMED ED PRGM-LAB (ASSIGNED TIME)		σ, σ, <u>Σ</u> σ.τσ. τ. σ.τ. μ
		23. 01		
192.00 19200 PHYS	SICIANS' PRIVATE OFFICES	0		192. 00
194.00 07950 COMM	MUNITY HEALTH SERVICES	0		194. 00
194. 01 07951 WORK	( FITNESS	0		194. 01
194. 02 07952 MARK	KETING AND PUBLIC RELATIONS	0		194. 02
194.03 07953 MH R	RESI DENTI AL	0		194. 03
194. 04 07954 UNUS	SED SPACE	0		194. 04
194. 05 07955 MOB		0		194. 05
194. 06 07956 FOUN	NDATI ON	0		194. 06
194. 07 07957 KNOX	COUNTY HEALTH DEPT	0		194. 07
194. 08 07958 I NDU	JSTRI AL HEALTH	0		194. 08
194. 09 07959 NRCC		0		194. 09
	ss Foot Adjustments			200. 00
	ative Cost Centers			201. 00
202.00 Cost Part	t to be allocated (per Wkst. B,	40, 364		202. 00
203. 00 Uni t	cost multiplier (Wkst. B, Part I)	403. 640000		203. 00
	to be allocated (per Wkst. B,	184		204. 00
1 1	cost multiplier (Wkst. B, Part	1. 840000		205. 00

| Peri od: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared:

				10 12/31/2014	6/3/2015 1: 34		
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Ādj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDI ATRI CS	25, 878, 565		25, 878, 56	5 0	25, 878, 565	30. 00
31.00	03100 INTENSIVE CARE UNIT	4, 035, 427		4, 035, 42	7 0	4, 035, 427	31.00
40.00	04000 SUBPROVI DER - I PF	2, 760, 620		2, 760, 62	0	2, 760, 620	40. 00
41.00	04100 SUBPROVI DER - I RF	6, 961, 544		6, 961, 54	4 0	6, 961, 544	41.00
43.00	04300 NURSERY	686, 634		686, 63	4 0	686, 634	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	9, 341, 597		9, 341, 59	7 0	9, 341, 597	50. 00
51.00	05100 RECOVERY ROOM	0			0	0	51.00
51. 01	05101  ENDOSCOPY	2, 914, 388		2, 914, 38	3 0	2, 914, 388	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	869, 473		869, 47	3 0	869, 473	52. 00
53.00	05300 ANESTHESI OLOGY	0			0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	10, 534, 015		10, 534, 01	5 0	10, 534, 015	54. 00
54. 01	05401 RADI OLOGY-NON-CAMPUS	2, 144, 326		2, 144, 32	5 0	2, 144, 326	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	292, 198		292, 19	600	292, 798	54. 08
60.00	06000 LABORATORY	7, 119, 083		7, 119, 08	3 0	7, 119, 083	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 165, 279		1, 165, 27	9 0	1, 165, 279	63.00
65.00	06500 RESPI RATORY THERAPY	3, 949, 293	0	3, 949, 29	3 0	3, 949, 293	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 961, 564	0	4, 961, 56	4 0	4, 961, 564	66. 00
69.00	06900 ELECTROCARDI OLOGY	5, 964, 558		5, 964, 55	3, 534	5, 968, 092	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	1, 386, 539		1, 386, 53	9 4, 171	1, 390, 710	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 395, 789		9, 395, 78	9 0	9, 395, 789	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 273, 478		3, 273, 47	3 0	3, 273, 478	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	19, 209, 464		19, 209, 46	4 0	19, 209, 464	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	4, 523, 140		4, 523, 14	0	4, 523, 140	75. 00
76.00	03020 MH ANCILLARY OUTPATIENT	0			0	0	76. 00
76. 01	03950 INPATIENT DIALYSIS	657, 314		657, 31	14, 186	671, 500	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	1, 906, 617		1, 906, 61	7 0	1, 906, 617	90.00
91.00	09100 EMERGENCY	7, 536, 811		7, 536, 81	1 26, 308		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 588, 493		2, 588, 49	3	2, 588, 493	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	307, 275		307, 27	5 0	307, 275	96. 00
101.00	10100 HOME HEALTH AGENCY	0			)	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	2, 020, 839		2, 020, 83		2, 020, 839	
200.00		142, 384, 323					
201.00		2, 588, 493	l	2, 588, 49		2, 588, 493	1
202.00	Total (see instructions)	139, 795, 830	0	139, 795, 83	48, 799	139, 844, 629	202. 00

| Peri od: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared:

				'	0 12/31/2014	6/3/2015 1: 34	
			Ti tl	e XVIII	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	26, 447, 640		26, 447, 640			30. 00
31. 00	03100 I NTENSI VE CARE UNI T	6, 349, 700		6, 349, 700			31. 00
40.00	04000 SUBPROVI DER - I PF	5, 143, 872		5, 143, 872			40. 00
41. 00	04100 SUBPROVI DER - I RF	6, 924, 045		6, 924, 045			41. 00
43.00	04300 NURSERY	1, 030, 098		1, 030, 098	3		43. 00
	ANCILLARY SERVICE COST CENTERS	,					
50. 00	05000 OPERATING ROOM	13, 848, 076	15, 823, 244			0. 000000	
51. 00	05100 RECOVERY ROOM	0	0			0. 000000	1
51. 01	05101 ENDOSCOPY	1, 752, 484	9, 094, 659			0. 000000	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 449, 695	333, 932			0.000000	1
53. 00	05300 ANESTHESI OLOGY	0	0			0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	12, 094, 473	62, 781, 795			0. 000000	1
54. 01	05401 RADI OLOGY-NON-CAMPUS	2, 150, 582	15, 639, 458			0. 000000	1
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	7, 206	364, 327	371, 533		0. 000000	1
60.00	06000 LABORATORY	14, 981, 341	31, 658, 517			0. 000000	•
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 776, 566	788, 817			0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	6, 221, 115	3, 124, 231			0. 000000	1
66.00	06600 PHYSI CAL THERAPY	11, 609, 916	13, 465, 862			0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	7, 783, 169	21, 610, 007			0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	107 110	0		0.00000	0.000000	1
70. 01	07001 NEURODI AGNOSTI CS	187, 113	5, 585, 375			0.000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 526, 676	1, 664, 279			0.000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 709, 494	2, 330, 460			0.000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	16, 164, 846	38, 229, 014			0.000000	•
75. 00	07500 ASC (NON-DISTINCT PART)	31, 460	20, 939, 872			0.000000	1
76. 00	03020 MH ANCI LLARY OUTPATI ENT	0	0			0. 000000	•
76. 01	03950 I NPATI ENT DI ALYSI S	1, 155, 094	50, 495	1, 205, 589	0. 545222	0. 000000	76. 01
00.00	OUTPATIENT SERVICE COST CENTERS		2 505 510	2 505 510	0 542000	0.000000	00.00
90.00	09000 CLINIC	0	3, 505, 519			0. 000000	90.00
91.00	09100 EMERGENCY	5, 528, 920	27, 414, 250			0.000000	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, 123, 457	8, 529, 276	12, 652, 733	0. 204580	0. 000000	92. 00
0/ 00	OTHER REIMBURSABLE COST CENTERS	74 (50	F// 0F0	(40.71)	0 470570	0.000000	96. 00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	74, 659	566, 059			0. 000000	
101.00	10100 HOME HEALTH AGENCY	0	0	(	/		101. 00
112 00	SPECIAL PURPOSE COST CENTERS 11300   NTEREST EXPENSE						112 00
	1	0 400	2 /// 042	2 (74 52)			113. 00
200.00	11600 HOSPICE   Subtotal (see instructions)	8, 482 165, 080, 179	2, 666, 042 286, 165, 490				116. 00 200. 00
200.00	, ,	100,000,179	∠00, 100, 490	431, 243, 009			200.00
	i i	165 000 170	206 165 400	151 215 440			201.00
202.00	Total (see instructions)	165, 080, 179	286, 165, 490	451, 245, 669	'I I		1202. UU

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-			
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150042	From 01/01/2014	Worksheet C Part I Date/Time Prepared: 6/3/2015 1:34 pm		

					6/3/2015 1:34 pm
			Title XVIII	Hospi tal	PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
		11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS				
	03000 ADULTS & PEDI ATRI CS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVI DER - I PF				40. 00
41.00	04100 SUBPROVI DER - I RF				41.00
43.00	04300 NURSERY				43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0. 314836			50.00
51.00	05100 RECOVERY ROOM	0. 000000			51.00
51. 01	05101   ENDOSCOPY	0. 268678			51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 229799			52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 140686			54.00
54.01	05401 RADI OLOGY-NON-CAMPUS	0. 120535			54. 01
54.08	05408 RADI OLOGY-GSH BREAST CENTER	0. 788081			54. 08
60.00	06000 LABORATORY	0. 152639			60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 454232			63.00
65.00	06500 RESPIRATORY THERAPY	0. 422595			65. 00
66.00	06600 PHYSI CAL THERAPY	0. 197863			66. 00
69.00	06900 ELECTROCARDI OLOGY	0. 203043			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
70. 01	07001 NEURODI AGNOSTI CS	0. 240920			70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 147093			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 271885			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 353155			73.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 215682			75. 00
76.00	03020 MH ANCILLARY OUTPATIENT	0. 000000			76. 00
76. 01	03950 INPATIENT DIALYSIS	0. 556989			76. 01
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0. 543890			90.00
91.00	09100 EMERGENCY	0. 229581			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 204580			92.00
	OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 479579			96. 00
101.00	10100 HOME HEALTH AGENCY				101. 00
	SPECIAL PURPOSE COST CENTERS				
	11300 I NTEREST EXPENSE				113. 00
116.00	11600 H0SPI CE				116. 00
200.00	Subtotal (see instructions)				200. 00
201.00	Less Observation Beds				201. 00
202.00	Total (see instructions)				202. 00
		·			•

					10 12/31/2014	6/3/2015 1:34	
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	·	(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				_		
30.00	03000 ADULTS & PEDI ATRI CS	25, 878, 565		25, 878, 56	5 0	25, 878, 565	30. 00
31.00	03100 INTENSIVE CARE UNIT	4, 035, 427		4, 035, 42	7 0	4, 035, 427	31.00
40.00	04000 SUBPROVI DER - I PF	2, 760, 620		2, 760, 62	0	2, 760, 620	40. 00
41.00	04100 SUBPROVI DER - I RF	6, 961, 544		6, 961, 54	4 0	6, 961, 544	41.00
43.00	04300 NURSERY	686, 634		686, 63	4 0	686, 634	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 341, 597		9, 341, 59	7 0	9, 341, 597	50.00
51.00	05100 RECOVERY ROOM	0			0	0	51.00
51. 01	05101 ENDOSCOPY	2, 914, 388		2, 914, 38	3 0	2, 914, 388	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	869, 473		869, 47	3 0	869, 473	52. 00
53.00	05300 ANESTHESI OLOGY	0			0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 534, 015		10, 534, 01	5 0	10, 534, 015	54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS	2, 144, 326		2, 144, 32	6 0	2, 144, 326	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	292, 198	l e	292, 19		292, 798	ł
60.00	06000 LABORATORY	7, 119, 083	l	7, 119, 08		7, 119, 083	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	1, 165, 279	l .	1, 165, 27		1, 165, 279	
65. 00	06500 RESPIRATORY THERAPY	3, 949, 293				3, 949, 293	
66. 00	06600 PHYSI CAL THERAPY	4, 961, 564	0	4, 961, 56		4, 961, 564	66. 00
69. 00	06900 ELECTROCARDI OLOGY	5, 964, 558	_	5, 964, 55		5, 968, 092	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0,111,111			0	0,110,112	70.00
70. 01	07001 NEURODI AGNOSTI CS	1, 386, 539		1, 386, 53	9 4, 171	1, 390, 710	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 395, 789		9, 395, 78		9, 395, 789	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 273, 478		3, 273, 47		3, 273, 478	
73. 00	07300 DRUGS CHARGED TO PATIENTS	19, 209, 464		19, 209, 46		19, 209, 464	
75. 00	07500 ASC (NON-DISTINCT PART)	4, 523, 140		4, 523, 14		4, 523, 140	
76. 00	03020 MH ANCILLARY OUTPATIENT	1,020,110			0	0	76. 00
	03950 I NPATIENT DIALYSIS	657, 314		657, 31	-	671, 500	ł
70.01	OUTPATIENT SERVICE COST CENTERS	007,011		007,01	11, 100	071,000	70.01
90. 00	09000 CLINIC	1, 906, 617		1, 906, 61	7 0	1, 906, 617	90.00
91. 00	09100 EMERGENCY	7, 536, 811		7, 536, 81		7, 563, 119	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 588, 493		2, 588, 49		2, 588, 493	
72.00	OTHER REIMBURSABLE COST CENTERS	2,000,170		2,000,17	<b>3</b>	2,000,170	72.00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	307, 275		307, 27	5 0	307, 275	96.00
	10100 HOME HEALTH AGENCY	0 0	l e			•	101.00
101.00	SPECIAL PURPOSE COST CENTERS			·	2	0	101.00
113 00	11300 I NTEREST EXPENSE						113. 00
	11600 HOSPI CE	2, 020, 839		2, 020, 83		2, 020, 839	
200.00		142, 384, 323	l e				
201.00	,	2, 588, 493	l e	2, 588, 49	· ·	2, 588, 493	1
201.00		139, 795, 830					
202.00	Total (See Histractions)	137, 173, 030	1	1 137, 173, 03	اد ۲۵, ۱۹۶	137, 044, 027	1202.00

| Peri od: | Worksheet C | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared:

				'	0 12/31/2014	6/3/2015 1: 34	
			Ti t	le XIX	Hospi tal	Cost	·
			Charges				
Cost Center Descrip	ti on	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE	COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS		26, 447, 640		26, 447, 640			30. 00
31.00 03100 INTENSIVE CARE UNIT		6, 349, 700		6, 349, 700			31. 00
40. 00   04000   SUBPROVI DER - I PF		5, 143, 872		5, 143, 872			40. 00
41. 00   04100   SUBPROVI DER - I RF		6, 924, 045		6, 924, 045			41.00
43. 00   04300   NURSERY	NTERO.	1, 030, 098		1, 030, 098	3		43. 00
ANCILLARY SERVICE COST CE	NIERS	10 010 07/	45 000 044	00 (74 000			
50. 00 05000 OPERATI NG ROOM		13, 848, 076	15, 823, 244			0.000000	50.00
51. 00   05100   RECOVERY   ROOM		0	0	_	0.00000	0.000000	
51. 01   05101   ENDOSCOPY	20 0004	1, 752, 484	9, 094, 659			0. 000000	51. 01
52. 00 05200 DELIVERY ROOM & LABO	JR ROOM	3, 449, 695	333, 932			0.000000	
53. 00 05300 ANESTHESI OLOGY	_	0	(2.701.705	_		0.000000	
54. 00   05400   RADI OLOGY - DI AGNOSTI (	4	12, 094, 473	62, 781, 795			0.000000	
54. 01   05401   RADI OLOGY-NON-CAMPUS 54. 08   05408   RADI OLOGY-GSH   BREAS		2, 150, 582	15, 639, 458			0.000000	
	I CENTER	7, 206	364, 327	371, 533		0.000000	
60. 00   06000   LABORATORY 63. 00   06300   BLOOD   STORI NG, PROCI	TOTAL O TOTAL	14, 981, 341	31, 658, 517 788, 817	46, 639, 858 2, 565, 383		0. 000000 0. 000000	
65. 00   06500   RESPI RATORY THERAPY	ESSING & IRANS.	1, 776, 566	3, 124, 231	9, 345, 346		0. 000000	
66. 00   06600 PHYSI CAL THERAPY		6, 221, 115 11, 609, 916	13, 465, 862			0. 000000	
69. 00   06900   FHTST CAL THERAPT		7, 783, 169	21, 610, 007			0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAI	DUV	7, 763, 109	21, 010, 007			0. 000000	
70. 01   07000   EEECTROENCELTHAEGGRAI	***	187, 113	5, 585, 375	· ·		0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHA	ADGED TO DATIENT	6, 526, 676	1, 664, 279			0. 000000	
72. 00 07200 I MPL. DEV. CHARGED		9, 709, 494	2, 330, 460			0. 000000	
73. 00 07300 DRUGS CHARGED TO PA		16, 164, 846	38, 229, 014			0. 000000	
75. 00 07500 ASC (NON-DISTINCT PA		31, 460	20, 939, 872			0. 000000	
76. 00 03020 MH ANCI LLARY OUTPAT		01, 100	0		0.000000	0. 000000	76.00
76. 01   03950   NPATIENT DIALYSIS	2.01	1, 155, 094	50, 495	_		0. 000000	76. 01
OUTPATIENT SERVICE COST C	FNTERS	1, 100, 071	00, 170	1,200,007	0.010222	0.000000	70.01
90. 00 09000 CLINIC	ENTERO	0	3, 505, 519	3, 505, 519	0. 543890	0. 000000	90.00
91. 00 09100 EMERGENCY		5, 528, 920	27, 414, 250			0. 000000	
92. 00 09200 OBSERVATION BEDS (NO	ON-DISTINCT PART	4, 123, 457	8, 529, 276			0. 000000	
OTHER REIMBURSABLE COST C		., .==,	0, 00., 00.	,,,			
96. 00 09600 DURABLE MEDICAL EQUI		74, 659	566, 059	640, 718	0, 479579	0.000000	96. 00
101.00 10100 HOME HEALTH AGENCY		0	0	· ·			101. 00
SPECIAL PURPOSE COST CENT	ERS	-1		-			
113. 00 11300   NTEREST EXPENSE							113. 00
116. 00 11600 HOSPI CE		8, 482	2, 666, 042	2, 674, 524			116. 00
200.00 Subtotal (see instru	uctions)	165, 080, 179	286, 165, 490				200. 00
201.00 Less Observation Bed	ds						201. 00
202.00 Total (see instructi	ons)	165, 080, 179	286, 165, 490	451, 245, 669			202. 00
•	'	,	'	•			-

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 150042	From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Prepared:

				6/3/2015 1:34 pm
		Title XIX	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
·	Rati o			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
40. 00   04000   SUBPROVI DER - 1 PF				40.00
41. 00   04100   SUBPROVI DER -   I RF				41.00
43. 00   04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 000000			50.00
51. 00   05100 RECOVERY ROOM	0. 000000			51.00
51. 01   05101 ENDOSCOPY	0. 000000			51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 000000			54.00
54. 01   05401 RADI OLOGY-NON-CAMPUS	0. 000000			54. 01
54. 08   05408 RADI OLOGY-GSH BREAST CENTER	0. 000000			54. 08
60. 00   06000   LABORATORY	0. 000000			60.00
63.00 06300 BLOOD STORING, PROCESSING & 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. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 00 03020 MH ANCI LLARY OUTPATIENT	0. 000000			76.00
76. 01   03950   INPATIENT DIALYSIS	0. 000000			76. 01
OUTPATIENT SERVICE COST CENTERS	0.00000			75.51
90. 00 09000 CLINIC	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.00
OTHER REIMBURSABLE COST CENTERS	0. 000000			72. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
101.00 10100 HOME HEALTH AGENCY	0.00000			101. 00
SPECIAL PURPOSE COST CENTERS				
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
202.00 Total (see instructions)				202. 00
1.212. (222.1101.401.01.0)	1 1			1202.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014 To 12/31/2014		
				To 12/31/2014	Date/Time Pre 6/3/2015 1:34	pareu: nm
		Ti tl	e XVIII	Hospi tal	PPS	рш
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost		,	
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 446, 045	0	3, 446, 04	5 24, 264	142. 02	30. 00
31.00   INTENSIVE CARE UNIT	252, 951		252, 95	1 2, 581	98. 01	31. 00
40. 00 SUBPROVI DER - I PF	696, 074	0	696, 07	4, 536	153. 46	40. 00
41. 00 SUBPROVI DER - I RF	378, 484	0	378, 48	4 7, 693	49. 20	41. 00
43. 00 NURSERY	11, 543		11, 54	3 1, 070	10. 79	43. 00
200.00 Total (lines 30-199)	4, 785, 097		4, 785, 09	7 40, 144		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 CENTERS		1	1			
30. 00 ADULTS & PEDI ATRI CS	13, 402					30. 00
31. 00   INTENSIVE CARE UNIT	1, 706					31. 00
40. 00 SUBPROVI DER – I PF	1, 782					40. 00
41. 00   SUBPROVI DER - I RF	6, 459		1			41. 00
43. 00 NURSERY	0	_				43.00
200.00 Total (lines 30-199)	23, 349	2, 661, 806	1			200. 00

Health Financial Systems	GOOD SAMARITA	AN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT.	AL COSTS		Provi der			Worksheet D Part II Date/Time Pre 6/3/2015 1:34	
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	(fro	m Wkst. C, t I, col. 8)	(col . 1 ÷ col 2)	Program	Capital Costs (column 3 x column 4)	
	4 00				4 00		

					6/3/2015 1:34	pm
			tle XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal		es Ratio of Cost		Capital Costs	
	Related Cost	(from Wkst.	C, to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col	. (col . 1 ÷ col .	Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	1, 026, 890	29, 671,	320 0. 034609	10, 722, 204	371, 085	50. 00
51.00   05100   RECOVERY ROOM	0		0.000000	0	0	51.00
51. 01   05101   ENDOSCOPY	473, 217	10, 847,	0. 043626	995, 182	43, 416	51. 01
52.00 05200 DELIVERY ROOM & LABOR ROOM	15, 082	3, 783,	527 0. 003986	3, 740	15	52.00
53. 00 05300 ANESTHESI OLOGY	0		0. 000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 035, 607	74, 876, 3	268 0. 013831	7, 136, 741	98, 708	54.00
54. 01   05401 RADI OLOGY-NON-CAMPUS	163, 055	17, 790, (	0. 009166	1, 111, 068	10, 184	54. 01
54. 08   05408 RADI OLOGY-GSH BREAST CENTER	1, 092	371,	0. 002939	0	0	54. 08
60. 00   06000   LABORATORY	480, 875	46, 639,	358 0. 010310	9, 648, 236	99, 473	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	3, 794	2, 565,	383 0. 001479	1, 635, 649	2, 419	63.00
65. 00 06500 RESPIRATORY THERAPY	189, 610	9, 345,	346 0. 020289	3, 190, 261	64, 727	65. 00
66. 00 06600 PHYSI CAL THERAPY	242, 016	25, 075,	778 0. 009651	3, 503, 567	33, 813	66.00
69. 00 06900 ELECTROCARDI OLOGY	449, 312		I		90, 875	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0. 000000		0	70.00
70. 01   07001   NEURODI AGNOSTI CS	357, 043	5, 772,	I		6, 651	•
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 686				9, 430	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	62, 368					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	504,006		I		88, 332	73.00
75. 00 07500 ASC (NON-DISTINCT PART)	137, 054		I		0	75. 00
76. 00 03020 MH ANCI LLARY OUTPATIENT	0		0.000000		0	76. 00
76. 01 03950 I NPATI ENT DI ALYSI S	79, 104	1, 205,	I		63, 381	76. 01
OUTPATIENT SERVICE COST CENTERS	,	.,				
90. 00 09000 CLI NI C	49, 086	3, 505,	0. 014002	0	0	90.00
91. 00 09100 EMERGENCY	535, 468				49, 000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	344, 689		I		· ·	92.00
OTHER REIMBURSABLE COST CENTERS	3,007	12,002,	0.027212	7.5,070	20,000	1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	14, 250	640,	718 0. 022241	0	0	96.00
200. 00 Total (lines 50-199)	6, 190, 304		I	65, 863, 363	-	
	0,	,, ., .,	1	00,000,000	., 55., 270	1-20.00

Health Financial Systems	GOOD SAMARIT	AN HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS		CCN: 150042	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T	0	0		0 0	0	30. 00 31. 00
40. 00   04000  SUBPROVI DER -   PF				0	0	40.00
41. 00   04100   SUBPROVI DER -   RF		0			0	41. 00
43. 00   04300   NURSERY		0		0	0	43. 00
200.00 Total (lines 30-199)	0	O	)	0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
	4.00	7.00	0.00	col . 8)		
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00		
30. 00 03000 ADULTS & PEDIATRICS	24, 264	0.00	13, 40	12		30.00
31. 00   03100   NTENSI VE CARE UNI T	2, 581					31.00
40. 00   04000   SUBPROVI DER -   PF	4, 536		, ,			40.00
41. 00   04100   SUBPROVI DER -   RF	7, 693					41. 00
43. 00   04300   NURSERY	1, 070			0 0		43.00
200.00 Total (lines 30-199)	40, 144	l .	23, 34	19 0		200. 00

Health Financial Systems	GOOD SAMARITAN HO	u of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150042	Peri od: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Prepared:

					0 12/31/2014	6/3/2015 1: 34	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	0	(	0	0	0	50.00
	5100 RECOVERY ROOM	0	(	0	0	0	51. 00
	5101 ENDOSCOPY	0	(	0	0	0	51. 01
1	5200 DELIVERY ROOM & LABOR ROOM	0	(	0	0	0	52. 00
1	5300 ANESTHESI OLOGY	0	(	0	0	0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	0	(	232, 152	0	232, 152	54. 00
	5401 RADI OLOGY-NON-CAMPUS	0	(	0	0	0	54. 01
1	5408 RADI OLOGY-GSH BREAST CENTER	0	(	0	0	0	54. 08
1	6000 LABORATORY	0	(	40, 364	0	40, 364	60.00
	6300 BLOOD STORING, PROCESSING & TRANS.	0	(	0	0	0	63. 00
	6500 RESPI RATORY THERAPY	0	(	) C	0	0	65. 00
	6600 PHYSI CAL THERAPY	0	(	0	0	0	66. 00
1	6900 ELECTROCARDI OLOGY	0	(	) C	0	0	69. 00
	7000 ELECTROENCEPHALOGRAPHY	0	(	) C	0	0	70. 00
	7001 NEURODI AGNOSTI CS	0	(	) C	0	0	70. 01
1	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(	) C	0	0	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	(	) C	0	0	72. 00
	7300 DRUGS CHARGED TO PATIENTS	0	(	) C	0	0	73. 00
	7500 ASC (NON-DISTINCT PART)	0	(	) C	0	0	75. 00
	3020 MH ANCILLARY OUTPATIENT	0	(	) C	0	0	76. 00
	3950 INPATIENT DIALYSIS	0	(	0	0	0	76. 01
	UTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	0	(	) c	0	0	, , , , , ,
	9100 EMERGENCY	0	(	) C	0	0	91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0	(	) C	0	0	92. 00
	THER REIMBURSABLE COST CENTERS						
	9600 DURABLE MEDICAL EQUIP-RENTED	0	(		0	0	
200.00	Total (lines 50-199)	0	(	272, 516	0	272, 516	200. 00

Health Financial Systems	GOOD SAMARIT	AN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	S	Provi der		Peri od:	Worksheet D	
THROUGH COSTS					From 01/01/2014		
					To 12/31/2014	Date/Time Pre	pared:
						6/3/2015 1: 34	pm
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total			Ratio of Cos		I npati ent	
	Outpati ent	(from	n Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part	I, col.	(col. 5 ÷ col		Charges	
	col. 2, 3 and		8)	7)	(col. 6 ÷ col.		
	4)				7)		
	6.00		7. 00	8. 00	9. 00	10.00	
ANCILLADY SERVICE COST CENTERS							

			Titl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total		Ratio of Cost		I npati ent	
			(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
		col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
		4)			7)		
		6.00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	29, 671, 320	0.000000	0.000000	10, 722, 204	50. 00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
51. 01	05101 ENDOSCOPY	0	10, 847, 143	0.000000	0.000000	995, 182	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	3, 783, 627	0.000000	0.000000	3, 740	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	232, 152	74, 876, 268	0.003100	0.003100	7, 136, 741	54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0	17, 790, 040	0.000000	0.000000	1, 111, 068	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0	371, 533	0. 000000	0.000000	0	54. 08
60.00	06000 LABORATORY	40, 364	46, 639, 858	0. 000865	0. 000865	9, 648, 236	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	2, 565, 383	0. 000000	0.000000	1, 635, 649	63.00
65.00	06500 RESPI RATORY THERAPY	0	9, 345, 346	0. 000000	0.000000	3, 190, 261	65. 00
66.00	06600 PHYSI CAL THERAPY	0	25, 075, 778	0.000000	0. 000000	3, 503, 567	66. 00
69.00	06900 ELECTROCARDI OLOGY	0	29, 393, 176	0.000000	0. 000000	5, 944, 991	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 000000	0. 000000	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	0	5, 772, 488	0. 000000	0. 000000	107, 532	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8, 190, 955	0. 000000	0. 000000	2, 894, 451	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	12, 039, 954	0. 000000	0. 000000	4, 480, 479	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	54, 393, 860	0. 000000	0. 000000	9, 532, 931	73. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	20, 971, 332	0. 000000	0. 000000	0	75. 00
	03020 MH ANCILLARY OUTPATIENT	0	0	0. 000000	0. 000000	0	76. 00
	03950 INPATIENT DIALYSIS	0	1, 205, 589	0. 000000	0. 000000	965, 964	76. 01
	OUTPATIENT SERVICE COST CENTERS			<u>'</u>			
90.00	09000 CLI NI C	0	3, 505, 519	0.000000	0.000000	0	90.00
91.00	09100 EMERGENCY	0	32, 943, 170			3, 014, 672	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	12, 652, 733			975, 695	1
	OTHER REIMBURSABLE COST CENTERS		, ,				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	640, 718	0.000000	0.000000	0	96. 00
200.00	1	272, 516				65, 863, 363	
		, , , , ,	,,	1	ı	,,	

Health Financial Systems	GOOD SAMARITAN HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150042	From 01/01/2014	Worksheet D Part IV Date/Time Prepared:

					6/3/2015 1: 3	4 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11.00	12.00	13. 00			
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	14, 251, 163	0			50. 00
51.00   05100   RECOVERY ROOM	0	0	0			51.00
51. 01   05101   ENDOSCOPY	0	5, 006, 752	0			51. 01
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	0	0			52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0			53. 00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	22, 124	24, 905, 423	77, 207			54.00
54. 01   05401 RADI OLOGY-NON-CAMPUS	0	4, 752, 473	0			54. 01
54. 08   05408 RADI OLOGY-GSH BREAST CENTER	0	0	0			54. 08
60. 00   06000   LABORATORY	8, 346	5, 119, 973	4, 429			60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	693, 671	0			63. 00
65. 00 06500 RESPIRATORY THERAPY	0	2, 853, 123	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0	6, 412	0			66. 00
69. 00 06900 ELECTROCARDI OLOGY	0	6, 919, 510	0			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	0	o			70. 00
70. 01 07001 NEURODI AGNOSTI CS	o	2, 054, 991	l o			70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	1, 453, 636	o			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	2, 034, 045				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	21, 542, 245				73. 00
75.00 07500 ASC (NON-DISTINCT PART)	o		o			75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0	0			76. 00
76. 01 03950 I NPATIENT DIALYSIS	0	32, 976	0			76. 01
OUTPATIENT SERVICE COST CENTERS			-1			
90. 00 09000 CLI NI C	0	0	0			90.00
91. 00 09100 EMERGENCY	o	6, 662, 037	l o			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	O	1, 660, 292	O			92.00
OTHER REIMBURSABLE COST CENTERS	, ,		1			1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0			96. 00
200.00 Total (lines 50-199)	30, 470	99, 948, 722	81, 636			200.00
		· · · · · · · · · · · · · · · · · · ·				

Health Financial Systems	GOOD SAMARIT	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der		Peri od:	Worksheet D	
				rom 01/01/2014	Part V	
				Γο 12/31/2014		
-		Ti +I	e XVIII	Hospi tal	6/3/2015 1: 34 PPS	pm
		11 (1	Charges	nospi tai	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
cost center bescription	Ratio From	Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(366 11131.)	
	Part I, col. 9		Subject To	Subject To		
	1 41 6 1, 661.		Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATI NG ROOM	0. 314836	14, 251, 163		0	4, 486, 779	50.00
51. 00   05100   RECOVERY ROOM	0. 000000			0	1, 100, 777	51.00
51. 01   05101 ENDOSCOPY	0. 268678		1		1, 345, 204	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 229799			0	1, 343, 204	52. 00
53. 00   05300   ANESTHESI OLOGY	0. 000000			0	0	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 140686	l .	1		3, 503, 844	1
54. 01   05401 RADI OLOGY-NON-CAMPUS	0. 120535				572, 839	
54. 08   05408 RADI OLOGY-GSH BREAST CENTER	0. 786466				372, 839	54. 01
60. 00   06000   LABORATORY	0. 152639		1	-	781, 508	1
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.	0. 454232			0	315, 088	1
65. 00 06500 RESPIRATORY THERAPY	0. 422595		1		1, 205, 716	1
66. 00   06600   PHYSI CAL THERAPY	0. 422595		1		1, 203, 718	1
69. 00   06900   ELECTROCARDI OLOGY	0. 197863		1			
					1, 404, 128	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			-	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 240198			0	493, 605	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 147093			0	1, 667, 456	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 271885			0	553, 026	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 353155			41, 239	7, 607, 752	
75. 00 07500 ASC (NON-DISTINCT PART)	0. 215682			0	0	75. 00
76. 00 03020 MH ANCILLARY OUTPATIENT	0. 000000		1	0	0	
76. 01 03950 I NPATI ENT DI ALYSI S	0. 545222	32, 976	1	0	17, 979	76. 01
OUTPATIENT SERVICE COST CENTERS	0 542000	\	J		0	00 00
90. 00 09000 CLI NI C	0. 543890			0	0	
91. 00   09100   EMERGENCY	0. 228782			0	1, 524, 154	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0. 204580	1, 660, 292		0	339, 663	92.00
	O 470E70		J ,		0	0, 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 479579		1	0	0	70.00
200.00 Subtotal (see instructions)		99, 948, 722	3, 416	41, 239		
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges 202.00 Net Charges (line 200 +/- line 201)		99, 948, 722	2 41.	41, 239	25 020 010	202 00
202.00    Net Charges (Title 200 +/ - Title 201)	1	77, 740, 722	3, 410	ار 4۱, 239	25, 820, 010	1202.00

Health Financial Systems		GOOD SAMARITAN HO	SPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AN	ND VACCINE COST	Provi der CCN: 150042		Worksheet D
				From 01/01/2014	

				To 12/31/2014	Date/Time Pro 6/3/2015 1:34	
		Ti tl	e XVIII	Hospi tal	PPS	
<u> </u>	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Servi ces Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
ANOLLI ADV. CEDVI OF COCT. CENTEDO	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	0	0				50.00
51. 00   05100   RECOVERY ROOM	0	0				51. 00 51. 01
51. 01   05101   ENDOSCOPY	0	0				51.01
52. 00   05200   DELI VERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY	0	0				52.00
	0	0				54.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 54. 01   05401   RADI OLOGY-NON-CAMPUS	0	0				54. 00
54. 01   05401   RADI OLOGY-NON-CAMPUS 54. 08   05408   RADI OLOGY-GSH   BREAST CENTER	0	0				54. 01
60. 00   06000   LABORATORY	521	0				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	321	0				63. 00
65. 00   06500   RESPIRATORY THERAPY	0	0				65. 00
66. 00   06600 PHYSI CAL THERAPY						66. 00
69. 00   06900   ELECTROCARDI OLOGY						69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY						70.00
70. 01   07001   NEURODI AGNOSTI CS		0				70. 01
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	14, 564				73. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0	o				76. 00
76. 01 03950 I NPATIENT DIALYSIS	0	0				76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90. 00
91. 00 09100 EMERGENCY	0	0				91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	_				96. 00
200.00 Subtotal (see instructions)	521	14, 564				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	521	14, 564				202. 00

