	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai			
payments made	since the beginning of the cost reporting period being	g deemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION	Provider CCN: 15-0042	Peri od:	Worksheet S
AND SETTLEMENT	SUMMARY		From 01/01/2018	
			To 12/31/2018	Date/Time Prepared:
				1/20/2020 10:18 am
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically filed cost report		Date: 1/20/202	20 Time: 10:18 am
use only	2. [] Manually submitted cost report			
	3. [1] If this is an amended report enter the number		esubmitted this c	ost report
	4. [F] Medicare Utilization. Enter "F" for full or "I	L" for low.		•
Contractor	5. [5]Cost Report Status 6. Date Received:	10. N	PR Date:	
use only	(1) Ås Submitted 7. Contractor No.	11. C	ontractor's Vendo	or Code: 4
· · · · · · · · · · · · · · · · · · ·	(2) Settled without Audit 8. [N] Initial Report for	or this Provider CCN12.[0]Ifline 5, co	lumn 1 is 4: Enter
	(3) Settled with Audit 9. [N] Final Report for	this Provider CCN		es reopened = 0-9.
	(4) Reopened			
	(E) Amondod			

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOOD SAMARITAN HOSPITAL (15-0042) for the cost reporting period beginning 01/01/2018 and ending 12/31/2018 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

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

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-2, 841	193, 607	0	-325, 807	1.00
2.00	Subprovi der - IPF	0	7, 056	-9		44, 196	2.00
3.00	Subprovi der - IRF	0	20, 181	15		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	24, 396	193, 613	0	-281, 611	200.00

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

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0042 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 1/20/2020 10:18 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 520 SOUTH 7TH STREET 1.00 PO Box: 1.00 State: IN Zi p Code: 47591 2.00 City: VINCENNES County: KNOX 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal GOOD SAMARITAN HOSPITAL 150042 99915 07/01/1966 Ν 0 3.00 1 Subprovi der - IPF GOOD SAMARITAN HOSPITAL 4.00 15S042 99915 01/01/1984 Р 0 4.00 4 Ν Р 5.00 Subprovi der - IRF GOOD SAMARITAN - REHAB 15T042 99915 5 01/01/2001 Ν 0 5.00 Subprovi der - (Other) 6.00 6.00 7.00 Swing Beds - SNF 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital -Based SNF 9.00 10.00 Hospital -Based NF 10.00 Hospi tal -Based OLTC 11 00 11 00 Hospital -Based HHA 12.00 GOOD SAMARITAN HOME 157432 99915 06/27/1995 N Ρ Ν 12.00 CENTER Separately Certified ASC 13 00 14.00 Hospi tal -Based Hospi ce GOOD SAMARITAN LINCOLN 151526 99915 01/01/1984 14.00 TRALL HOSPICE 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2018 12/31/2018 20.00 21.00 Type of Control (see instructions) 9 21.00 1.00 3.00 2.00 Inpatient PPS Information 22.00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this Ν 22.01 cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν 22 03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 2 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. In-State In-State Out-of Out-of Medi cai d 0ther Medi cai d Medicaid Medicaid State State HMO days

	pai d days	el i gi bl e	Medi cai d	Medi cai d		days	
		unpai d	paid days	, ,			
		days		unpai d			
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is an IPPS hospital, enter the	276	1, 012	0	344	1, 196	0	24.00
in-state Medicaid paid days in column 1, in-state							
Medicaid eligible unpaid days in column 2,							
out-of-state Medicaid paid days in column 3,							
out-of-state Medicaid eligible unpaid days in column							
4, Medicaid HMO paid and eligible but unpaid days in							
column 5, and other Medicaid days in column 6.							

Health Financial Systems GOOD S	SAMARITAN H	IOSPI TAL			In Lieu	ı of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provi der CO	CN: 15-0042	Period: From 01/0	1/2018	Workshe Part I	et S-2	
					1/2018		me Pre	pared:
	In-State	In-State	Out-of	Out-of	Medi ca	id 0	ther	TO alli
	Medicaid paid days	Medicaid eligible	State Medi cai d	State Medicaid	HMO da	- I	li cai d lays	
		unpai d	pai d days	el i gi bl e				
	1.00	2. 00	3.00	unpai d 4. 00	5. 00	6	. 00	
25.00 If this provider is an IRF, enter the in-state	(0		49		25. 00
Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2,								
out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid								
HMO paid and eligible but unpaid days in column 5.								
				Urban/R		Date of 2.0		
26.00 Enter your standard geographic classification (not w		s at the be	ginning of t		2	2. 0	,0	26. 00
cost reporting period. Enter "1" for urban or "2" fo 27.00 Enter your standard geographic classification (not w		s at the en	nd of the cos	it	2			27. 00
reporting period. Enter in column 1, "1" for urban o	r"2" for	rural. If a						
enter the effective date of the geographic reclassif 35.00 If this is a sole community hospital (SCH), enter the			CH status ir	1	О			35. 00
effect in the cost reporting period.		·		Begi nı	ni na:	Endi	na:	
				1. (2. 0		
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		script line	36 for numb	er				36.00
37.00 If this is a Medicare dependent hospital (MDH), ente		er of perio	ds MDH statu	ıs	0			37. 00
is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for t	he MDH tra	nsitional p	payment in					37. 01
accordance with FY 2016 OPPS final rule? Enter "Y" f	or yes or	"N" for no.	(see					
instructions) 38.00 If line 37 is 1, enter the beginning and ending date	s of MDH s	tatus. If I	ine 37 is					38. 00
greater than 1, subscript this line for the number of enter subsequent dates.	f periods	in excess o	of one and					
subsequent dates.				Y/		Υ/		
39.00 Does this facility qualify for the inpatient hospita	l payment	adi ustment	for low volu	ıme N		2. C		39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), o	r (iii)? En	iter in colum					
1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (i	ii)? Enter	e requireme in column	ents in 2 "Y" for ye	es				
or "N" for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction					,	Υ		40. 00
"N" for no in column 1, for discharges prior to Octo	ber 1. Ent	er "Y" for						40.00
no in column 2, for discharges on or after October 1	. (see ins	tructions)			V	XVIII	XIX	
Prospective Payment System (PPS)-Capital					1. 00	2.00	3. 00	
45.00 Does this facility qualify and receive Capital payme	nt for dis	proporti ona	ite share in	accordance	e N	N	N	45.00
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exc	ention for	extraordi n	arv circumst	ances	N	N	N I	46. 00
pursuant to 42 CFR §412.348(f)? If yes, complete Wks					'`	"	'`	10.00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS	capi tal?	Enter "Y fo	or yes or "N"	for no.	N	N	N	47. 00
48.00 Is the facility electing full federal capital paymen Teaching Hospitals					N	N	N	48. 00
56.00 Is this a hospital involved in training residents in	approved	GME program	ns? Enter "Y	" for yes	N			56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting	period dur	ing which r	esidents in	approved				57.00
GME programs trained at this facility? Enter "Y" fo	r yes or "	N" for no i	n column 1.	If column				
is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "								
"N", complete Wkst. D, Parts III & IV and D-2, Pt. I 58.00 If line 56 is yes, did this facility elect cost reim			ans' service	ns as				58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete '	Wkst. D-5.		.s as				
59.00 Are costs claimed on line 100 of Worksheet A? If ye	s, complet	e Wkst. D-2	Pt. I. NAHE 413.8	5 Worksh	eet A	Pass-Th	rough	59. 00
			Y/N	Li ne		Qualifi	cati on	
						Cri te Cod		
60 00 Are you claiming pursing and allied health advection	(NAUE) co	ete for	1. 00	2. (00	3. 0	00	60.00
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?	(see instr	uctions)	l f					60.00
60.01 If line 60 is yes, complete columns 2 and 3 for each instructions)	program.	(see			23. 00	1		60. 01
60.02 If line 60 is yes, complete columns 2 and 3 for each	program.	(see			23. 01	1		60. 02
i nstructi ons)			l	I				

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0042 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 1/20/2020 10:18 am Y/N IME Direct GME IME Direct GME 5.00 1.00 2.00 3.00 4.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0.00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61.04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unwei ghted Program Name Unwei ghted IME FTE Count Direct GME FTE Count 1. 00 2.00 3. 00 4. 00 0.00 61.10 Of the FTEs in line 61.05, specify each new program 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. Enter in column 4, the 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. Enter in column 4, the 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 62 01 0.00 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 63.00 for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) Unwei ghted Unwei ghted Ratio (col. **FTES** FTEs in 1/(col.1 +

		Nonprovi der	Hospi tal	col. 2))	
		Si te			
		1. 00	2. 00	3. 00	
S	ection 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost	reporti ng	
р	eriod that begins on or after July 1, 2009 and before June 30, 2010.				
	nter in column 1, if line 63 is yes, or your facility trained residents	0.00	0.00	0. 000000	64.00
i	n the base year period, the number of unweighted non-primary care				
r	esident FTEs attributable to rotations occurring in all nonprovider				
s	ettings. Enter in column 2 the number of unweighted non-primary care				ł
r	esident FTEs that trained in your hospital. Enter in column 3 the ratio				ł
О	f (column 1 divided by (column 1 + column 2)). (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: 15-0042 Peri od: Worksheet S-2 From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 1/20/2020 10:18 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. FTĔs FTEs in 3/ (col. 3 + col. 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0.00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ (col . 1 + col . 2)) FTEs in FTFs Nonprovi der Hospi tal 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 Enter in column 1 the number of unweighted non-primary care resident 0.00 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. FTĔs 3/ (col. 3 + FTEs in Nonprovi der col. 4)) Hospi tal 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. C	0 2.00	3.00	
Inpatient Psychiatric Facility PPS				
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subpro	vi der? Y			70.00
Enter "Y" for yes or "N" for no.				
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the	most N	N	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	ng			
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no.				
Column 3: If column 2 is Y, indicate which program year began during this cost reporting p	eri od.			
(see instructions)				
Inpatient Rehabilitation Facility PPS				
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF	Y			75.00
subprovi der? Enter "Y" for yes and "N" for no.				

lealth Financial Systems GOOD SAMARITAN HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 1		Peri od:	Workshe	et S-2
		From 01/01/20 To 12/31/20	8 Date/Ti	me Prepared: 120 10:18 am
		1		
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching recent cost reporting period ending on or before November 15, 2004? Enter "Y" no. Column 2: Did this facility train residents in a new teaching program in CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If colindicate which program year began during this cost reporting period. (see in:	" for yes accordand lumn 2 is	the most or "N" for e with 42 Y,	00 2.00 N N	3. 00 0 76. 00
			1.0	10
Long Term Care Hospital PPS 30.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
Is this a LTCH co-located within another hospital for part or all of the cos "Y" for yes and "N" for no. TEFRA Providers	t reportir	g period? Ent	er N	81.00
ls this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "` 16.00 Did this facility establish a new Other subprovider (excluded unit) under 42			D. N	85. 00 86. 00
\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 17.00 Is this hospital an extended neoplastic disease care hospital classified undo 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	er section		N	87. 00
1000(d)(1)(b)(vi)? Eillei i ioi yes oi ii ioi iio.		V	XLX	
Title V and XIX Services		1. 00	2.0	0
0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter	r "Y" for	N	Y	90.00
1.00 Is this hospital reimbursed for title V and/or XIX through the cost report eifull or in part? Enter "Y" for yes or "N" for no in the applicable column.	ither in	N	Y	91.00
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification) instructions) Enter "Y" for yes or "N" for no in the applicable column.)? (see		N	92.0
Does this facility operate an ICF/IID facility for purposes of title V and XI "Y" for yes or "N" for no in the applicable column.	IX? Enter	N	N	93.00
4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in applicable column.	n the	N	N	94.00
05.00 If line 94 is "Y", enter the reduction percentage in the applicable column. Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no inapplicable column.	n the	O. 00 N	0. 0 N	
17.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 18.00 Does title V or XIX follow Medicare (title XVIII) for the interns and resident stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for column 1 for title V, and in column 2 for title XIX.		0. 00 N	0. 0 Y	1
8.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charge C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in col title XIX.			Y	98. 0
88.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of obselect costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in a for title V, and in column 2 for title XIX.		N	Y	98. 0
28.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospi reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no i for title V, and in column 2 for title XIX.	ital (CAH) in column	1 N	N	98.0
8.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for ti in column 2 for title XIX.		N	N	98.0
8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disall Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title column 2 for title XIX.			Y	98.0
8.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for WI Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, a column 2 for title XIX. Rural Providers		N	Y	98.0
05.00 Does this hospital qualify as a CAH? 06.00 If this facility qualifies as a CAH, has it elected the all-inclusive method	of paymon	N N		105. 00 106. 00
for outpatient services? (see instructions) 07.00 f this facility qualifies as a CAH, is it eligible for cost reimbursement for training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)	or I&R	t N N		107.00
yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the progreimbursed. If yes complete Wkst. D-2, Pt. II.				108.0

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0042 Peri od: Worksheet S-2 From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 1/20/2020 10:18 am Physi cal Occupati onal Speech Respi ratory 1.00 2. 00 3. 00 4. 00 109.00 If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν 109.00 therapy services provided by outside supplier? Enter for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes 110 00 N complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e. 1.00 2.00 111.00|f this facility qualifies as a CAH, did it participate in the Frontier Community Ν 111.00 Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services. 1.00 2.00 3.00 Miscellaneous Cost Reporting Information 115.00|Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 Ν 0 115.00 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no. 116.00 117.00|s this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for Υ 117.00 no. 118.00 118.00 s the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence. Premi ums Losses Insurance 1. 00 2.00 3.00 0118.01 118.01 List amounts of mal practice premiums and paid losses: 443, 199 5. 494 1. 00 2.00 118.02 Are mal practice premiums and paid losses reported in a cost center other than the 118. 02 Ν Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein. 119.00 DO NOT USE THIS LINE 119 00 120.00|s this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA Ν Ν 120.00 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or 'N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no. 121.00|Did this facility incur and report costs for high cost implantable devices charged to 121.00 patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the 5.00 122. 00 Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If Ν 125.00 yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 of this is a Medicare certified kidney transplant center, enter the certification date 126.00 in column 1 and termination date, if applicable, in column 2. 127.00|If this is a Medicare certified heart transplant center, enter the certification date 127.00 in column 1 and termination date, if applicable, in column 2. 128.00 of 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|If 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 If 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 If 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 of this is an organ procurement organization (OPO), enter the OPO number in column 1 134 00 and termination date, if applicable, in column 2. All Providers

OSPITAL AND HOSPITAL HEALTH CARE COMPLI	EX IDENTIFICATION DATA	Provi der CC	N: 15-0042	From O	1/01/2018 2/31/2018	Worksheet S Part I Date/Time Pi 1/20/2020 10	repared:
					1. 00	2. 00	
40.00 Are there any related organization chapter 10? Enter "Y" for yes or are claimed, enter in column 2 th	"N" for no in column 1. I	If yes, and home	office co	,	N	2.00	140.00
1.00	2.	. 00			3. 00		
If this facility is part of a cha			ugh 143 th	ne name an	nd address	of the home	
office and enter the home office 41.00 Name:	contractor name and cont Contractor's Name:	ractor number.	Contro	actor's Nu	mhor		141.00
41.00 Name. 42.00 Street:	PO Box:		Contra	ictoi 5 ivu	ilibei .		142.0
43. 00 Ci ty:	State:		Zi p Co	ode:			143. 0
44.00	ala la la la la la Mandada a la					1.00	111 0
44.00 Are provider based physicians' co	sts included in worksheet	t A?				Y	144. 0
					1. 00	2. 00	_
45.00 f costs for renal services are clinpatient services only? Enter "Y no, does the dialysis facility in period? Enter "Y" for yes or "N" 46.00 Has the cost allocation methodolo Enter "Y" for yes or "N" for no iyes, enter the approval date (mm/	" for yes or "N" for no i clude Medicare utilizatio for no in column 2. gy changed from the previ n column 1. (See CMS Pub.	in column 1. If on for this cost iously filed cost	column 1 i reporting t report?	ı .	N		145. 0
						1.00	_
47.00 Was there a change in the statist	ical basis? Enter "V" for	r voc or "N" for	no			1. 00 N	147. C
48.00Was there a change in the statist						N	148. 0
49.00Was there a change to the simplif				for no.		N	149.0
		Part A	Part E		itle V	Title XIX	
Dana this facility contains a new	: ++ :	1.00	2.00		3. 00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
55. 00 Hospi tal		N	N		N	N	155.0
56.00 Subprovi der – IPF		N	N		N	N	156. 0
57. 00 Subprovi der – IRF		N	N		N	N	157. 0
58. 00 SUBPROVI DER 59. 00 SNF		N	N		N	N	158. 0 159. 0
60.00 HOME HEALTH AGENCY		N N	N		N	N N	160.0
61. 00 CMHC			N		N	N	161.0
				·			
h						1. 00	
Multicampus 65.00 s this hospital part of a Multic	ampue hospital that has o	ano or more campi	isos in di	fforont C	DSAs2	N	— 165. 0
Enter "Y" for yes or "N" for no.	allipus Hospi tai that has t	one or more campo	ases III ui	i i ei eiit C	DOAS!	IN IN	105. 0
, , , , , , , , , , , , , , , , , , , ,	Name	County	State	Zi p Code	CBSA	FTE/Campus	
(4,00),011, 445,1	0	1. 00	2. 00	3. 00	4. 00	5. 00	
66.00 ffline 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0. (00166.0
						1 00	
Health Information Technology (HI	T) incentive in the Ameri	ican Recovery and	d Reinvest	ment Act		1.00	
67.00 s this provider a meaningful use 68.00 f this provider is a CAH (line 1	r under §1886(n)? Enter O5 is "Y") and is a meani	"Y" for yes or ' ingful user (line	'N" for no).	r the	Y	167. 0 0168. 0
reasonable cost incurred for the 68.01 If this provider is a CAH and is			c qualific	for a bar	dehi n		168. 0
		N" for no. (see i	instructio	ns)			99169. 0
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	user (line 167 is "Y") ar	nd is not a CAH ((Title 105	13 11),	enter the	7.	11.2
exception under §413.70(a)(6)(ii)	user (line 167 is "Y") ar	nd is not a CAH ((TTHE TOS				
exception under §413.70(a)(6)(ii) 69.00 If this provider is a meaningful	user (line 167 is "Y") ar	nd is not a CAH ((TTHE TOS	Beg	gi nni ng 1. 00	Endi ng	