	Financial Systems	GOOD SAMARITA				u of Form CMS-2	2552-10
APPORTI (	ONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der	CCN: 150042	Peri od:	Worksheet D	
			Componen	t CCN: 15SO42	From 01/01/2014 To 12/31/2014	Part II	narad.
			Componen	L CCN: 155042	To 12/31/2014	Date/Time Pre 6/3/2015 1:34	pareu: nm
			Ti tl	e XVIII	Subprovi der -	PPS	рш
			11.61	CAVIII	IPF	113	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	<b>'</b>	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)		ĺ	
		26)	ĺ	,			
		1.00	2.00	3.00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
50.00 0	05000 OPERATING ROOM	1, 026, 890	29, 671, 320	0. 03460	9, 359	324	50. 00
51.00 0	05100 RECOVERY ROOM	0	C	0. 00000	00	0	51.00
51. 01 0	05101 ENDOSCOPY	473, 217	10, 847, 143	0. 04362	26 600	26	51. 01
52.00 0	05200 DELIVERY ROOM & LABOR ROOM	15, 082	3, 783, 627	0. 00398	36 0	0	52.00
53.00 0	05300 ANESTHESI OLOGY	0	C	0. 00000	00	0	53.00
54.00 0	05400 RADI OLOGY-DI AGNOSTI C	1, 035, 607	74, 876, 268	0. 01383	69, 007	954	54.00
54. 01 0	05401 RADI OLOGY-NON-CAMPUS	163, 055	17, 790, 040	0.00916	14, 614	134	54. 01
54.08 0	05408 RADIOLOGY-GSH BREAST CENTER	1, 092	371, 533	0. 00293	39 0	0	54. 08
60.00 0	06000 LABORATORY	480, 875	46, 639, 858	0. 0103	166, 864	1, 720	60.00
63.00 0	06300 BLOOD STORING, PROCESSING & TRANS.	3, 794	2, 565, 383	0. 0014	79 0	0	63.00
65.00 0	06500 RESPI RATORY THERAPY	189, 610	9, 345, 346	0. 02028	64, 512	1, 309	65. 00
66.00 0	06600 PHYSI CAL THERAPY	242, 016	25, 075, 778	0. 0096	51 18, 379	177	66. 00
69.00 0	06900 ELECTROCARDI OLOGY	449, 312	29, 393, 176	0. 01528	15, 051	230	69. 00
70.00 0	77000 ELECTROENCEPHALOGRAPHY	0	C	0. 00000	00	0	70. 00
70. 01 0	77001 NEURODI AGNOSTI CS	357, 043	5, 772, 488	0. 0618	53 1, 730	107	70. 01
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	26, 686	8, 190, 955	0. 0032	58 4, 422	14	71.00
72.00 0	07200 IMPL. DEV. CHARGED TO PATIENTS	62, 368	12, 039, 954	0. 00518	30 0	0	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	504, 006	54, 393, 860	0.00926	169, 666	1, 572	73. 00
75.00 0	07500 ASC (NON-DISTINCT PART)	137, 054	20, 971, 332	0. 00653	35 0	0	75. 00
76.00 0	3020 MH ANCILLARY OUTPATIENT	0	l c	0. 00000	00	0	76. 00
76. 01 0	3950 INPATIENT DIALYSIS	79, 104	1, 205, 589	0. 0656	14 5, 153	338	76. 01
0	UTPATIENT SERVICE COST CENTERS						
	99000 CLI NI C	49, 086	3, 505, 519	0. 01400	02 0	0	90.00
91.00 0	9100 EMERGENCY	535, 468	32, 943, 170	0. 0162	152, 696	2, 482	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART	0	12, 652, 733	0. 00000	00	0	92.00
0.	THER REIMBURSABLE COST CENTERS						
96.00 0	9600 DURABLE MEDICAL EQUIP-RENTED	14, 250	640, 718	0. 02224	41 0		
200.00	Total (lines 50-199)	5, 845, 615	402, 675, 790	)	692, 053	9, 387	200. 00

	inancial Systems	GOOD SAMARITA			In Lie	eu of Form CMS-2	2552-10
APPORTI O THROUGH	ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER COSTS	VICE OTHER PASS		CCN: 150042 t CCN: 15S042	Peri od: From 01/01/2014 To 12/31/2014		pared:
			Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Non Physician N	Nursing School	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
AN	NCILLARY SERVICE COST CENTERS		2.00	0.00	11.00	0.00	
50.00 05	5000 OPERATING ROOM	0	C	)	0 0	0	50. 00
51.00 05	5100 RECOVERY ROOM	0	C		0 0	0	51.00
51. 01   05	5101 ENDOSCOPY	0	C		0 0	0	51. 01
52. 00 05	5200 DELIVERY ROOM & LABOR ROOM	0	C		0	0	52. 00
	5300 ANESTHESI OLOGY	0	C		0	0	53. 00
	5400 RADI OLOGY-DI AGNOSTI C	0	C	232, 1	52 0	232, 152	54.00
- 1	5401 RADI OLOGY-NON-CAMPUS	0	C	)	0	0	54. 01
	5408 RADIOLOGY-GSH BREAST CENTER	0	C		0	0	54. 08
	6000 LABORATORY	0	C	40, 3		40, 364	60.00
1	6300 BLOOD STORING, PROCESSING & TRANS.	0	C		0	0	63. 00
	6500 RESPI RATORY THERAPY	0	C	)	0	0	65. 00
	6600 PHYSI CAL THERAPY	0	C	)	0	0	66. 00
	6900 ELECTROCARDI OLOGY	0	C	2	0 0	0	69. 00
	7000 ELECTROENCEPHALOGRAPHY	0	C	2	0 0	0	70.00
	7001 NEURODIAGNOSTICS 7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	70. 01 71. 00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT 7200 IMPL. DEV. CHARGED TO PATIENTS				0	0	71.00
	7300 DRUGS CHARGED TO PATTENTS				0	0	73.00
	7500 ASC (NON-DISTINCT PART)				0		75.00
	3020 MH ANCILLARY OUTPATIENT					Ö	76.00
	3950 I NPATIENT DIALYSIS		C		0 0	0	76. 01
	UTPATIENT SERVICE COST CENTERS	<u> </u>		1	<u> </u>		70.0.
	9000 CLI NI C	0	C		0 0	0	90.00
91.00 09	9100 EMERGENCY	0	C		0 0	0	91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0	C	)	0 0	0	92. 00
	THER REIMBURSABLE COST CENTERS						
	OZOO DUDADI E MEDI CAL FOULD DENTED	O	C	NI	0 0	0	96.00
96. 00 09 200. 00	9600 DURABLE MEDICAL EQUIP-RENTED Total (lines 50-199)	0	C	•			

Heal th Financial Systems  GOOD SAMARITAN HOSPITAL  APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS  Provider CCN: 150042 Component CCN: 155042  Title XVIII  Cost Center Description  Total Outpatient Cost (sum of col. 2, 3 and col. 3, 2015 in the col. 2, 3 and col. 2, 3 and col. 3, 2015 in the col. 2, 3 and col. 2, 3 and col. 3, 2015 in the col. 2, 3 and col. 3, 2015 in the col. 3, 2016 in the coll 2, 3 and col. 3, 2015 in the col. 3, 2016 in the coll 2, 2, 3, 2, 2, 2, 2, 2, 2, 2, 3, 2, 3, 2, 3, 2, 3, 2, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3, 3,
THROUGH COSTS  Component CCN: 15S042  Component CCN: 15S042  To 12/31/2014  To 12/31/2014  Part IV Date/Time Prepared: 6/3/2015 1: 34 pm  Title XVIII  Cost Center Description  Total Outpatient Cost (sum of cost (sum of col. 2, 3 and col. 2, 3 and s)  Total Charges (col. 5 + col. to Charges (col. 6 + col. col. col. 5 + col. col. col. col. col. col. col. col.
Component CCN: 15S042 To 12/31/2014 Date/Time Prepared: 6/3/2015 1: 34 pm  Title XVIII Subprovider - IPF  Cost Center Description Total Outpatient Cost (sum of C
Title XVIII Subprovider - IPF  Cost Center Description Total Charges Ratio of Cost Outpatient Outpatient (from Wkst. C, Cost (sum of Co
Cost Center Description  Total Outpatient (from Wkst. C, Cost (sum of
Cost Center Description  Total Charges Ratio of Cost Outpatient   Inpatient Outpatient   Cost (sum of cost (sum of cost 2, 3 and 8)   Cost (sum of cost 2, 3 and 8)   Cost (sum of cost 2, 3 and cost
Outpatient (from Wkst. C, to Charges Ratio of Cost Program Cost (sum of Cost (sum of Cost Col. 2, 3 and S) 7) (col. 6 ÷ col.
Cost (sum of Part I, col. (col. 5 ÷ col. to Charges col. 2, 3 and 8) 7) (col. 6 ÷ col.
4)   7)
6.00 7.00 8.00 9.00 10.00
ANCI LLARY SERVI CE COST CENTERS
50. 00   05000   OPERATING ROOM   0   29, 671, 320   0. 000000   0. 000000   9, 359   50. 00
51. 00   05100   RECOVERY ROOM   0   0. 000000   0. 000000   0   51. 00
51. 01   05101   ENDOSCOPY   0   10, 847, 143   0. 000000   0. 000000   600   51. 0
52. 00   05200   DELI VERY ROOM & LABOR ROOM   0   3, 783, 627   0.000000   0.000000   0   52. 00
53. 00   05300   ANESTHESI OLOGY   0   0, 000000   0, 000000   0   53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C   232, 152   74, 876, 268   0.003100   0.003100   69, 007   54. 00
54. 01   05401   RADI OLOGY-NON-CAMPUS   0   17, 790, 040   0.000000   0.000000   14, 614   54. 0
54. 08   05408   RADI OLOGY-GSH BREAST CENTER   0   371, 533   0.000000   0.000000   0   54. 08
60. 00   06000   LABORATORY   40, 364   46, 639, 858   0. 000865   0. 000865   166, 864   60. 00
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   2,565,383   0.000000   0.000000   0   63.00
65. 00   06500   RESPI RATORY THERAPY   0   9, 345, 346   0. 000000   0. 000000   64, 512   65. 00
66. 00   06600   PHYSI CAL THERAPY   0   25, 075, 778   0. 000000   0. 000000   18, 379   66. 00
69. 00   06900   ELECTROCARDI OLOGY   0   29, 393, 176   0. 000000   0. 000000   15, 051   69. 00
70. 00   07000  ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0. 000000 0 70. 00
70. 01   07001   NEURODI AGNOSTI CS   0   5, 772, 488   0. 000000   0. 000000   1, 730   70. 0
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT   0 8, 190, 955 0.000000 0.000000 4, 422   71. 00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   12, 039, 954   0. 000000   0. 000000   0   72. 00
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   54, 393, 860   0.000000   0.000000   169, 666   73. 00
75. 00   07500   ASC (NON-DISTINCT PART)   0   20, 971, 332   0.000000   0.000000   0   75. 00
76. 00   03020   MH ANCI LLARY OUTPATI ENT   0   0. 000000   0. 000000   0   76. 00
76. 01 03950 INPATIENT DIALYSIS 0 1, 205, 589 0. 000000 0. 000000 5, 153 76. 0
OUTPATIENT SERVICE COST CENTERS
90. 00   09000   CLINIC   0   3, 505, 519   0. 000000   0. 000000   0   90. 00
91. 00   09100   EMERGENCY   0   32, 943, 170   0. 000000   0. 000000   152, 696   91. 00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART   0   12,652,733   0.000000   0.000000   0   92. 00
OTHER REIMBURSABLE COST CENTERS
96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0 640, 718   0. 000000   0. 000000   0 96. 00
200.00   Total (lines 50-199)   272,516   402,675,790   692,053   200.00

Health Financial Systems	GOOD SAMARITA	OH NA	SPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERTHROUGH COSTS	VICE OTHER PASS	6			Peri od: From 01/01/2014 To 12/31/2014		
			Ti tl	e XVIII	Subprovi der  - I PF	PPS	
Cost Center Description	Inpatient Program Pass-Through	Р	tpatient rogram harges	Outpatient Program Pass-Through	n		

					I PF	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent		
		Program	Program	Program		
		Pass-Through	Charges	Pass-Through		
		Costs (col. 8		Costs (col. 9		
		x col. 10)		x col. 12)		
		11. 00	12. 00	13. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	0	556	0		50. 00
51.00	05100 RECOVERY ROOM	0	0	0		51. 00
51. 01	05101 ENDOSCOPY	0	0	0		51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	214	0	0		54.00
54.01	05401 RADI OLOGY-NON-CAMPUS	0	0	0		54. 01
54.08	05408 RADI OLOGY-GSH BREAST CENTER	0	0	0		54. 08
60.00	06000 LABORATORY	144	0	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0	0		63. 00
65.00	06500 RESPI RATORY THERAPY	o	0	0		65. 00
66.00	06600 PHYSI CAL THERAPY	o	0	0		66. 00
69.00	06900 ELECTROCARDI OLOGY	o	0	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	0		70. 00
70. 01	07001 NEURODI AGNOSTI CS	o	0	0		70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	0	0		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	0		73. 00
75.00	07500 ASC (NON-DISTINCT PART)	o	0	0		75. 00
76.00	03020 MH ANCI LLARY OUTPATI ENT	o	0	0		76. 00
76. 01	03950 INPATIENT DIALYSIS	o	0	0		76. 01
	OUTPATIENT SERVICE COST CENTERS	,				
90.00	09000 CLI NI C	0	0	0		90. 00
91.00	09100 EMERGENCY	0	0	0		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92. 00
	OTHER REIMBURSABLE COST CENTERS	-1			1	
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	O	0	0		96. 00
200.00		358	556			200. 00
	· · · · · · · · · · · · · · · · · · ·				•	

	Financial Systems	GOOD SAMARITA				u of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150042	Peri od: From 01/01/2014	Worksheet D Part V	
			Component	t CCN: 15SO42	To 12/31/2014		pared: pm
			Ti tl	e XVIII	Subprovi der - I PF	PPS	•
			·	Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	Ded. & Coins.		
				(see inst.)			
		1.00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 314836	556	1	0	175	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	0	)	0	0	51. 00
51. 01	05101 ENDOSCOPY	0. 268678	0	)	0	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 229799	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 140686	0		0	0	54. 00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0. 120535	0		0	0	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0. 786466	0		0	0	54. 08
60.00	06000 LABORATORY	0. 152639	0	1	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 454232	0		0	0	63. 00
65. 00	06500 RESPI RATORY THERAPY	0. 422595	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 197863	0		0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 202923	0		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0	0	70. 00
70. 01	07001 NEURODI AGNOSTI CS	0. 240198	0		0	0	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 147093	0	)	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 271885	0	)	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 353155	0	)	0 552	0	73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 215682	0		0	0	75. 00
	03020 MH ANCILLARY OUTPATIENT	0. 000000	0	)	0	0	76. 00
76. 01	03950 INPATIENT DIALYSIS	0. 545222	0		0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 543890		1	0	0	
91. 00	09100 EMERGENCY	0. 228782	0		0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 204580	0	1	0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			1			
04 00	09600 DURARIE MEDICAL FOLLP-RENTED	0 479579	l n	il .		Λ .	96 00

0. 479579

0 96.00 175 200.00 201.00

175 202. 00

0 0 0

556

556

0 552 0

552

96. 00 200. 00 201. 00

202.00

Health Financial Systems	GOOD SAMARITAN				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150042	Period: From 01/01/2014	Worksheet D	
		Component	CCN: 15S042	To 12/31/2014	Part V Date/Time Pre	nared.
		· ·			6/3/2015 1: 34	pm
		Ti tl	e XVIII	Subprovi der - I PF	PPS	
	Cost					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
		Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
		(see inst.)				
ANCILL ADV. SEDVICE COST CENTEDS	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS  50.00 OPERATING ROOM	0	0				50.00
51. 00   05100   RECOVERY ROOM		0				51.00
51. 00   05100   RECOVERT ROOM 51. 01   05101   ENDOSCOPY	0	0				51.00
52. OO   05200  DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00   05200   DELI VERT ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0				54.00
54. 01   05401   RADI OLOGY - NON - CAMPUS	0	0				54. 00
54. 08   05408 RADI OLOGY-GSH BREAST CENTER	0	0				54. 01
60. 00   06000   LABORATORY	0	0				60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
65. 00   06500   RESPIRATORY THERAPY	0	0				65. 00
66. 00   06600   PHYSI CAL THERAPY		0				66.00
69. 00   06900   ELECTROCARDI OLOGY		0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0				70.00
70. 01   07001   NEURODI AGNOSTI CS		0				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		195				73.00
75. 00 07500 ASC (NON-DISTINCT PART)		0				75. 00
76. 00 03020 MH ANCILLARY OUTPATIENT		0				76.00
76. 01   03950   NPATIENT DIALYSIS		0				76. 01
OUTPATIENT SERVICE COST CENTERS	<u> </u>					1 /0.01
90. 00 09000 CLINIC	O	0				90.00
01 00 00100 EMEDCENCY		0				01.00

0 0 0

0

0

0

195

195

90. 00 91. 00 92. 00

96. 00 200. 00 201. 00

202. 00

91. 00 09100 EMERGENCY

92.00

96.00

200. 00 201. 00

202.00

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

Health Financial Systems		GOOD SAMARITA				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT AND	CILLARY SERVICE CAPITA	L COSTS	Provi de	r CCN: 150042	Peri od:	Worksheet D	
			Compone	nt CCN: 15T042	From 01/01/2014 To 12/31/2014		narad.
			Compone	11 CON: 151042	To 12/31/2014	6/3/2015 1: 34	pareu: nm
			Ti ·	le XVIII	Subprovi der -	PPS	РШ
				NO AVIII	IRF	110	
Cost Center Descri	iption	Capi tal	Total Charge	s Ratio of Cos		Capital Costs	
	•	Related Cost	(from Wkst. (	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ co	I. Charges	column 4)	
		Part II, col.	8)	2)	3	· ·	
		26)	ĺ	1			
		1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST	CENTERS						
50. 00 05000 OPERATING ROOM		1, 026, 890	29, 671, 32	0. 0346	09 145, 484	5, 035	50. 00
51.00   05100 RECOVERY ROOM		0		0.0000	00 0	0	51.00
51. 01   05101 ENDOSCOPY		473, 217	10, 847, 14	0. 0436	26 72, 965	3, 183	51. 01
52. 00   05200   DELI VERY ROOM & LA	ABOR ROOM	15, 082	3, 783, 62	0. 0039	86 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0		0.0000	00 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOS	TIC	1, 035, 607	74, 876, 26	0. 0138	31 409, 768	5, 668	54.00
54. 01   05401 RADI OLOGY-NON-CAMI	PUS	163, 055	17, 790, 04	0. 0091	66 106, 040	972	54. 01
54. 08   05408   RADI OLOGY-GSH   BREA	AST CENTER	1, 092	371, 53	0. 0029	39 0	0	54. 08
60. 00   06000   LABORATORY		480, 875	46, 639, 85	0. 0103	10 748, 762	7, 720	60.00
63. 00 06300 BLOOD STORING, PRO	OCESSING & TRANS.	3, 794	2, 565, 38	0. 0014	79 33, 536	50	63.00
65. 00 06500 RESPIRATORY THERAI	PY	189, 610	9, 345, 34	0. 0202	89 540, 306	10, 962	65.00
66. 00 06600 PHYSI CAL THERAPY		242, 016	25, 075, 77	78 0.0096	51 5, 481, 473	52, 902	66.00
69. 00 06900 ELECTROCARDI OLOGY		449, 312	29, 393, 17	76 0. 0152	86 83, 822	1, 281	69. 00
70. 00 07000 ELECTROENCEPHALOGI	RAPHY	0		0.0000	00 0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS		357, 043	5, 772, 48	0. 0618	53 14, 283	883	70. 01
71.00 07100 MEDICAL SUPPLIES (	CHARGED TO PATIENT	26, 686	8, 190, 95	0. 0032	58 221, 531	722	71.00
72.00 07200 I MPL. DEV. CHARGEI	D TO PATIENTS	62, 368	12, 039, 95	0. 0051	80 33, 221	172	72.00
73.00 07300 DRUGS CHARGED TO I	PATI ENTS	504, 006	54, 393, 86	0. 0092	66 768, 402	7, 120	73.00
75.00 07500 ASC (NON-DISTINCT	PART)	137, 054	20, 971, 33	0. 0065	35 0	0	75. 00
76. 00 03020 MH ANCI LLARY OUTP	ATI ENT	0		0.0000	00 0	0	76. 00
76. 01 03950 INPATIENT DIALYSI:	S	79, 104	1, 205, 58	0. 0656	14 0	0	76. 01
OUTPATIENT SERVICE COST	CENTERS						
90. 00 09000 CLINIC		49, 086	3, 505, 5	9 0.0140	02 0	0	90.00
91.00 09100 EMERGENCY		535, 468	32, 943, 17	0. 0162	54 105, 001	1, 707	91.00
92.00 09200 OBSERVATION BEDS	(NON-DISTINCT PART	0	12, 652, 73	0.0000	00 0	0	92. 00
OTHER REIMBURSABLE COST	CENTERS						
96.00 09600 DURABLE MEDICAL E	QUI P-RENTED	14, 250	640, 7	8 0. 0222	41 0	_	
200.00 Total (lines 50-19	99)	5, 845, 615	402, 675, 79	0	8, 764, 594	98, 377	200. 00

	Financial Systems	GOOD SAMARITA			In Lie	u of Form CMS-2	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PASS		CCN: 150042 t CCN: 15T042	Peri od: From 01/01/2014 To 12/31/2014		pared:
			Ti tl	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost		
		1.00	2.00	3.00	4. 00	4) 5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM			N .	0 0	0	50.00
51. 00	05100 RECOVERY ROOM				0 0	0	51.00
51. 01	05101 ENDOSCOPY					0	51. 00
	05200 DELIVERY ROOM & LABOR ROOM	o o	(	ó	0 0	0	52.00
53. 00	05300 ANESTHESI OLOGY	o	Č		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	o	Ċ	232, 1	52 0	232, 152	54.00
54.01	05401 RADI OLOGY-NON-CAMPUS	o	C		0 0	0	54. 01
54.08	05408 RADIOLOGY-GSH BREAST CENTER	o	C		0 0	0	54. 08
60.00	06000 LABORATORY	o	C	40, 3	64 0	40, 364	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	C		0 0	0	63. 00
65.00	06500 RESPI RATORY THERAPY	0	C		0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0	70. 00
	07001 NEURODI AGNOSTI CS	0	C		0 0	0	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(	)	0 0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	(	)	0	0	73. 00
	07500 ASC (NON-DISTINCT PART)	0	(		0	0	75. 00 76. 00
	03020 MH ANCILLARY OUTPATIENT 03950 INPATIENT DIALYSIS	0	(		0 0	0	76.00
76.01	OUTPATIENT SERVICE COST CENTERS	l ol		ή	0 0	U	76.01
90. 00	09000 CLINIC	0	(	1	0 0	0	90.00
	09100 EMERGENCY		0		0 0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	o o	(	1	0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS	<u> </u>		<u>'</u>			1
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	96. 00
	Total (lines 50-199)	o		272, 5	16 0		

Health Financial Systems	GOOD SAMARIT		2011 450040		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Peri od: From 01/01/2014	Worksheet D Part IV	
THROUGH COSTS		Component	CCN: 15T042	To 12/31/2014	Date/Time Pre	pared:
		·			6/3/2015 1: 34	
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Total	Total Charges		t Outpatient	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4) 6. 00	7. 00	8.00	7) 9. 00	10.00	
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
50. 00 05000 OPERATING ROOM	1 0	29, 671, 320	0.00000	0. 000000	145, 484	50.00
51. 00   05100   RECOVERY   ROOM		27, 071, 320			143, 404	
51. 01   05101   ENDOSCOPY		_			72, 965	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		3, 783, 627			72, 703	52.00
53. 00   05300   ANESTHESI OLOGY					0	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	232, 152	_			409, 768	
54. 01   05401   RADI OLOGY - NON - CAMPUS	232, 132				106, 040	ł
54. 08 05408 RADI OLOGY-GSH BREAST CENTER					0	54. 08
60. 00   06000   LABORATORY	40, 364				748, 762	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	10,001		•		33, 536	ł
65. 00 06500 RESPIRATORY THERAPY	0	9, 345, 346			540, 306	
66. 00 06600 PHYSI CAL THERAPY	0				5, 481, 473	1
69. 00 06900 ELECTROCARDI OLOGY	0		•		83, 822	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	•		0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	5, 772, 488	0.00000	0. 000000	14, 283	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8, 190, 955	0.00000	0.000000	221, 531	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	12, 039, 954	0.00000	0. 000000	33, 221	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	54, 393, 860		0. 000000	768, 402	73. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	20, 971, 332	0. 00000	0. 000000	0	75. 00
76.00 03020 MH ANCILLARY OUTPATIENT	0	0	0.00000	0. 000000	0	76. 00
76. 01 03950 INPATIENT DIALYSIS	0	1, 205, 589	0.00000	0. 000000	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0				0	
91. 00   09100   EMERGENCY	0				105, 001	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	12, 652, 733	0.00000	0. 000000	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0. 000000	0	
200.00   Total (lines 50-199)	272, 516	402, 675, 790	1		8, 764, 594	[200. 00

	Financial Systems	GOOD SAMARITA				u of Form CMS-	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der	CCN: 150042	Peri od:	Worksheet D	
THROUG	H COSTS		Componen	t CCN: 15T042	From 01/01/2014 To 12/31/2014		enared:
			Componen	1 0011. 101042	10 12/31/2014	6/3/2015 1: 34	
			Ti tl	e XVIII	Subprovi der -	PPS	
					IRF		
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Throug			
		Costs (col. 8		Costs (col.	9		
		x col . 10)		x col. 12)			
	ANOULLARY OFFICE OF COURT OFFITTERS	11. 00	12. 00	13. 00			
F0 00	ANCILLARY SERVICE COST CENTERS		4.476				
50. 00	05000 OPERATI NG ROOM	0	1, 468		0		50. 00
51.00	05100 RECOVERY ROOM	0	C	)	0		51. 00
51. 01	05101 ENDOSCOPY	0	C	)	0		51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	)	0		52. 00
53.00	05300 ANESTHESI OLOGY	0	C	)	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 270	C	)	0		54. 00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0	C		0		54. 01
54. 08	05408  RADI OLOGY-GSH BREAST CENTER	0	C	)	0		54. 08
60.00	06000 LABORATORY	648	C	)	0		60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	)	0		63. 00
65.00	06500 RESPI RATORY THERAPY	0	C	)	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C	)	0		66. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C	)	0		69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	C	)	0		70. 00
70. 01	07001 NEURODI AGNOSTI CS	0	C	)	0		70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	)	0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	)	0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	C		0		73. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	C	)	0		75. 00
76.00	03020 MH ANCILLARY OUTPATIENT	0	C		0		76. 00
76. 01	03950 INPATIENT DIALYSIS	0	C	)	0		76. 01
	OUTPATIENT SERVICE COST CENTERS						
00 00	00000 CLINIC						$\neg \circ \circ \neg \circ$

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09000 CLI NI C

09100 EMERGENCY

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

96. 00 09600 | DURABLE | MEDICAL EQUIP-RENTED

Total (lines 50-199)

	Financial Systems	GOOD SAMARITA				u of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150042 CCN: 15T042	Peri od: From 01/01/2014 To 12/31/2014		nared:
			Component	1 CCN. 151042	10 12/31/2014	6/3/2015 1: 34	
			Ti tl	e XVIII	Subprovi der – I RF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			1			
50. 00	05000 OPERATING ROOM	0. 314836		1	0 0	462	1
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
51. 01	05101 ENDOSCOPY	0. 268678	0		0	0	51. 01
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 229799	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 140686	0		0	0	54.00
54. 01	05401 RADI OLOGY-NON-CAMPUS	0. 120535	0		0	0	54. 01
54. 08	05408 RADI OLOGY-GSH BREAST CENTER	0. 786466			0	0	54. 08
60.00	06000 LABORATORY	0. 152639	0		0	0	60.00
63. 00	06300 BL00D STORING, PROCESSING & TRANS. 06500 RESPIRATORY THERAPY	0. 454232	0		0	0	63.00
65. 00 66. 00	06600 PHYSI CAL THERAPY	0. 422595 0. 197863	0		0	0	65. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 197863	0		0	0	66. 00 69. 00
	07000 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0. 202923	0		0	0	70.00
	07000  REURODI AGNOSTI CS	0. 240198	0		0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 147093	0		0	0	70.01
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 271885	0		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 353155	0		0 1, 640	0	73.00
	07500 ASC (NON-DISTINCT PART)	0. 215682	0		0 1, 640	0	75.00
	03020 MH ANCILLARY OUTPATIENT	0. 213002				0	76.00
	03950 INPATIENT DIALYSIS	0. 545222	0	•	0 0	0	76. 00
70.01	OUTPATIENT SERVICE COST CENTERS	0. 545222			0	0	70.01
90. 00	09000 CLINIC	0. 543890	0		0 0	0	90.00
	09100 EMERGENCY	0. 228782	0	•		0	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 204580				0	91.00
12.00	OTHER REIMBURSABLE COST CENTERS	0. 204360		1	<u> </u>	<u> </u>	72.00
0/ 00	OGGOO DIDADIE MEDICAL FOLLD DENTED	0.470570		1	0	0	06.00

0. 479579

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0 96.00 462 200.00 201.00

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Component	CCN: 150042 t CCN: 15T042 e XVIII	Peri od: From 01/01/2014 To 12/31/2014 Subprovi der - I RF	epared: 1 pm
Cost Center Description  Cost Reimbursed Services Services Not Subject To Ded. & Coins. (see inst.)  Cost Reimbursed Services Services Not Subject To Ded. & Coins. (see inst.)	e XVIII		4 pm
Cost Center Description  Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)  Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
ANCILLARY SERVICE COST CENTERS			
50. 00       05000       OPERATI NG ROOM       0         51. 00       05100       RECOVERY ROOM       0         51. 01       05101       ENDOSCOPY       0         52. 00       05200       DELI VERY ROOM & LABOR ROOM       0         53. 00       05200       DALI VERY ROOM & LABOR ROOM       0         54. 00       05400       RADI OLOGY - DI AGNOSTI C       0         54. 01       05401       RADI OLOGY - NON - CAMPUS       0         54. 08       05408       RADI OLOGY - SCH BREAST CENTER       0         60. 00       06000       LABORATORY       0         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0         65. 00       06500       RESPI RATORY THERAPY       0         66. 00       06600       PHYSI CAL THERAPY       0       0         69. 00       066900       PHYSI CAL THERAPY       0       0         69. 00       06900       ELECTROCARDI OLOGY       0       0         70. 01       07001       NEURODI AGNOSTI CS       0       0         71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0         72. 00       07200 I MPL. DEV. CHARGED TO PATI ENTS <td></td> <td></td> <td>50. 00 51. 00 51. 01 52. 00 53. 00 54. 01 54. 08 60. 00 63. 00 66. 00 69. 00 70. 00 70. 01 71. 00 72. 00 73. 00 75. 00 76. 00</td>			50. 00 51. 00 51. 01 52. 00 53. 00 54. 01 54. 08 60. 00 63. 00 66. 00 69. 00 70. 00 70. 01 71. 00 72. 00 73. 00 75. 00 76. 00

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

Heal th F	inancial Systems	GOOD SAMARII	AN HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTI (	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der		Period: From 01/01/2014 To 12/31/2014		
			Ti t	le XIX	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS						
50.00 0	5000 OPERATING ROOM	0. 314836	0	1, 449, 31	6 0	0	50.00
	5100 RECOVERY ROOM	0. 000000			0	0	51.00
51.01 0	5101 ENDOSCOPY	0. 268678	0	872, 72	9 0	0	51. 01
52.00 0	5200 DELIVERY ROOM & LABOR ROOM	0. 229799	0	32, 04	4 0	0	52.00
53.00 0	5300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	0. 140686	0	6, 024, 57	8 0	0	54.00
54. 01 0	15401 RADI OLOGY-NON-CAMPUS	0. 120535	5 o	1, 500, 77		0	54. 01
	5408 RADI OLOGY-GSH BREAST CENTER	0. 786466	1	34, 96		0	1
	6000 LABORATORY	0. 152639		3, 037, 97		0	
	6300 BLOOD STORING, PROCESSING & TRANS.	0. 454232		95, 14		0	63.00
	6500 RESPIRATORY THERAPY	0. 422595				0	65. 00
	6600 PHYSI CAL THERAPY	0. 197863		1, 292, 19		0	66.00
	6900 ELECTROCARDI OLOGY	0. 202923		2, 073, 70		1	69.00
	7000 ELECTROENCEPHALOGRAPHY	0. 000000		2,070,70	o o	1	1
	77001 NEURODI AGNOSTI CS	0. 240198		535, 97	-	o o	1
	7700 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 147093		159, 70		0	
	77200 IMPL. DEV. CHARGED TO PATIENTS	0. 271885		223, 63		ľ	1
	17300 DRUGS CHARGED TO PATIENTS	0. 353155		3, 668, 47		0	
	7500 ASC (NON-DISTINCT PART)	0. 215682		2, 009, 40		0	1
	3020 MH ANCILLARY OUTPATIENT	0. 000000			0 0	ľ	1
	3950 INPATIENT DIALYSIS	0. 545222		1			1
	UTPATIENT SERVICE COST CENTERS	0. 545222	<u> </u>	4, 04	3  0	0	70.01
	19000 CLINIC	0. 543890	0	336, 39	2 0	0	90.00
	19100 EMERGENCY	0. 228782				•	1
	19200 OBSERVATION BEDS (NON-DISTINCT PART	0. 204580					
	THER REIMBURSABLE COST CENTERS	0. 204360	,, 0	010, 47	4  0	0	72.00
	9600 DURABLE MEDICAL EQUIP-RENTED	0. 479579	0	54, 31	9 0	0	96. 00
200.00	Subtotal (see instructions)	0. 477377	<u> </u>				200.00
201.00	Less PBP Clinic Lab. Services-Program			27, 120, 43	0 0	l	201. 00
201.00	Only Charges						201.00
202.00	Net Charges (line 200 +/- line 201)		0	27, 126, 43	6 0	n	202. 00
_02.00	1 2 300 (1 200 1, 1 201)	I	1	2.7 .23, 10	-1	,	1-02.00

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

To 12/31/2014 Date/Time Prepared: 6/3/2015 1:34 pm Title XIX Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 456, 297 50.00 51.00 05100 RECOVERY ROOM 0 51.00 05101 ENDOSCOPY 234. 483 0 51 01 51.01 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 7, 364 52.00 53. 00 | 05300 | ANESTHESI OLOGY 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 847.574 54.00 05401 RADI OLOGY-NON-CAMPUS 0 54.01 180, 896 54.01 54.08 05408 RADI OLOGY-GSH BREAST CENTER 27, 496 0 54.08 06000 LABORATORY 0 60.00 463, 713 60.00 06300 BLOOD STORING, PROCESSING & TRANS. 43, 218 0 63.00 63 00 65.00 06500 RESPIRATORY THERAPY 114, 569 0 65.00 66.00 06600 PHYSI CAL THERAPY 255, 677 0 66.00 06900 ELECTROCARDI OLOGY 69.00 420, 803 69.00 Ol 07000 ELECTROENCEPHALOGRAPHY 70.00 70 00 70.01 07001 NEURODI AGNOSTI CS 128, 740 0 70.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 183, 196 71.00 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 60, 802 0 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 295, 542 0 73.00 73.00 75.00 07500 ASC (NON-DISTINCT PART) 433, 392 0 75.00 03020 MH ANCILLARY OUTPATIENT 0 76.00 76.00 03950 INPATIENT DIALYSIS 76.01 2,642 0 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 182, 960 0 90.00 09100 EMERGENCY 91.00 601, 854 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 167, 443 0 92.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 26, 050 96.00 200.00 Subtotal (see instructions) 6, 134, 711 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00 Only Charges 202.00 Net Charges (line 200 +/- line 201) 6, 134, 711 0 202.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150042	From 01/01/2014	Worksheet D-1 Date/Time Prep 6/3/2015 1:34	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

DATE I ALL SHOW DER COMMONENTS    DATE OF ALL SHOW DER COMMONENTS   1.00			Title XVIII	Hospi tal	6/3/2015 1: 34 PPS	pm
PART   - ALL PROVIDER COMPONENTS		Cost Center Description	TI LIE XVIII	позрі таї	113	
Impatient days (including private room days and seing-bed days, excluding neeborn)   24, 244   2.00   Impatient days (including private room days, sed using seing-bed and neoborn days)   24, 246   2.00   Private room days (excluding seing-bed and observation bed days). If you have only private room days.   2.1, 837   3.0		DADT I ALL DROWNER COMPONENTS			1. 00	
1.00   Inpatient days (including private room days and swing-bed days, excluding newborn)						-
2,00   Injustient days (including private room days, excluding swing-bed and nowborn days)   24,244   2,00   2,00   Private room days (culding swing-bed and observation bed days). If you have only private room days.   3,00	1. 00		excluding newborn)		24, 264	1.00
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Total nursery days (title V or XIX only)  10.00  10	14. 00				0	14. 0
SWING BED ADJUSTMENT  18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period reporting rep	15. 00				0	15. 0
Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period reporting period (19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (20.00 Period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (20.00 Period (20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost (20.00 Period (20.00 Perio	16. 00	Nursery days (title V or XIX only)			0	16.0
reporting period  Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period  Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period  Total general inpatient routine service cost (see instructions)  Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 9 x line 20)  Swing-bed cost applicable to NF type serv						
Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   0.00   19.0	17. 00	1.	through December 31 o	f the cost	0. 00	17.0
reporting period  Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00) Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00) Total general inpatient routine service cost (see instructions) (25,878,565) 21.00  20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) (22.00) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) (23.00) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) (24.00) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) (25.00) (26.00) (27.00) (	10 00		after December 21 of	the cost	0.00	10 0
Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (December 31 of the cost reporting period (D	16.00		arter becember 31 or	the cost	0.00	10.0
reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period Total general inpatient routine service cost (see instructions) 22.00 Total general inpatient routine services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Total general inpatient routine services through December 31 of the cost reporting period (line 6 x line 17) 24.00 Total general inpatient routine services through December 31 of the cost reporting period (line 6 x line 18) Total general inpatient to NF type services after December 31 of the cost reporting period (line 6 x line 18) Total general inpatient to NF type services through December 31 of the cost reporting period (line 7 x line 19) Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) Total swin	19. 00		through December 31 of	the cost	0.00	19.00
reporting period Total general inpatient routine service cost (see instructions) 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Swing-bed cost (line 27 * line 28) 31.00 Average perivate room per diem charge (line 29 * line 3) 31.00 Average perivate room per diem charge (line 30 * line 4) 32.00 Average peridem private room cost differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 33.00 Average per diem private room cost differential (line 34 x line 31) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Finite room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 * line 38) 38.00 Average per diem private room cost differential (line 34 x line 31) 38.00 Average per diem private room cost differential (line 34 x line 31) 38.00 Average perivate room cost differential (line 34 x line 31) 39.00 Average perivate room cost differential (line 34 x line 31) 39.00 Average pe			3			
Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions)  26.00 Total swing-bed cost (see instructions)  27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room per diem charge (line 29 + line 3)  30.00 Average peri inpatient routine service cost/charge ratio (line 27 + line 28)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  30.00 Average per diem private room cost differential (line 34 x line 31)  30.00 Average per diem private room cost differential (line 3 x line 35)  30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 25, 878, 565)  30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  30.00 Program general inpatient routine service cost ((line 9 x line 38))  30.00 Program general inpatient routine service cost ((line 9 x line 38))  30.00 Program general inpatient routine service cost ((line 9	20.00		after December 31 of t	he cost	0. 00	20.00
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Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00	22.00		31 of the cost report	ing period (ine	0	22.00
x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost/charge ratio (line 27 * line 28) Ceneral inpatient routine service cost (line 30 * line 4) Ceneral inpatient routine service cost (line 30 * line 4) Ceneral inpatient routine service cost reporting period (line 30 * line 27 * line 28) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 25, 878, 565) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 25, 878, 565) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost	23. 00	1	of the cost reportin	g period (line 6	0	23.00
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27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  30. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average pri vate room per diem charge (line 29 + line 3)  33. 00 Average semi-pri vate room per diem charge (line 30 + line 4)  34. 00 Average per diem pri vate room cost differential (line 32 minus line 33)(see instructions)  35. 00 Average per diem pri vate room cost differential (line 34 x line 31)  36. 00 Pri vate room cost differential djustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 25, 878, 565)  37. 00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 25, 878, 565)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40 Average per diem private room cost differential (line 25, 878, 565)  41, 293, 769  41, 293, 769	26 00	1			0	26 00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  Average private room per diem charge (line 29 ÷ line 3)  Average semi-private room per diem charge (line 30 ÷ line 4)  Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 25, 878, 565)  Adjusted general inpatient routine service cost per diem (see instructions)  1, 066.54  Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)	27. 00		ne 21 minus line 26)		_	
Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 25, 878, 565)  37. 00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  1, 066. 54  14, 293, 769  39. 00			,			Ī
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33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 25, 878, 565)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  1, 066.54  14, 293, 769  39.00		, ,	i ne 28)			
Average per diem private room charge differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 34 x line 31)  Brivate room cost differential adjustment (line 3 x line 35)  General inpatient routine service cost net of swing-bed cost and private room cost differential (line 25, 878, 565)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost (line 9 x line 38)  Adjusted general inpatient routine service cost (line 9 x line 38)  O 0 34.00  34.00  35.00  36.00  37.00  38.00  38.00  Average per diem private room cost differential (line 25, 878, 565)  O 36.00  37.00  38.00  38.00  Adjusted general inpatient routine service cost (line 9 x line 38)						
Average per diem private room cost differential (line 34 x line 31)  35.00 Private room cost differential adjustment (line 3 x line 35)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 25, 878, 565)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1, 066.54 14, 293, 769 39.00			s line 33)(see instruc	tions)		1
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27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,066.54 38.00 Program general inpatient routine service cost (line 9 x line 38)  14,293,769 39.00	36. 00		•			36. 0
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,066.54 38.0  39.00 Program general inpatient routine service cost (line 9 x line 38)  14,293,769 39.0	37. 00	1	d private room cost di	fferential (line	25, 878, 565	37.0
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,066.54 38.00 Program general inpatient routine service cost (line 9 x line 38)  14,293,769 39.00						1
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  1,066.54 38.00 Program general inpatient routine service cost (line 9 x line 38)  1,066.54 38.00 14,293,769 39.00			FMENTO			1
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		'	,			
	40.00	, ,	•			1
41.00 Total Program general inpatient routine service cost (line 39 + line 40)						

Heal th	Financial Systems	GOOD SAMARITAN	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Prep	pared:
				20/11/1		6/3/2015 1: 34	
	Cost Center Description	Total	Total	e XVIII  Average Per	Hospital Program Days	PPS Program Cost	
		Inpatient Cost Ir				(col. 3 x col.	
				col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	<u> </u>		0.00	,,	0	42.00
43.00	INTENSIVE CARE UNIT	4, 035, 427	2, 581	1, 563. 51	1, 706	2, 667, 348	43.00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					4.00	
48. 00	Program inpatient ancillary service cost (Wks	t D-3 col 3	line 200)			1. 00 19, 606, 744	48. 00
	Total Program inpatient costs (sum of lines 4			ns)		36, 567, 861	49. 00
	PASS THROUGH COST ADJUSTMENTS	<u>.</u>					
50. 00	Pass through costs applicable to Program inpa	tient routine se	ervices (from	ı Wkst. D, sum	of Parts I and	2, 070, 557	50. 00
51. 00	Pass through costs applicable to Program inpa	tient ancillary	services (fr	om Wkst. D, su	m of Parts II	1, 111, 768	51. 00
	and IV)		•				
52. 00	Total Program excludable cost (sum of lines 5		atad nan nhu	ololon oncothe	+: a+ and	3, 182, 325 33, 385, 536	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		ated, non-pny	SICI an anestne	etist, and	33, 385, 536	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	_,					
	Program di scharges					0	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	, ,	ng cost and targ	get amount (I	ine 56 minus I	ine 53)	Ö	57. 00
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period er	nding 1996, u	pdated and com	pounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year of	ost report, upda	ated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines					0	61. 00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		(lines 54 x	60), or 1% of	the target		
62. 00	Relief payment (see instructions)	nstructions)				0	62. 00
63. 00		nt (see instruct	tions)			0	63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cost	s through Decemb	ner 31 of the	cost reportin	ng period (See	0	64. 00
04.00	instructions)(title XVIII only)	3 thi ough become	ser or the	cost reportir	ig perrou (see	Ĭ	04.00
65. 00	Medicare swing-bed SNF inpatient routine cost	s after December	r 31 of the c	ost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin</pre>	e costs (line 64	4 plus line 6	5)(title XVIII	only) For	ol	66. 00
00.00	CAH (see instructions)	0 00010 (11.10 0	. p. do o	, (:: :: 0 /	o yy o.		00.00
67. 00	9 1	costs through [	December 31 o	of the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	costs after Dec	cember 31 of	the cost repor	ting period	0	68. 00
	(line 13 x line 20)			·	9	-	
69. 00	Total title V or XIX swing-bed NF inpatient r					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70. 00
71. 00	Adjusted general inpatient routine service co	st per diem (lir					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		(line 14 v li	no 2E)			72.00
74. 00	Total Program general inpatient routine servi						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient r	•			ırt II, column		75. 00
7/ 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	o 2)					76. 00
76. 00 77. 00	Program capital-related costs (line 9 x line	,					77. 00
78. 00	Inpatient routine service cost (line 74 minus	line 77)					78. 00
79.00	Aggregate charges to beneficiaries for excess	, ,		,	us line 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		st IIIII täti on	i (iine /& minu	15 TTHE 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (li						82. 00
83.00	Reasonable inpatient routine service costs (s		)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation (		5)				84. 00 85. 00
86. 00							86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					07.00
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per d	iem (line 27 ± l	ine 2)			2, 427 1, 066. 54	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	2)			2, 588, 493	
						·	

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Prep 6/3/2015 1:34	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	3, 446, 045	25, 878, 565	0. 13316	2 2, 588, 493	344, 689	90.00
91.00 Nursing School cost	0	25, 878, 565	0.00000	2, 588, 493	0	91.00
92.00 Allied health cost	0	25, 878, 565	0.00000	2, 588, 493	0	92.00
93.00 All other Medical Education	0	25, 878, 565	0. 00000	2, 588, 493	0	93. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150042	Peri od: From 01/01/2014	Worksheet D-1
	Component CCN: 15SO42		
	Title XVIII	Subprovider -	PPS

AAL PROVIDER COMPONENTS  1.00			II the Aviii	I PF	FF3	
Name		Cost Center Description			1.00	
MATLETT GAYS		PART I - ALL PROVIDER COMPONENTS			1.00	
1.00   Impatient days (including private room days, excluding saing-bed and networn days)   4.536   2.00						
2.00   Private room days (excluding swing-bed and observation bed days). If you have only private room days.   4.00   4.00   5						
do not complete this line.  do						
Semi-perivate room days (excluding swing-bed and observation bed days)  5.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if called any servate room days) after December 31 of the cost of the cost reporting period (if called any servate room this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calledary servate room this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calledary servate room this line)  7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost reporting period (if calledary servate room days) after December 31 of the cost period (if calledary servate room days) after December 31 of the cost period (if calledary servate room days) after December 31 of the cost period (if calledary servate room days) after December 31 of the cost period (if calledary servate room days) after December 31 of the cost period (if any total servate room days) after December 31 of the cost period (if any total servate room days) after December 31 of the	3.00		i. II you have only pri	vate room days,	U	3.00
reporting period.  1.00 Total saving-bed SNP type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.01 Total saving-bed NP type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.02 Swing-bed NP type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.03 Swing-bed SNP type inpatient days (applicable to the Program (excluding swing-bed and new period days) and the period (see instructions)  1.04 Inpatient days including private room days applicable to the Program (excluding private room days)  1.05 Swing-bed SNP type inpatient days applicable to this Vill only (including private room days) after becomber 31 of the cost reporting period (see instructions)  1.06 Swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) after becomber 31 of the cost reporting period (see instructions)  1.06 Swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) after becomber 31 of the cost reporting period (see instructions)  1.05 Swing-bed SNP type inpatient days applicable to titles V or XIX only (including private room days)  1.06 Swing-bed SNP type inpatient days applicable to titles V or XIX only (including private room days)  1.07 Swing-bed SNP type inpatient days applicable to titles V or XIX only (including private room days)  1.08 Swing-bed SNP type inpatient days applicable to titles V or XIX only (including private room days)  1.09 Swing-bed SNP type inpatient days applicable to services through becember 31 of the cost or services applicable to services through becember 31 of the cost or services applicable to services after December 31 of the cost or services applicable to services after December 31 of the cost or service applicable to SNP type services after December 31 of the cost reporting	4.00		days)		4, 536	4.00
10tal swing-bed SNF type Inpatient days (Including private room days) after December 31 of the cost reporting period (Ir calendar year, enter 0 on this Irine)   7.00	5.00		days) through December	31 of the cost	0	5. 00
reporting period (if calendar year, enter 0 on this line)  1. 00 Total swing-bed NF type inpatient days (including private room days) through becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  2. 01 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  3. 02 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and including private room days) including private room days (swein including private room days)  3. 03 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  3. 05 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  4. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  4. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  4. 00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  4. 00 Middle year of the cost reporting period (if calendar year, enter 0 on this line)  4. 00 Middle year of the cost reporting period (if calendar year, enter 0 on this line)  5. 00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  6. 01 16. 00 Miscrey days (title V or XIX only)  7. 01 Miscrey days (title V or XIX only)  8. 02 Miscrey days (title V or XIX only)  8. 03 Miscrey days (title V or XIX only)  8. 04 Miscrey days (title V or XIX only)  8. 05 Miscrey days (title V or XIX only)  8. 06 Miscrey days (title V or XIX only)  8. 07 Miscrey days (title V or XIX only)  8. 08 Miscrey days (title V or XIX only)  8. 08 Miscrey days (title V or XIX only)  8. 09 Miscrey days (title V or XIX only)  8. 00 Miscrey days (title V or XIX only)  8. 00 Miscrey days (title V or XIX only)  8. 00 Miscrey days (title V or XIX only)  8. 00 Mi	6 00		days) after December 3	21 of the cost	0	6 00
1.00   Total swingbed NF type Inpatient days (including private room days) after December 31 of the cost   0   7.00	0.00		uays) arter becember t	or or the cost	U	0.00
10   10   10   10   10   10   10   10	7.00		days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 10.00 Sing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Sing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only related to this line) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only related to this line) 13.00 Swing-bed SNF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period (see a fixed base) through December 31 of the cost reporting period (if calendary year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15.00 Total nursery days (title V or XIX only) 10.15.00 Total nursery days (title	0.00	1 31	dava) aftan Dagamban 21	l of the cost	0	0.00
1.782   9.00	8.00		lays) at ter beceiliber 3	i oi tile cost	U	6.00
10.00   Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days)   10.00	9.00		the Program (excluding	swi ng-bed and	1, 782	9. 00
through December' 31 of the cost reporting period (see instructions)  12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  15.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  16.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)  18.00 Total nursery days (title V or XIX only)  19.01 Nursery days (title V or XIX only)  19.02 Nursery days (title V or XIX only)  19.03 Nursery days (title V or XIX only)  19.04 Nursery days (title V or XIX only)  19.05 Nursery days (title V or XIX only)  19.00 Medical or rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medical or rate for swing-bed SNF services applicable to services after December 31 of the cost  19.00 Medical or rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Medical or rate for swing-bed NF services applicable to services after December 31 of the cost  19.00 Teporting period  29.00 Medical or rate for swing-bed NF services applicable to services after December 31 of the cost  29.00 Nursery of the cost applicable to SNF type services through December 31 of the cost reporting period (line S X II ne 17)  29.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line S X II ne 17)  29.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line S X II ne 18)  29.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line S X	10.00		. (:!		0	10.00
11.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 18.00 Nursery days (title V or XIX only) 19.01 Medicare rate For swing-bed SMF services applicable to services through December 31 of the cost 19.00 Medicare rate For swing-bed SMF services applicable to services after December 31 of the cost 19.00 Medical rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x line 17) 19.00 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 6 x line 17) 19.00 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 6 x line 17) 19.00 Medical drate for swing-bed Cost applicable to SNF type	10.00			oom days)	0	10.00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) of through December 31 of the cost reporting period of after December 31 of the cost reporting period (if callendar year, enter 0 on this line) of the cost reporting period (if callendar year, enter 0 on this line) of the cost of the program (excluding swing-bed days) of the cost reporting period (if callendar year, enter 0 on this line) of the cost of the program (excluding swing-bed days) of the cost of the program (excluding swing-bed days) of the cost of the	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11.00
through December 31 of the cost reporting period  13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14. 00 Medical Iv necessary private room days applicable to the Program (excluding swing-bed days)  15. 00 Total nursery days (title V or XIX only)  16. 00 Nursery days (title V or XIX only)  17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost  19. 00 Medicader are for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicader are for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  19. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost  20. 00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 5 x iine 17)  20. 00 Medicaid rate for swing-bed NF services after December 31 of the cost reporting period (line 6 x iine 18)  20. 00 Medicaid rate for swing-bed services after December 31 of the cost reporting period (line 6 x iine 18)  20. 00 Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x iine 18)  20. 00 Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x iine 18)  20. 00 Ming-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x iine 18)  20. 00 Medicand NF MF					_	
13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days)   13.00   14.00   After December 31 of the cost reporting period (If called private room days)   0   14.00   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   15.00   16.00   Nursery days (title V or XIX only)   0   16.00   17.00   17.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   18.00   19.00   18.00   19.00   1	12. 00		only (including private	e room days)	0	12. 00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   0   15.00   0   15.00   0   0   15.00   0   15.	13. 00		only (including private	e room days)	0	13. 00
15.00   Total nursery days (title V or XIX only)   0   15.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   16.00   0   17.00   0   17.00   0   18.00   0			-	, I		
16. 00   Nursery days (title V or XIX only)     0   16. 00			(excluding swing-bed of	days)	-	
SWING BED ADJUSTMENT  1.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period period rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period rate for swing-bed NF services applicable to services through December 31 of the cost reporting period rate for swing-bed NF services applicable to services through December 31 of the cost reporting period reporting reporting period reporting						
Reporting period					3	
18.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost   0.00   19.	17. 00		through December 31 of	the cost	0.00	17. 00
reporting period  Medical drate for swing-bed NF services applicable to services through December 31 of the cost reporting period  20.00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost cost applicable to services after December 31 of the cost reporting period  21.00 Total general inpatient routine service cost (see instructions)  22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19)  26.00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  28.00 Total swing-bed cost (see instructions)  29.00 Total swing-bed cost (see instructions)  20.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  20.00 General inpatient routine service cost net of swing-bed charges)  20.00 Semi-private room charges (excluding swing-bed charges)  20.00 Average per vate room per diem charge (line 29 + line 3)  20.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  20.00 Average per diem private room cost differential (line 32 minus line 33)  20.00 Average per diem private room cost differential (line 32 minus line 33)  20.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27,760,620)  20.00 General inpatient routine service cost per diem (see instructions)  20.00 General	18 00	1 31	after December 31 of t	the cost	0.00	18 00
reporting period	10.00	9	arter becomber 51 or 1	ine cost	0.00	10.00
Medicaid a a tract for swing-bed NF services applicable to services after December 31 of the cost reporting period   2,760,620   21.00	19. 00		through December 31 of	the cost	0. 00	19. 00
reporting period Total general inpatient routine service cost (see instructions) 2. 760,620 21. 00 22. 00 23. 00 24. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 20. 00 2	20.00	. 91	ofter December 21 of th	no cost	0.00	20.00
21.00   Total general inpatient routine service cost (see instructions)   2,760,620   21.00   22.00   5 x line 17)   23.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 x line 18)   22.00   23.00   x line 18)   24.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   X line 18)   24.00   3.00   24.00   25.00   3.	20.00		arter becember 31 of th	ie cost	0.00	20.00
5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  6.00  Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00  General inpatient routine service charges (excluding swing-bed and observation bed charges)  December 31 of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 8 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period (line 2 x line 20)  Comparison of the cost reporting period		Total general inpatient routine service cost (see instructions)			2, 760, 620	
23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 0 24. 00 7 x line 19)  25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 Private room charges (excluding swing-bed charges)  29. 00 Private room charges (excluding swing-bed charges)  29. 00 Average period (line 8 x line 20)  30. 00 Semi-private room per diem charge (line 29 * line 3)  30. 00 Average per diem private room charge differential (line 32 minus line 23) (see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 34 x line 35)  30. 00 Average per diem private room cost differential (line 34 x line 35)  30. 00 Average per diem private room cost differential (line 34 x line 35)  30. 00 Average per diem private room cost differential (line 34 x line 35)  30. 00 Average per diem private room cost differential (line 37 x line 35)  30. 00 Average per diem private room cost differential (line 37 x line 35)  30. 00 Average per diem private room cost differential (line 37 x line 35)  30. 00 Average per diem private room cost differential (line 37 x line 35)  30. 00 Average per diem private room cost differential (line 37 x line 35)  30. 00 Average per diem private room cost differential (line 37 x line 38)  30. 00 Average per diem private room cost differential (line 37 x line 38)  30. 00 Average per diem private room cost differential (line 37 x line 38)  30. 00 Average per diem private room cost differential (line 37 x line 38)  30. 00 Average per diem pr	22. 00		31 of the cost reporti	ng period (line	0	22. 00
X   I   in = 18   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	23. 00	,	of the cost reporting	period (line 6	0	23. 00
7 x line 19)  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  25.00 x line 20)  26.00 Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Private room charges (excluding swing-bed charges)  9.01 Semi-private room charges (excluding swing-bed charges)  9.02 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  9.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  9.01 Average private room per diem charge (line 29 ÷ line 3)  9.02 Average semi-private room per diem charge (line 30 ÷ line 4)  9.02 Average per diem private room cost differential (line 32 minus line 33) (see instructions)  9.00 Average per diem private room cost differential (line 34 x line 31)  9.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620)  9.00 Average per diem private room cost differential (line 3 x line 35)  9.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620)  9.00 Average per diem private room cost differential (line 3 x line 35)  9.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620)  9.00 Average per diem private room cost differential (line 3 x line 35)  9.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620)  9.00 Average per diem private room cost differential (line 3 x line 35)  9.00 General inpatient routine service cost reper diem (see instructions)  9.00 Average per diem private room cost differential (line 3 x line 35)  10 Average per diem private room cost differential (line 3 x line 35)  10 Average per diem private room cost differential (line 3 x		x line 18)		, , ,		
25.00	24. 00	9	31 of the cost reportin	ng period (line	0	24. 00
x line 20) Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges) Ceneral inpatient routine service charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 30 ÷ line 4) Ceneral inpatient routine service cost differential (line 32 minus line 33)(see instructions) Ceneral inpatient routine service cost differential (line 34 x line 31) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem charges Ceneral inpatient routine service cost per diem charges Ceneral inpatient routine serv	25. 00	,	of the cost reporting	period (line 8	0	25. 00
27. 00   Coneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   2, 760, 620   27. 00     PRIVATE ROOM DIFFERENTIAL ADJUSTMENT   28. 00     Semi-private room charges (excluding swing-bed charges)   0   29. 00     30. 00   Semi-private room charges (excluding swing-bed charges)   0   29. 00     31. 00   General inpatient routine service cost/charge ratio (line 27 ÷ line 28)   0.000000     32. 00   Average private room per diem charge (line 29 ÷ line 3)   0.00     33. 00   Average semi-private room per diem charge (line 30 ÷ line 4)   0.00     34. 00   Average per diem private room charge differential (line 32 minus line 33) (see instructions)   0.00   34. 00     35. 00   Average per diem private room cost differential (line 34 x line 31)   0.00   35. 00     36. 00   Private room cost differential adjustment (line 3 x line 35)   0.00   36. 00     37. 00   Coneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)   0.00   37. 00     PART II - HOSPITAL AND SUBPROVIDERS ONLY   PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS   0.00   0.00   0.00   0.00   0.00   0.00     38. 00   Program general inpatient routine service cost (line 9 x line 38)   0.00   0.0						
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average pri vate room per diem charge (line 29 ÷ line 3)  33.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  34.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem pri vate room cost differential (line 34 x line 31)  36.00 Pri vate room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 2, 760, 620)  37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  9.00 Program general inpatient routine service cost per diem (see instructions)  9.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00 28.00 29.00 29.00 29.00 29.00 29.00 30			04 ' '' 04'		-	
28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  30. 00 Average private room per diem charge (line 29 ÷ line 3)  30. 00 Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620) Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 2, 760, 620) Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 2, 760, 620) Average per diem private room cost differential (line 2, 760, 620) Average per diem private room cost differential (line 2, 760, 620) Average per diem private room cost differential (line 3 x line 35)  30. 00 Average per diem private room cost differential (line 3 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 32)  30. 00 Average per diem private room cost differential (line 3 x line 33)  30. 00 Average per diem private room cost differential (line 3 x line 33)  30. 00 Average per diem private room cost differential (line 3 x line 31)  30. 00 A	27.00		ne 21 minus iine 26)		2, 760, 620	27.00
29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room compercion content (line 27 ÷ line 28)  30. 00 Semi-private room percion content (line 29 ÷ line 39)  30. 00 Semi-private room percion content (line 30 + line 28)  30. 00 Semi-private room percion content (line 30 + line 30)  30. 00 Semi-private room percion content (line 30 + line 30)  30. 00 Semi-private room percion content (line 30 + line 30)  30. 00 Semi-private room percion content (line 30 + line 30)  30. 00 Semi-private room percion content (line 30 + line 30)  30. 00 Semi-private room percion charges (line 30 + line 30)  30. 00 Semi-private room percion content (line 30 + line 30)  30. 00 Semi-private room percion content (line 30 + line 31)  31. 00 Semi-private room percion content (line 30 + line 31)  32. 00 Semi-private room percion content (line 30 + line 31)  33. 00 Semi-private room percion saturation (line 30 + line 31)  34. 00 Semi-private room percion content (line 30 + line 31)  35. 00 Semi-private room percion content (line 30 + line 31)  36. 00 Semi-private room percion content (line 30 + line 31)  37. 00 Semi-private room percion content (line 30 + line 31)  38. 00 Semi-private room percion content (line 30 + line 31)  39. 00 Semi-private room percion content (line 30 + line 31)  30. 00 Semi-private room percion content (line 30 + line 31)  30. 00 Semi-private room percion content (line 30 + line 31)  30. 00 Semi-private room percion content (line 30 + line 31)  30. 00 Semi-private room percion content (l	28. 00		and observation bed cha	arges)	0	28. 00
31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32. 00 Average private room per diem charge (line 29 ÷ line 3)  33. 00 Average semi-private room per diem charge (line 30 ÷ line 4)  34. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35. 00 Average per diem private room cost differential (line 34 x line 31)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620)  37. 00 PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0. 0000000000000000000000000000000000	29. 00	Private room charges (excluding swing-bed charges)				
32.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 32.00 Average per diem private room cost differential (line 34 x line 31) 32.00 Average per diem private room cost differential (line 34 x line 31) 32.00 Average per diem private room cost differential (line 3 x line 35) 32.00 Average per diem private room cost differential (line 3 x line 35) 32.00 Average per diem private room cost differential (line 3 x line 35) 32.00 Average per diem private room cost differential (line 3 x line 35) 33.00 Average per diem private room cost differential (line 3 x line 35) 34.00 Average per diem private room cost differential (line 3 x line 35) 35.00 Average per diem private room cost differential (line 2 x 760, 620) 37.00 General inpatient routine service cost and private room cost differential (line 2 x 760, 620) 37.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2 x 760, 620) 37.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2 x 760, 620) 37.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2 x 760, 620) 37.00 Average per diem private room cost net of swing-bed cost and private room cost differential (line 2 x 760, 620) 37.00 Average per diem private room cost differential (line 3 x line 31) 38.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Ave			ino 20)			
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0.00 33.00  0.00 34.00  37.00 35.00  38.00 36.00  39.00 Program general inpatient routine service cost (line 9 x line 38)  1,084,525 39.00		1	The 28)			
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620 37.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  90.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0.00 35.00 0 36.00 37.00 27.00 0 37.00 0 37.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620 37.00 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 36.00 2, 760, 620 37.00 3				tions)		
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 760, 620 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  37. 00  2, 760, 620  37. 00  38. 00  39. 00  40. 00		9	31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 608.60 38.00 Program general inpatient routine service cost (line 9 x line 38) 1,084,525 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			d private room cost dif	ferential (line	-	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  608.60 38.00  Program general inpatient routine service cost (line 9 x line 38)  1,084,525 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	200	27 minus line 36)	,		_, , 55, 520	
38.00 Adjusted general inpatient routine service cost per diem (see instructions)  608.60 38.00  Program general inpatient routine service cost (line 9 x line 38)  1,084,525 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			MENTO			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,084,525 39.00 40.00	38 00				608 60	38 00
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
41.00   Total Program general inpatient routine service cost (line 39 + line 40)   1,084,525   41.00	40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		0	40.00
	41. 00	lotal Program general inpatient routine service cost (line 39 +	line 40)	I	1, 084, 525	41. 00

Cost Center Description  NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	Total Inpatient Cost Inp 1.00 0		Subprovider - IPF er Program Days	Date/Time Pre 6/3/2015 1:34 PPS Program Cost (col. 3 x col. 4) 5.00	
NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	Inpatient Cost Inp	Total Average Popatient Days Diem (col. col. 2) 2.00 3.00 0 0	Program Days 1 ÷ 4.00	PPS Program Cost (col. 3 x col. 4)	рш
NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	Inpatient Cost Inp	patient Days Diem (col. col. 2) 2.00 3.00 0 0	Program Days 1 ÷ 4.00	(col. 3 x col. 4)	
NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	Inpatient Cost Inp	patient Days Diem (col. col. 2) 2.00 3.00 0 0	1 ÷	(col. 3 x col. 4)	
Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	2.00 3.00			
Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0 0			
INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	ما م			42.00
CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			0.00	0	43.00
SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	1	o o	. 00	U	44. 00
OTHER SPECIAL CARE (SPECIFY)	1				45. 00
<u> </u>				  -	46. 00 47. 00
Cost Center Description					47.00
				1. 00	40.00
Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines				177, 335 1, 261, 860	
PASS THROUGH COST ADJUSTMENTS	· · · · · · · · · · · · · · · · · · ·	7 111011 4011 0110)		172017000	]
	atient routine se	rvices (from Wkst. D, s	um of Parts I and	273, 466	50.00
	atient ancillary s	services (from Wkst. D.	sum of Parts II	9. 745	51.00
and IV)	,				
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	norting period end	ding 1996 undated and	compounded by the	-	58. 0 59. 0
	por tring por roa on	aring 1770, apactod and	compounded by the		
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				U <sub> </sub>	61.00
	instructions)		Ü	  -	
	ent (see instructi	ons)			
	cire (300 matriaeti	01137		0	] 00.00
	ts through Decembe	er 31 of the cost repor	ting period (See	0	64. 00
	ts after December	31 of the cost reporti	ng period (See	0	65.00
instructions)(title XVIII only)		·			
	ne costs (line 64	plus line 65)(title XV	III only). For	0	66. 00
	e costs through De	ecember 31 of the cost	reporting period	0	67. 00
	a aceta after Deer	mbon 21 of the cost ro	nanting paried		40.00
	e costs after bece	sliber 31 of the cost re	portring perrou	U <sub> </sub>	68. 00
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			)		70.00
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	ne 2)			  -	76. 00
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		ugh 85)			86.00
				0	87. 00
Adjusted general inpatient routine cost per	diem (line 27 ÷ li	ne 2)		0. 00	88. 00
	Pass through costs applicable to Program inp and IV) Total Program excludable cost (sum of lines Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Target amount (line 54 x line 55) Difference between adjusted inpatient operat Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost remarket basket Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see Relief payment (see instructions) Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine (SAH (see instructions)) Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) Title V or XIX swing-bed NF inpatient routine (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine Adjusted general inpatient routine service cost (line 9 x line Program routine service cost (line 9 x line Adjusted general inpatient routine service Capital -related costs (line 75 ÷ line Program routine service cost per diem limi Inpatient routine service cost for compunpatient routine service cost for compunpatient routine service cost see in Utilization review - physician compensation Total Program inpatient noperating costs (see in Utilization review - physician compensation Total Program inpatient ancillary services (see in Utilization review - physician compensation Total Program inpatient poperat	Pass through costs applicable to Program inpatient ancillary sand IV) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital relations and inpatient operating cost excluding capital relations and costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period end market basket Lesser of lines 53/54 or 55 from prior year cost report, updat If line 53/54 is less than the lower of lines 55, 59 or 60 ent which operating costs (line 53) are less than expected costs (amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) Relief payment (see instructions) Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs through December instructions) (title XVIII only) Total Medicare swing-bed NF inpatient routine costs through December instructions) Title V or XIX swing-bed NF inpatient routine costs after December instructions and the patient routine costs after December instructions are swing-bed NF inpatient routine costs for comparison to the cost (line 13 x line 20) Total title V or XIX swing-bed NF inpatient routine costs after December instructions are swing-bed NF inpatient routine costs for comparison to the cost (line 75 x line 71) Medically necessary private room cost applicable to Program (line 170) Medically necessary private room cost applicable to Program (line 10 x line 10	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. and IV) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anes medical education costs (line 49 minus line 52) TARRET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Target amount per discharge Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target amount (line 56 minu Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket Lesser of lines 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST Medicare sing-bed SNF inpatient routine costs through December 31 of the cost report instructions) (title XVIII only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost report instructions) (title XVIII only) Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XV CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost (line 12 x line 19) Total Medicare swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICCF/MR ONLY Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37 + line 2) Program countine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35) Total Program general inpatient routine service costs (from provider records) Total Program inpatient routine service co	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II and IV) Total Program excludable cost (sum of lines 50 and 51) Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52) TARGET AMOUNT AND LIMIT COMPUTATION Program discharges Target amount per discharge Target amount per discharge Target amount (line 54 x line 55) Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions) Relief payment (see instructions) Relief payment (see instructions) Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT BOUITBE SWIMC BED COST Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (It It & XVI II only) Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See Instructions)  Notal Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19) Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19) Total Villa (see instructions)  PART III - SKILLED NUSSING FACILITY Offer NuRSING FACILITY, AND ICFKNR ONLY  SKILLED NUSSING FACILITY Offer NuRSING FACILITY, AND ICFKNR ONLY  SKILLED NUSSING FACILITY Offer Nursing Facility/ICF/WR routine service cost (line 37) Algored the cost reporting period to the cost reporting period (line 12 x li	111)   20   283   291   281   281   283   213   283   211   283   213   213