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDEN	TIFICATION DATA	Provider CCN: 15		eriod: rom 01/01/2018	Worksheet S-2 Part I	
			Te	0 12/31/2018	Date/Time Pre	
					1/20/2020 10:	18 am
				1. 00	2. 00	
171.00 If line 167 is "Y", does this provider h	nave any days for in	ndi vi dual s enrol l ed	in	N	0	171.00
section 1876 Medicare cost plans reporte	ed on Wkst. S-3, Pt.	I, line 2, col. 6'	? Enter			
"Y" for yes and "N" for no in column 1.	If column 1 is yes,	enter the number o	of section			
1876 Medicare days in column 2. (see ins	structions)					

	Financial Systems GOOD SAMARITA				u of Form CMS	
HOSPI TAI	L AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0042	Period: From 01/01/2018 To 12/31/2018		
				Y/N	1/20/2020 10 Date	:18 am
				1.00	2. 00	
	eneral Instruction: Enter Y for all YES responses. Enter N	for all NO re	esponses. Ent			
	m/dd/yyyy format. :OMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
	Has the provider changed ownership immediately prior to the			. N		1.00
r	reporting period? If yes, enter the date of the change in c	olumn 2. (see	instructions Y/N	Date	V/I	
			1.00	2.00	3. 00	
	Has the provider terminated participation in the Medicare F		N			2.00
	yes, enter in column 2 the date of termination and in colum	n 3, "V" for				
	oluntary or "I" for involuntary. s the provider involved in business transactions, includin	a management	N			3.00
	contracts, with individuals or entities (e.g., chain home o					3.00
	or medical supply companies) that are related to the provid					
	officers, medical staff, management personnel, or members o					
	of directors through ownership, control, or family and othe relationships? (see instructions)	r Similar				
			Y/N	Type	Date	
			1. 00	2.00	3. 00	
	inancial Data and Reports Column 1: Were the financial statements prepared by a Cert	ified Dublic	Υ	A		4.00
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f		'	A		4.00
	or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.					
	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.00
	those on the fired financial statements: If yes, submit fee	oner i a tron.		Y/N	Legal Oper.	
				1. 00	2. 00	
	pproved Educational Activities	16		. I N		
	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	ir yes, is ti	ne provider i	s N		6.00
	Are costs claimed for Allied Health Programs? If "Y" see in	structi ons.		Υ		7.00
	Were nursing school and/or allied health programs approved	and/or renewed	d during the	N		8.00
	cost reporting period? If yes, see instructions.					0.00
	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		car education	N N		9.00
	Was an approved Intern and Resident GME program initiated o		the current	N		10.00
	cost reporting period? If yes, see instructions.					
	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	oroved	N		11.00
	reacting Frogram on worksheet A: IT yes, see Instructions.				Y/N	
					1. 00	
_	ad Debts	!	L!		V	12.00
	s the provider seeking reimbursement for bad debts? If yes fline 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12.00
	period? If yes, submit copy.	orrey change .	adiring time c	lost reporting	.,	10.00
	fline 12 is yes, were patient deductibles and/or co-payme	nts waived? I	fyes, see in	structi ons.	N	14.00
	ed Complement Did total beds available change from the prior cost reporti	ng neriod2 lf	ves see ins	tructions	Y	15.00
13. 00 E	ora total boas avairable change from the prior cost reporti		t A		t B	13.00
		Y/N	Date	Y/N	Date	
D	ICAD Data	1. 00	2. 00	3. 00	4. 00	
	YS&R Data Was the cost report prepared using the PS&R Report only?	Υ	03/21/2019	N	03/21/2019	16.00
	f either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	nstructions) Vas the cost report prepared using the PS&R Report for	N		N		17.00
	totals and the provider's records for allocation? If	IN		IN .		17.00
I	either column 1 or 3 is yes, enter the paid-through date					
	n columns 2 and 4. (see instructions)					
	f line 16 or 17 is yes, were adjustments made to PS&R	N		N		18.00
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
9. 00 I	fline 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					1
	nformation? If yes, see instructions.					

Heal th	Financial Systems GOOD SAMARIT	AN HOSPITAL		In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	Provider CCN: 15-0042 Period From 0 To 1		Worksheet S Part II Date/Time F 1/20/2020 1	Prepared:
		Descr	iption	Y/N	Y/N	0. 10 (
20, 00	16 1: 1/ 17 :		0	1.00	3. 00 N	20.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	IN	20. 00
		Y/N	Date	Y/N	Date	
	T 5	1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	EPT CHILDRENS	HOSPI TALS)			
22.00	Capital Related Cost	a i natruati ana			N	22.00
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, se Have changes occurred in the Medicare depreciation expense			ring the cost	N N	22. 00 23. 00
20.00	reporting period? If yes, see instructions.	due to applial	Sar S made adi	ring the cost		20.00
24. 00	Were new leases and/or amendments to existing leases enter If yes, see instructions	ed into during	this cost re	eporting period?	Υ	24. 00
25. 00	Have there been new capitalized leases entered into during	, the cost repo	rting period	? If yes, see	N	25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during t	he cost report	ing period? I	f yes, see	N	26.00
27. 00	instructions.	'	na nariada It	E voo oubmit	N	27. 00
27.00	Has the provider's capitalization policy changed during th copy.	e cost reporti	ng perrous ri	yes, subiii t	IV	27.00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit e	entered into du	ring the cost	t reporting	N	28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service F	Reserve Fund)	N	29. 00
30. 00	treated as a funded depreciation account? If yes, see instructions .00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see					
31. 00	instructions. Has debt been recalled before scheduled maturity without i	,	,		N N	30.00
31.00	i nstructi ons.	SSuarice of flew	debt? IT yes	s, see	IV	31.00
32. 00	Purchased Services Have changes or new agreements occurred in patient care se		ed through co	ontractual	N	32.00
33. 00	arrangements with suppliers of services? If yes, see instr If line 32 is yes, were the requirements of Sec. 2135.2 ap no, see instructions.		ng to competi	tive bidding? If	-	33. 00
	Provi der-Based Physi ci ans					
34.00		rrangement wit	h provider-ba	ased physicians?	Υ	34.00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended ex	disting agreeme	ents with the	provi der-based	Υ	35.00
	physicians during the cost reporting period? If yes, see i	nstructions.		. V (N)	D-+-	
				Y/N 1.00	2. 00	
	Home Office Costs			1.00	2.00	
	Were home office costs claimed on the cost report?			N		36.00
37. 00	If line 36 is yes, has a home office cost statement been p If yes, see instructions.	repared by the	home office	?		37. 00
38. 00	If line 36 is yes , was the fiscal year end of the home of			=		38. 00
39. 00	j			5,		39. 00
40. 00	see instructions. If line 36 is yes, did the provider render services to the	e home office?	If yes, see			40.00
	i nstructi ons.		-			
		1.	00	2.	00	
44 05	Cost Report Preparer Contact Information	lou E		CM TH		46.00
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KYLE		SMI TH		41.00
42. 00	Enter the employer/company name of the cost report	BLUE & CO, LLC				42. 00
43. 00	preparer. Enter the telephone number and email address of the cost	317-713-7957		KCSMI TH@BLUEAN	DCO. COM	43.00
	report preparer in columns 1 and 2, respectively.					

Heal th Fina	ancial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPI TAL A	ND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE	Provider CCN		Peri od:	Worksheet S-2	
					From 01/01/2018 Fo 12/31/2018	Part II Date/Time Pre	narad:
					10 12/31/2016	1/20/2020 10:	рагец. 18 am
				<u> </u>			
			3.00	1			
Cost	Report Preparer Contact Information						
	er the first name, last name and the		SENIOR MANAGER				41.00
helo	d by the cost report preparer in colu	mns 1, 2, and 3,					
resp	pecti vel y.						
42. 00 Ente	er the employer/company name of the c	ost report					42.00
	parer.						
	er the telephone number and email add						43. 00
repo	ort preparer in columns 1 and 2, resp	ecti vel y.					

Heal th Fi nancial SystemsGOOD SAHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provi der CCN: 15-0042

					Т	o 12/31/2018	Date/Time Pro 1/20/2020 10:	
							I/P Days /	10 4111
							0/P Visits /	
							Tri ps	
	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		69	25, 185	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 I RF Subprovi der							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	
6. 00	Hospital Adults & Peds. Swing Bed NF				05.405	0.00	0	
7. 00	Total Adults and Peds. (exclude observation			69	25, 185	0. 00	0	7. 00
0.00	beds) (see instructions)	04.00		20	40.050	0.00		0.00
8. 00	INTENSIVE CARE UNIT	31.00		30	10, 950	0. 00	0	
9.00	CORONARY CARE UNIT							9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11.00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	OTHER SPECIAL CARE (SPECIFY)							12.00
13.00	NURSERY	43.00			0, 105	0.00	0	
14.00	Total (see instructions)			99	36, 135	0. 00	0	
15.00	CAH visits	40.00		00	7 000		0	
16.00	SUBPROVI DER - I PF	40.00		20			0	16.00
17.00	SUBPROVI DER - I RF	41.00		25	9, 125		0	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	101 00					0	21.00
22. 00	HOME HEALTH AGENCY	101.00					U	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	44/ 00						23.00
24.00	HOSPI CE	116.00		0	C			24.00
24. 10	HOSPICE (non-distinct part)	30.00						24. 10
25. 00	CMHC - CMHC							25.00
26. 00	RURAL HEALTH CLINIC	00.00						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		111			0	
27. 00	Total (sum of lines 14-26)			144			0	27.00
28. 00	Observation Bed Days						U	
29. 00	Ambulance Trips							29.00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF			0	0			31. 00 32. 00
32.00	Labor & delivery days (see instructions)			U				32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)							32.01
33. 00	, , , , , , , , , , , , , , , , , , , ,							33.00
	LTCH site neutral days and discharges							33.00
33.01	Lion site neutral days and discharges		I		I			33.01