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2014 To 12/31/2014		narod:
		Component	CCN. 153042	10 12/31/2014	6/3/2015 1: 34	
		Ti tl	e XVIII	Subprovi der -	PPS	•
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	696, 074	2, 760, 620	0. 25214	4 0	0	90. 00
91.00 Nursing School cost	0	2, 760, 620	0.00000	0	0	91. 00
92.00 Allied health cost	0	2, 760, 620	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 760, 620	0.00000	0 0	0	93. 00
90.00 Capital-related cost 91.00 Nursing School cost 92.00 Allied health cost	OST	2, 760, 620 2, 760, 620 2, 760, 620	0. 25214 0. 00000 0. 00000	4.00 4.00 0 0 0	(col. 3 x col. 4) (see instructions) 5.00	91. 00 92. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150042	Peri od: From 01/01/2014	Worksheet D-1
	Component CCN: 15TO42		
	Title XVIII	Subprovi der -	PPS

		TI LIE AVIII	I RF	FF3	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			7, 693	
2.00	Inpatient days (including private room days, excluding swing-bed Private room days (excluding swing-bed and observation bed days)			7, 693	
3. 00	do not complete this line.	i. II you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		7, 693	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	days) after December 3	21 of the cost	o	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber a	or or the cost	ŏ	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room)	Mays) after December 21	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	lays) arter becember 3	or the cost	٥	8.00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	6, 459	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	, (including privata re	om dove)	o	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Joili days)	٥	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	(including private ro	oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, enti-		s seem devel	0	12.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14.00	after December 31 of the cost reporting period (if calendar yea	-	, I		14.00
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed o	lays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			ő	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 of	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of t	he cost	0. 00	18. 00
40.00	reporting period				40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	inrough December 31 of	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20.00
21 00	reporting period			6, 961, 544	21. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	na period (line	0, 901, 544	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December 3	l of the cost reporting	period (line 6	0	23. 00
24. 00	x line 18)   Swing-bed cost applicable to NF type services through December:	31 of the cost reportir	na period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20)   Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	ne 21 minus line 26)		6, 961, 544	27. 00
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	and abasement on had abs	, race)	0	28. 00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	ii ges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	i ne 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minu:	e line 33)(see instruct	i one)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	.1 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and	d private room cost dif	ferential (line	6, 961, 544	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUST	MENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i	nstructions)		904. 92	
39. 00	Program general inpatient routine service cost (line 9 x line 3	-		5, 844, 878	
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	•		0 5, 844, 878	40. 00 41. 00
<del>-</del> 1. 00	Trotal Trogram general impatrent routine service cost (Tille 37 +	11110 40)	I	5, 544, 676	<del>+</del> 1. 00

	Financial Systems ATION OF INPATIENT OPERATING COST	GOOD SAMARITAN	Provi der CCN:		Peri od:	u of Form CMS-1 Worksheet D-1	
			Component CCI		From 01/01/2014 To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
			Title XV	711	Subprovi der -	PPS	μш
	Cost Center Description	Total	Total Av	erage Per	IRF Program Days	Program Cost	
		Inpatient Cost In	patient Days Dier	n (col. 1 -		(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	<u>4)</u> 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.00			42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	l ol	ol	0. 00	ol o	0	43.00
44. 00	CORONARY CARE UNIT			0.00		O	44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
17.00	Cost Center Description		<u> </u>				17.00
48. 00	Program inpatient ancillary service cost (Wk	est D 2 col 2	Line 200)			1. 00 2, 157, 354	48. 00
49. 00	Total Program inpatient costs (sum of lines					8, 002, 232	1
	PASS THROUGH COST ADJUSTMENTS	<b>y</b> , ,	,				
50. 00	Pass through costs applicable to Program inp	oatient routine se	rvices (from Wks	st. D, sum	of Parts I and	317, 783	50.00
51. 00	Pass through costs applicable to Program inp	patient ancillary	services (from V	lkst. D, sı	um of Parts II	100, 295	51.00
E2 00	and IV)	EO and E1)				410 070	E2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ted, non-physici	an anesthe	etist, and	418, 078 7, 584, 154	1
00.00	medical education costs (line 49 minus line				orror, and	7,001,101	]
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge						55.00
56. 00	Target amount (line 54 x line 55)				>	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and targ	et amount (line	56 minus I	ine 53)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period en	ding 1996, updat	ed and cor	npounded by the		59.00
(0.00	market basket		A			0.00	(0.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	60. 00 61. 00
	which operating costs (line 53) are less that	in expected costs					
62. 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)				0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym	nent (see instruct	i ons)			0	
	PROGRAM I NPATIENT ROUTINE SWING BED COST		04 6 11				
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts through Decemb	er 31 of the cos	t reportir	ng perioa (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after December	31 of the cost	reporti ng	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 64	nlus line 65)(t	itle XVIII	only) For	0	66. 00
00. 00	CAH (see instructions)	110 00313 (11110 04	prus rrne os) (i	TUC AVIII	0111 y). 101		
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through D	ecember 31 of th	ie cost rep	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	ne costs after Dec	ember 31 of the	cost repor	rting period	0	68.00
	(line 13 x line 20)			•	3 1	_	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70. 00	Skilled nursing facility/other nursing facil	ity/ICF/MR routin	e service cost (	line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line	•	e 70 ÷ line 2)				71.00
73. 00	Medically necessary private room cost applic		line 14 x line 3	35)			73.00
74. 00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service c	osts (from Works	sheet B, Pa	art II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess	,	vider records)				79.00
80. 00	Total Program routine service costs for comp	parison to the cos		ne 78 minu	us line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (	,					83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 0
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
50.00	PART IV - COMPUTATION OF OBSERVATION BED PAS						30.00
87. 00	Total observation bed days (see instructions	5)				0	87. 00 88. 00
88. 00	Adjusted general inpatient routine cost per						

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi de		Peri od:	Worksheet D-1	
				From 01/01/2014		
		Compone	nt CCN: 15T042	To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
		Ti 1	le XVIII	Subprovi der -	PPS	piii
			TO AVITT	IRF	113	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27	) column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	378, 484	6, 961, 54	4 0. 05436	58 0	0	90. 00
91.00 Nursing School cost	0	6, 961, 54	4 0.00000	00	0	91. 00
92.00 Allied health cost	0	6, 961, 54	4 0.00000	00	0	92. 00
93.00 All other Medical Education	0	6, 961, 54	4 0.00000	00	0	93. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL		In Lie	eu of Form CMS-2	2552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		CCN: 150042	Peri od:	Worksheet D-3	
THE ATTEM TANOT LEARN SERVICE COST ATTORT CHIMENT	11 ovi dei		From 01/01/2014	WOI KSHEEL D 3	
			To 12/31/2014		
	T: ±1	- ////	11: +-1	6/3/2015 1: 34	pm
Cost Contan Decemintion		e XVIII Ratio of Cos	Hospi tal t Inpati ent	PPS Inpatient	
Cost Center Description		To Charges	Program	Program Costs	
		To charges	Charges	(col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS			16, 162, 065		30.00
31. 00 03100 INTENSIVE CARE UNIT			3, 843, 584		31.00
40. 00   04000   SUBPROVI DER - I PF			488		40.00
41. 00   04100   SUBPROVI DER - I RF			0		41. 00
43. 00   04300   NURSERY					43.00
ANCILLARY SERVICE COST CENTERS					
50.00   05000   OPERATING ROOM		0. 31483		3, 375, 736	50.00
51.00   05100   RECOVERY ROOM		0.00000		0	51. 00
51. 01   05101   ENDOSCOPY		0. 26867			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 22979		l	
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 14068		1, 004, 040	
54. 01 05401 RADI OLOGY-NON-CAMPUS		0. 12053			
54. 08 05408 RADIOLOGY-GSH BREAST CENTER		0. 78808		0	54. 08
60. 00 06000 LABORATORY		0. 15263			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 45423			
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY		0. 42259		1, 348, 188	
66. 00   06600   PHYSI CAL THERAPY 69. 00   06900   ELECTROCARDI OLOGY		0. 1978 <i>6</i> 0. 20304		693, 226	
70. 00   07000   ELECTROCARDI OLOGY		0. 20304		1, 207, 089 0	70.00
70. 00   07000  ELECTROENCEPHALOGRAPHY 70. 01   07001   NEURODI AGNOSTI CS		0.00000			70.00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT		1. 14709		3, 320, 204	
72. 00   07200   MPL. DEV. CHARGED TO PATIENTS		0. 27188			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 35315		3, 366, 602	
75. 00   07500   ASC (NON-DISTINCT PART)		0. 21568		1	

0

692, 111 91. 00 199, 608 92. 00

19, 606, 744 200. 00 201. 00

538, 031

76.00

76. 01

90.00

96.00

202. 00

0.000000

0. 556989

0. 543890

0. 229581

0. 204580

0. 479579

965, 964

3, 014, 672 975, 695

65, 863, 363

65, 863, 363

03020 MH ANCILLARY OUTPATIENT 03950 INPATIENT DIALYSIS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

09000 CLI NI C

09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

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

Net Charges (line 200 minus line 201)

Total (sum of line 50-94 and 96-98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

76.00

76. 01

90.00

91.00

92.00

200. 00 201. 00

202.00

		CCN: 150042	Peri od:	Worksheet D-3	,
			From 01/01/2014		
	Componen	t CCN: 15S042	To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
	Ti tl	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	<b>.</b>	Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	$\vdash$
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	_
0. 00 03000 ADULTS & PEDI ATRI CS			0		30
I. 00 03100 I NTENSI VE CARE UNI T			0		31
0. 00   04000   SUBPROVI DER - 1 PF			2, 027, 649		40
I. 00 04100 SUBPROVI DER – I RF			0		41
3. 00 04300 NURSERY					43
ANCI LLARY SERVI CE COST CENTERS					
0. 00   05000   OPERATING ROOM		0. 3148	36 9, 359	2, 947	50
. 00   05100   RECOVERY ROOM		0.0000	00	0	1 -
. 01   05101   ENDOSCOPY		0. 2686		161	
05200 DELIVERY ROOM & LABOR ROOM		0. 2297		0	
3. 00 05300 ANESTHESI OLOGY		0.0000		0	
I. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1406	·	9, 708	
I. 01   05401   RADI OLOGY-NON-CAMPUS		0. 1205		1, 761	
I. 08   05408   RADI OLOGY-GSH BREAST CENTER D. 00   06000   LABORATORY		0. 7880		0	
B. 00   06300   BLOOD STORING, PROCESSING & TRANS.		0. 1526 0. 4542	·	25, 470 0	
5. 00   06500   RESPIRATORY THERAPY		0. 4342		27, 262	
b. 00   06600  PHYSI CAL THERAPY		0. 4223			
00 06900 ELECTROCARDI OLOGY		0. 2030	·	3, 056	
0. 00   07000   ELECTROENCEPHALOGRAPHY		0.0000		0,000	
0. 01   07001   NEURODI AGNOSTI CS		0. 2409			
.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 1470		5, 072	
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2718		0	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 3531	55 169, 666	59, 918	73
5. OO 07500 ASC (NON-DISTINCT PART)		0. 2156	82 0	0	75
5. OO 03020 MH ANCILLARY OUTPATIENT		0.0000	00	0	76
0. 01 03950 INPATIENT DIALYSIS		0. 5569	5, 153	2, 870	76
OUTPATIENT SERVICE COST CENTERS					4
. 00   09000   CLI NI C		0. 5438			
. 00   09100   EMERGENCY		0. 2295	·		
. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2045	80 0	0	92
OTHER REIMBURSABLE COST CENTERS			70	=	4 .
0.00 O9600 DURABLE MEDICAL EQUIP-RENTED		0. 4795		0	
00.00 Total (sum of lines 50-94 and 96-98)	(11=, 74)		692, 053	177, 335	
D1.00 Less PBP Clinic Laboratory Services-Program only charges D2.00 Net Charges (line 200 minus line 201)	s (IIne 61)		692, 053		201

ealth Financial Systems GOOD SAMA NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ARI TAN HOSPI TAL Provi der	CCN: 150042	Peri od:	wof Form CMS-3 Worksheet D-3	
THE THE PROPERTY OF THE STATE OF THE OWN OWN OWN.			From 01/01/2014		
		CCN: 15T042		6/3/2015 1: 34	
	Ti tl	e XVIII	Subprovi der  - I RF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1. 00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
0. 00 03000 ADULTS & PEDI ATRI CS			0		30.
1. 00   03100   NTENSI VE CARE UNI T			0		31.
0. 00   04000   SUBPROVI DER - I PF			0		40.
1. 00   04100   SUBPROVI DER -   RF			5, 797, 829		41. (
3. 00   04300   NURSERY			2, ,		43.
ANCILLARY SERVICE COST CENTERS					
0.00 O5000 OPERATING ROOM		0. 3148	36 145, 484	45, 804	50.
1.00 05100 RECOVERY ROOM		0.0000	00	0	51.
1. 01   05101   ENDOSCOPY		0. 2686	78 72, 965	19, 604	51.
2.00   05200   DELIVERY ROOM & LABOR ROOM		0. 2297	99 0	0	52.
3. 00   05300   ANESTHESI OLOGY		0.0000	00	0	53.
4. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1406	86 409, 768	57, 649	54.
4. 01   05401   RADI OLOGY-NON-CAMPUS		0. 1205	35 106, 040	12, 782	
4. 08   05408   RADI OLOGY-GSH BREAST CENTER		0. 7880	81 0	0	54.
0. 00   06000   LABORATORY		0. 1526		114, 290	
3.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4542		15, 233	
5. 00 06500 RESPI RATORY THERAPY		0. 4225		228, 331	1
6. 00   06600   PHYSI CAL THERAPY		0. 1978		1, 084, 581	
9. 00   06900   ELECTROCARDI OLOGY		0. 2030		17, 019	
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	1
0. 01   07001   NEURODI AGNOSTI CS		0. 2409			
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 1470		254, 117	
2.00  07200 IMPL. DEV. CHARGED TO PATIENTS 3.00  07300 DRUGS CHARGED TO PATIENTS		0. 2718		9, 032	1
5. 00   07500   ASC (NON-DISTINCT PART)		0. 3531 0. 2156		271, 365 0	1
6.00 03020 MH ANCILLARY OUTPATIENT		0. 2130		0	1
6.01 03950 INPATIENT DIALYSIS		0. 5569		0	
OUTPATIENT SERVICE COST CENTERS		0. 3307	0 7 0	0	70.
0. 00 09000 CLINIC		0. 5438	90 0	0	90.
1. 00 09100 EMERGENCY		0. 2295		24, 106	1
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2045		0	1
OTHER REI MBURSABLE COST CENTERS		3. 2010	,	·	1
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 4795	79 0	0	96.
00.00 Total (sum of lines 50-94 and 96-98)		3, 70	8, 764, 594		
01.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0		201.
02.00 Net Charges (line 200 minus line 201)	3-2 ( 0.)		8, 764, 594		202.

Health Financial Systems	GOOD SAMARITAN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od: From 01/01/2014	Worksheet D-3	
			To 12/31/2014		
	Ti t	le XIX	Hospi tal	Cost	-1-
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			2, 248, 806		30.00
31. 00 03100 INTENSIVE CARE UNIT			539, 906		31.00
40. 00   04000   SUBPROVI DER - I PF			0		40.00
41. 00   04100   SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY			87, 588		43.00
ANCILLARY SERVICE COST CENTERS					

	ncial Systems GOOD SAMARITAN H NCILLARY SERVICE COST APPORTIONMENT		CCN: 150042	Peri od:	eu of Form CMS-: Worksheet D-3	
				From 01/01/2014		
		· ·	t CCN: 15SO42		6/3/2015 1:34	
		Tit	le XIX	Subprovi der - I PF	Cost	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	9	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	O ADULTS & PEDIATRICS			0		30.0
	OINTENSIVE CARE UNIT			0		31.00
	O SUBPROVI DER - I PF			0		40.0
41.00 0410	O SUBPROVI DER - I RF			359, 681		41.0
	0 NURSERY			0		43. 0
	LLARY SERVICE COST CENTERS					
	O OPERATING ROOM		0. 3148	36 0	0	50.0
	O RECOVERY ROOM		0.0000		-	
	1 ENDOSCOPY		0. 2686			
	O DELIVERY ROOM & LABOR ROOM		0. 2297		0	
1	O ANESTHESI OLOGY		0.0000		0	
4	O RADI OLOGY-DI AGNOSTI C		0. 1406		1, 403	
	1 RADI OLOGY -NON-CAMPUS		0. 1205		70	
	8 RADI OLOGY-GSH BREAST CENTER		0. 7864		0	
	O LABORATORY O BLOOD STORING, PROCESSING & TRANS.		0. 1526 0. 4542		3, 628	
	O RESPIRATORY THERAPY		0. 4342		-	
1	O PHYSI CAL THERAPY		0. 4223		1, 152	1
	0 ELECTROCARDI OLOGY		0. 1978			
1	0 ELECTROENCEPHALOGRAPHY		0.0000		0	1
	1 NEURODI AGNOSTI CS		0. 2401			
	O MEDICAL SUPPLIES CHARGED TO PATIENT		1. 1470			
1	O I MPL. DEV. CHARGED TO PATIENTS		0. 2718		0	1
73. 00 0730	O DRUGS CHARGED TO PATIENTS		0. 3531	55 26, 811	9, 468	73.0
75. 00 0750	OASC (NON-DISTINCT PART)		0. 2156	82 0	0	75.0
76. 00   0302	OMH ANCILLARY OUTPATIENT		0.0000	00 0	0	76. 0
	O INPATIENT DIALYSIS		0. 5452	22 472	257	76. 0
	ATLENT SERVICE COST CENTERS					
	O CLI NI C		0. 5438			
	O EMERGENCY		0. 2287			
92. 00 0920	O OBSERVATION BEDS (NON-DISTINCT PART		0. 2045	80 0	0	92. 0
	R REIMBURSABLE COST CENTERS		0.4705	70 0		1 0, 0
96. 00   0960 200. 00	ODURABLE MEDICAL EQUIP-RENTED Total (sum of lines 50-94 and 96-98)		0. 4795	79 0 77, 695	-	
200.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		//, 695	20, 699	201. 0
20 I. UU	TEESS FOR VITALL EARLY ALDEV SELVICES FLOULAID OULV CHALDES		1			

ealth Financial Systems GOOD SAM  NPATIENT ANCILLARY SERVICE COST APPORTIONMENT	MARITAN HOSPITAL Provider	CCN: 150042	Peri od:	eu of Form CMS-: Worksheet D-3	
THE PROPERTY OF SECTION SECTIO			From 01/01/2014		
		t CCN: 15T042		6/3/2015 1:34	
	Ti t	le XIX	Subprovi der - I RF	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	9	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30. c
31.00 03100 INTENSIVE CARE UNIT			0		31.0
10. 00   04000   SUBPROVI DER - 1 PF			0		40.0
11. 00   04100   SUBPROVI DER - 1 RF			262, 802		41.0
13. 00 04300 NURSERY			0		43. C
ANCILLARY SERVICE COST CENTERS			0.1	1 05/	
50. 00   05000   OPERATI NG ROOM		0. 3148		256	1
1. 00   05100   RECOVERY ROOM		0.0000		0	
1. 01   05101   ENDOSCOPY		0. 2686		567	
22.00   05200   DELIVERY ROOM & LABOR ROOM 33.00   05300   ANESTHESIOLOGY		0. 2297		0	
33. 00   05300  ANESTHESI OLOGY 44. 00   05400  RADI OLOGY-DI AGNOSTI C		0. 0000 0. 1406		· -	
44. 01   05401   RADI OLOGY-DI AGNOSTI C		0. 1400		467	1
44. 08   05408   RADI OLOGY-GSH   BREAST CENTER		0. 7864		0	1
0. 00   06000   LABORATORY		0. 1526			
33. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 4542			1
5. 00 06500 RESPIRATORY THERAPY		0. 4225	95 9, 320	3, 939	65.
.6. 00   06600   PHYSI CAL THERAPY		0. 1978	63 215, 749	42, 689	66.
9. 00 06900 ELECTROCARDI OLOGY		0. 2029	23 3, 915	794	69. (
0. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	70.
0. 01 07001 NEURODI AGNOSTI CS		0. 2401			1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 1470		8, 961	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2718		l e	1
3. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 3531			
5. 00 07500 ASC (NON-DISTINCT PART)		0. 2156		0	1
6.00 03020 MH ANCILLARY OUTPATIENT		0.0000			
(6. 01   03950   I NPATI ENT DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS		0. 5452	22 0	0	76.
0.00 09000 CLINIC		0. 5438	90 0	0	90.
1. 00   09100   EMERGENCY		0. 3438		-	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 2045			1
OTHER REIMBURSABLE COST CENTERS		3. 2010	, 0		1 /
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 4795	79 0	0	96.
00.00 Total (sum of lines 50-94 and 96-98)			325, 941	-	
01.00 Less PBP Clinic Laboratory Services-Program only	charges (line 61)		0	.,	201.
Net Charges (line 200 minus line 201)	,		325, 941		202.

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150042	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre 6/3/2015 1:34	pared:
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1. 00	2. 00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2.00	
1.00	DRG Amounts Other than Outlier Payments			0		1.00
1. 01	DRG amounts other than outlier payments for discharges occurrin	g prior		23, 000, 738		1. 01
1. 02	to October 1 (see instructions) DRG amounts other than outlier payments for discharges occurrin	a on or		0		1. 02
1.02	after October 1 (see instructions)	9 011 01				1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 03
1 04	discharges occurring prior to October 1 (see instructions)			0		1. 04
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)					1.04
2.00	Outlier payments for discharges. (see instructions)			1, 039, 224		2. 00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02 3. 00	Outlier payment for discharges for Model 4 BPCI (see instructio Managed Care Simulated Payments	ns)		0		2. 02 3. 00
4. 00	Bed days available divided by number of days in the cost report	i na		185. 35		4. 00
	peri od (see i nstructi ons)					]
	Indirect Medical Education Adjustment		1	1		
5. 00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instr			0.00		5. 00
6.00	FTE count for allopathic and osteopathic programs which meet th			0.00		6. 00
	criteria for an add-on to the cap for new programs in accordanc	e with 42				
7 00	CFR 413.79(e)	dos 10		0.00		7 00
7. 00	MMA Section 422 reduction amount to the IME cap as specified un CFR $\S412.105(f)(1)(iv)(B)(1)$	uer 42		0.00		7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7. 01
	CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July	1, 2011				
8. 00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8. 00
0.00	osteopathic programs for affiliated programs in accordance with			0.00		0.00
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67					
8. 01	(August 1, 2002).	s under		0.00		8. 01
6.01	The amount of increase if the hospital was awarded FTE cap slot section 5503 of the ACA. If the cost report straddles July 1, 2			0.00		0.01
	instructions.	,				
8. 02	The amount of increase if the hospital was awarded FTE cap slot			0.00		8. 02
9. 00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
7. 00	and 8,02) (see instructions)	(0, 0,01		0.00		7.00
10.00	FTE count for allopathic and osteopathic programs in the curren	t year		0.00		10.00
11. 00	from your records  FTE count for residents in dental and podiatric programs.			0.00		11. 00
12. 00	Current year allowable FTE (see instructions)			0.00		12.00
13. 00	Total allowable FTE count for the prior year.			0.00		13. 00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
15. 00	or after September 30, 1997, otherwise enter zero.  Sum of lines 12 through 14 divided by 3.			0.00		15. 00
16. 00				0.00		16. 00
17. 00	Adjusment for residents displaced by program or hospital closur	е		0.00		17. 00
18. 00	Adjusted rolling average FTE count			0.00		18.00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4). Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000		19. 00 20. 00
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000		21.00
22. 00	IME payment adjustment (see instructions)			0		22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)	- 422 -6 +	In a MANA A	0		22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for Section Number of additional allopathic and osteopathic IME FTE residen		TIE IVIVIA	0.00		23. 00
20.00	slots under 42 Sec. 412.105 (f)(1)(iv)(C).	СОСР		0.00		20.00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0.00		24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lourine 23 or line 24 (see instructions)	wer of		0.00		25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0.000000		26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000		27. 00
28. 00	IME add-on adjustment amount (see instructions)			0		28. 00
28. 01 29. 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment ( sum of lines 22 and 28)			0		28. 01 29. 00
29. 00	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 00
	Di sproporti onate Share Adjustment					
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days		5. 43		30. 00
31. 00	(see instructions) Percentage of Medicaid patient days (see instructions)			14. 29		31.00
32. 00	Sum of lines 30 and 31			19. 72		32. 00
33.00	Allowable disproportionate share percentage (see instructions)			5. 57		33. 00
34. 00	Disproportionate share adjustment (see instructions)		ĺ	320, 285		34. 00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2014 To 12/31/2014	Worksheet E Part A Date/Time Pre	
		Ti +Lo VVIII	Hospi tal	6/3/2015 1: 34 PPS	pm
		Title XVIII	Hospi tal Pri or to	On/After	
			October 1	October 1	
		0	1.00	2. 00	
	Uncompensated Care Adjustment		1.00	2.00	
35. 00	Total uncompensated care amount (see instructions)		9 046 380 143	7, 647, 644, 855	35. 00
35. 01	Factor 3 (see instructions)		0. 000096432	0. 000099244	35. 01
35. 02	Hospital uncompensated care payment (If line 34 is zero,		872, 361	758, 983	35. 02
33. 02	enter zero on this line) (see instructions)		072, 301	730, 703	33.02
35. 03	Pro rata share of the hospital uncompensated care payment		652, 478	191, 305	35. 03
33. 03	amount (see instructions)		032, 476	171, 303	35.03
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		843, 783		36. 00
30. 00	35.03)		043, 703		30.00
	Additional payment for high percentage of ESRD beneficiary of	discharges (Lines 40 through	h 16)		
40. 00	Total Medicare discharges on Worksheet S-3, Part I	di scharges (Times 40 tili odg	0		40.00
40.00	excluding discharges for MS-DRGs 652, 682, 683, 684 and		٩		40.00
	685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,				41.00
41.00	682, 683, 684 an 685. (see instructions)				+1.00
41. 01	Total ESRD Medicare covered and paid discharges excluding		0		41. 01
11.01	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				''' ''
42. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42. 00
00	qualify for adjustment)		3.00		50
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		n		43. 00
. 5. 55	682, 683, 684 an 685. (see instructions)		Y		.5. 50
44. 00	Ratio of average length of stay to one week (line 43		0. 000000		44.00
50	divided by line 41 divided by 7 days)		3. 300000		55
45. 00	Average weekly cost for dialysis treatments (see		0.00		45. 00
	instructions)				
46. 00	Total additional payment (line 45 times line 44 times line		o		46.00
	41.01)				
47.00	Subtotal (see instructions)		25, 204, 030		47.00
48. 00	Hospital specific payments (to be completed by SCH and		0		48. 00
	MDH, small rural hospitals only (see instructions)				
49. 00	Total payment for inpatient operating costs (see		25, 204, 030		49.00
	instructions)				
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		1, 920, 625		50.00
	and Pt. II, as applicable)				
51. 00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
	Pt. III, see instructions)				
52.00	Direct graduate medical education payment (from Wkst. E-4,		o		52.00
	line 49 see instructions).				
53.00	Nursing and Allied Health Managed Care payment		6, 031		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
	line 69)				
56.00	Cost of physicians' services in a teaching hospital (see		0		56.00
	intructions)				
57.00	Routine service other pass through costs (from Wkst. D,		0		57.00
	Pt. III, column 9, lines 30 through 35).				
58. 00	Ancillary service other pass through costs from Wkst. D,		30, 470		58.00
	Pt. IV, col. 11 line 200)				
59. 00	Total (sum of amounts on lines 49 through 58)		27, 161, 156		59.00
60.00	Primary payer payments		12, 077		60.00
61. 00	Total amount payable for program beneficiaries (line 59		27, 149, 079		61.00
	minus line 60)				
62. 00	Deductibles billed to program beneficiaries		2, 410, 464		62.00
63. 00	Coinsurance billed to program beneficiaries		90, 872		63.00
64. 00	Allowable bad debts (see instructions)		173, 699		64. 00
65. 00	Adjusted reimbursable bad debts (see instructions)		112, 904		65. 00
66. 00	Allowable bad debts for dual eligible beneficiaries (see		101, 835		66.00
	instructions)				
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		24, 760, 647		67. 00
68. 00	Credits received from manufacturers for replaced devices		0		68. 00
	for applicable to MS-DRGs (see instructions)				
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69. 00
	96). (For SCH see instructions)				
70. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70. 00
70. 50	RURAL DEMONSTRATION PROJECT		0		70. 50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
	instructions)				
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
	instructions)				
70. 91	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
70. 92	Bundled Model 1 discount amount (see instructions)		0		70. 92
70. 93	HVBP payment adjustment amount (see instructions)		110, 652		70. 93
70. 94	HRR adjustment amount (see instructions)		-28, 687		70. 94
70. 95	Recovery of accelerated depreciation				70. 95

Heal th	Financial Systems GOOD SAMARITA	TAN HOSPITAL			In Lieu of Form CMS-2552-10		
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150042	Peri od: From 01/01/2014 To 12/31/2014			
			Title XVIII		Hospi tal	PPS	
					Prior to October 1	On/After October 1	
			0		1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)			0	0		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)			0	0		70. 97
70. 98	Low Volume Payment-3				0		70. 98
70. 99	HAC adjustment amount (see instructions)				0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)				24, 842, 612		71. 00
71. 01	Sequestration adjustment (see instructions)				496, 852		71. 01
72.00	Interim payments				24, 274, 307		72. 00

	(Enter in column 0 the corresponding federal year for the			
	period ending on or after 10/1)			
70. 98	Low Volume Payment-3		0	70. 98
70. 99	HAC adjustment amount (see instructions)		0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus	24, 842,	o12	71. 00
	lines 69 & 70)			
71. 01	Sequestration adjustment (see instructions)	496,	352	71. 01
72.00	Interim payments	24, 274,	307	72. 00
73.00	Tentative settlement (for contractor use only)		0	73. 00
74.00	Balance due provider (Program) (line 71 minus lines 71.01,	71,	153	74. 00
	72, and 73)			
75.00	Protested amounts (nonallowable cost report items) in	74,	580	75. 00
	accordance with CMS Pub. 15-2, chapter 1, §115.2			
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	,		
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see		0	90. 00
	instructions)			
	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92. 00	Operating outlier reconciliation adjustment amount (see		0	92. 00
	instructions)			
93. 00	Capital outlier reconciliation adjustment amount (see		0	93. 00
	instructions)			
94. 00	The rate used to calculate the time value of money (see	0	00	94. 00
	instructions)			1
95.00	Time value of money for operating expenses (see		0	95. 00
04 00	instructions)			0, 00
96.00	Time value of money for capital related expenses (see		٥	96. 00
	instructions)	Dri on to 10	/1 On/After 10/1	
		1.00	2. 00	
	HSP Bonus Payment Amount	1.00	2.00	
100.00	HSP bonus amount (see instructions)		0 0	100.00
100.00	HVBP Adjustment for HSP Bonus Payment		Ol C	1100.00
101 00	HVBP adjustment factor (see instructions)		ol c	101.00
	HVBP adjustment amount for HSP bonus payment (see instructi	one)		102.00
102.00	HRR Adjustment for HSP Bonus Payment	UI3)	0	102.00
103 00	HRR adjustment factor (see instructions)	0.0	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instruction			104.00
104.00	Think adjustificite amount for his bonds payment (see this truction	ons)	٩	71104.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet E |
| From 01/01/2014 | Part A Exhibit 4 |
| To 12/31/2014 | Date/Time Prepared: 6/3/2015 1:34 pm Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 150042

					•	0 12/31/2014	6/3/2015 1: 34	
					e XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3. 00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0.00		0	1. 00
1. 01	payments DRG amounts other than outlier	1. 01	23, 000, 738	0	0	23, 000, 738	23, 000, 738	1. 01
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	0	0	0	0	0	1. 02
1.02	payments for discharges occurring on or after October	1. 02	U	0	O	0	0	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0	O	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	o	0	0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	1, 039, 224	0	0	1, 039, 224	1, 039, 224	2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
3. 00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments Indirect Medical Education Adju	3. 00	0	0	0	0	0	4. 00
5. 00	Amount from Worksheet E, Part	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions)  IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see instructions)							
	Indirect Medical Education Adju							
7. 00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see instructions)	28. 01	O	0	0	O	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	O	О	0	О	0	9. 01
	Disproportionate Share Adjustme	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0557	0. 0557	0. 0557	0. 0557		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	320, 285	0	0	320, 285	320, 285	11. 00
11. 01	Uncompensated care payments	36. 00	843, 783	0	0	843, 783	843, 783	11. 01
	Additional payment for high per	centage of ESF						
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH,	47. 00 48. 00	25, 204, 030 0	O O	0	25, 204, 030 0	25, 204, 030 0	13. 00 14. 00
45.00	small rural hospitals only.) (see instructions)	40.00	05.007.00		_	05 00 05 0	OF 224 5	45.00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	25, 204, 030	0	0	25, 204, 030	25, 204, 030	15.00
16. 00	Payment for inpatient program capital	50. 00	1, 920, 625	0	0	1, 920, 625	1, 920, 625	16. 00
17. 00	Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Capital received from	55. 00 68. 00	0	0 0	0	0	0	17. 01 17. 02
18. 00	manufacturers for replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see	93. 00	0	0	0	0	0	18. 00
	instructions)							

							o 12/31/2014		pared:
					Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Po	st	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitler	nent	to 10/01	On/After 10/01	through 4)	
		0	1.00	2.00		3.00	4. 00	5. 00	
19.00	SUBTOTAL				0	(	27, 124, 655	27, 124, 655	19. 00
		W/S L, line	(Amounts from						
			L)						
		0	1.00	2.00		3. 00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1.00	1, 823, 346		0	(	1, 823, 346	1, 823, 346	20. 00
20. 01	Model 4 BPCI Capital DRG other	1. 01	0		0		0	0	20. 01
	than outlier								
21.00	Capital DRG outlier payments	2. 00	97, 279		0	(	97, 279	97, 279	21. 00
21. 01	Model 4 BPCI Capital DRG	2. 01	0		0		0	0	21. 01
	outlier payments								
22. 00	Indirect medical education	5. 00	0. 0000	О (	. 0000	0.0000	0. 0000		22. 00
	percentage (see instructions)								
23.00	Indirect medical education	6. 00	0		0		0	0	23. 00
	adjustment (see instructions)								
24.00	Allowable disproportionate	10.00	0. 0000	l о	. 0000	0.0000	0. 0000		24. 00
	share percentage (see								
	instructions)								
25.00	Di sproporti onate share	11.00	0		0		0	0	25. 00
	adjustment (see instructions)								
26.00	Total prospective capital	12.00	1, 920, 625		0	(	1, 920, 625	1, 920, 625	26. 00
	payments (see instructions)								
		W/S E, Part A	(Amounts to E,						
		line	Part A)						
		0	1.00	2.00		3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor					0.000000	0.000000		27. 00
28. 00	Low volume adjustment	70. 96						0	28. 00
	(transfer amount to Wkst. E,								
	Pt. A, line)								
29.00	Low volume adjustment	70. 97					0	0	29. 00
	(transfer amount to Wkst. E,								
	Pt. A, line)								
100.00	Transfer low volume		N						100. 00
	adjustments to Wkst. E, Pt. A.								
	•	•	,	•		•		•	•

From 01/01/2014 Part A Exhibit 5 Date/Time Prepared: 6/3/2015 1:34 pm 12/31/2014 Title XVIII Hospi tal Period to Total (cols. 2 Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line and 3) A) 2.00 3. 00 4.00 0 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 DRG amounts other than outlier payments for 23, 000, 738 23, 000, 738 1.01 1.01 23, 000, 738 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 0 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 0 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 1, 039, 224 1, 039, 224 1, 039, 224 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 2. 01 Operating outlier reconciliation 3 00 2 01 O Ω 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 0.000000 0.000000 7.00 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) 9.00 Total IME payment (sum of lines 6 and 8) 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment Allowable disproportionate share percentage 10.00 33.00 0.0557 0.0557 0.0557 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 320, 285 320, 285 0 320, 285 11.00 instructions) 843, 783 843, 783 843, 783 11.01 Uncompensated care payments 36.00 0 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see 0 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 25, 204, 030 25, 204, 030 25, 204, 030 13.00 0 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 25, 204, 030 25, 204, 030 0 25, 204, 030 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 1, 920, 625 1, 920, 625 1, 920, 625 16.00 Special add-on payments for new technologies 17.00 54.00 17.00 Net organ aquisition cost 55.00 0 0 17.01 17.01 0 17.02 Capital received from manufacturers for 68.00 0 0 17.02 replaced devices for applicable MS-DRGs

93.00

27, 124, 655

0 18.00

27, 124, 655 19. 00

18.00

19 00

Capital outlier reconciliation adjustment

amount (see instructions)

SUBTOTAL

Health Financial Systems	GOOD SAMARITA	AN HO	SPI TAL		In Lie	eu of Form CMS-2552-10		
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5		Provi der		From 01/01/2014 Part A Exhibi To 12/31/2014 Date/Time Pre 6/3/2015 1:34		pared:	
			Ti tl	e XVIII	Hospi tal	PPS		
	Wkst. L, line	•	mt. from kst. L)					
	0		1.00	2. 00	3. 00	4. 00		
20.00 Capital DRG other than outlier	1. 00		1, 823, 346	1, 823, 34	6 0	1, 823, 346	1	

			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
			Wkst. L)				
		0	1. 00	2.00	3. 00	4. 00	
20. 00	Capital DRG other than outlier	1.00	1, 823, 346	1, 823, 346	0	1, 823, 346	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	97, 279	97, 279	0	97, 279	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	0	0	21. 01
22.00	Indirect medical education percentage (see	5. 00	0.0000	0. 0000	0.0000		22. 00
	instructions)						
23.00	Indirect medical education adjustment (see	6. 00	0	0	0	0	23. 00
	instructions)						
24.00	Allowable disproportionate share percentage	10.00	0.0000	0. 0000	0.0000		24. 00
	(see instructions)						
25.00	Di sproporti onate share adjustment (see	11. 00	0	0	0	0	25. 00
	instructions)						
26.00	Total prospective capital payments (see	12.00	1, 920, 625	1, 920, 625	0	1, 920, 625	26. 00
	instructions)						
	•	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt.				
			A)				
		0	1.00	2.00	3. 00	4. 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		0	0	29. 00
30.00	HVBP payment adjustment (see instructions)	70. 93	110, 652	110, 652	0	110, 652	30.00
30. 01	HVBP payment adjustment for HSP bonus	70. 90	0	0	0	0	30. 01
	payment (see instructions)						
31.00	HRR adjustment (see instructions)	70. 94	-28, 687	-28, 687	0	-28, 687	31.00
31. 01	HRR adjustment for HSP bonus payment (see	70. 91	0	0	0	0	31. 01
	instructions)						
	•					(Amt. to Wkst.	
						E, Pt. A)	
		0	1. 00	2. 00	3. 00	4. 00	
32.00	HAC Reduction Program adjustment (see	70. 99		0	0	0	32. 00
	instructions)						
100.00	Transfer HAC Reduction Program adjustment to		N				100.00
	Wkst. E, Pt. A.						

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150042	From 01/01/2014	Worksheet E Part B Date/Time Prepared: 6/3/2015 1:34 pm

			To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
		Title XVIII	Hospi tal	PPS	- PIII
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			15, 085	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		25, 738, 374	2. 00
3.00	PPS payments			20, 605, 478	
4.00	Outlier payment (see instructions)			48, 626	
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	ions)		0. 000 0	5. 00 6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		81, 636	9. 00
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			15, 085	11. 00
	Reasonable charges				
12.00	Ancillary service charges			44, 655	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1. 4)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			44, 655	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	vment for services on	a charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	
	had such payment been made in accordance with 42 CFR §413.13(e)		, , , , , , , , , , , , , , , , , , ,		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)	ifling 10 avegade Li	no 11) (coo	44, 655	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	II IIIle 18 exceeds II	ne II) (see	29, 570	19. 00
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		15, 085	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	ctions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	Cti ons)		20, 735, 740	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			.,,	
25. 00	Deductibles and coinsurance (for CAH, see instructions)	0411		0	
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl			4, 482, 945 16, 267, 880	
27.00	CAH, see instructions)	us the sum of filles 22	2 and 25) (10)	10, 207, 000	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29)			16, 267, 880 3, 298	
32. 00	Primary payer payments Subtotal (line 30 minus line 31)			3, 296 16, 264, 582	
02.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		10/201/002	02.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34. 00 35. 00	Allowable bad debts (see instructions)			473, 277 307, 630	
36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		351, 309	
	Subtotal (see instructions)	011 0110)		16, 572, 212	
38. 00	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50 39. 98	Pioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replace	d dovices (see instru	stions)	0	39. 50 39. 98
39. 90	RECOVERY OF ACCELERATED DEPRECIATION	u devices (see ilistiud	Ztions)	0	39. 96 39. 99
40. 00	Subtotal (see instructions)			16, 572, 347	40. 00
40. 01	01 Sequestration adjustment (see instructions)		331, 447		
41.00	i y		16, 116, 687		
42. 00 43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0 124, 213	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2	chapter 1	124, 213	1
1 1. 00	§115. 2		5aptor 1,		11.00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91. 00 92. 00
93. 00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			0	

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150042	Peri od: From 01/01/2014	Worksheet E Part B
	Component CCN: 15SO42	To 12/31/2014	Date/Time Prepared: 6/3/2015 1:34 pm
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I PF	PPS	
	DART R. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			195	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		175	
3.00	PPS payments	•		305	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
5. 00 6. 00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	ions)		0. 000	5. 00 6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0. 00	
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 195	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			170	11.00
	Reasonable charges				
12.00	Ancillary service charges				12.00
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co Total reasonable charges (sum of lines 12 and 13)	I. 4)		0 552	
14.00	Customary charges			552	14.00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for	payment for services o	on a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17 00
18. 00	Total customary charges (see instructions)			552	
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	357	
	instructions)		10) (		
20. 00	Excess of reasonable cost over customary charges (complete only instructions)	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		195	21. 00
22. 00	Interns and residents (see instructions)	,		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			305	24. 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)	)	0	26. 00
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	2 and 23} (for	500	27. 00
28. 00	CAH, see instructions) Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0 00)		0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)			500	
31.00	Primary payer payments			0	31. 00
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	5)		500	32. 00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			0	
35.00	Adjusted reimbursable bad debts (see instructions)	ati ana)		0	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	CTI ONS)		0 500	36. 00 37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pi oneer ACO demonstration payment adjustment (see instructions)	d davi asa (asa i nataw	ati ana)	0	
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	a devices (see instruc	CTI ONS)	0	
40.00	Subtotal (see instructions)			500	
40. 01	Sequestration adjustment (see instructions)			10	•
41.00	Interim payments			407 0	
42. 00 43. 00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			83	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	
	§115. 2				
00 00	TO BE COMPLETED BY CONTRACTOR		T	0	00.00
90. 00 91. 00	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	90. 00 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	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15		Worksheet E
		From 01/01/2014	
	Component CCN: 1	15T042 To 12/31/2014	
			6/3/2015 1:34 pm
	Title XVIII	I Subprovi der -	DDS

		Title XVIII	Subprovi der - I RF	PPS	
			TIM		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			579	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		462	2. 00
3.00	PPS payments			794	3.00
4. 00 5. 00	Outlier payment (see instructions) Enter the hospital specific payment to cost ratio (see instruct	ions)		0. 000	4. 00 5. 00
6. 00	Line 2 times line 5	1 0113)		0.000	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0. 00	7. 00
8.00	Transitional corridor payment (see instructions)	aal 12 lina 200		0	8. 00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV Organ acquisitions	, COI. 13, TTHE 200		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			579	
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			1 640	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	1. 4)		1, 040	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)	,		1, 640	
45.00	Customary charges				45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	payment for services of	ii a chargebasi s	O	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18.00	Total customary charges (see instructions)	if line 10 evecede li	no 11) (coo	1, 640	
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	II Tine 18 exceeds II	ne II) (See	1, 061	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	instructions)	instructions)		E70	21. 00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	i iisti ucti olis)		0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			794	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT  Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		0	26. 00
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23} (for	1, 373	27. 00
28. 00	CAH, see instructions) Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0 00)		0	
30.00	Subtotal (sum of lines 27 through 29)			1, 373	
31. 00	Primary payer payments			1 272	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES	5)		1, 373	32. 00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	- /		0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		0	35. 00 36. 00
37. 00	Subtotal (see instructions)	011 0110)		1, 373	
38. 00	MSP-LCC reconciliation amount from PS&R			0	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00 39. 50
39. 98	Prioneer ACO demonstration payment adjustment (see instructions) Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(**************************************		0	39. 99
40.00	Subtotal (see instructions)			1, 373	
40. 01 41. 00	Sequestration adjustment (see instructions)			27 1, 136	
42. 00				0	
43.00	Balance due provider/program (see instructions)			210	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)				93.00
	, , , , , , , , , , , , , , , , , , ,		'	- 1	

Health Financial Systems GOO ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 150042 | Period: | Worksheet E-1 | Part I | Date/Time Prepared: 6/3/2015 1:34 pm

					6/3/2015 1: 34	pm
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		24, 123, 60		16, 116, 687	1. 00
2.00	Interim payments payable on individual bills, either			O	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER	07/31/2014	104, 70		1 0	3. 01
3.01	ADJUSTMENTS TO PROVIDER	07/31/2014	46, 00			3. 01
		07/31/2014	-	0		3. 02
3.03				~	1	
3.04				O	0	3. 04
3. 05	Dravi dan ta Dragnam			0	0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM				0	3. 50
3. 50	ADJUSTWENTS TO PROGRAW			0		3. 50
3. 51				0		3. 51
3. 52				0		3. 52
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		150, 70			3. 99
3. 99	3. 50-3. 98)		130, 70	3	١	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		24, 274, 30	7	16, 116, 687	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		21,271,00	<b>'</b>	10, 110, 007	1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			O	0	5. 01
5.02				O	0	5. 02
5.03				0	0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	5. 51
5. 52				O	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			O	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		74 :-		404.013	, 00
6. 01	SETTLEMENT TO PROVIDER		71, 45		124, 213	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)		24, 345, 76		16, 240, 900	7. 00
				Contractor	NPR Date	
			)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor			1.00	2.00	8. 00
5.00	name of contractor	ı		1	1	0.00

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

		Ti tl	e XVIII	Subprovi der - I PF	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 257, 961		407	1. 00
2.00	Interim payments payable on individual bills, either		C	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
3. 00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3. 00
3.00	amount based on subsequent revision of the interim rate					3.00
	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		C		0	3. 01
3.02			C		0	3. 02
3.03			C		0	3. 03
3.04			0		0	3. 04
3. 05	Provider to Program		C		0	3. 05
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51	ADJUSTIMENTS TO TROUVAIM		0			3. 51
3. 52			O		Ö	3. 52
3. 53			C		O	3. 53
3.54			C	)	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C	)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 257, 961		407	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	5. 02
5. 03	Dravidan to Dragnam		C		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		C	1	0	5. 50
5. 50	TENTATIVE TO FROGRAM		0			5. 51
5. 52			Ö		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C	)	o	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		4, 334		83	6. 01
6. 02	SETTLEMENT TO PROGRAM		1 242 205		0 490	6. 02 7. 00
7. 00	Total Medicare program liability (see instructions)		1, 262, 295	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	·				,	

 
 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150042
 Period: From 01/01/2014
 Worksheet E-1 Part I Date/Time Prepared: 6/3/2015 1:34 pm

 Component CCN: 15T042
 Supprovider - PPS
 Health Financial Systems GOO ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Inpatient Part A			Ti tl	e XVIII	Subprovider - IRF	PPS	
1.00   Total Interim payments paid to provider   1.00   2.00   3.00   4.00   1.136   1.00   2.00   Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "MONE" or enter a zero   3.00   3.0			Inpatien	t Part A		t B	
1.136   1.00   1.136   1.00   1.136   1.00   2.00   1.136   1.00   2.00   1.136   1.00   2.00   1.136   1.00   2			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interlin payments payable on Individual bills, either subtitited or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.				2.00		4. 00	
Submitted for to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero   3.00   Ust 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)   1.00   1				8, 836, 07	9	1, 136	
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	2.00				0	0	2. 00
write "NONE" or enter a zero  1. 00 List separately gach 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  3. 02 0 0 0 3. 02 3. 03 0 0 0 3. 03 3. 04 0 0 0 0 3. 03 3. 04 0 0 0 0 3. 03 3. 05  Provider to Program  3. 51 0 0 0 0 3. 55  Provider to Program  4. 00 0 0 0 3. 55  8. 52 0 0 0 0 3. 55  8. 53 0 0 0 0 3. 55  9. 54 0 0 0 0 0 3. 55  9. 55 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
List separately each retroactive Lump sum adjustment amount based on subsequent revision of the interin mate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)		1 91					
amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3 00						3 00
Bayment. If none, write "NONE" or enter a zero. (1)   Program to Provider	0.00						0.00
Program to Provider		for the cost reporting period. Also show date of each					
ADJUSTMENTS TO PROVIDER							
3.02   3.03   3.04   0   0   3.03   3.04   3.05						ı	
3.03   3.04   3.05   3.03   3.04   3.05   3.03   3.04   3.05		ADJUSTMENTS TO PROVIDER					
3.04   0   0   0   3.04   3.05   3.					~	1 -1	
3.05							
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3.50							
3. 50   ADJUSTMENTS TO PROGRAM   0   0   3. 50     3. 51   3. 52   0   0   0   3. 51     3. 52   3. 53   0   0   0   0     3. 53   3. 54   0   0   0   0     3. 53   3. 54   0   0   0     3. 50   3. 50   3. 50     3. 50   3. 50   3. 50     4. 00   Total interim payments (sum of lines 1, 2, and 3. 99)   8, 836, 079   1, 136     4. 00   Total interim payments (sum of lines 1, 2, and 3. 99)   8, 836, 079   1, 136     5. 00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)     70   TENTATIVE TO PROVIDER   0   0   5. 01     5. 01   TENTATIVE TO PROGRAM   0   0   5. 55     5. 50   5. 50   5. 50     6. 00   Determined net settlement amount (balance due) based on the cost report. (1)     6. 01   STILLMENT TO PROGRAM   0   0   5. 59     7. 02   TELLEMENT TO PROGRAM   0   0   0     8. 874, 639   1, 346   7, 00     7. 02   TOTAL INDER   0   0   0     8. 874, 639   1, 346   7, 00     8. 874, 639   1, 300   0     9. 00   0   0     9. 00   0   0     9. 00   0   0     9. 00   0     9	0.00	Provider to Program			<u> </u>	Ŭ.	0.00
3.52   Subtotal (sum of lines 3.01-3.49 minus sum of lines   Subtotal (sum of lines 3.01-3.49 minus sum of lines   Subtotal (sum of lines 3.01-3.49 minus sum of lines   Subtotal (sum of lines 3.01-3.49 minus sum of lines   Subtotal (sum of lines 3.01-3.49 minus sum of lines   Subtotal (sum of lines 3.01-3.49 minus sum of lines   Subtotal (sum of lines 1, 2, and 3.99)   Subtotal (sum of lines 5.01-5.49 minus sum of lines   Subtotal (sum of lines 5.01-5.49 minus sum of lines   Subtotal (sum of lines 5.01-5.49 minus sum of lines   Subtotal (sum of lines 5.01-5.49 minus sum of lines   Subtotal (sum of lines 5.01-5.49 minus sum of lines   Subtotal (sum of lines 5.01-5.49 minus sum of lines   Subtotal (sum of lines 5.01-5.49 minus sum of lines   Subtotal (sum of lines 5.01-5.49 minus sum of lines   Subtotal (sum of lines 5.01-5.49 minus sum of lines   Subtotal (sum of lines subtotal (sum of lines subtotal (sum of lines subtotal (sum of lines subtotal s	3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.53   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.54   3.55   3.59   3.50-3.98   3.50-3.99							
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   8,836,079   1,136   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50 minus							
3.50-3.98   Total interim payments (sum of lines 1, 2, and 3.99)   8,836,079   1,136   4.00		Subtatal (sum of lines 2.01.2.40 minus sum of lines			~	- 1	
A. 00   Total interim payments (sum of lines 1, 2, and 3.99)   8,836,079   1,136   4.00	3. 99			'	0	ا	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR	4.00			8, 836, 07	9	1. 136	4. 00
To BE COMPLETED BY CONTRACTOR				2, 222, 21		.,	
5.00   List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider		TO BE COMPLETED BY CONTRACTOR				1	
Write "NONE" or enter a zero. (1)   Program to Provider	5. 00						5. 00
Program to Provider							
TENTATI VE TO PROVI DER							
Description	5. 01				0	0	5. 01
Provider to Program	5.02				0	0	5. 02
TENTATI VE TO PROGRAM	5.03				0	0	5. 03
5.51   0				<u> </u>	_		
Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.52   0		TENTATIVE TO PROGRAM			~		
5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 38,560 210 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 0 6.02 7.00 Total Medicare program liability (see instructions) 8,874,639 1,346 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  8,874,639  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00		Subtotal (sum of lines 5.01-5.49 minus sum of lines			-		
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 38,560 210 6.01 6.02 SETTLEMENT TO PROGRAM 0 0 6.02 7.00 Total Medicare program liability (see instructions) 8,874,639 1,346 7.00  Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	0. 77					Ĭ	0. 77
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  8,874,639  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6.00						6.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr) 0 1.00 2.00							
7.00 Total Medicare program liability (see instructions)  8,874,639  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00							
Contractor NPR Date (Mo/Day/Yr)           0         1.00         2.00					~	1 - 1	
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Total Medicare program Hability (see Instructions)		8,8/4,63			7.00
0 1.00 2.00							
8.00 Name of Contractor 8.00			(	)			
	8. 00	Name of Contractor					8. 00

Heal th	Financial Systems GOOD SAMARITAN H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 150042	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II	pared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	6, 080	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-	12		15, 108	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			1, 113	3. 00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-	12		24, 418	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			451, 245, 669	5. 00
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20			12, 932, 406	6.00	
7. 00	CAH only - The reasonable cost incurred for the purchase of ce line 168 $$	rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			1, 021, 131	8. 00
9. 00				20, 423	9. 00
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)			1, 000, 708	10.00	
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1, 064, 991	30.00
	Other Adjustment (specify)			0	31.00
32 00	Balance due provider (Line 8 (or Line 10) minus line 30 and Li	ne 31) (see instruction	s)	-64 283	32 00

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

-64, 283 32. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150042		Worksheet E-3
		From 01/01/2014	
	Component CCN: 15SO42	To 12/31/2014	Date/Time Prepared:
			6/3/2015 1: 34 pm
	Title XVIII	Subprovi der -	PPS
		I PF	

	I PF			
		1.00		
	PART II - MEDICARE PART A SERVICES - IPF PPS	1.00		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1. 484	9, 591	1. 00
2.00	Net IPF PPS Outlier Payments	1, 10	0	2. 00
3.00	Net IPF PPS ECT Payments		0	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before Novembe	r	0.00	4. 00
	15, 2004. (see instructions)			
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42		0.00	4. 01
F 00	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		0 00	F 00
5.00	New Teaching program adjustment. (see instructions)		0.00	5. 00
6. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "net seeking program" (see instructions)	ew	0.00	6. 00
7. 00	teaching program" (see instuctions)  Current year's unweighted I&R FTE count for residents within the new program growth period of a "ne	OW	0.00	7. 00
7.00	teaching program" (see instuctions)	EW	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8. 00
9. 00	Average Daily Census (see instructions)	12 4	27397	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	l .	00000	
11. 00	Teaching Adjustment (line 1 multiplied by line 10).		0	11. 00
12. 00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 489	9, 591	12. 00
13.00		, , , , ,	0	13.00
14.00				14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)	1, 489	9, 591	16.00
17.00	Primary payer payments	:	2, 696	17.00
18.00	Subtotal (line 16 less line 17).	1, 486	6, 895	18.00
19.00	Deducti bl es	198	8, 080	19.00
20.00	Subtotal (line 18 minus line 19)	1, 288	8, 815	20.00
21. 00	Coi nsurance	ţ	5, 152	21. 00
	Subtotal (line 20 minus line 21)	1, 283	3, 663	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	(	6, 207	23. 00
	Adjusted reimbursable bad debts (see instructions)	4	4, 035	
25. 00		l .	5, 836	
	Subtotal (sum of lines 22 and 24)	1, 28	7, 698	
27. 00			0	27. 00
28. 00	Other pass through costs (see instructions)		358	28. 00
	Outlier payments reconciliation		0	29. 00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
	1		0	30. 50
30. 99	Recovery of Accelerated Depreciation	1 200	0	30. 99
31.00			8, 056	
31.01	Sequestration adjustment (see instructions)	l	5, 761	
32.00	Interim payments  Tentative settlement (for contractor use only)	1, 25	7, 961 0	32.00
34. 00	Tentative settlement (for contractor use only) Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		4, 334	
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,		4, 334 0	35. 00
33.00	§115. 2		۷	33.00
	TO BE COMPLETED BY CONTRACTOR			
50. 00			0	50.00
	Outlier reconciliation adjustment amount (see instructions)		0	51.00
	The rate used to calculate the Time Value of Money		0.00	
	Time Value of Money (see instructions)			53. 00
			- 1	

Health Financial Systems	GOOD SAMARITAN HO	SPI TAL			In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN:	150042	Peri c	od:	Worksheet E-3
					01/01/2014	
		Component CCN	N: 15T042	To	12/31/2014	Date/Time Prepared:
						6/3/2015 1:34 pm
		Title XV	/111	Subr	provi der -	PPS
					LDE	

		II LIE AVIII	I RF	PPS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			8, 832, 527	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0248	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		165, 168	3. 00	
4.00	Outlier Payments			295, 418	
5.00	Unweighted intern and resident FTE count in the most recent costo November 15, 2004 (see instructions)	t reporting period em	nding on or prior	0. 00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count	for residents that we	re displaced by	0. 00	5. 01
0.01	program or hospital closure, that would not be counted without			0.00	0.01
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	a temperary cap aay ac	cinorit direct 12		
6.00	New Teaching program adjustment. (see instructions)			0.00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the	e new program growth p	period of a "new	0.00	7.00
	teaching program" (see instructions)				
8.00	Current year's unweighted I&R FTE count for residents within the	e new program growth p	period of a "new	0.00	8.00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjustment	ent (see instructions)	)	0. 00	
10. 00	Average Daily Census (see instructions)			21. 076712	
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
12. 00	Teaching Adjustment (see instructions)			0	12. 00
13. 00	Total PPS Payment (see instructions)			9, 293, 113	
14. 00	Nursing and Allied Health Managed Care payments (see instruction	٦)		0	
15.00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
17. 00	Subtotal (see instructions)			9, 293, 113	
18.00	Primary payer payments			0 202 112	
19.00	Subtotal (line 17 less line 18).			9, 293, 113	
20.00	Deductibles			224, 576	
21. 00 22. 00	Subtotal (line 19 minus line 20)			9, 068, 537	
22. 00	Coinsurance Subtotal (line 21 minus line 22)			21, 280 9, 047, 257	
24. 00	Allowable bad debts (exclude bad debts for professional service:	s) (soo instructions)		10, 121	
25. 00	Adjusted reimbursable bad debts (see instructions)	s) (see Histiactions)		6, 579	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		9, 209	
27. 00	Subtotal (sum of lines 23 and 25)	2010113)		9, 053, 836	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	2 49)		7, 033, 030	28. 00
29. 00	Other pass through costs (see instructions)	3 17)		1, 918	
30.00	Outlier payments reconciliation			0	
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	31. 50
31. 99	Recovery of Accelerated Depreciation			0	
32. 00	Total amount payable to the provider (see instructions)			9, 055, 754	32. 00
32. 01	Sequestration adjustment (see instructions)			181, 115	
33.00	Interim payments			8, 836, 079	33.00
34.00	Tentative settlement (for contractor use only)			0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and	34		38, 560	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	36.00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR		1		
50. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			295, 418	
51.00	Outlier reconciliation adjustment amount (see instructions)			0	51.00
	The rate used to calculate the Time Value of Money			0.00	
os. 00	Time Value of Money (see instructions)		I	0	53. 00

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

			'		6/3/2015 1: 34	pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
	I	1.00	2.00	3. 00	4. 00	
4 00	CURRENT ASSETS	40 404 440				4 00
1.00	Cash on hand in banks	19, 121, 140	l .	0	0	
2.00	Temporary investments	55, 442, 933	i	-	1	
3.00	Notes recei vable	U 51 424 272	C	1	0	
4.00	Accounts receivable	51, 434, 372		0	0	1
5.00	Other receivable	5, 410, 099	l .		0	
6.00	Allowances for uncollectible notes and accounts receivable	-16, 650, 139	l .			1
7. 00 8. 00	Inventory Prepai d expenses	2, 188, 742	l .		0	
9. 00	Other current assets	6, 751, 989	l .			1
10. 00	Due from other funds	7, 464, 992		1	0	
11. 00	Total current assets (sum of lines 1-10)	131, 164, 128		-	1	1
11.00	FIXED ASSETS	131, 104, 120	1	, 0		11.00
12. 00	Land	8, 487, 647		0	0	12.00
13. 00	Land improvements	6, 102, 833			1	
14. 00	Accumulated depreciation	-4, 354, 395	1	_		
15. 00	Buildings	88, 343, 615	1		l ő	
16. 00	Accumulated depreciation	-52, 616, 661	ĺ	_	Ö	
17. 00	Leasehold improvements	02,010,001	1	_	o o	
18. 00	Accumulated depreciation	0	1	o o	o o	
19. 00	Fixed equipment	0	l č	0	Ö	
20. 00	Accumulated depreciation	0	d	0	Ō	
21. 00	Automobiles and trucks	l o	d	0	l o	
22. 00	Accumulated depreciation	l o	d	0	l o	
23. 00	Major movable equipment	150, 954, 732	d	0	Ō	
24. 00	Accumulated depreciation	-113, 613, 098	l .	0	0	
25. 00	Mi nor equipment depreciable	0		0	0	
26.00	Accumulated depreciation	0	l c	0	0	26.00
27.00	HIT designated Assets	92, 840, 682	d c	0	0	27. 00
28.00	Accumul ated depreciation	0	ol c	0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0	ol c	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	176, 145, 355	c	0	0	30.00
	OTHER ASSETS					1
31. 00	Investments	100, 000	C	0	0	31. 00
32.00	Deposits on Leases	0	C	0	0	32. 00
33.00	Due from owners/officers	0	C	0	0	33. 00
34.00	Other assets	2, 037, 849	· C	0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	2, 137, 849	r  C	0	0	
36.00	Total assets (sum of lines 11, 30, and 35)	309, 447, 332	C	0	0	36. 00
	CURRENT LIABILITIES					1
37. 00	Accounts payable	16, 928, 349	1	0		
38. 00	Salaries, wages, and fees payable	10, 392, 475		_		
39. 00	Payroll taxes payable	1, 015, 034	1	0	0	1
40. 00	Notes and Loans payable (short term)	1, 669, 644	1	0	0	
41. 00	Deferred income	72, 813	1	0	0	
42. 00	Accel erated payments	1, 551, 753				42. 00
43. 00	Due to other funds	0		0	0	1
44. 00	Other current liabilities	0	· ·	1	l ~	
45. 00	Total current liabilities (sum of lines 37 thru 44)	31, 630, 068	<u>C</u>	0	0	45. 00
47.00	LONG TERM LIABILITIES	-		-	-	4/ 00
46. 00	Mortgage payable	00 /75 75	C	1	0	
47. 00	Notes payable	82, 675, 754	1	-		1
48. 00	Unsecured Loans	0	C	-	1	1
49. 00	Other long term liabilities	00 (75 754	C	-	1	1
50.00	Total long term liabilities (sum of lines 46 thru 49	82, 675, 754	1			
51. 00	Total liabilites (sum of lines 45 and 50)	114, 305, 822	<u> </u> C	0	0	51.00
E2 00	CAPITAL ACCOUNTS  General fund balance	105 141 510	ı			F2 00
52. 00		195, 141, 510	l .			52.00
53. 00 54. 00	Specific purpose fund Donor created - endowment fund balance - restricted		C			53. 00 54. 00
55. 00	Donor created - endowment fund balance - restricted  Donor created - endowment fund balance - unrestricted					55.00
56. 00	Governing body created - endowment fund balance					56.00
57. 00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	
50.00	replacement, and expansion					30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	195, 141, 510		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	309, 447, 332	l .	n n	Ö	
	59)					
	•	1	•	i,	1	•

					To 12/31/2014	Date/Time Prep 6/3/2015 1:34	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period	1.00	185, 711, 804	3.00	4.00		1, 00
2. 00	Net income (loss) (from Wkst. G-3, line 29)		9, 429, 706			1	2.00
3. 00	Total (sum of line 1 and line 2)		195, 141, 510		(		3. 00
4. 00	Additions (credit adjustments) (specify)	o	, ,		0	0	4. 00
5.00	, , , , , , , , , , , , , , , , , , , ,	O			0	0	5. 00
6.00		O			0	0	6.00
7.00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		0		(		10.00
11. 00	Subtotal (line 3 plus line 10)		195, 141, 510		(		11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12. 00
13.00		0			0	0	13. 00
14.00		0			0	0	
15. 00		0			0	0	
16. 00		0			0	0	
17. 00		0			0	0	
18. 00	Total deductions (sum of lines 12-17)		0		(	)	18. 00
19. 00	Fund balance at end of period per balance		195, 141, 510		(	)	19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Erraeimerre rana					
		6. 00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8. 00 9. 00			U				8. 00 9. 00
10.00	Total additions (sum of line 4.0)		٩		0		10.00
11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0		11.00
12.00	Deductions (debit adjustments) (specify)	٥	0		U		12.00
13. 00	beductions (debit adjustments) (specify)		0				13.00
14. 00			0				14. 00
15. 00			0				15. 00
16. 00			0				16.00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	٩		0		18.00
19. 00	Fund balance at end of period per balance				0		19.00
17.00	sheet (line 11 minus line 18)						17.50
	1						
			'		l	!	