Provider CCN: 15-0042

				T	o 12/31/2018	Date/Time Pre 1/20/2020 10:	
		I/P Days	/ O/P Visits	/ Trins	Full Time F	Equi val ents	TO alli
		171 bays 7 071 VISITS 7 111 ps			Tarr Trille Equivarents		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	8, 314	232	12, 998			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)	1, 757	2, 517				2.00
3.00	HMO IPF Subprovider	91	0				3.00
4.00	HMO IRF Subprovider	270	138				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0				5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	_			6.00
7.00	Total Adults and Peds. (exclude observation	8, 314	232	12, 998			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	4, 530	0	7, 149			8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		43				13.00
14.00	Total (see instructions)	12, 844	275	· ·	0. 00	1, 253. 58	ł
15.00	CAH visits	0	0		0.00	24 00	15.00
16.00	SUBPROVI DER - I PF	1, 645	179			31. 89	ł
17.00	SUBPROVI DER - I RF	6, 323	0	7, 324	0. 00	35. 75	
18. 00 19. 00	SUBPROVI DER						18. 00 19. 00
20.00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
20.00	OTHER LONG TERM CARE						20.00
21.00	HOME HEALTH AGENCY	0	0	0	0. 00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	٩	U	U	0.00	0.00	23.00
24. 00	HOSPICE	0	0	0	0. 00	9. 86	
24. 00	HOSPICE (non-distinct part)	٩	U	681	0.00	7.00	24. 00
25. 00	CMHC - CMHC			001			25.00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0. 00	0.00	
27. 00	Total (sum of lines 14-26)	٩	O	J	0.00	1, 331. 08	
28. 00	Observation Bed Days		811	4, 160	0.00	1,001.00	28. 00
29. 00	Ambul ance Trips	0	011	1, 100			29.00
30.00	Employee discount days (see instruction)	٩		0			30.00
31. 00	Employee discount days - IRF			ő			31.00
32. 00	Labor & delivery days (see instructions)	o	36	_			32.00
32. 01	Total ancillary labor & delivery room		00	, o			32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	О					33.00
	LTCH site neutral days and discharges	O					33. 01
		•			. '	•	

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part I | To 12/31/2018 | Date/Time Prepared: | Date/Time Prepar Provider CCN: 15-0042

				10) 12/31/2018	Date/IIMe Pre 1/20/2020 10:	
		Full Time		Di sch	arges	17 207 2020 10.	
		Equi val ents		, and the second			
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	·	Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	3, 160	66	5, 385	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)			338	619		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO I RF Subprovi der				11		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00 6. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8.00
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0.00	0	3, 160	66	5, 385	•
15. 00	CAH visits					,	15.00
16. 00	SUBPROVIDER - IPF	0.00	0	194	37	824	•
17.00	SUBPROVI DER - I RF	0.00	0	486	o	556	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	` ′						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	0.00					26. 25
27. 00	` ,	0. 00					27.00
28. 00	,						28.00
29. 00							29.00
30.00	Employee discount days (see instruction) Employee discount days - IRF						30. 00 31. 00
	Labor & delivery days (see instructions)						32.00
32. 00	, ,						32.00
JZ. U1	outpatient days (see instructions)						32.01
33. 00				o			33.00
	LTCH site neutral days and discharges						33. 01
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1		١ - ١	'		

	Financiai systems		GOOD SAWARI IA				u or Form CWS-2	
HOSPI T	AL WAGE INDEX INFORMATION			Provi der C		Period: From 01/01/2018 To 12/31/2018		pared:
		Wkst. A Line Number	Amount Reported	Reclassificat ion of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	4.00	5. 00	6. 00	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4.00	3.00	0.00	
1. 00	SALARIES Total salaries (see	200.00	103, 922, 123	0	103, 922, 12	3, 356, 846. 00	30. 96	1.00
	instructions)						0.00	
2. 00	Non-physician anesthetist Part A		0			0.00	0. 00	
3. 00	Non-physician anesthetist Part B		0	0		0.00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		19, 721	0	19, 72	1 120. 00	164. 34	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0 4, 243, 413	0	4, 243, 41	0. 00 3 22, 830. 00	0. 00 185. 87	•
	Physician-Part B							
6. 00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0		0.00	0. 00	6.00
7. 00	Interns & residents (in an	21. 00	0	0		0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0)	0.00	0. 00	7. 01
8. 00	programs) Home office and/or related		0	0		0.00	0. 00	8. 00
9. 00	organization personnel SNF	44. 00	0	0		0.00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)		35, 800, 677	0	35, 800, 67	866, 965. 00	41. 29	10.00
11. 00	OTHER WAGES & RELATED COSTS Contract labor: Direct Patient		237, 056	0	237, 05	3, 450. 00	68. 71	11.00
12. 00	Care Contract Labor: Top Level		0	0		0.00	0.00	12. 00
	management and other management and administrative							
13. 00	services Contract Labor: Physician-Part A - Administrative		519, 470	0	519, 470	4, 948. 00	104. 99	13. 00
14. 00	Home office and/or related organization salaries and		0	0		0.00	0. 00	14.00
14. 01	wage-related costs Home office salaries		0	0		0.00	0. 00	14. 01
14. 02	Related organization salaries		0	0		0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		0	0		0.00	0. 00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		0	0		0.00	0.00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		19, 619, 894	0	19, 619, 89	1		17. 00
18. 00	instructions) Wage-related costs (other)		0	0				18. 00
19. 00	(see instructions) Excluded areas		8, 078, 488	0	8, 078, 48	3		19. 00
20. 00	Non-physician anesthetist Part A		0	0				20. 00
21. 00	Non-physician anesthetist Part B		0	0		D		21.00
22. 00	Physician Part A - Administrative		2, 071	0	2, 07	1		22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0 417, 953	0	417, 95)		22. 01 23. 00
24.00	Wage-related costs (RHC/FQHC)		0	0)	o l		24.00
25. 00 25. 50	Interns & residents (in an approved program) Home office wage-related		0	0				25. 00 25. 50
	(core)		_	_				
25. 51	Related organization wage-related (core)		0	_				25. 51
25. 52	Home office: Physician Part A - Administrative -		0	0				25. 52
25. 53	wage-related (core) Home office & Contract Physicians Part A - Teaching -		0	0				25. 53
	wage-related (core)							

Provider CCN: 15-0042

					T	o 12/31/2018		
		Wkst. A Line	Amount	Recl assi fi cat	Adjusted	Pai d Hours	1/20/2020 10:	18 am
		Number	Reported	ion of	Sal ari es	Related to	Average Hourly Wage	
		Nullibei	керот гец	Sal ari es	(col. 2 ± col.	Salaries in		
				(from Wkst.	, ·	col. 4	(col. 4 ÷	
				A-6)	3)	COI. 4	col . 5)	
		1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	OVERHEAD COSTS - DIRECT SALARI		2.00	3.00	4.00	5.00	0.00	
26. 00	Employee Benefits Department	4.00	5, 307, 818	1	5, 307, 818	292, 955. 00	18. 12	26. 00
27.00	Administrative & General	5.00	9, 068, 076		9, 068, 076	· ·		27.00
	Administrative & General under							
28. 00			224, 803	0	224, 803	1, 431. 00	157. 10	28.00
20.00	contract (see inst.)	/ 00	0			0.00	0.00	20.00
29. 00	Maintenance & Repairs	6.00	2 100 000	0	2 100 000	0.00		29. 00
30.00	Operation of Plant	7. 00	2, 180, 898		2, 180, 898		22. 81	
31. 00	Laundry & Linen Service	8. 00	206, 759		206, 759	· ·		
32. 00	Housekeepi ng	9. 00	1, 994, 584	0	1, 994, 584	138, 570. 00		32.00
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34.00	Dietary	10. 00	1, 639, 560	-1, 209, 046	430, 514	27, 890. 00		34.00
35. 00	Dietary under contract (see		0	0	0	0. 00	0. 00	35.00
	instructions)							
36.00	Cafeteri a	11. 00	0	1, 209, 046	1, 209, 046			36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0. 00		37.00
38. 00	Nursing Administration	13. 00	1, 428, 144	0	1, 428, 144	32, 033. 00		
39. 00	Central Services and Supply	14. 00	367, 321	0	367, 321	23, 029. 00	15. 95	39. 00
40.00	Pharmacy	15. 00	2, 883, 987	0	2, 883, 987	71, 616. 00	40. 27	40.00
41.00	Medical Records & Medical	16.00	2, 436, 861	0	2, 436, 861	104, 191. 00	23. 39	41.00
	Records Library							
42.00	Social Service	17. 00	717, 946	0	717, 946	26, 662. 00	26. 93	42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0. 00	43.00

HOSPI TA	AL WAGE INDEX INFORMATION			Provider Co		Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part III Date/Time Prep 1/20/2020 10:	pared:
		Worksheet A	Amount	Recl assi fi cat	Adj usted	Pai d Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
				Sal ari es	(col.2 ± col	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4.00	5. 00	6. 00	
-	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		99, 903, 513	0	99, 903, 51	3 3, 335, 447. 00	29. 95	1.00
	instructions)							
2. 00	Excluded area salaries (see		35, 800, 677	0	35, 800, 67	7 866, 965. 00	41. 29	2.00
	instructions)							
3. 00	Subtotal salaries (line 1		64, 102, 836	0	64, 102, 83	6 2, 468, 482. 00	25. 97	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		756, 526	0	756, 52	8, 398. 00	90. 08	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		19, 621, 965	0	19, 621, 96	5 0.00	30. 61	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		84, 481, 327	0	84, 481, 32	7 2, 476, 880. 00	34. 11	6.00
7. 00	Total overhead cost (see		28, 456, 757	0	28, 456, 75	7 1, 177, 559. 00	24. 17	7.00
	instructions)			1				

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0042	
		From 01/01/2018 Part IV

	To 12/31/2018	Date/Time Pre 1/20/2020 10:	
		Amount	TO dill
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4, 566, 143	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)	0	8.00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	15, 547, 599	8. 02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	327, 875	10.00
11. 00		147, 120	11.00
12.00		0	12.00
13.00		342, 607	
14.00		0	14.00
15.00		0	15.00
16.00		0	16.00
	Non cumulative portion)		
	TAXES		
17. 00		6, 799, 320	17. 00
18. 00		0	18.00
19. 00		33, 159	
20. 00		0	20.00
	OTHER		
21. 00		0	21. 00
	instructions))		
22. 00		47, 026	22. 00
23. 00		307, 557	23. 00
24. 00		28, 118, 406	24.00
05.00	Part B - Other than Core Related Cost	0	05.00
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0042	Period: Worksheet S-3 From 01/01/2018 Part V
		To 12/31/2018 Date/Time Prepared

		Го 12/31/2018	Date/Time Pre 1/20/2020 10:	
	Cost Center Description	Contract	Benefit Cost	
		Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	237, 056	28, 118, 406	1.00
2.00	Hospi tal	237, 056	28, 118, 406	2.00
3.00	Subprovi der - IPF	0	0	3.00
4.00	Subprovi der - I RF	0	0	4.00
5.00	Subprovi der - (0ther)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7. 00	Swing Beds - NF	0	0	7.00
8.00	Hospi tal -Based SNF			8. 00
9. 00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11.00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

Hool +b	Financial Systems		GOOD SAMARITA	AN HOSDITAL		India	u of Form CMS 1	DEE2 10
	Financial Systems FAL-BASED HOSPICE IDENTIFICATION	I DATA	GOOD SAMARITA	Provi der C	CN: 15-0042	Peri od: From 01/01/2018	worksheet S-9 PARTS I THROU	
				Hospi ce CC	N: 15-1526	To 12/31/2018		pared:
						Hospi ce I	17 207 2020 10.	10 dili
		Undupl i cated		'				
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
		1. 00	2. 00	Facility 3.00	4. 00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS FOR C					3.00	0.00	
1.00	Hospi ce Conti nuous Home Care		ERT ODS BEST WIN	THE BEI GIVE GOT	1, 2010			1.00
2. 00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4.00	Hospice General Inpatient Care							4.00
5.00	Total Hospice Days							5.00
Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015								
6. 00	Number of patients receiving							6. 00
	hospi ce care							
7. 00	Total number of unduplicated Continuous Care hours billable							7. 00
	to Medicare							
8. 00	Average Length of Stay (line 5							8.00
0.00	/ line 6)							0.00
9. 00	Unduplicated census count							9.00
	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2.00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTIN	G PERLODS BEGI	NNING ON OR AF	TER OCTOBER 1			
10.00				070		0 0		10.00
11.00				6, 873	1	24 932 7 24	·	11.00
12. 00 13. 00	Hospice Inpatient Respite Care Hospice General Inpatient Care			32 514		7 24 15 93		12.00 13.00
	Total Hospi ce Days			7, 419	1	46 1, 049		14.00
14.00	PART IV - CONTRACTED STATISTIC	AL DATA FOR CO	ST REPORTING P					14.00
15. 00			JI KLIOKIING F	CKTODS BEGINNI		0 0		15.00
	Hospice General Inpatient Care					0 0		16.00
	The second of th			1	1	-1	ı	1

Heal th	Financial Systems GOOD SAMARITAN H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10			
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0042	Peri od:	Worksheet S-1				
				From 01/01/2018	D. I. (T' D.				
				To 12/31/2018	Date/Time Pre 1/20/2020 10:	pared: 18 am			
					17 207 2020 10.	TO dill			
					1. 00				
	Uncompensated and indigent care cost computation								
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ine 202 colur	nn 8)	0. 244668	1. 00			
0.00	Medicaid (see instructions for each line)				00 (00 (07	0.00			
2. 00 3. 00	Net revenue from Medicaid				29, 608, 637 Y	2. 00 3. 00			
4. 00	Did you receive DSH or supplemental payments from Medicaid? If line 3 is yes, does line 2 include all DSH and/or supplement	ntal navmon	ts from Madia	rai d2	Y	4.00			
5. 00	If line 4 is no, then enter DSH and/or supplemental payments in			aiu:	, 0	5.00			
6. 00	Medicaid charges	. om mour ou			185, 953, 717	6. 00			
7. 00	Medicaid cost (line 1 times line 6)				45, 496, 924	7.00			
8.00	· · · · · · · · · · · · · · · · · · ·								
	< zero then enter zero)								
	Children's Health Insurance Program (CHIP) (see instructions 1	for each lir	ne)						
9.00	Net revenue from stand-alone CHIP				0	9.00			
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10. 00 11. 00			
12. 00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	inus line 9·	if < zero then	0				
.2.00	enter zero)	(7,	2010 111011	· ·	12.00			
	Other state or local government indigent care program (see ins	structions 1	for each line	e)					
13.00	Net revenue from state or local indigent care program (Not in				0				
14. 00	Charges for patients covered under state or local indigent can	re program	(Not included	lin lines 6 or	0	14.00			
15 00	10)	1.43			0	15 00			
15. 00 16. 00	State or local indigent care program cost (line 1 times line 1 Difference between net revenue and costs for state or local in	,	o program (Li	no 15 minus Lina	0	15. 00 16. 00			
10.00	13; if < zero then enter zero)	idi gerit care	e program (ri	ile io illitius i i ile	0	10.00			
	Grants, donations and total unreimbursed cost for Medicaid, Ch	HP and stat	te/Local indi	gent care progra	ıms (see				
17. 00	instructions for each line) Private grants, donations, or endowment income restricted to	fundi na jehai	ri ty caro		0	17. 00			
18. 00	Government grants, appropriations or transfers for support of				0				
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local			ns (sum of lines	15, 888, 287				
	8, 12 and 16)	3							
			Uni nsured	Insured	Total (col. 1				
			patients	pati ents	+ col . 2)				
	Uncompensated Care (see instructions for each line)		1.00	2. 00	3. 00				
20. 00	Charity care charges and uninsured discounts for the entire fa	acility	9, 744, 1	1, 554, 659	11, 298, 823	20. 00			
	(see instructions)	,							
21. 00	Cost of patients approved for charity care and uninsured disc	ounts (see	2, 384, 0	1, 554, 659	3, 938, 744	21.00			
	instructions)				_				
22. 00	Payments received from patients for amounts previously written	n off as		0 0	0	22. 00			
23. 00	charity care Cost of charity care (line 21 minus line 22)		2, 384, 0	35 1, 554, 659	3, 938, 744	33 00			
23.00	cost of chartty care (fine 21 minus fine 22)		2, 304, 0	1, 334, 037	3, 730, 744	23.00			
					1. 00				
24. 00	Does the amount on line 20 column 2, include charges for patie	ent days be	yond a Length	of stay limit	N	24. 00			
	imposed on patients covered by Medicaid or other indigent care	e program?	_	-					
25. 00	If line 24 is yes, enter the charges for patient days beyond stay limit	the indigen	t care progra	m's length of	0	25. 00			
26. 00	Total bad debt expense for the entire hospital complex (see in	nstructions`)		19, 998, 906	26. 00			
27. 00	Medicare reimbursable bad debts for the entire hospital comple				619, 686				
27. 01	Medicare allowable bad debts for the entire hospital complex				953, 362	27. 01			
28. 00	Non-Medicare bad debt expense (see instructions)				19, 045, 544				
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	kpense (see	instructions	5)	4, 993, 511				
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	ine 20)			8, 932, 255				
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	rne 30)			24, 820, 542	31.00			