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

		T	12/31/2014	Date/Time Prep 6/3/2015 1:34	
	Cost Center Description	I npati ent	Outpati ent	Total	P
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	26, 527, 297		26, 527, 297	1. 00
2.00	SUBPROVI DER - I PF	5, 834, 009		5, 834, 009	2. 00
3.00	SUBPROVI DER - I RF	6, 925, 172		6, 925, 172	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	0		0	5. 00
6.00	Swing bed - NF SKILLED NURSING FACILITY	0		0	6. 00
7. 00 8. 00	NURSING FACILITY				7. 00 8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	39, 286, 478		39, 286, 478	
10.00	Intensive Care Type Inpatient Hospital Services	37, 200, 470		37, 200, 470	10.00
11. 00	INTENSIVE CARE UNIT	6, 368, 302		6, 368, 302	11. 00
12. 00	CORONARY CARE UNIT	0,000,002		0, 000, 002	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14. 00	SURGI CAL INTENSI VE CARE UNI T				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	6, 368, 302		6, 368, 302	16.00
	11-15)				
17.00	Total inpatient routine care services (sum of lines 10 and 16)	45, 654, 780		45, 654, 780	17.00
18. 00	Ancillary services	126, 902, 958	280, 272, 288	407, 175, 246	
19. 00	Outpati ent servi ces	0	0	0	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )	0.400	2 ((( 042	2 (74 524	25. 00
26. 00	HOSPI CE	8, 482	2, 666, 042	2, 674, 524	
27. 00 27. 01	PHYSICIAN OFFICE MH RESIDENTIAL	0	51, 919, 069 1, 057, 019	51, 919, 069 1, 057, 019	
27. 01	MOB	0	1, 457, 288	1, 457, 288	
27. 02	ASC		24, 838, 168	24, 838, 168	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	172, 566, 220	362, 209, 874	534, 776, 094	28. 00
20.00	G-3, line 1)	172, 300, 220	302, 207, 074	334, 770, 074	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		215, 498, 883		29.00
30.00	NURSI NG HOME EXPENSES	17, 653, 204			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34. 00		0			34.00
35. 00		0			35. 00
36. 00	Total additions (sum of lines 30-35)		17, 653, 204		36. 00
37. 00	MI SCELLANEOUS EXPENSES	16, 992			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40.00		0			40.00
41. 00	Total deductions (sum of Lines 27 41)		17 000		41. 00
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	r	16, 992 233, 135, 095		42. 00 43. 00
43.00	to Wkst. G-3, line 4)		∠აა, 1აט, 095		43.00
	ito most. 6 6, 11116 4)	ı			

Heal th	Financial Systems GOOD SAMARITAN H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
STATE	ENT OF REVENUES AND EXPENSES	Provider CCN: 150042	Peri od:	Worksheet G-3	
			From 01/01/2014 To 12/31/2014	Date/Time Pre 6/3/2015 1:34	
				1 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1. 00 534, 776, 094	1. 00
2.00	Less contractual allowances and discounts on patients' account			327, 285, 718	2. 00
3. 00	Net patient revenues (line 1 minus line 2)	3		207, 490, 376	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 4	3)		233, 135, 095	4. 00
5.00	Net income from service to patients (line 3 minus line 4)	3)		-25, 644, 719	5. 00
0.00	OTHER I NCOME			20, 011, 717	0.00
6.00	Contributions, donations, bequests, etc			3, 557, 527	6. 00
7.00	Income from investments			3, 001, 370	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			527, 911	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to other th	an patients		6, 890, 239	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18. 00	Revenue from sale of medical records and abstracts			0	18.00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23.00
24.00	NURSING HOME REVENUE			21, 097, 378	24.00
25. 00	Total other income (sum of lines 6-24)			35, 074, 425	25. 00
	Total (line 5 plus line 25)			9, 429, 706	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	
20 00	Total other expenses (sum of Line 27 and subscripts)			0	20 00

28. 00

9, 429, 706 29. 00

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

			nospi ce (	CIN. 131320 1	0 12/31/2014	6/3/2015 1: 34	
					Hospi ce I		
		Salaries (from	Empl oyee	Transportati or		Other	
			Benefits (from		Services (from		
		,	Wkst. K-2)		Wkst. K-3)		
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			(	)	0	1.00
2.00	Capital Related Costs-Movable Equip.					0	2. 00
3.00	Plant Operation and Maintenance	0	0		0	0	3. 00
4.00	Transportation - Staff	0	0		0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6.00	Administrative and General	695, 325	182, 225	75, 238	275, 634	192, 946	6, 00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	0	0		0	1, 519	7.00
8.00	Inpatient - Respite Care	0	0		0		8. 00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0	(	0	0	9. 00
10.00	Nursi ng Care	0	0		0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physical Therapy	0	0	(	0	0	12. 00
13.00	Occupational Therapy	0	0	(	0	0	13. 00
14.00	Speech/ Language Pathology	0	0	(	0	0	14. 00
15.00	Medical Social Services	0	0	(	0	0	15. 00
16.00	Spiritual Counseling	0	0	(	0	0	16.00
17.00	Di etary Counseling	0	0	(	0	0	17. 00
18.00	Counseling - Other	0	0	(	0	0	18. 00
19.00	Home Health Aide and Homemaker	0	0	(	0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	(	0	0	20. 00
21.00	Other	0	0	(	0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0	(	0	0	22. 00
23. 00	Anal gesi cs	0	0	(	0	0	23. 00
24.00	Sedatives / Hypnotics	0	0	(	0	0	24. 00
25.00	Other - Specify	0	0	(	0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0	(	0	0	26. 00
27. 00	Patient Transportation	0	0	(	0	0	27. 00
28. 00	I maging Services	0	0	(	0	0	28. 00
29. 00	Labs and Diagnostics	0	0	(	0	0	29. 00
30.00	Medical Supplies	0	0	(	0	0	30. 00
31. 00	Outpatient Services (including E/R Dept.)	0	0	(	-	0	31. 00
32.00	Radiation Therapy	0	0	(	0	0	32. 00
33.00	Chemotherapy	0	0	(	0	0	33. 00
34.00	Other	0	0	(	0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0	(	0	0	35. 00
36. 00	Volunteer Program Costs	0	0	(	0	0	36. 00
37. 00	Fundrai si ng	0	0	(	0	0	37. 00
38. 00	Other Program Costs	0	0	(	0	0	38. 00
39. 00	Total (sum of lines 1 thru 38)	695, 325	182, 225	75, 238	275, 634	194, 465	39.00

Health Financial Systems	GOOD SAMARITA	N HOSPITAL	In Lie	u of Form CMS-2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS		Provi der CCN: 150042	Peri od: From 01/01/2014	Worksheet K
		Hospi ce CCN: 151526	To 12/31/2014	Date/Time Prepared: 6/3/2015 1:34 pm
			Hospi ce I	
	Total (cols.	Reclassificati Subtotal (co	I. Adjustments	Total (col. 8

			·			6/3/2015 1: 34	pm
					Hospi ce I		
			Reclassi fi cati		. Adjustments	Total (col. 8	
		1-5)	on	6 ± col. 7)		± col. 9)	
		6. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	_			_		
1.00	Capital Related Costs-Bldg and Fixt.	0	0	)	0	1	
2.00	Capital Related Costs-Movable Equip.	0	0	)	0	1	
3.00	Plant Operation and Maintenance	0	0	1	0	0	3. 00
4.00	Transportation - Staff	0	0	1	0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6.00	Administrative and General	1, 421, 368	-162, 533	1, 258, 83	5 -748	1, 258, 087	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	1, 519	-19, 219	-17, 70	0 0	-17, 700	7. 00
8.00	Inpatient - Respite Care	0	0	)	0	0	8. 00
	VISITING SERVICES						1
9.00	Physi ci an Servi ces	0	C		0 0	0	9. 00
10.00	Nursi ng Care	0	0	)	0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0	1	0	0	11. 00
12.00	Physical Therapy	0	0	1	0	0	12. 00
13.00	Occupational Therapy	0	0	1	0 0	0	13. 00
14.00	Speech/ Language Pathology	0	0	1	0 0	0	14. 00
15.00	Medical Social Services	0		)	o o	0	15. 00
16.00	Spiritual Counseling	0		)	o o	0	16.00
17.00	Di etary Counseling	0	l o	)	0 0	0	17. 00
18.00	Counseling - Other	0	l o	)	0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	l o	)	0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	l o	)	0 0	0	20.00
21.00	Other	0	0	)	0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS				•		1
22.00	Drugs, Biological and Infusion Therapy	0	C		0 0	0	22. 00
23.00	Anal gesi cs	0	0	1	0 0	0	23. 00
24.00	Sedatives / Hypnotics	0	0	1	0 0	0	24. 00
25.00	Other - Specify	0		)	o o	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0		)	o o	0	26. 00
27.00	Patient Transportation	0	0	1	0 0	0	27. 00
28.00	I maging Services	0	0	1	0 0	0	28. 00
29.00	Labs and Diagnostics	0	0	1	0 0	0	29. 00
30.00	Medical Supplies	0	0	1	0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	)	0 0	0	31.00
32.00	Radi ati on Therapy	0		,	o o	0	32. 00
33. 00	Chemotherapy	0		,	0	o o	
34.00	Other	0		,	0	0	
	HOSPICE NONREIMBURSABLE SERVICE			•	-		1
35. 00	Bereavement Program Costs	0	С		0 0	0	35. 00
36. 00	Volunteer Program Costs	0	l d	,	o o		
37. 00	Fundrai si ng	0	l d	,	ol o	ő	
38. 00	Other Program Costs	0	l o	,	ol o	ő	
	Total (sum of lines 1 thru 38)	1, 422, 887	-181, 752	1, 241, 13	5 -748		
		, , , , , , , , , , , , , , , , , , , ,	, , , , ,	, , , , , , ,	, , ,	,	

			Hospi ce C	CN: 151526	10 12/31/2014	6/3/2015 1:34	
					Hospi ce I	0/3/2013 1.34	рш
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	o	0		0 0	0	3.00
4.00	Transportation - Staff	o	0		0 0	0	4. 00
5.00	Volunteer Service Coordination	0	0		0 0	0	5. 00
6.00	Administrative and General	695, 325	0		0 0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0 0	0	7. 00
8.00	Inpatient - Respite Care	0	0		0 0	0	8. 00
	VISITING SERVICES						
9.00	Physician Services	0	0		0 0	0	9. 00
10.00	Nursi ng Care	0	0		0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	
12.00	Physi cal Therapy	0	0		0	0	12. 00
13.00	Occupational Therapy	0	0		0	0	
14. 00	Speech/ Language Pathology	0	0		0	0	
15. 00	Medical Social Services	0	0		0	0	
16. 00	Spiritual Counseling	0	0		0	0	
17. 00	Dietary Counseling	0	0	1	0	0	
18. 00	Counseling - Other	0	0		0	0	
19. 00	Home Health Aide and Homemaker	0	0	1	0	1	
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0	-	
21. 00	Other	0	0		0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS			T			
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Pati ent Transportation	0	0		0	-	
28. 00	I maging Services	0	0		0	0	
29. 00	Labs and Diagnostics	0	0		0	0	
30.00	Medical Supplies	0	0		0	0	
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	
32.00	Radiation Therapy	0	0		0	_	
33.00	Chemotherapy	0	0		0		
34. 00	Other	0	0		0 0	0	34. 00
25 00	HOSPI CE NONREI MBURSABLE SERVI CE	0	0	1	0 0	0	25 00
35. 00 36. 00	Bereavement Program Costs		0		0 0		
36.00	Volunteer Program Costs Fundraising		0	1		1	
38.00	Other Program Costs		0	1		-	
	Total (sum of lines 1 thru 38)	695, 325	0				
37.00	Trotal (Sam of Triles I till a 50)	075, 325	0	1	0	, 0	J 37. 00

Health Financial Systems	GOOD SAMARITA	AN HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES			Provi der	CCN: 150042	Peri od: From 01/01/2014	Worksheet K-1	
			Hospi ce (	CCN: 151526	To 12/31/2014		
					Hospi ce I		
	Total Theranists		Ai des	All-Other	Total (1)		

Total   Therapists				1.00p. 00		10 12,01,2011	6/3/2015 1: 34 pm
Therapists   The						Hospi ce I	
Capital Related Costs-Blug and Fixt.   1.00   2.0			Total	Ai des	All-Other	Total (1)	
CEMERAL SERVICE COST CENTERS							
1.00			6.00	7. 00	8. 00	9. 00	
2.00							
Plant Operation and Maintenance	1.00	Capital Related Costs-Bldg and Fixt.					1.00
4.00   Transportation - Staff   0 0 0 0 0 0 5.00   5.00   6.00							
5.00   Volunteer Service Coordination   0   0   0   0   5.00				0			
Administrative and General				0	)	0	4. 00
INPATIENT CARE SERVICE   Inpatient - General Care   Inpatient - General Care   Inpatient - General Care   Inpatient - Respite Care   Inpatient - Inpati	5.00	Volunteer Service Coordination		0	)	0	5. 00
Type	6.00			0	)	0 695, 325	6. 00
Inpatient - Respite Care   0   0   0   8.00							
VISITING SERVICES	7.00	Inpatient - General Care			II.		
9.00   Physician Services   0   0   0   0   0   0   10.00   11	8.00	Inpatient - Respite Care		0	)	0 0	8. 00
10.00   Nursing Care							
11.00   Nursing Care-Continuous Home Care   0 0 0 0   11.00	9.00	Physi ci an Servi ces		0	)	0 0	9. 00
12.00   Physical Therapy   0   0   0   0   12.00   13.00   0   0   0   0   13.00   13.00   0   0   0   0   0   14.00   14.00   15.00				0	)	0	
13. 00   0   0   0   0   0   0   0   0   0	11. 00	Nursing Care-Continuous Home Care		0	)	0	11. 00
14. 00   Speech / Language Pathology   0   0   0   0   0   14. 00     15. 00   Medical Social Services   0   0   0   0   0     15. 00   Medical Social Services   0   0   0   0     15. 00   Medical Social Services   0   0   0   0     15. 00   Medical Social Services   0   0   0   0     15. 00   Dietary Counseling   0   0   0   0     17. 00   Dietary Counseling   0   0   0   0     18. 00   Counseling - Other   0   0   0   0     19. 00   Home Heal th Aide and Homemaker   0   0   0   0     19. 00   Hild Aide & Homemaker - Cont. Home Care   0   0   0   0     19. 00   Other   0   0   0   0     19. 00   Other Home Heal th Aide and Infusion Therapy   22. 00     22. 00   Other - Specify   22. 00     23. 00   Other - Specify   24. 00     24. 00   Sedatives / Hypnotics   24. 00     25. 00   Other - Specify   25. 00     26. 00   Durable Medical Equipment/Oxygen   26. 00     27. 00   Patient Transportation   0   0   0   27. 00     28. 00   Imaging Services   0   0   0   28. 00     29. 00   Labs and Diagnostics   0   0   0   32. 00     30. 00   Medical Supplies   0   0   0   32. 00     31. 00   Otherapy   0   0   0   32. 00     32. 00   Radiation Therapy   0   0   0   32. 00     33. 00   Other Program Costs   0   0   0   0     34. 00   Hore   Hospite MBURSABLE SERVICE   0   0   0   0     35. 00   Greavement Program Costs   0   0   0   0     36. 00   Other Program Costs   0   0   0   0     36. 00   Other Program Costs   0   0   0   0     36. 00   Other Program Costs   0   0   0   0     37. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     39. 00   Other Program Costs   0   0   0   0     30	12.00	Physi cal Therapy	0	0	)	0 0	12. 00
15.00   Medical Social Services   0   0   0   0   15.00     16.00   Spiritual Counseling   0   0   0   0   16.00     17.00   Dietary Counseling   0   0   0   0   0     18.00   Counseling - Other   0   0   0   0   18.00     19.00   Home Health Aide and Homemaker   0   0   0   0   19.00     19.00   HH Aide & Homemaker - Cont. Home Care   0   0   0   0   0     19.00   Other   0   0   0   0   0     19.00   Other   0   0   0   0   0     19.00   Other   0   0   0   0     19.00   Other   0   0   0   0     21.00   Other   Other   Other   Other   Other     22.00   Drugs, Biological and Infusion Therapy   22.00     23.00   Anal gesics   23.00     24.00   Sedatives / Hypnotics   24.00     25.00   Other - Specify   25.00     26.00   Durable Medical Equipment/Oxygen   26.00     27.00   Patient Transportation   0   0   0   0     28.00   Imaging Services   0   0   0   0     29.00   Labs and Diagnostics   0   0   0   0     31.00   Outpatient Services (including E/R Dept.)   0   0   0   0     32.00   Radiation Therapy   0   0   0   0     33.00   Other   Hospical Mursable Services   0   0   0     34.00   Other   Hospical Mursable Services   0   0   0     35.00   Bereavement Program Costs   0   0   0     36.00   Other Program Costs   0   0   0     37.00   Other Program Costs   0   0   0     38.00   Other Program Costs   0   0   0     38.	13.00		0	0	)	0 0	13. 00
16. 00   Spiritual Counseling   0   0   0   0   16. 00     17. 00   Dietary Counseling   0   0   0   0   0     18. 00   Counseling   0   0   0   0     18. 00   Counseling   0   0   0   0     18. 00   Ous   Ous   Ous   Ous   Ous   Ous     19. 00   Home Heal th Aide and Homemaker   0   0   0   0     20. 00   Hil Aide & Homemaker - Cont. Home Care   0   0   0   0     21. 00   Other   0   0   0   0     21. 00   Other   Out   Ous   Ous   Ous     22. 00   Other   Ous   Ous   Ous   Ous     23. 00   Anal gesics   Ous   Ous   Ous   Ous     24. 00   Sedatives / Hypnotics   Ous   Ous   Ous     25. 00   Other - Specify   Ous   Ous   Ous     26. 00   Durable Medical Equipment/Oxygen   Ous   Ous   Ous     28. 00   Imaging Services   Ous   Ous   Ous   Ous     29. 00   Labs and Diagnostics   Ous   Ous   Ous   Ous     30. 00   Medical Supplies   Ous   Ous   Ous   Ous     31. 00   Outpatient Services (including E/R Dept.)   Ous   Ous   Ous     32. 00   Radiation Therapy   Ous   Ous   Ous   Ous     33. 00   Other   Ous   Ous   Ous   Ous   Ous     34. 00   Other   Ous   Ous   Ous   Ous   Ous     35. 00   Bereavement Program Costs   Ous   Ous   Ous     36. 00   Output errogram Costs   Ous   Ous   Ous   Ous     37. 00   Other Program Costs   Ous   Ous   Ous   Ous   Ous     38. 00   Other Program Costs   Ous   Ous   Ous   Ous   Ous     38. 00   Other Program Costs   Ous   Ous   Ous   Ous   Ous   Ous     38. 00   Other Program Costs   Ous   Ous   Ous   Ous   Ous   Ous     38. 00   Other Program Costs   Ous   Ous   Ous   Ous   Ous     38. 00   Other Program Costs   Ous   Ous   Ous   Ous   Ous     38. 00   Other Program Costs   Ous   Ous   Ous   Ous   Ous     38. 00   Other Program Costs   Ous	14.00	Speech/ Language Pathology	0	0	)	0 0	14. 00
17. 00   Dile tarry Counsel ing   0   0   0   17. 00     18. 00   Counsel ing - Other   0   0   0   18. 00     19. 00   Home Heal th Aide and Homemaker   0   0   0   0     20. 00   HH Aide & Homemaker - Cont. Home Care   0   0   0   0     21. 00   Other   0   0   0   0     22. 00   Other   0   0   0   0     23. 00   Other   0   0   0     24. 00   Other   0   0   0     25. 00   Other - Specify   25. 00     26. 00   Durable Medical Equipment/Oxygen   26. 00     27. 00   Patient Transportation   0   0   0   27. 00     29. 00   Labs and Diagnostics   0   0   0   28. 00     29. 00   Labs and Diagnostics   0   0   0   0     31. 00   Outpatient Services (including E/R Dept.)   0   0   0   31. 00     32. 00   Radi ation Therapy   0   0   0   33. 00     34. 00   Other   Program Costs   0   0   0   0     35. 00   Other Program Costs   0   0   0   0     36. 00   Other Program Costs   0   0   0   0     37. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0   0     38. 00   Other Program Costs   0   0   0     39. 00   Other Program Costs   0   0	15. 00	Medical Social Services		0	)	0 0	15. 00
18. 00 Counseling - Other	16.00	Spiritual Counseling		0	)	0 0	16. 00
19.00	17. 00			0	)	0 0	17. 00
20.00   HH Ai de & Homemaker - Cont. Home Care   0   0   0   0   0   21.00     21.00   Other   0   0   0   0   0   0     21.00   Other   0   0   0   0   0     21.00   Other   0   0   0   0   0     21.00   Other   Other   Other   Other   Other   Other     22.00   Drugs, Biological and Infusion Therapy   22.00     23.00   Anal gesics   23.00     24.00   Sedatives / Hypnotics   24.00     25.00   Other - Specify   24.00     26.00   Other - Specify   25.00     26.00   Other - Transportation   0   0   0   27.00     28.00   Imaging Services   0   0   0   28.00     29.00   Labs and Diagnostics   0   0   0   28.00     29.00   Labs and Diagnostics   0   0   0   29.00     30.00   Medical Supplies   0   0   0   31.00     31.00   Outpatient Services (including E/R Dept.)   0   0   0   31.00     32.00   Radiation Therapy   0   0   0   0   33.00     33.00   Chemotherapy   0   0   0   0   33.00     34.00   Other   0   0   0   0   35.00     35.00   Bereavement Program Costs   0   0   0   37.00     36.00   Volunteer Program Costs   0   0   0   37.00     38.00   Other Program Costs   0   0   0   38.00     38.00   Other Program Costs   0   0   0   38.00     38.00   Other Program Costs   0   0   0   0     38.00   Other Program Costs   0   0   0     39.00   Other Program Costs   0	18.00	Counseling - Other		0	)	0 0	18. 00
21.00   Other   OTHER HOSPICE SERVICE COSTS   OTHER HOSPICE SERVICE   OTHER HOSPICE SERVICE COSTS   OTHER HOSPICE SERVICE   OTHER HOSPIC	19.00	Home Health Aide and Homemaker		0	)		19. 00
DTHER HOSPICE SERVICE COSTS   22.00   Drugs, Biological and Infusion Therapy   22.00   23.00   Anal gesics   23.00   25.00   25.00   26.00   25.00   26.00   27.00   26.00   27.00   26.00   27.00   28.00   27.00   28.00	20.00	HH Aide & Homemaker - Cont. Home Care		0	)		20. 00
22.00   Drugs, Biological and Infusion Therapy   22.00   23.00   24.00   Sedatives / Hypnotics   24.00   25.00   24.00   25.00   24.00   25.00   24.00   25.	21. 00			0	)	0 0	21. 00
23.00   Anal gesics   23.00							
24.00   Sedatives / Hypnotics   24.00   25.00   Other - Specify   25.00   Other - Specify   26.00   Other - Specify   Other - Other - Specify   Other - Othe							
25.00   Other - Specify   25.00     26.00       26.00	23.00						23. 00
26.00   Durable Medical Equipment/Oxygen   26.00   27.00   Patient Transportation   0   0   0   27.00   28.00   Imaging Services   0   0   0   0   28.00   28.00   29.00   Labs and Diagnostics   0   0   0   0   29.00   30.00   Medical Supplies   0   0   0   0   30.00   31.00   0   0   0   0   0   0   31.00   32.00   31.00   0   0   0   0   0   0   0   0   32.00   33.00   Chemotherapy   0   0   0   0   0   33.00   34.00   0   0   0   0   0   0   0   0   0	24.00						24. 00
27.00	25.00						25. 00
28. 00       Imaging Services       0       0       0       28. 00         29. 00       Labs and Diagnostics       0       0       0       0       29. 00         30. 00       Medical Supplies       0       0       0       0       30. 00         31. 00       Outpatient Services (including E/R Dept.)       0       0       0       0       31. 00         32. 00       Radiation Therapy       0       0       0       0       32. 00         33. 00       Chemotherapy       0       0       0       0       33. 00         34. 00       Other       0       0       0       0       34. 00         HOSPICE NONREIMBURSABLE SERVICE         35. 00       Bereavement Program Costs       0       0       0       35. 00         36. 00       Vol unteer Program Costs       0       0       0       36. 00         37. 00       Fundraising       0       0       0       37. 00         38. 00       Other Program Costs       0       0       0       38. 00	26.00	Durable Medical Equipment/Oxygen					26. 00
29. 00       Labs and Diagnostics       0       0       0       29. 00         30. 00       Medical Supplies       0       0       0       30. 00         31. 00       Outpatient Services (including E/R Dept.)       0       0       0       0       31. 00         32. 00       Radiation Therapy       0       0       0       0       32. 00         33. 00       Chemotherapy       0       0       0       0       33. 00         34. 00       Other       0       0       0       0       34. 00         HOSPICE NONREIMBURSABLE SERVICE         35. 00       Bereavement Program Costs       0       0       0       35. 00         36. 00       Vol unteer Program Costs       0       0       0       36. 00         37. 00       Fundraising       0       0       0       37. 00         38. 00       Other Program Costs       0       0       0       38. 00				0	)	0	
30.00   Medical Supplies   0 0 0 0   30.00     31.00   Outpatient Services (including E/R Dept.)   0 0 0 0   31.00     32.00   Radiation Therapy   0 0 0 0   0     33.00   Chemotherapy   0 0 0 0   0     34.00   Other   HOSPICE NONREIMBURSABLE SERVICE				0	)	0	
31.00   Outpatient Services (including E/R Dept.)   0   0   0   31.00	29. 00	Labs and Diagnostics		0		0 0	29. 00
32.00   Radiation Therapy   0   0   0   32.00     33.00   Chemotherapy   0   0   0   33.00     34.00   Other   0   0   0   0     HOSPICE NONREIMBURSABLE SERVICE	30.00			0		0	30.00
33.00 Chemotherapy 0 0 0 33.00 34.00 Other 0 0 0 0 34.00 Other 0 0 0 0 0 34.00 Other	31.00	Outpatient Services (including E/R Dept.)		0		0	31.00
34. 00     Other     0     0     0     34. 00       HOSPI CE NONREI MBURSABLE SERVI CE     35. 00     0     0     0     0     35. 00       36. 00     Vol unteer Program Costs     0     0     0     0     36. 00       37. 00     Fundrai si ng     0     0     0     37. 00       38. 00     Other Program Costs     0     0     0     38. 00	32.00	Radiation Therapy		0		0 0	32. 00
HOSPI CE NONREI MBURSABLE SERVI CE	33.00	Chemotherapy		0		0 0	33. 00
35.00     Bereavement Program Costs     0     0     0     35.00       36.00     Volunteer Program Costs     0     0     0     36.00       37.00     Fundraising     0     0     0     37.00       38.00     Other Program Costs     0     0     0     38.00	34.00	Other		0	)	0 0	34.00
36.00     Volunteer Program Costs     0     0     0     36.00       37.00     Fundraising     0     0     0     37.00       38.00     Other Program Costs     0     0     0     38.00							
37.00     Fundraising       38.00     Other Program Costs       0     0       0     0       0     0       0     0					I .		
38.00 Other Program Costs 0 0 0 38.00				0	)		
				0	)	0	37.00
39.00  Total (sum of lines 1 thru 38)   0  0  0  695,325    39.00					1		
	39. 00	Total (sum of lines 1 thru 38)	0	0	)	0 695, 325	39.00

Hea	Ith Financial Systems	GOOD SAMARITA	AN HO	SPI TAL		In Lie	u of Form CMS-	2552-10
HOS	SPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (	PAYROLL RELATED)		Provi der	CCN: 150042	Peri od:	Worksheet K-2	2
						From 01/01/2014		
				Hospi ce (	CCN: 151526	To 12/31/2014		
							6/3/2015 1: 34	pm
						Hospi ce I		
		Admi ni strator	Di	rector	Soci al	Supervi sors	Nurses	
					Servi ces			
		1.00		2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.0	OO Capital Related Costs-Bldg and Fixt.							1.00
		1			1	1		1

		Administrator	Director	Soci al Servi ces	Supervi sors	Nurses	
		1.00	2.00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3. 00
4.00	Transportation - Staff	0	0	0	0	0	4. 00
5.00	Volunteer Service Coordination	0	0	0	0	0	5. 00
6.00	Administrative and General	0	182, 225	0	0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0		0	
8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0	0	0	0	9. 00
10. 00	Nursi ng Care	0	0	0	0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0	0	0	0	11. 00
	Physi cal Therapy	0	0	0	0	0	
	Occupational Therapy	0	0	0	0	0	
	Speech/ Language Pathology	0	0	0	0	0	14. 00
15. 00	Medical Social Services	0	0	0	0	0	15. 00
	Spiritual Counseling	0	0	0	0	0	1
	Di etary Counseling	0	0	0	0	0	17. 00
18. 00	Counseling - Other	0	0	0	0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0	0	0	0	19. 00
	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	
21. 00	Other	0	0	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS	T					
	Drugs, Biological and Infusion Therapy						22. 00
	Anal gesi cs						23. 00
	Sedatives / Hypnotics						24. 00
	Other - Specify						25. 00
	Durable Medical Equipment/Oxygen						26. 00
27. 00	Pati ent Transportation	0	0	0	0	0	
	I maging Services	0	0	0	0	0	
	Labs and Diagnostics	0	0	0	0	0	29. 00
	Medical Supplies	0	0	0	0	0	
31. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	000
32. 00	Radiation Therapy	0	0	0	0	0	
33. 00	Chemotherapy	0	0	0		0	
34. 00	Other	0	0	0	0	0	34. 00
25 62	HOSPI CE NONREI MBURSABLE SERVI CE		ام	^			25.00
	Bereavement Program Costs	0	0	0		0	
	Volunteer Program Costs	0	0	0	0	0	
	Fundrai si ng	0	0	0	0	0	07.00
38. 00	Other Program Costs		100 005	0		0	00.00
39.00	Total (sum of lines 1 thru 38)	0	182, 225	0	0	0	39.00

Health Financial Systems	GOOD SAMARITA	N HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS EMPLOYEE	BENEFITS (PAYROLL RELATED)	Provi der CCN: 150042	Peri od:	Worksheet K-2

From 01/01/2014 To 12/31/2014 Hospi ce CCN: 151526 Date/Time Prepared: 6/3/2015 1:34 pm Hospi ce I All-Other Total Ai des Total (1) Therapi sts 7.00 8.00 9. 00 6.00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 Capital Related Costs-Movable Equip. 2.00 2.00 3.00 0 3 00 Plant Operation and Maintenance 0 4.00 Transportation - Staff 0 0 4.00 5.00 Volunteer Service Coordination 0 5.00 6.00 Administrative and General 0 0 182, 225 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 0 0 7.00 8.00 0 0 0 8.00 VISITING SERVICES 9.00 Physi ci an Servi ces 0 0 0 9.00 10.00 Nursing Care 0 0 0 10.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 0 0 11.00 11.00 12.00 Physical Therapy 0 12.00 0 0 13.00 Occupational Therapy 0 13.00 14.00 Speech/ Language Pathology 0 14.00 0 Medical Social Services 0 0 0 15.00 15.00 0 16.00 Spiritual Counseling 16.00 17.00 Dietary Counseling 17.00 0 0 18.00 Counseling - Other 18.00 0 Home Heal th Aide and Homemaker 0 19.00 19.00 20.00 HH Aide & Homemaker - Cont. Home Care 0 20.00 21.00 21.00 OTHER HOSPICE SERVICE COSTS 22.00 Drugs, Biological and Infusion Therapy 22.00 23.00 Anal gesi cs 23.00 Sedatives / Hypnotics 24.00 24.00 Other - Specify 25.00 25.00 Durable Medical Equipment/Oxygen 26.00 26.00 27.00 Patient Transportation 27.00 0 28. 00 Imaging Services 0 0 0 28.00 0 29 00 Labs and Diagnostics 0 29.00 0 30.00 Medical Supplies 30.00 0 31.00 Outpatient Services (including E/R Dept.) 0 31.00 Radiation Therapy 0 0 32.00 0 32.00 0 0 33.00 Chemotherapy 33.00 34.00 0ther 0 0 0 34.00 HOSPICE NONREIMBURSABLE SERVICE 35 00 0 0 0 35.00 Bereavement Program Costs

0 0 0

0

0

0

182, 225

36.00

37.00

38. 00 39. 00

0

0

0

36.00

37.00

38.00

Volunteer Program Costs

39.00 Total (sum of lines 1 thru 38)

Other Program Costs

Fundrai si ng

 
 Heal th
 Financial
 Systems
 GOOD
 SAMARITAN HO

 HOSPICE
 COMPENSATION
 ANALYSIS
 CONTRACTED
 SERVICES/PURCHASED
 SERVICES
 GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150042 Peri od: From 01/01/2014 To 12/31/2014 Worksheet K-3 Date/Time Prepared: 6/3/2015 1:34 pm Hospi ce CCN: 151526 Hospi ce I Administrator Director Soci al Supervi sors Nurses

				Servi ces	•		
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1. 00
2.00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance	0	0	0	0	0	3. 00
4.00	Transportation - Staff	0	0	0	0	0	4.00
5.00	Volunteer Service Coordination	0	0	0	0	0	5. 00
6.00	Administrative and General	275, 634	0	0	0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0	0	0	0	7. 00
8.00	Inpatient - Respite Care	0	0	0	0	0	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0	0	0	0	9. 00
10.00	Nursi ng Care	0	0	0	0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0	0	0	0	11. 00
12. 00	Physical Therapy	0	0	0	0	0	12. 00
13.00	Occupational Therapy	0	0	0	0	0	13.00
14. 00	Speech/ Language Pathology	0	0	0	0	0	14. 00
15. 00	Medical Social Services	0	0	0	0	0	15. 00
16. 00	Spiritual Counseling	0	O	0	0	0	16.00
17. 00	Di etary Counsel i ng	0	O	0	0	0	17. 00
18. 00	Counseling - Other	0	0	0	0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0	0	0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	20.00
21.00	Other	0	0	0	0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23.00	Anal gesi cs						23. 00
24.00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Patient Transportation	0	0	0	0	0	27. 00
28. 00	I maging Services	0	0	0	0	0	28. 00
29. 00	Labs and Diagnostics	0	0	0	0	0	29. 00
30.00	Medical Supplies	0	0	0	0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	31.00
32.00	Radiation Therapy	0	0	0	0	0	32.00
33.00	Chemotherapy	0	0	0	0	0	33. 00
34.00	Other	0	0	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	<u> </u>	<u>'</u>				
35.00	Bereavement Program Costs	0	0	0	0	0	35. 00
	Volunteer Program Costs	0	O	0	0	0	36.00
	Fundrai si ng	O	O	0	0	0	1
38. 00	Other Program Costs	O	O	0	0	0	38. 00
	Total (sum of lines 1 thru 38)	275, 634	O	0	0	0	1
			,		. '		•

Heal th	Financial Systems	GOOD SAMARITAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI C	E COMPENSATION ANALYSIS CONTRACTED SERVICES/F	URCHASED SERVICE	S Provi der	CCN: 150042	Peri od:	Worksheet K-3	
					From 01/01/2014		
			Hospi ce (	CCN: 151526	To 12/31/2014	Date/Time Pre	
					11! 1	6/3/2015 1: 34	pm
		T	A ' 1	1 411 011	Hospi ce I		
		Total	Ai des	All-Other	Total (1)		
		Therapi sts	7.00	0.00	0.00		
	DENERAL DERIVERS COOT DENTERS	6. 00	7. 00	8. 00	9. 00		
	GENERAL SERVICE COST CENTERS			ı			
1.00	Capital Related Costs-Bldg and Fixt.						1. 00
2. 00	Capital Related Costs-Movable Equip.						2. 00
3.00	Plant Operation and Maintenance		0		0 0		3. 00
4.00	Transportation - Staff		0		0 0		4. 00
5.00	Volunteer Service Coordination		0		0 0		5. 00
6.00	Administrative and General		0		0 275, 634		6. 00
	I NPATI ENT CARE SERVI CE						
7. 00	Inpatient - General Care		0		0		7. 00
8.00	Inpatient - Respite Care		0		0 0		8. 00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces		0		0 0		9. 00
10.00	Nursing Care		0		0 0		10.00
11. 00	Nursing Care-Continuous Home Care		0		0 0		11. 00
12. 00	Physical Therapy	o	0		0 0		12. 00
13. 00	Occupational Therapy	0	0		0		13. 00
14. 00	Speech/ Language Pathology	0	0		0		14. 00
15. 00	Medical Social Services		0		0 0		15. 00
16. 00	Spiritual Counseling		0		0 0		16. 00
17. 00	Di etary Counsel i ng		0		0 0		17. 00
18. 00	Counseling - Other		0		0 0		18. 00
19. 00	Home Health Aide and Homemaker		0		0 0		19. 00
20. 00	HH Ai de & Homemaker - Cont. Home Care		0		0 0		20. 00
21. 00	Other		0		0 0		21. 00
21.00	OTHER HOSPICE SERVICE COSTS				0		21.00
22. 00	Drugs, Biological and Infusion Therapy						22. 00
23. 00	Anal gesi cs						23. 00
24. 00	Sedatives / Hypnotics						24. 00
25. 00	Other - Specify						25. 00
26. 00	Durable Medical Equipment/Oxygen						26. 00
27. 00	Patient Transportation		0		0		27. 00
28. 00	I maging Services		0		0 0		28. 00
29. 00	Labs and Diagnostics		0		0 0		29. 00
30. 00	Medical Supplies		0		0 0		30.00
31. 00	Outpatient Services (including E/R Dept.)		0		0 0		31. 00
32. 00	Radi ati on Therapy		0				32. 00
33. 00			0				33. 00
	Chemotherapy		0				34. 00
34. 00	Other HOSPICE NONREIMBURSABLE SERVICE		0		U U		34.00
35. 00	Bereavement Program Costs		0		0 0		35. 00
			0	1			
36. 00 37. 00	Volunteer Program Costs		0		0 0		36. 00 37. 00
	Fundrai si ng		0	1			
38. 00	Other Program Costs		0		0 275 (24		38. 00
39.00	Total (sum of lines 1 thru 38)	0	0	I	0 275, 634		39. 00