	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	GOOD SAMARITAI	Provider C	CN: 15 0042 D	eriod:	u of Form CMS-: Worksheet A	2552-10
KLULAS	STITEATION AND ADJUSTMENTS OF TRIAL BALANCE O	I LAFLINGLS	Frovider	F	rom 01/01/2018		
				T	o 12/31/2018	Date/Time Pre 1/20/2020 10:	pared:
	Cost Center Description	Sal ari es	Other	Total (col 1	Recl assi fi cat	Reclassi fi ed	18 8111
	oost center bescriptren	our ur res	Other	+ col . 2)	ions (See	Trial Balance	
				ĺ	A-6)	(col. 3 +-	
						col . 4)	
	CENEDAL CEDALCE COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FLXT		20, 183, 499	20, 183, 499	6, 157, 401	26, 340, 900	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		21, 758			21, 758	1
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	644, 952	2, 094, 650			29, 290, 254	
4. 01	00401 COMMUNI CATI ONS	280, 900	75, 476	•		281, 738	4. 01
4. 02	00402 PURCHASI NG & RECEI VI NG	694, 499	602, 549			998, 661	4. 02
4. 03 4. 04	00403 REGI STRATI ON 00404 PATI ENT ACCOUNTS	1, 253, 808 2, 433, 659	422, 561 2, 233, 538			1, 283, 794 3, 878, 331	
5. 00	00500 ADMI NI STRATI VE & GENERAL	9, 068, 076	22, 249, 155			28, 662, 771	5.00
7. 00	00700 OPERATION OF PLANT	2, 180, 898	4, 359, 468				1
8.00	00800 LAUNDRY & LINEN SERVICE	206, 759	186, 651			300, 653	
9. 00	00900 HOUSEKEEPI NG	1, 994, 584	997, 306				1
10.00	01000 DI ETARY	1, 639, 560	2, 039, 454 0			823, 053	1
11. 00 13. 00	O1100 CAFETERI A O1300 NURSI NG ADMI NI STRATI ON	1, 428, 144	516, 796	·	-/ /	2, 311, 446 1, 603, 954	
14. 00	01400 CENTRAL SERVICES & SUPPLY	367, 321	306, 186			536, 489	
15.00	01500 PHARMACY	2, 883, 987	16, 932, 211	•		3, 210, 896	
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 436, 861	1, 198, 210	3, 635, 071	-766, 178	2, 868, 893	1
17.00	01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
17. 01 21. 00	O1701 MENTAL HEALTH OH O2100 I &R SERVICES-SALARY & FRINGES APPRVD	717, 946	425, 023	1, 142, 969	-197, 522	945, 447	17. 01 21. 00
22. 00	02200 &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM-RADI OLOGY	222, 786	65, 919	288, 705	-60, 231	228, 474	
23. 01	02301 PARAMED ED PRGM-LAB	214, 465	32, 859	247, 324	-50, 949	196, 375	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS	4, 414, 604	1, 616, 150			4, 861, 598	
40.00	03100 INTENSIVE CARE UNIT 04000 SUBPROVI DER - I PF	3, 547, 217 1, 850, 794	1, 390, 388 597, 532			3, 946, 820 2, 012, 384	
41. 00	04100 SUBPROVI DER - I RF	1, 732, 693	603, 584				
43.00	04300 NURSERY	297, 324	99, 728				1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 516, 189	5, 647, 598	9, 163, 787	-4, 483, 960	4, 679, 827	
51. 00 51. 01	O5100 RECOVERY ROOM O5101 ENDOSCOPY	0 1, 005, 330	0 1, 092, 933	2, 098, 263	-533, 227	0 1, 565, 036	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 191, 158	414, 737			1, 304, 884	1
53.00	05300 ANESTHESI OLOGY	0	0	0	l '	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 829, 231	3, 631, 502			5, 603, 026	1
55.00	05500 RADI OLOGY-THERAPEUTI C	2, 610, 961	1, 578, 917			3, 539, 423	1
60. 00 63. 00	06000 LABORATORY 06300 BLOOD STORING, PROCESSING & TRANS.	2, 276, 662	4, 915, 097	7, 191, 759	-640, 660	6, 551, 099 0	1
65. 00	06500 RESPIRATORY THERAPY	2, 150, 183	1, 776, 258	3, 926, 441	-843, 315	3, 083, 126	
66.00	06600 PHYSI CAL THERAPY	3, 804, 055	1, 158, 145				
69. 00	06900 ELECTROCARDI OLOGY	4, 863, 753	3, 229, 099	8, 092, 852	-2, 501, 640	5, 591, 212	
	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
70. 01 71. 00	07001 NEURODI AGNOSTI CS 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	402, 980	321, 410	724, 390	-99, 088 7, 241, 917	625, 302 7, 241, 917	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	5, 349, 837	5, 349, 837	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	15, 898, 700	15, 898, 700	•
75.00	07500 ASC (NON-DISTINCT PART)	1, 198, 091	2, 342, 199	3, 540, 290	-1, 649, 670	1, 890, 620	
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76. 01	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	0	548, 854	548, 854	-5, 362	543, 492	76. 01
90. 00	09000 CLINIC	108, 848	37, 012	145, 860	-30, 300	115, 560	90.00
90. 01	04950 WOUND CLINIC	400, 108	2, 725, 135			1, 246, 593	1
91.00	09100 EMERGENCY	4, 181, 575	1, 708, 743		-1, 194, 036	4, 696, 282	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
04 00	OTHER REIMBURSABLE COST CENTERS O9600 DURABLE MEDICAL EQUIP-RENTED	01 222	00. 207	100 520	42.250	120 170	04 00
	10100 HOME HEALTH AGENCY	91, 223	99, 297 0			128, 170 0	101.00
101.00	SPECIAL PURPOSE COST CENTERS	<u> </u>			<u> </u>	0	101.00
113.00	11300 I NTEREST EXPENSE		5, 876, 718	5, 876, 718	-5, 876, 718	0	113.00
	11600 H0SPI CE	531, 026	682, 711			1, 056, 896	
118. 00		72, 673, 210	117, 037, 016	189, 710, 226	9, 794, 900	199, 505, 126	1118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	0	0	O	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	25, 628, 847	21, 845, 341		· ·	39, 219, 821	
	07950 COMMUNITY HEALTH SERVICES	0	16, 229				194.00
	07952 MARKETING AND PUBLIC RELATIONS	168, 477	463, 480			587, 914	1
	07953 MH RESIDENTIAL	375, 014	132, 795	507, 809		418, 318	1
	07954 UNUSED SPACE 07955 MOB	0	0 36, 956	0 36, 956	0		194. 04 194. 05
	07956 FOUNDATION	0	30, 7 30	30, 930			194. 05
	1				,		

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
				rom 01/01/2018		
				To 12/31/2018	Date/Time Pre	pared:
				_	1/20/2020 10:	18 am
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cat	Recl assi fi ed	
			+ col. 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
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 COMMUNITY MENTAL HEALTH CENTER	5, 076, 575	1, 884, 360	6, 960, 935	-1, 406, 999	5, 553, 936	194. 09
200.00 TOTAL (SUM OF LINES 118 through 199)	103, 922, 123	141, 416, 177	245, 338, 300	0	245, 338, 300	200. 00

Health FinancialSystemsGOOD SAMAIRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provi der CCN: 15-0042

			To 12/31/2018 Date/Time Pre 1/20/2020 10:	
Cost Center Description	Adjustments	Net Expenses	172072020 10.	TO dill
	(See A-8)	For		
	6. 00	Allocation 7.00	_	
GENERAL SERVICE COST CENTERS	0.00	7.00		
1.00 O0100 CAP REL COSTS-BLDG & FLXT	-1, 188, 554	25, 152, 346		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P	0	21, 758		2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATI ONS	-30, 425 0	29, 259, 829 281, 738		4. 00 4. 01
4. 02 O0402 PURCHASI NG & RECEI VI NG	-268, 518	730, 143		4. 02
4. 03 00403 REGI STRATI ON	0	1, 283, 794		4. 03
4. 04 00404 PATI ENT ACCOUNTS	-193, 387	3, 684, 944		4.04
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	-11, 012, 243 -22, 097	17, 650, 528 5, 872, 136		5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	-11, 571	289, 082		8.00
9. 00 00900 HOUSEKEEPI NG	-238, 795	1, 983, 152		9. 00
10. 00 01000 DI ETARY	0	823, 053		10.00
11. 00 01100 CAFETERI A	-1, 095, 804	1, 215, 642		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	0	1, 603, 954 536, 489		13. 00 14. 00
15. 00 01500 PHARMACY	-14, 953	3, 195, 943		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-96, 379	2, 772, 514		16.00
17. 00 01700 SOCI AL SERVI CE	0	0		17. 00
17. 01 01701 MENTAL HEALTH OH	-114, 639	830, 808		17. 01
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1	21. 00 22. 00
23. 00 02300 PARAMED ED PRGM-RADIOLOGY	-53, 861	174, 613		23. 00
23. 01 02301 PARAMED ED PRGM-LAB	0	196, 375		23. 01
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS	0	4, 861, 598	l e e e e e e e e e e e e e e e e e e e	30.00
31. 00 03100 I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	-317, 123	3, 946, 820 1, 695, 261	l e e e e e e e e e e e e e e e e e e e	31. 00 40. 00
41. 00 04100 SUBPROVI DER - RF	-90, 812	1, 729, 631		41.00
43. 00 04300 NURSERY	0	317, 892		43.00
ANCILLARY SERVICE COST CENTERS	1 000 040	2 242 422	,I	
50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM	-1, 339, 219 0	3, 340, 608 0	1	50. 00 51. 00
51. 00 05100 RECOVERT ROOM 51. 01 05101 ENDOSCOPY	-12,000	1, 553, 036		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 304, 884		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	-20, 927	5, 582, 099		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 60. 00 06000 LABORATORY	-1, 402, 941 -36, 212	2, 136, 482 6, 514, 887		55. 00 60. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0, 314, 007		63.00
65. 00 06500 RESPIRATORY THERAPY	-911, 964	2, 171, 162		65.00
66. 00 06600 PHYSI CAL THERAPY	-7, 656	3, 927, 264		66.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	-2, 717, 564 0	2, 873, 648 0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 70. 01 07001 NEURODI AGNOSTI CS	-11, 289	614, 013	1	70. 00 70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-1, 100	7, 240, 817		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	5, 349, 837		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	-385, 851	15, 512, 849		73.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03950 MH ANCILLARY OUTPATIENT	-60, 390	1, 830, 230		75. 00 76. 00
76. 01 03951 INPATIENT DIALYSIS	-199, 297	344, 195		76. 01
OUTPATIENT SERVICE COST CENTERS		·		
90. 00 09000 CLI NI C	0	115, 560		90.00
90. 01 04950 WOUND CLINIC 91. 00 09100 EMERGENCY	-1, 146 -83, 798	1, 245, 447 4, 612, 484	•	90. 01 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-03, 740	4,012,404		92.00
OTHER REIMBURSABLE COST CENTERS				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	128, 170		96. 00
101. 00 10100 HOME HEALTH AGENCY	0	0)	101. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE	O	0] 113. 00
116. 00 11600 HOSPI CE	-66	1, 056, 830		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-21, 940, 581	177, 564, 545		118. 00
NONREI MBURSABLE COST CENTERS			.1	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	20 210 921	l e e e e e e e e e e e e e e e e e e e	190.00
192.00 19200 PHYSICIANS PRIVATE OFFICES 194.00 07950 COMMUNITY HEALTH SERVICES		39, 219, 821 16, 229		192. 00 194. 00
194. 02 07952 MARKETING AND PUBLIC RELATIONS	ol	587, 914	l control of the cont	194. 02
194. 03 07953 MH RESIDENTIAL	o	418, 318		194. 03
194. 04 07954 UNUSED SPACE	0	0		194.04
194. 05 07955 MOB 194. 06 07956 FOUNDATI ON	0	36, 956 0		194. 05 194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	0		194.06
	·		I .	

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lieu	of Form CMS	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der (CCN: 15-0042	Peri od: From 01/01/2018	Worksheet A	
				To 12/31/2018	Date/Time Pr	
					1/20/2020 10): 18 am
Cost Center Description	Adjustments	Net Expenses				
	(See A-8)	For				
		Allocation				

7.00

5, 553, 936 223, 397, 719 194. 08 194. 09 200. 00

6. 00

0 0 -21, 940, 581

194. 08 07958 I NDUSTRI AL HEALTH 194. 09 07959 COMMUNI TY MENTAL HEALTH CENTER 200. 00 TOTAL (SUM OF LINES 118 through 199)

Provider CCN: 15-0042

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 1/20/2020 10: 18 am

		Increases			1/20/2020 10:	: 18 am
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
1. 00	A - DRUGS CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	73. 00	0	15, 898, 700		1.00
1.00	TOTALS			15, 898, 700		1.00
	B - MEDICAL SUPPLIES CHARGED	TO PATIENTS				
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	7, 241, 917		1.00
2. 00	PATIENTS IMPL. DEV. CHARGED TO	72. 00	0	5, 349, 837		2.00
2.00	PATI ENTS	72.00	Ĭ	0,017,007		2.00
3. 00	LABORATORY	60. 00	0	37, 917		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	o	0		6.00
7.00		0. 00	O	0		7.00
8.00		0.00	0	0		8.00
9. 00 10. 00		0. 00 0. 00	0	0		9. 00 10. 00
11. 00		0. 00	Ö	Ö		11.00
12.00		0.00	0	0		12.00
13. 00 14. 00		0. 00 0. 00	0	0		13. 00 14. 00
15. 00		0.00	o	0		15. 00
16.00		0. 00	О	0		16.00
17.00		0.00	0	0		17.00
18. 00 19. 00		0. 00 0. 00	0	0		18. 00 19. 00
20. 00		0. 00	o	Ö		20.00
21. 00		0.00	0	0		21.00
22. 00 23. 00		0. 00 0. 00	0	0		22. 00 23. 00
24. 00		0.00	o	0		24.00
25.00		0.00	O	0		25. 00
26.00		0.00	0	0		26.00
27. 00 28. 00		0. 00 0. 00	0	0		27. 00 28. 00
29.00		0. 00	О	0		29.00
30.00		0.00	0	0		30.00
31. 00	TOTALS — — — — —	0.00	0	<u>0</u> 12, 629, 671		31.00
	C - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	26, 594, 691		1.00
2. 00 3. 00		0. 00 0. 00	0	0		2. 00 3. 00
4. 00		0. 00	Ö	Ö		4.00
5. 00		0.00	0	0		5.00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	o	0		8.00
9. 00		0. 00	0	0		9. 00
10.00		0. 00 0. 00	0	0		10.00 11.00
11. 00 12. 00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	o	Ö		17. 00
18.00		0.00	0	0		18.00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0. 00	Ö	Ö		21.00
22. 00		0.00	0	0		22.00
23. 00 24. 00		0. 00 0. 00	0	0		23. 00 24. 00
25. 00		0.00	o	0		25. 00
26.00		0.00	O	0		26.00
27. 00		0.00	0	0		27.00
28. 00 29. 00		0. 00 0. 00	0	0		28. 00 29. 00
30.00		0.00	O	Ö		30.00
31.00		0. 00	O	0		31.00
32. 00 33. 00		0. 00 0. 00	0	0		32. 00 33. 00
34. 00		0.00	0	0		34.00
35. 00		0. 00	0	0		35. 00
		·				

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

RECLASSIFICATIONS
Provider CCN: 15-0042
From 01/01/2018
To 12/31/2018
Period:
From 01/01/2018
To 12/31/2018
Page Prepared:

					1/20/2020 10): 18 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
36. 00		0.00	0	0		36.00
37.00		0.00	0	0		37.00
38.00		0.00	0	0		38. 00
39.00		0.00	0	0		39.00
40.00		0.00	0	0		40.00
41.00		0.00	0	0		41.00
	TOTALS		0	26, 594, 691		
	D - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5, 836, 167		1.00
2.00	PATI ENT ACCOUNTS	4. 04	0	<u>40, 5</u> 51		2.00
	TOTALS		0	5, 876, 718		
	E - INSURANCE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	321, 234		1.00
	TOTALS		0	321, 234		
	F - DIETARY RECLASS					
1.00	CAFETERI A	1100	1, 209, 046	1, 102, 400		1.00
	TOTALS		1, 209, 046	1, 102, 400		
500.00	Grand Total: Increases		1, 209, 046	62, 423, 414		500.00

Provider CCN: 15-0042

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 1/20/2020 10:18 am Decreases

1.00			Decreases				1	
A DISSIS CUMBRIC TO PATIENTS 1.00		Cost Center	Li ne #	Sal ary	Other 0.00	Wkst. A-7 Ref.		
				8. 00	9.00	10.00		
DIASS DIOLAS CUMPLIES CHARGED TO PATIENTS 1.00 1.5,898,700 1.0	1 00			O	15 898 700	0		1 00
S. MEDICAL SUPPLIES CHARGE 10 PAYLENIS	1.00							1.00
2.00 DIRCHASH NG A RECEIVING 4.02 0 1.0 0 2.00 3.00 4.00 0 4.00 0 4.00 3.00 3.00 4.00 0 4.00			TO PATIENTS	-,		'		
ADMINISTRATIVE & CEREBAL 5 00	1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	44, 039			1.00
1.00 OPERATION OF PLANT				-				1
MOUSEREPTING				-				1
CATHER STRUCTS & SUPPLY 14.00				0				1
7. 0.0 PARBMACY 15. 0.0 0 9, 155 0 7, 0.0 8 0.0 0 0 0 0 0 0 0 0				0				1
8.00 ADULTS & PEDIATRICS 30.00 39.720 0 8.00 10.00			•	0				1
INTERSIVE CARE WINT				Ö				1
11.00 SIBBROWD BER - 1 INF 41.00 0 8.993 0 11.00 12.00 NURSER 43.00 0 8.578 0 12.20 13.00 PERATI NO RODU 50.00 0 3.055 073 0 13.00 14.00 HUNDSCHOM A LABOR RODU 50.00 0 3.055 073 0 13.00 14.00 HUNDSCHOM A LABOR RODU 50.00 0 2.70 707 14.00 HUNDSCHOM A LABOR RODU 51.00 0 2.70 707 14.00 ADD CLOCY - THERAPEUT 51.00 0 839.481 0 14.00 15.00 BADI OLOCY - THERAPEUT 55.00 0 10.855 0 17.00 18.00 RESPIRATORY THERAPY 65.00 0 198.306 0 18.00 18.00 PHYSICAL THERAPY 65.00 0 198.306 0 18.00 19.00 PHYSICAL THERAPY 65.00 0 15.818.515 0 19.00 19.00 PHYSICAL THERAPY 65.00 0 15.818.515 0 12.00 19.00 PHYSICAL THERAPY 65.00 0 15.818.515 0 12.00 19.00 PHYSICAL HERAPY 77.00 0 15.90 19.00 PHYSICAL HERAPY 77.00 0 15.90 19.00 PHYSICAL HERAPY 10.00 0 17.90 19.00 PHYSICAL HERAPY 10.00 0 17.90				O				1
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Health Financial Systems RECLASSIFICATIONS GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0042

Peri od: Worksheet A-6 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 1/20/2020 10:18 am