						6/3/2015 1: 34	pm
					Hospi ce I		
			CAPITAL RE	LATED COST			
		NET EXPENSES	BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATION	
		FOR COST	FIXTURES	EQUI PMENT	OPERATION &		
		ALLOCATION	TTATORES	LQ011 WLW1	MAI NT.		
		0	1. 00	2.00	3. 00	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	3.00	4.00	
1 00		1 0				I	1 00
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2.00	Capi tal Related Costs-Movable Equip.	0	_		0		2. 00
3.00	Plant Operation and Maintenance	0	0		0		3. 00
4.00	Transportation - Staff	0	0		0		4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6.00	Administrative and General	1, 258, 087	0		0 0	0	6. 00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	-17, 700	0		0 0	0	7. 00
8.00	Inpatient - Respite Care	o	0		0 0	0	8. 00
	VI SI TI NG SERVI CES				- 1		
9.00	Physician Services	0	0		0 0	0	9. 00
10. 00	Nursing Care	0	0		0 0		10. 00
11. 00	Nursing Care-Continuous Home Care		0		0 0	0	11. 00
12. 00	Physical Therapy		0		0 0	0	12. 00
		0	0			-	
13. 00	Occupational Therapy	0	0		0	1	13. 00
14. 00	Speech/ Language Pathology	0	0		0	1	14. 00
15. 00	Medical Social Services	0	0		0	0	15. 00
16. 00	Spiritual Counseling	0	0		0	0	16. 00
17. 00	Di etary Counseling	0	0		0	0	17. 00
18. 00	Counseling - Other	0	0		0	0	18. 00
19.00	Home Health Aide and Homemaker	0	0		0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20. 00
21.00	Other	0	0		0 0	0	21. 00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	22. 00
23. 00	Anal gesi cs	0	0		0 0	0	23. 00
24. 00	Sedatives / Hypnotics		0		0 0	l o	24. 00
25. 00	Other - Specify		0		0 0	•	25. 00
26. 00	Durable Medical Equipment/Oxygen		0		0 0	0	26. 00
27. 00		0	0		0 0		27. 00
	Patient Transportation	0	0				
28. 00	I maging Services	0	0		-	1	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30. 00	Medi cal Supplies	0	0		0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	31. 00
32. 00	Radiation Therapy	0	0		0	-	32. 00
33.00	Chemotherapy	0	0		0	0	33. 00
34.00	Other	0	0		0 0	0	34. 00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	0		0 0	0	35. 00
36. 00	Volunteer Program Costs	0	0		0 0	0	36. 00
37. 00	Fundrai si ng	ا	n		o o	0	37. 00
38. 00	Other Program Costs	ا	0		0 0	l o	38. 00
	Total (sum of lines 1 thru 38)	1, 240, 387	0		0 0		
37.00	Trotal (Sam of Tries I till a So)	1, 270, 307	O	l	<u>σ</u>	, 0	1 37.00

| Provider CCN: 150042 | Period: From 01/01/2014 | Part |

Company   Comp				Hospi ce (	LCN: 151526   I	0 12/31/2014	6/3/2015 1:34 pm
Committee   Comm						Hospi ce I	0/3/2013 1: 34 piii
SERVICES   CCOLOR   SO   SO   SO   SO   SO   SO   SO			VOLUNTEER	SUBTOTAL	ADMI NI STRATI VE		
COMPONENTION   COMPONENTIAL SERVICE COST CENTERS   5.00   5A   6.00   7.00							
CENERAL SERVICE COST CENTERS			COORDI NATOR	(		, i	
1.00			5. 00	5A	6.00	7. 00	
2.00		GENERAL SERVICE COST CENTERS					
1.00	1.00	Capital Related Costs-Bldg and Fixt.					1.00
4, 00	2.00	Capital Related Costs-Movable Equip.					2. 00
5.00   Volunteer Service Coordination   0   1,258,087   1,258,087   6.00     NATIENT CARE SERVICE	3.00	Plant Operation and Maintenance					3.00
Administrative and General   0	4.00						4. 00
INPATIENT CARE SERVICE	5.00	Volunteer Service Coordination	C				5. 00
Total Properties   Total Prope	6.00	Administrative and General	C	1, 258, 087	1, 258, 087		6. 00
8.00   Inpatient - Respite Care   0   0   0   0   8.00     VISTING SERVICES							
VISITING SERVICES   Physician Services   O   O   O   O   O   O   O   O   O			1		1		
9. 00 Physician Services 00 Nursing Care 00 00 00 00 00 00 10.00 11.00 Nursing Care-Continuous Home Care 00 00 00 00 00 11.00 12.00 Physical Therapy 00 00 00 00 00 12.00 13.00 Occupational Therapy 00 00 00 00 00 13.00 14.00 Speech/ Language Pathology 00 00 00 00 00 14.00 15.00 Medical Social Services 00 00 00 00 00 14.00 16.00 Spiritual Counseling 00 00 00 00 00 16.00 17.00 Dietary Counseling 00 00 00 00 00 17.00 18.00 Counseling 00 00 00 00 17.00 18.00 Counseling 00 00 00 00 17.00 19.00 Home Health Aide and Homemaker 00 00 00 00 19.00 19.00 Hhi Aide & Homemaker - Cont. Home Care 00 00 00 00 00 19.00 20.00 Hhi Aide & Homemaker - Cont. Home Care 00 00 00 00 00 00 00 21.00 Other Occupational Infusion Therapy 22.00 Drugs, Biological and Infusion Therapy 00 00 00 00 00 00 00 00 23.00 Anal gesics 00 00 00 00 00 00 00 00 00 24.00 Sedatives / Hypnotics 00 00 00 00 00 00 00 25.00 Other - Specify 00 00 00 00 00 00 00 00 26.00 Durable Medical Equipment/Oxygen 00 00 00 00 00 00 00 00 27.00 Patient Transportation 00 00 00 00 00 00 00 28.00 Imaging Services 00 00 00 00 00 00 00 00 29.00 Labs and Dilagnostics 00 00 00 00 00 00 00 00 30.00 Medical Supplies 00 00 00 00 00 00 00 00 00 00 31.00 Outpatient Services 00 00 00 00 00 00 00 00 00 00 33.00 Outpatient Services 00 00 00 00 00 00 00 00 00 00 00 33.00 Outpatient Program Costs 00 00 00 00 00 00 00 00 00 00 00 00 00	8. 00		C	C	) 0	0	8. 00
10.00   Nursing Care   0							
11. 00   Nursing Care-Continuous Home Care   0   0   0   0   11. 00		1 3	1				
12.00   Physical Therapy   0   0   0   0   12.00     13.00   Occupational Therapy   0   0   0   0   0     13.00   Occupational Therapy   0   0   0   0     14.00   Speech/ Language Pathology   0   0   0   0     15.00   Medical Social Services   0   0   0   0   0     15.00   Medical Social Services   0   0   0   0     16.00   Spiritual Counseling   0   0   0   0   0     17.00   Dietary Counseling   0   0   0   0   0     18.00   Counseling - Other   0   0   0   0   0     19.00   Home Health Aide and Homemaker   0   0   0   0   0     19.00   Home Health Aide and Homemaker   0   0   0   0   0     20.00   HI Aide & Homemaker - Cont. Home Care   0   0   0   0   0     21.00   Other   0   0   0   0   0     21.00   Other   0   0   0   0     22.00   Other   Other   0   0   0   0     23.00   Analgesics   0   0   0   0     24.00   Sedatives / Hypnotics   0   0   0   0     25.00   Other - Specify   0   0   0   0     26.00   Oburable Medical Equipment/Oxygen   0   0   0   0     27.00   Patient Transportation   0   0   0   0     28.00   Labs and Diagnostics   0   0   0   0     29.00   Cabs and Diagnostics   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00   Outpatient Services (Including E/R Dept.)   0   0   0   0     20.00			1	_	ή	_	
13.00   Occupational Therapy   0   0   0   0   0   13.00     14.00   Speech Language Pathology   0   0   0   0   0     15.00   Medical Social Services   0   0   0   0   0     15.00   Medical Social Services   0   0   0   0   0     16.00   Spiritual Counseling   0   0   0   0   0     17.00   Dietary Counseling   0   0   0   0   0     18.00   Counseling - Other   0   0   0   0     19.00   Obme Health Alde and Homemaker   0   0   0   0     19.00   Hand Alde and Homemaker   0   0   0   0     19.00   Obme Health Alde and Homemaker   0   0   0   0     19.00   Other   Obtained Berlin			C	_	1	0	
14. 00   Speech / Language Pathology			C	_	ή	0	
15. 00   Medical Social Services   0   0   0   0   0   15. 00   16. 00   Spiritual Counseling   0   0   0   0   0   16. 00   17. 00   Dietary Counseling   0   0   0   0   0   17. 00   18. 00   Counseling - Other   0   0   0   0   0   18. 00   19. 00   Home Health Aide and Homemaker   0   0   0   0   0   19. 00   20. 00   HH Aide & Homemaker - Cont. Home Care   0   0   0   0   0   0   21. 00   Other   0   0   0   0   0   0   22. 00   Other   0   0   0   0   0   23. 00   Anal gesics   0   0   0   0   0   22. 00   24. 00   Sedatives / Hypnotics   0   0   0   0   23. 00   25. 00   Other - Specify   0   0   0   0   25. 00   26. 00   Durable Medical Equipment/Oxygen   0   0   0   0   27. 00   27. 00   Patient Transportation   0   0   0   0   28. 00   28. 00   Imaging Services   0   0   0   0   0   28. 00   29. 00   Labs and Diagnostics   0   0   0   0   0   29. 00   31. 00   Outpatient Services (including E/R Dept.)   0   0   0   0   0   31. 00   32. 00   Radiation Therapy   0   0   0   0   0   32. 00   33. 00   Other HOSPICE NONEI MBURSABLE SERVICE   0   0   0   0   0   0   35. 00   Bereavement Program Costs   0   0   0   0   0   0   36. 00   37. 00   Fundraising   0   0   0   0   0   0   37. 00   38. 00   Other Program Costs   0   0   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   0   38. 00   Other Program Costs   0   0   0   38. 00   Other Program Costs   0   0   0   38. 00   Other Program Costs   0   0   0   39. 00   Other Program Costs			1	_	1	١	
16.00   Spiritual Counseling		1 3 3	1	_	1		
17. 00   Dietary Counseling		1	C	_	1		
18. 00   Counseling - Other   0   0   0   0   0   18. 00   19. 00   Home Health Aide and Homemaker   0   0   0   0   0   0   19. 00   20. 00   21. 00   0   0   0   0   0   0   0   0   0			C	_	1		
19.00   Home Heal th Ai de and Homemaker   0   0   0   0   0   0   20.00		, ,		_	1	0	
20.00   HH Ai de & Homemaker - Cont. Home Care   0   0   0   0   0   0   0   0   0		, ,		_	1	0	
21.00   Other   Othe			1		1		
OTHER HOSPICE SERVICE COSTS   O			1		1		
22.00   Drugs, Biological and Infusion Therapy   0   0   0   0   22.00	21.00			1	)	l U	21.00
23.00	22.00						22.00
24. 00     Sedatives / Hypnotics     0     0     0     0     0     24. 00       25. 00     Other - Specify     0     0     0     0     0     25. 00       26. 00     Durable Medical Equipment/Oxygen     0     0     0     0     0     26. 00       27. 00     Patient Transportation     0     0     0     0     0     27. 00       28. 00     Imaging Services     0     0     0     0     0     28. 00       29. 00     Labs and Diagnostics     0     0     0     0     0     29. 00       30. 00     Medical Supplies     0     0     0     0     0     29. 00       31. 00     Outpatient Services (including E/R Dept.)     0     0     0     0     30. 00       31. 00     Radiation Therapy     0     0     0     0     32. 00       33. 00     Chemotherapy     0     0     0     0     33. 00       34. 00     Other     0     0     0     0     34. 00       HOSPICE NONREIMBURSABLE SERVICE       35. 00     0     0     0     0     0     36. 00       36. 00     0     0     0     0     0     36.							
25.00   Other - Specify   0   0   0   0   0   25.00				_	1		
26. 00       Durable Medical Equipment/Oxygen       0       0       0       0       26. 00         27. 00       Patient Transportation       0       0       0       0       0       27. 00         28. 00       Imaging Services       0       0       0       0       0       28. 00         29. 00       Labs and Diagnostics       0       0       0       0       0       29. 00         30. 00       Medical Supplies       0       0       0       0       0       29. 00         31. 00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       31. 00         32. 00       Radiation Therapy       0       0       0       0       0       32. 00         33. 00       Chemotherapy       0       0       0       0       0       33. 00         34. 00       Other       0       0       0       0       0       34. 00         HOSPICE NONREIMBURSABLE SERVICE       0       0       0       0       0       35. 00         35. 00       Fundraising       0       0       0       0       0       36. 00         37. 00       Fundr		7.		1	Ί ,	0	
27.00						0	
28. 00       Imaging Services       0       0       0       0       0       28. 00         29. 00       Labs and Diagnostics       0       0       0       0       0       29. 00         30. 00       Medical Supplies       0       0       0       0       0       30. 00         31. 00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       31. 00         32. 00       Radiation Therapy       0       0       0       0       0       32. 00         33. 00       Chemotherapy       0       0       0       0       0       33. 00         34. 00       Other       0       0       0       0       0       34. 00         HOSPICE NONREIMBURSABLE SERVICE       8       0       0       0       0       35. 00         36. 00       Vol unteer Program Costs       0       0       0       0       36. 00         37. 00       Fundraising       0       0       0       0       0       37. 00         38. 00       Other Program Costs       0       0       0       0       0       38. 00						0	
29.00       Labs and Diagnostics       0       0       0       0       29.00         30.00       Medical Supplies       0       0       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       31.00         32.00       Radiation Therapy       0       0       0       0       0       32.00         33.00       Chemotherapy       0       0       0       0       0       33.00         34.00       Other       0       0       0       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE         35.00       Bereavement Program Costs       0       0       0       0       35.00         36.00       Vol unteer Program Costs       0       0       0       0       36.00         37.00       Fundraising       0       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       0       38.00				_	1	0	
30.00   Medical Supplies   0   0   0   0   30.00   31.00   Outpatient Services (including E/R Dept.)   0   0   0   0   31.00   32.00   Radiation Therapy   0   0   0   0   32.00   33.00   Chemotherapy   0   0   0   0   0   33.00   34.00   Other			_	1	0		
31.00   Outpatient Services (including E/R Dept.)   0   0   0   0   0   31.00     32.00   Radiation Therapy   0   0   0   0   0     33.00   Chemotherapy   0   0   0   0   0     34.00   Other   Other   Other   Other   Other   Other   Other   Other     35.00   Bereavement Program Costs   0   0   0   0     36.00   Volunteer Program Costs   0   0   0   0     37.00   Fundraising   0   0   0   0     38.00   Other Program Costs   0   0   0   0     38.00   Other Program Costs   0   0   0     39.00   Other Program Costs   0   0   0     30.00   Other Program Costs   0   0   0     31.00   0   0   0     32.00   0   0   0     33.00   0   0   0     34.00   0   0   0     35.00   0   0   0     36.00   0   0   0     37.00   0   0   0     38.00   0   0   0     38.00   0   0   0     38.00   0   0   0     39.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0   0     30.00   0     30.00   0   0     30.00   0     3						0	
32.00   Radiation Therapy   0   0   0   0   32.00		1					
33.00 Chemotherapy 0 0 0 0 0 33.00 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,	1	_	ή	0	
34. 00     Other     O     O     O     O     34. 00       HOSPI CE NONREI MBURSABLE SERVI CE     35. 00     O     O     O     O     O     35. 00       36. 00     Vol unteer Program Costs     O     O     O     O     O     O     36. 00       37. 00     Fundrai si ng     O     O     O     O     O     O     37. 00       38. 00     Other Program Costs     O     O     O     O     O     38. 00			1	_	1	0	
HOSPICE NONREIMBURSABLE SERVICE		, , ,	-			_	
35.00     Bereavement Program Costs     0     0     0     0     35.00       36.00     Volunteer Program Costs     0     0     0     0     36.00       37.00     Fundraising     0     0     0     0     0     37.00       38.00     Other Program Costs     0     0     0     0     38.00				· · · · · · · · · · · · · · · · · · ·	-	-1	
36.00     Volunteer Program Costs     0     0     0     0     36.00       37.00     Fundraising     0     0     0     0     37.00       38.00     Other Program Costs     0     0     0     0     38.00	35. 00		C	C	0	0	35. 00
37.00       Fundraising       0       0       0       0       37.00         38.00       Other Program Costs       0       0       0       0       0       38.00			1	1	ol o	o	
38.00 Other Program Costs 0 0 0 0 38.00				C	ol o	o	
	38. 00	Other Program Costs	0	C	0	o	38. 00
	39. 00	Total (sum of lines 1 thru 38)	C	1, 240, 387	'	1, 240, 387	39. 00

			·			6/3/2015 1: 34	pm
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
		·		FT.)		(HOURS)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1. 00
2.00	Capital Related Costs-Movable Equip.	0	0				2. 00
3.00	Plant Operation and Maintenance	0	0		)		3. 00
4.00	Transportation - Staff	0	0		0		4. 00
5.00	Volunteer Service Coordination	0	0		0	0	5. 00
6.00	Administrative and General	0	0		0	0	6. 00
	I NPATI ENT CARE SERVI CE		_				
7.00	Inpatient - General Care	0	0		0	0	7. 00
8. 00	Inpatient - Respite Care	0			o o	0	8. 00
0.00	VI SI TI NG SERVI CES			<u> </u>	5	0	0.00
9. 00	Physi ci an Servi ces	0	0		0 0	0	9. 00
10. 00	Nursing Care	0	0			0	10.00
11. 00	Nursing Care-Continuous Home Care	0	0			0	11.00
12.00		0				0	12.00
	Physical Therapy	0				0	
13.00	Occupational Therapy	0	1				13.00
14.00	Speech/ Language Pathol ogy	0	0	1	0	0	14. 00
15. 00	Medical Social Services	0	0		0	0	15. 00
16. 00	Spiritual Counseling	0	0		0	0	16. 00
17. 00	Di etary Counsel i ng	0	0		0	0	17. 00
18. 00	Counseling - Other	0	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0	•	0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	20. 00
21. 00	Other	0	0		0	0	21. 00
	OTHER HOSPICE SERVICE COSTS	1			1		
22. 00	Drugs, Biological and Infusion Therapy	0	ľ	•	0	0	22. 00
23. 00	Anal gesi cs	0	0		0	0	23. 00
24. 00	Sedatives / Hypnotics	0	0		0	0	24. 00
25.00	Other - Specify	0	0		0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0		0	0	26. 00
27.00	Patient Transportation	0	0		0	0	27. 00
28.00	I maging Services	0	0		0	0	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30.00	Medical Supplies	0	l o		0	0	30.00
31. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	31.00
32. 00	Radi ati on Therapy	0	0		0	0	32. 00
33. 00	Chemotherapy	0	0		0	0	33. 00
34. 00	Other	0	0		0	0	34. 00
5 1. 00	HOSPI CE NONREI MBURSABLE SERVI CE			·	<u>-</u>	0	3 1. 00
35. 00	Bereavement Program Costs	0	0		0	0	35. 00
36. 00	Volunteer Program Costs		0	•		0	36.00
37. 00	Fundrai si ng					0	37.00
38. 00	Other Program Costs			1		0	38.00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)			]		0	39.00
	1	0. 000000	0 000000	0 00000	0 000000	_	
40.00	Unit Cost Multiplier	0.000000	0. 000000	0. 00000	0. 000000	0. 000000	40.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS GOOD SAMARITAN HOSPITAL

					Hospi ce I	0/3/2013 1.34	. р
Seneral Service COST CENTERS			RECONCLLIATION	ADMI NI STRATI VE	1.0001.001		
CEMERAL SERVICE COST CENTERS							
CENERAL SERVICE COST CENTERS							
CEMERAL SERVICE COST CENTERS			6A				İ
1.00		GENERAL SERVICE COST CENTERS					
2.00   Capit fall Related Costs-Movable Equip.   0   3.00	1.00		0				1.00
1.00	2.00	1 '	0				2.00
4.00			0				
5.00   Anin instrative and General   -1, 258, 887   -17, 700   6.00     INPATIENT CARE SERVICE     Inpati ent - General Care   0   -17, 700   8.00     INPATIENT CARE SERVICE     Inpati ent - General Care   0   0   0   8.00     INSTITUS SERVICES     Inpati ent - Respite Care   0   0   0   8.00     INSTITUS SERVICES			0				
Administrative and General		· ·	, and the second				
INPATIENT CARE SERVICE		1	-1 258 087	-17 700			
Type   Type	0.00		1,200,007	17,700			1 0.00
Section   Inpartient - Respite Care   O   O   O   O	7 00		0	-17 700			7 00
VISITING SERVICES		1 .	-				
9.00   Physician Services	0.00			9			1 0.00
10.00   Nursing Care	9.00		0	0			9.00
11.00   Nursing Care-Continuous Home Care   0   0   0   12.00   Physical Therapy   0   0   0   0   12.00   0   12.00   0   12.00   0   13.00   0   0   14.00   0   14.00   0   0   0   14.00   0   14.00   0   0   0   14.00   0   14.00   0   0   14.00   0   0   15.00   Medical Social Services   0   0   0   0   0   16.00   0   16.00   0   0   16.00   0   0   16.00   0   0   16.00   0   0   17.00   0   0   0   0   17.00   0   0   0   17.00   0   0   0   0   0   0   17.00   0   0   0   0   0   0   0   0   0			0				
12.00   Physical Therapy   0   0   0   12.00   13.00   13.00   14.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   15.00   16.00   15.00   16.00   15.00   16.00			0	-			
13.00			0	-			
14.00   Speech/ Language Pathology   0   0   0   0   15.00   Medical Social Services   0   0   0   0   15.00   Medical Social Services   0   0   0   0   15.00   15.00   Medical Social Services   0   0   0   0   15.00   1			0	-			
15.00   Medical Social Services			0	-			•
16. 00   Spiritual Counseling   0   0   0   0   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00   17. 00   18. 00   0   0   0   17. 00   18. 00   18. 00   18. 00   18. 00   18. 00   18. 00   19. 00   18. 00   19.			0				
17. 00   Di etary Counsel ing   0   0   0   0   17. 00     18. 00   Counsel ing - Other   0   0   0   0     19. 00   Home Heal th Aide and Homemaker   0   0   0     20. 00   HH Aide & Homemaker - Cont. Home Care   0   0   0     21. 00   Other   0   0   0     22. 00   Other   0   0   0     23. 00   Anal gesi cs   0   0   0     24. 00   Sedatives / Hypnotics   0   0   0     25. 00   Other - Speci fy   0   0   0     26. 00   Durable Medical Equipment/Oxygen   0   0   0     27. 00   Patient Transportation   0   0   0     28. 00   Imaging Services   0   0   0     29. 00   Labs and Di agnostics   0   0   0     20. 00   Outpatient Services (including E/R Dept.)   0   0   0     31. 00   Outpatient Services (including E/R Dept.)   0   0     32. 00   Radiation Therapy   0   0   0     33. 00   Other - Program Costs   0   0   0     34. 00   Fundraising   0   0   0     35. 00   Sereavement Program Costs   0   0   0     36. 00   Other Program Costs   0   0   0     37. 00   Fundraising   0   0   0     38. 00   Other Program Costs   0   0   0     39. 00   Cost to be Allocated (per Wkst. K-4, Part I)   1,258,087   39.00			0	-			
18.00   Counseling - Other   0   0   0   0   18.00   19.00			0				•
19. 00   Home Heal th Ai de and Homemaker   0   0   0   0   20. 00     20. 00   HH Ai de & Homemaker - Cont. Home Care   0   0   0   21. 00     21. 00   Other   0   0   0     21. 00   Other   0   0   0     21. 00   Other		0	o				
20.00   HH Ai de & Homemaker - Cont. Home Care   0   0   0   0   0   21.00			0	o			
21.00   Other			0	o			
OTHER HOSPICE SERVICE COSTS			0				
23. 00		OTHER HOSPICE SERVICE COSTS					
23. 00	22. 00	Drugs, Biological and Infusion Therapy	0	0			22. 00
24.00       Sedatives / Hypnotics       0       0       24.00         25.00       Other - Specify       0       0       25.00         26.00       Durable Medical Equipment/Oxygen       0       0       26.00         27.00       Patient Transportation       0       0       27.00         28.00       Imaging Services       0       0       28.00         29.00       Labs and Diagnostics       0       0       29.00         30.00       Medical Supplies       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       31.00         32.00       Radiation Therapy       0       0       32.00         33.00       Chemotherapy       0       0       33.00         34.00       Other       0       0       33.00         35.00       Bereavement Program Costs       0       0       35.00         36.00       Vol unteer Program Costs       0       0       37.00         37.00       Fundraising       0       0       37.00         38.00       Other Program Costs       0       0       38.00         39.00       Cost to be Allocated (per Wkst. K			0	o			23. 00
26.00     Durable Medical Equipment/Oxygen     0     0       27.00     Patient Transportation     0     0       28.00     Imaging Services     0     0       29.00     Labs and Diagnostics     0     0       30.00     Medical Supplies     0     0       31.00     Outpatient Services (including E/R Dept.)     0     0       32.00     Radiation Therapy     0     0       33.00     Chemotherapy     0     0       34.00     Other     0     0       HOSPICE NONREIMBURSABLE SERVICE       35.00     Bereavement Program Costs     0     0       36.00     Volunteer Program Costs     0     0       37.00     Fundraising     0     0       38.00     Other Program Costs     0     0       39.00     Cost to be Allocated (per Wkst. K-4, Part I)     1, 258, 087     39.00	24.00	Sedatives / Hypnotics	0	o			24. 00
26.00     Durable Medical Equipment/Oxygen     0     0       27.00     Patient Transportation     0     0       28.00     Imaging Services     0     0       29.00     Labs and Diagnostics     0     0       30.00     Medical Supplies     0     0       31.00     Outpatient Services (including E/R Dept.)     0     0       32.00     Radiation Therapy     0     0       33.00     Chemotherapy     0     0       34.00     Other     0     0       HOSPICE NONREIMBURSABLE SERVICE       35.00     Bereavement Program Costs     0     0       36.00     Volunteer Program Costs     0     0       37.00     Fundraising     0     0       38.00     Other Program Costs     0     0       39.00     Cost to be Allocated (per Wkst. K-4, Part I)     1, 258, 087     39.00	25. 00	7.	0	ol			25. 00
27.00	26.00		0	ol			26. 00
29.00       Labs and Diagnostics       0       0       29.00         30.00       Medical Supplies       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       31.00         32.00       Radiation Therapy       0       0       32.00         33.00       Chemotherapy       0       0       33.00         34.00       Other       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE       8       0       0       35.00         35.00       Volunteer Program Costs       0       0       36.00         37.00       Fundraising       0       0       0       37.00         38.00       Other Program Costs       0       0       0       38.00         39.00       Cost to be Allocated (per Wkst. K-4, Part I)       1,258,087       39.00	27.00		0	ol			27. 00
29.00       Labs and Diagnostics       0       0       29.00         30.00       Medical Supplies       0       0       30.00         31.00       Outpatient Services (including E/R Dept.)       0       0       31.00         32.00       Radiation Therapy       0       0       32.00         33.00       Chemotherapy       0       0       33.00         34.00       Other       0       0       34.00         HOSPICE NONREIMBURSABLE SERVICE       8       0       0       35.00         35.00       Volunteer Program Costs       0       0       36.00         37.00       Fundraising       0       0       0       37.00         38.00       Other Program Costs       0       0       0       38.00         39.00       Cost to be Allocated (per Wkst. K-4, Part I)       1,258,087       39.00	28. 00	I maging Services	0	ol			28. 00
30.00 Medical Supplies 0 0 0 0 31.00 31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29. 00		0	ol			29. 00
31.00 Outpatient Services (including E/R Dept.) 0 0 0 31.00 32.00 Radiation Therapy 0 0 0 32.00 33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 34.00  HOSPICE NONREIMBURSABLE SERVICE  35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 0 37.00 38.00 Other Program Costs 0 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 1,258,087	30.00		0	ol			30.00
32.00 Radiation Therapy 0 0 0 33.00 Chemotherapy 0 0 0 0 33.00 Other 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00		0	ol			31.00
33.00 Chemotherapy 0 0 0 0 33.00 34.00 Other 0 0 0 0 34.00  HOSPICE NONREIMBURSABLE SERVICE  35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 1,258,087			0	o			32. 00
34.00 Other			0	o			33.00
HOSPICE NONREIMBURSABLE SERVICE		1	o				
35.00 Bereavement Program Costs 0 0 0 35.00 36.00 Volunteer Program Costs 0 0 0 36.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 1,258,087							
36.00 Volunteer Program Costs 0 0 0 37.00 37.00 Fundraising 0 0 0 37.00 38.00 Other Program Costs 0 0 0 38.00 Cost to be Allocated (per Wkst. K-4, Part I) 1,258,087 39.00	35.00		0	0			35. 00
37.00     Fundraising     0     0       38.00     Other Program Costs     0     0       39.00     Cost to be Allocated (per Wkst. K-4, Part I)     1,258,087     39.00			0				36.00
38.00 Other Program Costs 0 0 39.00 Cost to be Allocated (per Wkst. K-4, Part I) 1,258,087 38.00	37.00	Fundrai si ng	0	ol			37. 00
39.00 Cost to be Allocated (per Wkst. K-4, Part I) 1,258,087 39.00			o	ol			
	39. 00			1, 258, 087			39. 00
	40.00						40.00

Provi der CCN: 150042 Hospi ce CCN: 151526

Peri od: Worksheet K-5
From 01/01/2014
To 12/31/2014 Date/Time Prepared: 6/3/2015 1:34 pm

Hospi ce I

					Hospi ce I		
				CAPITAL REI	LATED COSTS		
	Cost Center Description	Hospi ce Tri al	BLDG & FIXT	NEW CRC - CT	NEW CRC- CT	NEW CRC-	
	555 Conton 2555 (pt. 6)	Bal ance (1)	5250 a	EAST	WEST	MEMORI AL	
		0	1.00	1. 01	1. 02	1. 03	
1.00	Administrative and General		0	0	0	0	1. 00
2.00	Inpatient - General Care	1, 240, 387	0	0	o	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	o	0	3. 00
4.00	Physi ci an Servi ces	O	0	0	o	0	4. 00
5.00	Nursi ng Care	O	0	0	o	0	5. 00
6.00	Nursing Care-Continuous Home Care	O	0	0	o	0	6. 00
7.00	Physical Therapy	O	0	0	o	0	7. 00
8.00	Occupational Therapy	o	0	0	o	0	8. 00
9.00	Speech/ Language Pathology	o	0	0	o	0	9. 00
10.00	Medical Social Services	O	0	0	o	0	10. 00
11. 00	Spiritual Counseling	o	0	0	o	0	11. 00
12.00	Di etary Counseling	o	0	0	o	0	12. 00
13.00		o	0	0	o	0	13. 00
14.00	Home Health Aide and Homemaker	o	0	0	o	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	o	0	15. 00
16.00	Other	0	0	0	o	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22.00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24. 00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	0ther	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30. 00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32. 00
33.00		0	0	0	0	0	33. 00
34.00		1, 240, 387	0	0	0	0	
35.00	Unit Cost Multiplier (see instructions)						35. 00

Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS | Provider CCN: 150042 | Period: From 01/01/2014 | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | | Part | P

						0/3/2013 1.34	РШ
		_			Hospi ce I		
			CAP	ITAL RELATED	COSTS		
	Cost Center Description	NEW CRC -	NEW CRD -	NEW CRC -	NEW CRC -	MVBLE EQUIP	
		OUTPATI ENT	HEALTH	STORAGE	DI AGNOSTI C		
			PAVI LI ON		CENTER		
		1. 04	1. 05	1. 06	1. 07	2. 00	
1.00	Administrative and General	9, 172	0		0	0	
2.00	Inpatient - General Care	0	0		0	0	
3.00	Inpatient - Respite Care	0	0		0	0	
4. 00	Physi ci an Servi ces	0	0		0	0	
5.00	Nursing Care	0	0		0	0	
6.00	Nursing Care-Continuous Home Care	0	0		0	0	
7.00	Physi cal Therapy	0	0		0	0	
8.00	Occupational Therapy	0	0		0	0	
9.00	Speech/ Language Pathology	0	0		0	0	
10. 00	Medical Social Services	0	0		0	0	
11. 00	Spiritual Counseling	0	0		0	0	
12. 00	Dietary Counseling	0	0		0	0	
13. 00	Counseling - Other	0	0		0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0		0	0	
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0 0	15. 00
16.00	Other	0	0		0	0 0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0 0	17. 00
18. 00	Anal gesi cs	0	0		0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0		0	0 0	19. 00
20.00	Other - Specify	0	0		0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
22. 00	Patient Transportation	0	0		0	0 0	22. 00
23. 00	I maging Services	0	0		0	0 0	23. 00
24.00	Labs and Diagnostics	0	0		0	0 0	
25. 00	Medi cal Supplies	0	0		0	0 0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	0 0	
27. 00	Radi ati on Therapy	0	0		0	0 0	27. 00
28. 00	Chemotherapy	0	0		0	0	28. 00
29. 00	Other	0	0		0	0	29. 00
30.00	Bereavement Program Costs	0	0		0	0	30. 00
31. 00	Volunteer Program Costs	0	0		0	0	31. 00
32.00	Fundrai si ng	0	0		0	0	32. 00
33.00	Other Program Costs	0	0		0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	9, 172	0		0	0	34. 00
35. 00	Unit Cost Multiplier (see instructions)						35. 00

Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 150042 | Peri od: From 01/01/2014 | Part I | Date/Time Prepared: 6/3/2015 1:34 pm

						0/3/2013 1.34	piii
					Hospi ce I		
		CAPITAL RELA	ATED COSTS				
	Cost Center Description	NEW CRC -	NEW CRC -	EMPLOYEE	COMMUNI CATI ONS		
		EQUI PMENT	HEALTH	BENEFITS		RECEI VI NG	
			PAVI LI ON	DEPARTMENT			
		2. 01	2. 02	4. 00	4. 01	4. 02	
1.00	Administrative and General	17, 535	0	160, 14	435	2, 305	1.00
2.00	Inpatient - General Care	0	0	(	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	(	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	(	0	0	4. 00
5.00	Nursi ng Care	0	0	(	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	(	0	0	6. 00
7.00	Physi cal Therapy	0	0	(	0	0	7. 00
8.00	Occupational Therapy	O	0	(	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	(	0	0	9. 00
10.00	Medical Social Services	0	0		0	0	10.00
11.00	Spiritual Counseling	0	0	(	0	0	11. 00
12.00	Di etary Counsel i ng	0	0	(	0	0	12.00
13.00	Counseling - Other	0	0	(	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0	(	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	o	0		0	0	15. 00
16.00	Other	o	0		0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	0		0	0	17. 00
18.00	Anal gesi cs	o	0		0	0	18. 00
19.00	Sedatives / Hypnotics	o	0		0	0	19. 00
20.00	Other - Specify	o	0		0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	o	0		0	0	21. 00
22. 00	Pati ent Transportation	o	0		0	0	22. 00
23.00	I maging Services	o	0		0	0	23. 00
24.00	Labs and Diagnostics	o	0		0	0	24. 00
25.00	Medical Supplies	o	0		0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0		0	0	26. 00
27.00	Radi ati on Therapy	o	0		0	0	27. 00
28. 00	Chemotherapy	o	0		0	0	28. 00
29. 00	Other	o	0		0	0	29. 00
30.00	Bereavement Program Costs	l	0		o o	0	30.00
31.00	Volunteer Program Costs	o	0		0	0	31.00
32.00	Fundrai si ng	o	0	(	0	0	32. 00
33.00	Other Program Costs	o	0		0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	17, 535	0	160, 14	7 435	2, 305	34. 00
35.00	Unit Cost Multiplier (see instructions)						35. 00
				•	•		

Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 150042 Hospi ce CCN: 151526

					Hospi ce I	0, 0, 2010 11 01	-
	Cost Center Description	REGI STRATI ON	PATI ENT	Subtotal	ADMI NI STRATI VE	OPERATION OF	
	cost center bescription	REGISTRATION	ACCOUNTS	Subtotal	& GENERAL	PLANT	
		4. 03	4. 04	4A. 04	5. 00	7. 00	
1. 00	Administrative and General	6, 146	25, 256	220, 996		99, 812	1. 00
2. 00	Inpatient - General Care	0, 140	23, 230	1, 240, 387		99, 012	2. 00
3. 00	Inpatient - Respite Care		0	1, 240, 30	220, 310	0	3. 00
4. 00	Physician Services		0			0	4. 00
5. 00	Nursing Care		0			0	5. 00
6. 00	Nursing Care-Continuous Home Care		0			0	6. 00
7. 00	Physical Therapy		0			0	7. 00
8. 00	Occupational Therapy		0			0	8. 00
9. 00	Speech/ Language Pathology		0			0	9. 00
10. 00	Medical Social Services		0			0	10. 00
11. 00	Spiritual Counseling		0			0	11. 00
12. 00	Di etary Counseling		0			0	12.00
13. 00	Counseling - Other		0			0	13. 00
14. 00	Home Health Aide and Homemaker		0			0	14. 00
15. 00	HH Ai de & Homemaker - Cont. Home Care		0			0	15. 00
16. 00	Other		0			0	16. 00
17. 00	Drugs, Biological and Infusion Therapy		0			0	17. 00
18. 00	Anal gesi cs	o	0	(		0	18. 00
19. 00	Sedatives / Hypnotics	0	0	(	o	0	19. 00
20. 00	Other - Specify	o	0	(	ol	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	O	0	(	o	0	21. 00
22. 00	Patient Transportation	o	o	(	ol ol	0	22. 00
23.00	I maging Services	O	o	(	ol	0	23. 00
24.00	Labs and Diagnostics	0	0	(	o	0	24.00
25.00	Medical Supplies	0	O	(	ol ol	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	(	o	0	26. 00
27.00	Radi ati on Therapy	0	0	(	0	0	27. 00
28. 00	Chemotherapy	0	0	(	0	0	28. 00
29. 00	Other	0	0	(	0	0	29. 00
30.00	Bereavement Program Costs	0	0	(	0	0	30.00
31.00	Volunteer Program Costs	0	0	(	0	0	31.00
32.00	Fundrai si ng	0	0	(	0	0	32.00
33.00	Other Program Costs	0	0	(	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	6, 146	25, 256	1, 461, 383		99, 812	34.00
35. 00	Unit Cost Multiplier (see instructions)			0. 000000	)		35. 00

 
 Provi der CCN:
 150042
 Peri od: From 01/01/2014
 Worksheet K-5 Part I Date/Time Prepared: 6/3/2015 1: 34 pm
 Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						Hospi ce I		
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DIETARY	1	CAFETERI A	NURSI NG	
	cost contor boson per on	LINEN SERVICE		512.7			ADMI NI STRATI ON	
		8.00	9. 00	10.00		11. 00	13. 00	
1. 00	Administrative and General	0	41, 190		0	26, 671	106, 121	1. 00
2.00	Inpatient - General Care	0	0		0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0		0	0	0	4. 00
5.00	Nursi ng Care	0	0		0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	0	6. 00
7.00	Physi cal Therapy	0	0		0	0	0	7. 00
8.00	Occupational Therapy	0	0		0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0		0	0	0	9. 00
10.00	Medi cal Soci al Servi ces	0	0		0	0	0	10. 00
11. 00	Spiritual Counseling	0	0		0	0	0	11. 00
12.00	Di etary Counsel i ng	0	0		0	0	0	12. 00
13.00	Counseling - Other	0	0		0	0	0	13. 00
14.00	Home Health Aide and Homemaker	0	0		0	0	0	14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	15. 00
16.00	Other	0	0		0	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0	0	17. 00
18.00	Anal gesi cs	0	0		0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0		0	0	0	19. 00
20.00	Other - Specify	0	0		0	0	0	20. 00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	0	21. 00
22. 00	Patient Transportation	0	0		0	0	0	22. 00
23.00	I maging Services	0	0		0	0	0	23. 00
24.00	Labs and Diagnostics	0	0		0	0	0	24. 00
25.00	Medi cal Supplies	0	0		0	0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	26. 00
27. 00	Radi ati on Therapy	0	0		0	0	0	27. 00
28. 00	Chemotherapy	0	0		0	0	0	28. 00
29. 00	Other	0	0		0	0	0	29. 00
30.00	Bereavement Program Costs	0	0		0	0	0	30. 00
31. 00	Volunteer Program Costs	0	0		0	0	0	31. 00
32.00	Fundrai si ng	0	0		0	0	0	32. 00
33. 00	Other Program Costs	0	0		0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	41, 190		0	26, 671	106, 121	34. 00
35. 00	Unit Cost Multiplier (see instructions)							35. 00

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

						6/3/2015 1: 34	pm
					Hospi ce I		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	MENTAL HEALTH	
		SERVICES &		RECORDS &		OVERHEAD	
		SUPPLY		LI BRARY			
		14. 00	15. 00	16. 00	17. 00	17. 01	
1.00	Administrative and General	1, 758	14, 910		0	0	1. 00
2.00	Inpatient - General Care	0	0		0	0	2. 00
3.00	Inpatient - Respite Care	0	0		0	0	3. 00
4.00	Physi ci an Servi ces	0	0		0	0	4. 00
5.00	Nursing Care	0	0		0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	6. 00
7.00	Physi cal Therapy	0	0		0	0	
8.00	Occupational Therapy	0	0		0	0	
9.00	Speech/ Language Pathology	0	0		0	0	9. 00
10.00	Medical Social Services	0	0		0	0	10. 00
11. 00	Spiritual Counseling	0	0		0	0	11. 00
12.00	Di etary Counseling	0	0		0	0	12.00
13. 00	Counseling - Other	0	0		0	0	
14. 00	Home Health Aide and Homemaker	0	0		0	0	14.00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15. 00
16. 00	Other	0	0		0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18. 00	Anal gesi cs	0	0		0	0	
19. 00	Sedatives / Hypnotics	0	0		0	0	19. 00
20. 00	Other - Specify	0	0		0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0		0	0	21. 00
22. 00	Patient Transportation	0	0		0	0	22. 00
23. 00	I maging Services	0	0		0	0	23. 00
24. 00	Labs and Diagnostics	0	0		0	0	24. 00
25. 00	Medical Supplies	0	0		0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	26. 00
27. 00	Radiation Therapy	0	0		0	0	27. 00
28. 00	Chemotherapy	0	0		0	0	28. 00
29. 00	Other	0	0		0	0	29. 00
30.00	Bereavement Program Costs	0	0		0	0	30. 00
31. 00	Volunteer Program Costs	0	0		0	0	31. 00
32. 00	Fundrai si ng	0	0		0	0	32. 00
33. 00	Other Program Costs	0	0		0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	1, 758	14, 910		0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00

 
 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150042
 Period: From 01/01/2014
 Worksheet K-5 Part I Date/Time Prepared: 6/3/2015 1: 34 pm
 Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

						6/3/2015 1:34	pm
					Hospi ce I		
	Cost Center Description	PARAMED ED	PARAMED ED	Subtotal	Intern &	Subtotal	
		PRGM	PRGM-LAB	(col s. 4A-23)	Residents Cost	(cols. 24 ±	
					& Post	25)	
					Stepdown	·	
					Adjustments		
		23. 00	23. 01	24. 00	25.00	26.00	
1.00	Administrative and General	0	0	552, 13 <i>6</i>	b		1.00
2.00	Inpatient - General Care	0	0	1, 468, 703	0	1, 468, 703	2.00
3.00	Inpatient - Respite Care	0	0	(	0	0	3.00
4.00	Physi ci an Servi ces	0	0	(	0	0	4. 00
5.00	Nursi ng Care	0	0	(	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	(	0	0	6.00
7.00	Physi cal Therapy	0	0	(	0	0	7. 00
8.00	Occupational Therapy	0	0	(	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	(	0	0	9. 00
10.00	Medical Social Services	0	0	(	0	0	10.00
11.00	Spiritual Counseling	0	0	(	o	0	11. 00
12.00	Di etary Counsel i ng	0	0	(	0	0	12.00
13.00	Counseling - Other	0	0	(	o	0	13.00
14.00	Home Health Aide and Homemaker	0	0	(	o	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	O	0		o	0	15. 00
16.00	Other	O	0		o	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	O	0		o	0	17. 00
18.00	Anal gesi cs	0	0	(	o	0	18. 00
19.00	Sedatives / Hypnotics	0	0	(	o	0	19.00
20.00	Other - Specify	0	0	(	o	0	20.00
21.00	Durable Medical Equipment/Oxygen	O	0	(	o	0	21. 00
22.00	Pati ent Transportation	O	0	(	o	0	22. 00
23.00	I maging Services	0	0	(	0	0	23. 00
24.00	Labs and Diagnostics	0	0	(	0	0	24.00
25.00	Medical Supplies	0	0	(	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	(	0	0	26. 00
27.00	Radi ati on Therapy	O	0	(	o	0	27. 00
28.00	Chemotherapy	0	0	(	0	0	28. 00
29.00	Other	O	0	(	o	0	29. 00
30.00	Bereavement Program Costs	O	0	(	o	0	30.00
31.00	Volunteer Program Costs	0	0	(	ol ol	0	31. 00
32.00	Fundrai si ng	0	0	(	ol ol	0	32.00
33.00	Other Program Costs	0	0		ol ol	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	2, 020, 839	o	2, 020, 839	34.00
35.00	Unit Cost Multiplier (see instructions)						35. 00
				•			

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

Hospi ce CCN: 151526

						6/3/2015 1: 34	pm
					Hospi ce I		
	Cost Center Description	Allocated	Total	Hospi ce			
		Hospi ce A&G	Cost	s (cols.			
		(See Part II)	26	± 27)			
		27.00	1	28. 00			
1.00	Administrative and General						1. 00
2.00	Inpatient - General Care	552, 136	,	2, 020, 839			2. 00
3.00	Inpatient - Respite Care	0		0			3. 00
4.00	Physi ci an Servi ces	0		0			4. 00
5.00	Nursi ng Care	0		O			5. 00
6.00	Nursing Care-Continuous Home Care	0		o			6.00
7.00	Physical Therapy	0		o			7. 00
8.00	Occupational Therapy	0	ol .	o			8. 00
9.00	Speech/ Language Pathology	0	ol .	o			9. 00
10.00	Medical Social Services	0	ol .	o			10.00
11.00	Spiritual Counseling	0	ol .	o			11. 00
12.00	Di etary Counseling	1 0		o			12.00
13.00	Counseling - Other	1 0		o			13.00
14.00	Home Health Aide and Homemaker	1 0		o			14.00
15.00	HH Aide & Homemaker - Cont. Home Care	1 0		o			15. 00
16.00	Other	1 0		o			16.00
17.00	Drugs, Biological and Infusion Therapy	0	ol .	o			17. 00
18.00	Anal gesi cs	0	ol .	o			18. 00
19.00	Sedatives / Hypnotics	0	ol .	o			19. 00
20.00	Other - Specify	0	ol .	o			20.00
21.00	Durable Medical Equipment/Oxygen	0		o			21. 00
22. 00	Pati ent Transportation	0		o			22. 00
23.00	I maging Services	0		o			23. 00
24.00	Labs and Diagnostics	0		0			24.00
25.00	Medical Supplies	0		0			25. 00
26.00	Outpatient Services (including E/R Dept.)	0		0			26. 00
27.00	Radi ati on Therapy	0		0			27. 00
28.00	Chemotherapy	0		0			28. 00
29.00	Other	0		0			29. 00
30.00	Bereavement Program Costs	0		O			30.00
31.00	Volunteer Program Costs	0		o			31.00
32.00	Fundrai si ng	0		o			32. 00
33.00	Other Program Costs	0		o			33. 00
34.00	Total (sum of lines 1 thru 33) (2)			2, 020, 839			34.00
35.00	Unit Cost Multiplier (see instructions)	0. 375934					35. 00

 
 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150042
 Period: From 01/01/2014 To 12/31/2014
 Worksheet K-5 Part II Date/Time Prepared: 6/3/2015 1: 34 pm
 Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS GOOD SAMARITAN HOSPITAL

STATISTICAL BASIS

					Hospi ce I		
			CAP	ITAL RELATED C	OSTS		
	Cost Center Description	BLDG & FIXT	NEW CRC - CT	NEW CRC- CT	NEW CRC-	NEW CRC -	
		(SQUARE FEET)	EAST	WEST	MEMORI AL	OUTPATI ENT	
			(SQUARE FEET)				
	Tarana arang arang arang arang arang arang arang arang arang arang arang arang arang arang arang arang arang ar	1.00	1. 01	1. 02	1. 03	1. 04	
1.00	Administrative and General	0	0	· -	0	4, 861	1. 00
2.00	Inpatient - General Care	0	0	0	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursing Care	0	0	0	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	0	0	0	0	0	7. 00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10. 00	Medical Social Services	0	0	0	0	0	10. 00
11. 00	Spiritual Counseling	0	0	0	0	0	11. 00
12.00	Dietary Counseling	0	0	0	0	0	12.00
13. 00	Counseling - Other	0	0	0	0	0	13. 00
14. 00	Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15. 00
16.00	Other	0	0	0	0	0	16. 00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17. 00
18.00	Anal gesi cs	0	0	0	0	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19. 00
20.00	Other - Specify	0	0	0	0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21. 00
22. 00	Pati ent Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	0	0	0	0	0	23. 00
24.00	Labs and Diagnostics	0	0	0	0	0	24. 00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radiation Therapy	0	0	0	0	0	27. 00
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30. 00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	4, 861	34.00
35.00	Total cost to be allocated	0	0	0	0	9, 172	35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 000000	0.000000	1. 886855	36. 00

Health Financial Systems GOOD SA ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 150042 | Peri od: From 01/01/2014 | Part II | Date/Time Prepared: 6/3/2015 1:34 pm STATISTICAL BASIS

						0/3/2013 1.34	piii
					Hospi ce I		
			CAP	ITAL RELATED C	OSTS		
					_		
	Cost Center Description	NEW CRD -	NEW CRC -	NEW CRC -	MVBLE EQUIP	NEW CRC -	
		HEALTH	STORAGE	DI AGNOSTI C	(SQUARE FEET)	EQUI PMENT	
		PAVI LI ON	(SQUARE FEET)	CENTER		(SQUARE FEET)	
		(SQUARE FEET)		(SQUARE FEET)			
		1. 05	1. 06	1. 07	2. 00	2. 01	
1.00	Administrative and General	0	0	C	0	4, 861	1. 00
2.00	Inpatient - General Care	0	0	C	0	0	2.00
3.00	Inpatient - Respite Care	0	0	C	0	0	3.00
4.00	Physician Services	0	0	C	0	0	4.00
5.00	Nursi ng Care	0	0	C	0	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	l c	0	0	6.00
7.00	Physical Therapy	0	0	l c	0	0	7. 00
8.00	Occupational Therapy	0	0	l c	0	0	8. 00
9. 00	Speech/ Language Pathology	0	0		0	0	9.00
10.00	Medi cal Soci al Servi ces	0	0		0	0	10.00
11. 00	Spiritual Counseling	0	0	0	0	0	11. 00
12. 00	Di etary Counsel i ng	0	0	0	0	0	12.00
13. 00	Counseling - Other	0	0	0	0	Ō	13. 00
14. 00	Home Health Aide and Homemaker	0	0	l o	0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15. 00
16. 00	Other	0	0		0	Ö	16.00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18. 00	Anal gesi cs	0	0		0	0	18.00
19. 00	Sedatives / Hypnotics	0	0		0	Ö	19.00
20. 00	Other - Specify	0	0	Ì	0	Ö	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0	Ì	0	Ö	21.00
22. 00	Patient Transportation	0	0		0	Ö	22. 00
23. 00	Imaging Services	0	0		0	Ö	23. 00
24. 00	Labs and Diagnostics	0	0		0	0	24.00
25. 00	Medical Supplies	0	0		0	Ö	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	Ö	26. 00
27. 00	Radi ati on Therapy	0			0	0	27.00
28. 00	Chemotherapy	0			o O	Ö	28. 00
29. 00	Other	0			0	Ö	29.00
30. 00	Bereavement Program Costs	0			0	0	30.00
31. 00	Volunteer Program Costs				0	0	31.00
32. 00	Fundrai si ng				0	0	32.00
33. 00	Other Program Costs					0	33.00
34. 00	Total (sum of lines 1 thru 33) (2)					4, 861	34.00
35. 00	Total cost to be allocated					17, 535	
		0. 000000	0. 000000	0. 000000	0. 000000		
36. 00	John Cost Multiplier (See Histructions)	0.000000	J 0. 000000	j 0.00000	1 0.000000	J. 00/282	J 30. 00

Provi der CCN: 150042 | Peri od: From 01/01/2014 | Part II | Date/Time Prepared: 6/3/2015 1: 34 pm STATISTICAL BASIS

						6/3/2015 1: 34	pm
					Hospi ce I		
		CAPI TAL					
		RELATED COSTS					
	Cost Center Description	NEW CRC -	EMPLOYEE	COMMUNICATIONS	PURCHASING &	REGI STRATI ON	
	•	HEALTH	BENEFITS		RECEI VI NG	(GROSS CHAR	
		PAVI LI ON	DEPARTMENT	(NUMBER OF	(SUPPLIES C	GES)	
		(SQUARE FEET)	(GROSS	PHONES)	OST)		
		(040/1112 / 221)	SALARI ES)	1	00.7		
		2. 02	4.00	4. 01	4. 02	4. 03	
1.00	Administrative and General	0	695, 325		55, 802	2, 674, 524	1. 00
2.00	Inpatient - General Care	o	0	) 0	0	O	2. 00
3.00	Inpatient - Respite Care	0	0	0	0	0	3. 00
4.00	Physi ci an Servi ces	0	0	o o	0	0	4. 00
5. 00	Nursing Care	0	0	0	0	0	5. 00
6. 00	Nursing Care-Continuous Home Care		0	0	0	0	6. 00
7. 00	Physical Therapy		Ô	o o	0	o o	7. 00
8. 00	Occupational Therapy		0	o o	o o	0	8. 00
9. 00	Speech/ Language Pathology		0	o o	0	0	9. 00
10. 00	Medical Social Services		0	o o	0	0	10.00
11. 00	Spiritual Counseling		0	1	0	0	11. 00
12. 00	Di etary Counseling		0		0	0	12. 00
13. 00	Counseling - Other		0		0	0	13. 00
14. 00	Home Health Aide and Homemaker		0		0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0	1	0	"	15. 00
		0	U		0	0	
16.00	Other District Laboratory	0	U	0	0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0	1	0	0	17. 00
18.00	Anal gesi cs	0	Ü	0	0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0	1	0	0	19. 00
20. 00	Other - Specify	0	0		0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0	1	0	0	21. 00
22. 00	Patient Transportation	0	0	1	0	0	22. 00
23. 00	I maging Services	0	0		0	0	23. 00
24. 00	Labs and Diagnostics	0	0	1	0	0	24. 00
25. 00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26. 00
27. 00	Radi ati on Therapy	0	0	0	0	0	27. 00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29.00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	O	0	0	0	0	32. 00
33. 00	Other Program Costs	O	0	o	0	o	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	0	695, 325		55, 802	2, 674, 524	34. 00
35. 00	Total cost to be allocated		160, 147	1	2, 305		35. 00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 230320	1			
	1		11.0020		1 2.2.7007	1 2: 2: 2: 2: 2: 7: 7: 7: 7: 7: 7: 7: 7: 7: 7: 7: 7: 7:	

 
 SPITAL
 In Lieu of Form CMS-2552-10

 Provider CCN: 150042
 Period: From 01/01/2014
 Worksheet K-5 Part II Date/Time Prepared: 6/3/2015 1: 34 pm
 STATISTICAL BASIS

						6/3/2015 1:34	pm
					Hospi ce I		
	Cost Center Description	PATI ENT	Reconciliation	ADMI NI STRATI V	OPERATION OF	LAUNDRY &	
	·	ACCOUNTS		& GENERAL	PLANT	LINEN SERVICE	
		(GROSS CHAR		(ACCUM. COST)	(SQUARE FEET)	(LBS OF LAU	
		GES)		,		NDRY)	
		4. 04	5A	5. 00	7. 00	8. 00	
1. 00	Administrative and General	2, 674, 524	0	220, 99	4, 861	0	1. 00
2.00	Inpatient - General Care	o	0	1, 240, 38	7 0	l ol	2. 00
3.00	Inpatient - Respite Care	o	0		0	l ol	3. 00
4.00	Physician Services	o	0		0	l ol	4. 00
5.00	Nursi ng Care	o	0		0	l ol	5. 00
6.00	Nursing Care-Continuous Home Care	o	0		0	l ol	6. 00
7.00	Physical Therapy	o	0		0	l ol	7. 00
8.00	Occupational Therapy	o	0		0	l ol	8. 00
9.00	Speech/ Language Pathology	o	0		0	o	9. 00
10.00	Medical Social Services	o	0		0	o	10. 00
11. 00	Spiritual Counseling	o	0		0	l ol	11. 00
12.00	Di etary Counseling	o	0		0	l ol	12. 00
13.00	Counseling - Other	o	0		0	l ol	13. 00
14.00	Home Health Aide and Homemaker	o	0		0	l ol	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0	l ol	15. 00
16. 00	Other	0	0		0	l ol	16. 00
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	17. 00
18. 00	Anal gesi cs	0	0		0	0	18. 00
19. 00	Sedatives / Hypnotics	0	0		0	l ol	19. 00
20. 00	Other - Specify	0	0		0	l ol	20. 00
21. 00	Durable Medical Equipment/Oxygen	0	0		0	l ol	21. 00
22. 00	Pati ent Transportation	0	0		0	0	22. 00
23. 00	Imaging Services	0	0		0	l ol	23. 00
24. 00	Labs and Diagnostics	0	0		0	ام	24. 00
25. 00	Medical Supplies	0	0		0	l ol	25. 00
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	l ol	26. 00
27. 00	Radi ati on Therapy	0	0		0	ام	27. 00
28. 00	Chemotherapy	0	0		0	l ol	28. 00
29. 00	Other	0	0		0	l ol	29. 00
30. 00	Bereavement Program Costs	0	0		0	Ö	30.00
31. 00	Volunteer Program Costs	0	0		0	l ol	31. 00
32. 00	Fundrai si ng	0	0		0	0	32. 00
33. 00	Other Program Costs	0	0		0	l ől	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	2, 674, 524		1, 461, 38	4, 861		34. 00
35. 00	Total cost to be allocated	25, 256		268, 99			35. 00
	Unit Cost Multiplier (see instructions)	0. 009443		0. 18406	1		
55. 50	James 3332 mar trpiror (300 matraotrons)	0.007440		0.15400	20.000224	, 0.000001	30.00

STATISTICAL BASIS

						6/3/2015 1: 34	pm
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
		(TIME SPENT)	(PATIENT DA	(MAN HOURS)	ADMI NI STRATI ON	SERVICES &	
			YS)			SUPPLY	
					(DI RECT NUR	(SUPPLIES C	
					SI NG)	OST)	
		9. 00	10.00	11. 00	13.00	14. 00	
1.00	Administrative and General	765	0	34, 865	34, 865	55, 802	1. 00
2.00	Inpatient - General Care	0	0	(	0	0	2. 00
3.00	Inpatient - Respite Care	0	0	(	이	0	3. 00
4.00	Physi ci an Servi ces	0	0	(	ol ol	0	4. 00
5.00	Nursi ng Care	0	0	(	ol ol	0	5. 00
6.00	Nursing Care-Continuous Home Care	0	0	(	ol ol	0	6. 00
7.00	Physi cal Therapy	0	0	(	ol ol	0	7. 00
8.00	Occupational Therapy	0	0	(	o o	0	8. 00
9.00	Speech/ Language Pathology	0	0	(	o o	0	9. 00
10.00	Medical Social Services	0	0	(	o o	0	10.00
11.00	Spiritual Counseling	0	0	(	ol ol	0	11. 00
12.00	Di etary Counseling	O	0	(	ol ol	0	12.00
13.00	Counseling - Other	o	0	(	ol ol	0	13. 00
14.00	Home Health Aide and Homemaker	o	0	(	ol ol	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	o	0		ol ol	0	15. 00
16.00	Other	o	0		ol ol	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	0		ol ol	0	17. 00
18.00	Anal gesi cs	o	0		ol ol	0	18. 00
19.00	Sedatives / Hypnotics	o	0		ol ol	0	19. 00
20.00	Other - Specify	o	0		ol ol	0	20. 00
21.00	Durable Medical Equipment/Oxygen	o	0		ol ol	0	21. 00
22. 00	Patient Transportation	o	0		ol ol	0	22. 00
23. 00	I maging Services	o	0		ol ol	0	23. 00
24. 00	Labs and Diagnostics	o	0		ol ol	0	24. 00
25. 00	Medical Supplies	o	0		ol ol	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0		ol ol	0	26. 00
27. 00	Radiation Therapy	o	0		ol ol	0	27. 00
28. 00	Chemotherapy	o	0		ol ol	0	28. 00
29. 00	Other	o	0		ol ol	0	29. 00
30.00	Bereavement Program Costs	o	0		ol ol	0	30. 00
31.00	Volunteer Program Costs	o	0		ol ol	0	31. 00
32.00	Fundrai si ng	o	0		ol ol	0	32. 00
33. 00	Other Program Costs	o	0		ol ol	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	765	0	34, 865	34, 865	55, 802	34.00
35. 00	Total cost to be allocated	41, 190	0			1, 758	
36.00			0. 000000	0. 764979			

 
 SPITAL
 In Lieu of Form CMS-2552-10

 Provi der CCN: 150042
 Peri od: From 01/01/2014
 Worksheet K-5 Part II Date/Time Prepared: 6/3/2015 1: 34 pm
 STATISTICAL BASIS

						6/3/2015 1:34	pm
					Hospi ce I		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVI	CE MENTAL HEALTH	PARAMED ED	
	·	(COSTED REC	RECORDS &		OVERHEAD	PRGM	
		QUIS)	LI BRARY	(TIME SPENT)	(CHARGES)	(ASSI GNED	
		·	(TIME SPENT)			TIME)	
		15.00	16. 00	17. 00	17. 01	23.00	
1.00	Administrative and General	30, 749	C	)	0 0	0	1. 00
2.00	Inpatient - General Care	0	C		0 0	0	2. 00
3.00	Inpatient - Respite Care	0	C		0 0	0	3. 00
4.00	Physician Services	o	C		0 0	0	4. 00
5.00	Nursi ng Care	o	C		0 0	0	5. 00
6.00	Nursing Care-Continuous Home Care	o	C		0 0	0	6. 00
7.00	Physical Therapy	o	C		0 0	0	7. 00
8.00	Occupational Therapy	o	C		0 0	0	8. 00
9.00	Speech/ Language Pathology	o	C		0 0	0	9. 00
10.00	Medical Social Services	o	C		0 0	0	10. 00
11.00	Spiritual Counseling	o	C		0 0	0	11. 00
12.00	Di etary Counsel i ng	o	C		0 0	0	12. 00
13.00	Counseling - Other	o	C		0 0	0	13. 00
14.00	Home Health Aide and Homemaker	o	C		0 0	0	14. 00
15. 00	HH Aide & Homemaker - Cont. Home Care	o	C		0 0	0	15. 00
16. 00	Other	o	C		0 0	0	16. 00
17. 00	Drugs, Biological and Infusion Therapy	o	C		0 0	0	17. 00
18.00	Anal gesi cs	o	C		0 0	0	18. 00
19. 00	Sedatives / Hypnotics	o	C		0 0	0	19. 00
20.00	Other - Specify	o	C		0 0	0	20. 00
21. 00	Durable Medical Equipment/Oxygen	o	C		0 0	0	21. 00
22. 00	Patient Transportation	o	C		0 0	0	22. 00
23. 00	I maging Services	o	C		0 0	0	23. 00
24.00	Labs and Diagnostics	o	C		0 0	0	24. 00
25. 00	Medical Supplies	o	C		0 0	0	25. 00
26. 00	Outpatient Services (including E/R Dept.)	o	C		0 0	0	26. 00
27. 00	Radi ati on Therapy	o	C		0 0	0	27. 00
28. 00	Chemotherapy	o	C		0 0	0	28. 00
29. 00	Other	o	C		0 0	0	29. 00
30.00	Bereavement Program Costs	o	C		0 0	0	30. 00
31.00	Volunteer Program Costs	o	C		0 0	0	31. 00
32.00	Fundrai si ng	o	C		0 0	0	32. 00
33. 00	Other Program Costs	0	Ċ		0 0	0	33. 00
34. 00	Total (sum of lines 1 thru 33) (2)	30, 749	d	ol .	0 0	o	34. 00
35. 00	Total cost to be allocated	14, 910	d	ol .	0 0	o	35. 00
	Unit Cost Multiplier (see instructions)	0. 484894	0. 000000	0. 00000	0. 000000	0.000000	
				•		•	•

Health Financial Systems GOOD SAMARITAN HOS	SPI TAL	AL In Lie		
STATI STI CAL BASI S	Provi der CCN: 150042 Hospi ce CCN: 151526	From 01/01/2014	Worksheet K-5 Part II Date/Time Prepared:	

				6/3/2015 1: 34	pm
			Hospi ce I		
	Cost Center Description	PARAMED ED			
		PRGM-LAB			
		(ASSI GNED			
		TIME)			
		23. 01			
1.00	Administrative and General	0			1.00
2.00	Inpatient - General Care	0			2. 00
3.00	Inpatient - Respite Care	0			3. 00
4.00	Physi ci an Servi ces	0			4. 00
5.00	Nursing Care	0			5. 00
6.00	Nursing Care-Continuous Home Care	0			6.00
7.00	Physi cal Therapy	0			7. 00
8.00	Occupational Therapy	0			8. 00
9.00	Speech/ Language Pathology	0			9. 00
10.00	Medical Social Services	0			10.00
11. 00	Spiritual Counseling	0			11. 00
12.00	Di etary Counsel i ng	0			12. 00
13.00	Counseling - Other	0			13. 00
14.00	Home Health Aide and Homemaker	0			14. 00
15.00	HH Aide & Homemaker - Cont. Home Care	O			15. 00
16.00	Other	0			16. 00
17.00	Drugs, Biological and Infusion Therapy	0			17. 00
18.00	Anal gesi cs	O			18. 00
19.00	Sedatives / Hypnotics	O			19. 00
20.00	Other - Specify	O			20.00
21.00	Durable Medical Equipment/Oxygen	0			21. 00
22.00	Patient Transportation	O			22. 00
23.00	I maging Services	O			23. 00
24.00	Labs and Diagnostics	O			24. 00
25.00	Medical Supplies	o			25. 00
26.00	Outpatient Services (including E/R Dept.)	o			26. 00
27.00	Radi ati on Therapy	o			27. 00
28.00	Chemotherapy	o			28. 00
29.00	Other	o			29. 00
30.00	Bereavement Program Costs	o			30.00
31.00	Volunteer Program Costs	0			31.00
32.00	Fundrai si ng	0			32. 00
33.00	Other Program Costs	0			33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0			34.00
35.00	Total cost to be allocated	0			35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 000000			36.00
					•

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150042	Peri od: From 01/01/2014	Worksheet K-5 Part III	
			Hospi ce (	CCN: 151526	To 12/31/2014	Date/Time Pre	
					Hospi ce I	6/3/2015 1: 34	pm
	Cost Center Description		Wkst C Part	Cost to Charc	je Total Hospi ce	Hospi ce Shared	
	3031 301101 30301 Pt 1011		I, col. 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
					Records)	x 2)	
			0	1.00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00	0. 19786	0	0	1. 00
2.00	OCCUPATI ONAL THERAPY		67.00				2. 00
3.00	SPEECH PATHOLOGY		68. 00	l .			3. 00
4.00	DRUGS CHARGED TO PATIENTS		73. 00	l .		0	4. 00
5.00	DURABLE MEDICAL EQUIP-RENTED		96. 00	l .	79 0	0	5. 00
6.00	LABORATORY		60.00		0	0	6. 00
6. 01	BLOOD LABORATORY		60. 01	l .			6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT		71. 00		0	0	7. 00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93. 00				8. 00
9.00	RADI OLOGY-THERAPEUTI C		55.00	l .			9. 00
10.00	MH ANCILLARY OUTPATIENT		76. 00			0	
10. 01	INPATIENT DIALYSIS		76. 01	0. 55698	0	0	
11. 00	Totals (sum of lines 1-10)	l				0	11. 00

Heal th	Financial Systems GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPICE PER DIEM COST	Provi der	CCN: 150042	Peri od:	Worksheet K-6	
		Hospi ce (	CCN: 151526	From 01/01/2014 To 12/31/2014	Date/Time Prep 6/3/2015 1:34	
				Hospi ce I		
		Title XVIII	Title XIX	0ther	Total	
		1. 00	2.00	3. 00	4.00	
1.00	Total cost (see instructions)				2, 020, 839	1. 00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				0	2. 00
3.00	Average cost per diem (line 1 divided by line 2)				0.00	3. 00
4.00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	0				4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)	0				5. 00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			0		6. 00
7.00	Aggregate Medicaid cost (line 3 time line 60)			0		7. 00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8. 00
9.00	Aggregate SNF cost (line 3 time line 8)	0				9. 00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11. 00	Aggregate NF cost (line 3 times line 10)			0		11. 00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12. 00
13.00	Aggregate cost for other days (line 3 times line 12)			0		13.00

	Period: From 01/01/2014 To 12/31/2014 Hospital	wof Form CMS-2 Worksheet L Parts I-III Date/Time Prep 6/3/2015 1:34 PPS	pared:
PART I - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT	Hospi tal	PPS	pm
CAPITAL FEDERAL AMOUNT		, <del>'</del>	
CAPITAL FEDERAL AMOUNT			
CAPITAL FEDERAL AMOUNT		1. 00	
			1
1.00 Capital DRG Other than outlier		1 022 244	1.00
1.01   Model 4 BPCI Capital DRG other than outlier		1, 823, 346 0	1
2.00 Capital DRG outlier payments		97, 279	
2.01   Model 4 BPCI Capital DRG outlier payments		97, 279	1
3.00 Total inpatient days divided by number of days in the cost reporting period (see instru	uctions)	67. 18	
4.00 Number of interns & residents (see instructions)	uctions)	0.00	
5.00 Indirect medical education percentage (see instructions)		0.00	
6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0.00	
7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, 30) (see instructions)	part A line	0.00	
8.00 Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00 Sum of lines 7 and 8		0.00	1
10.00 Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00 Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		0	11. 00
12.00 Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		1, 920, 625	12. 00
		1. 00	
PART II - PAYMENT UNDER REASONABLE COST			
1.00 Program inpatient routine capital cost (see instructions)		0	
2.00   Program inpatient ancillary capital cost (see instructions)		0	
3.00   Total inpatient program capital cost (line 1 plus line 2)		0	
4.00 Capital cost payment factor (see instructions)		0	
5.00   Total inpatient program capital cost (line 3 x line 4)		0	5. 00
		1. 00	
PART III - COMPUTATION OF EXCEPTION PAYMENTS			
1.00 Program inpatient capital costs (see instructions)		0	
2.00 Program inpatient capital costs for extraordinary circumstances (see instructions)		0	
3.00 Net program inpatient capital costs (line 1 minus line 2)		0	
4.00 Applicable exception percentage (see instructions)		0. 00	
5.00 Capital cost for comparison to payments (line 3 x line 4)		0	
6.00 Percentage adjustment for extraordinary circumstances (see instructions)		0.00	
7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x 1	line 6)	0	
8.00 Capital minimum payment level (line 5 plus line 7)		0	
9.00 Current year capital payments (from Part I, line 12, as applicable)	0)	0	
10.00 Current year comparison of capital minimum payment level to capital payments (line 8 lo		0	
11.00   Carryover of accumulated capital minimum payment level over capital payment (from prior Worksheet L, Part III, line 14)	ı year	0	11. 00
12.00 Net comparison of capital minimum payment level to capital payments (line 10 plus line	11)	0	12. 00
13.00   Current year exception payment (if line 12 is positive, enter the amount on this line)	,	0	
14.00 Carryover of accumulated capital minimum payment level over capital payment for the following		0	
(if line 12 is negative, enter the amount on this line)		ol	15. 00
(if line 12 is negative, enter the amount on this line) 15.00   Current year allowable operating and capital payment (see instructions)		, O	1 10.00
		0	