						1/20/2020 10:	_ 18_ alli
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
37.00	HOSPI CE	116. 00	0	152, 750	(37. 00
38.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	5, 526, 406	(38. 00
39. 00	MARKETING AND PUBLIC RELATIONS	194. 02	0	44, 043		0	39. 00
40.00	MH RESIDENTIAL	194. 03	0	89, 179	(0	40.00
41.00	COMMUNITY MENTAL HEALTH	194. 09	0	1, 405, 692	(0	41.00
	CENTER						
	TOTALS		0	26, 594, 691			
	D - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113. 00	0	5, 876, 718	1.	1	1.00
2.00		0. 00	0	0		0	2.00
	TOTALS		0	5, 876, 718			
	E - INSURANCE EXPENSE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	321, 234	1:	2	1.00
	TOTALS			321, 234			
	F - DIETARY RECLASS						
1.00	DI ETARY	10.00	1, 209, 046	1, 102, 400	(1.00
	TOTALS		1, 209, 046	1, 102, 400			
500.00	Grand Total: Decreases		1, 209, 046	62, 423, 414		7	500.00

Provi der CCN: 15-0042

					To 12/31/2018		
				Acqui si ti ons		172072020 10.	10 alli
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	6, 912, 648	0	(0	131, 200	1.00
2.00	Land Improvements	10, 608, 071	72, 355	(72, 355	3, 498	2.00
3.00	Buildings and Fixtures	160, 623, 658	414, 151	(414, 151	0	3.00
4.00	Building Improvements	837, 218	25, 732	(25, 732	0	4. 00
5.00	Fi xed Equi pment	0	0	(0	0	5.00
6.00	Movable Equipment	215, 638, 087	7, 030, 599	(7, 030, 599	5, 462, 533	6.00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	394, 619, 682	7, 542, 837	(7, 542, 837	5, 597, 231	8. 00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	394, 619, 682	7, 542, 837	(7, 542, 837	5, 597, 231	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	6, 781, 448	0				1.00
2.00	Land Improvements	10, 676, 928	0				2.00
3.00	Buildings and Fixtures	161, 037, 809	0				3.00
4.00	Building Improvements	862, 950	0				4. 00
5. 00	Fi xed Equi pment	0	0				5.00
6.00	Movable Equipment	217, 206, 153	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	396, 565, 288	0				8. 00
9. 00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	396, 565, 288	0				10.00

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-0042		Peri od: From 01/01/2018 To 12/31/2018		pared:
SUMMARY OF CAPITAL					I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9. 00	10. 00	11. 00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUI	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FLXT	20, 183, 499	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	21, 7!	58 0	0	2.00
3.00	Total (sum of lines 1-2)	20, 183, 499	0	21, 7!	58 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)				
		Capi tal -Rel at	(sum of cols.				
		ed Costs (see	9 through 14)				
		instructions)					
		14. 00	15. 00				

1.00 1.00 2.00 2.00 3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Pre 1/20/2020 10:	pared:
		COMF	PUTATION OF RA	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col. 2)	instructions)		
		1, 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C				1		
1.00	CAP REL COSTS-BLDG & FLXT	179, 359, 135	0	179, 359, 13	5 0. 452281	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	217, 206, 153	0	217, 206, 15	0. 547719	0	2.00
3. 00	Total (sum of lines 1-2)	396, 565, 288		396, 565, 28			3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	OF CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C				00 100 100		4 00
1.00	CAP REL COSTS-BLDG & FIXT	0	·		20, 183, 499		
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	0	0		0 20 102 400	0	2.00 3.00
3.00	Total (Sull of Titles 1-2)	0	<u> </u>	<u> </u> JMMARY OF CAPI	20, 183, 499	0	3.00
			30	JIVIIVIART OF CAPT	TAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DADT III DECONCILIATION OF CADITAL COCTO	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C CAP REL COSTS-BLDG & FIXT		221 224		0 0	25 152 244	1.00
2. 00	CAP REL COSTS-BLDG & FIXT	4, 647, 613 21, 758		1	0 0		2.00
3. 00	Total (sum of lines 1-2)	4, 669, 371	l e		0 0		
3.00	Total (Sum Of Titles 1-2)	4,007,3/1	321, 234	l '	0	25, 174, 104	J 3.00

From 01/01/2018 12/31/2018 Date/Time Prepared: 1/20/2020 10:18 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Cost Center Line # Wkst. A-7 Cost Center Description Amount (2) Ref. 1. 00 2.00 3.00 4.00 5. 00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) 4.00 Trade, quantity, and time В -86, 876 PURCHASING & RECEIVING 4.02 4.00 discounts (chapter 8) 5.00 Refunds and rebates of 0.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) 7.00 Tel ephone services (pay В -21, 801 OPERATION OF PLANT 7 00 7.00 stations excluded) (chapter 8.00 Television and radio service 0.00 8.00 0 (chapter 21) 9.00 Parking lot (chapter 21) 0.00 9.00 -7, 085, 183 Provi der-based physici an 10.00 10.00 A-8-2 adjustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 12.00 A-8-1 transactions (chapter 10) 13.00 Laundry and linen service 0.00 13.00 Cafeteria-employees and guests -473, 141 CAFETERI A 11.00 14.00 14.00 15.00 Rental of quarters to employee 0.00 15.00 and others Sale of medical and surgical -385, 851 DRUGS CHARGED TO PATIENTS 16.00 В 73.00 16.00 supplies to other than pati ents 17.00 Sale of drugs to other than 0 0.00 17.00 pati ents Sale of medical records and 18.00 0.00 18.00 abstracts 19.00 Nursing and allied health 0.00 19.00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 21.00 Income from imposition of 0.00 21.00 interest, finance or penalty charges (chapter 21) Interest expense on Medicare 22.00 0 00 ol 22.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory ORESPIRATORY THERAPY 65.00 23.00 A-8-3 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical OPHYSICAL THERAPY 24.00 A-8-3 66.00 therapy costs in excess of limitation (chapter 14) 0 *** Cost Center Deleted *** 25.00 25.00 Utilization review 114.00 physicians' compensation (chapter 21) OCAP REL COSTS-BLDG & FIXT 26.00 Depreciation - CAP REL 1.00 26.00 COSTS-BLDG & FLXT 27.00 Depreciation - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 27.00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant 0 *** Cost Center Deleted *** 28.00 19.00 28.00 29 00 0.00 29 00 Adjustment for occupational 0 *** Cost Center Deleted *** 30.00 A-8-3 67.00 30.00 therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see 30.99 OADULTS & PEDIATRICS 30.00 30.99 instructions)

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0042 Peri od: Worksheet A-8 From 01/01/2018 To 12/31/2018 Date/Time Prepared: 1/20/2020 10:18 am

	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				172072020 10:	io dili	
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	cost center bescription	(2)	Amount	cost center	Line #	Ref.	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
31. 00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	68. 00		31. 00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
33.00	MISC INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	33.00
33. 01	RENTAL	В		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 01
33. 02 33. 03	MISC INCOME	B B		PURCHASING & RECEIVING	4. 02 4. 04	0	33. 02
33. 04	MISC INCOME MISC INCOME	В		PATIENT ACCOUNTS OPERATION OF PLANT	7. 00	0	33. 03 33. 04
33. 05	MISC INCOME	В		LAUNDRY & LINEN SERVICE	8. 00	0	33. 05
33. 06	MISC INCOME	В		HOUSEKEEPI NG	9. 00	0	33. 06
33. 07	MISC INCOME	В		PHARMACY	15. 00	0	33.07
33. 08	MISC INCOME	В	-96, 379	MEDICAL RECORDS & LIBRARY	16. 00	0	33.08
33. 09	MISC INCOME	В	-30, 069	MENTAL HEALTH OH	17. 01	0	33.09
33. 10	MISC INCOME	В		PARAMED ED PRGM-RADIOLOGY	23. 00	0	33. 10
33. 11	MISC INCOME	В	· ·	SUBPROVI DER - I RF	41. 00	0	33. 11
33. 12	MISC INCOME	В		OPERATING ROOM	50.00	0	33. 12
33. 13	MISC INCOME	В		ENDOSCOPY	51. 01	0	33. 13
33. 14 33. 15	MISC INCOME MISC INCOME	B B		PHYSI CAL THERAPY	66. 00 69. 00	0	33. 14 33. 15
33. 16	MISC INCOME	В		ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO	71. 00	0	33. 16
33. 10	INT 3C T NCOME	Ь	-1, 100	PATI ENTS	71.00	O	33. 10
33. 17	MISC INCOME	В	-3.014	ASC (NON-DISTINCT PART)	75. 00	0	33. 17
33. 18	MISC INCOME	В		WOUND CLINIC	90. 01	0	33. 18
33. 19	MISC INCOME	В	-51	ELECTROCARDI OLOGY	69. 00	0	33. 19
33. 20	GME SALARY REIMBURSEMENT	В	-91, 267	ADMINISTRATIVE & GENERAL	5. 00	0	33. 20
33. 21	OTHER MISC FEES	В		CAFETERI A	11. 00	0	33. 21
33. 22	PROVI DER ASSESSMENT FEE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	33. 22
33. 23	GME CONSORTIUM FEES	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 23
33. 24	INTEREST INCOME	В		CAP REL COSTS-BLDG & FIXT	1.00	11	33. 24
33. 25 33. 26	PHYSICIAN BILLING COSTS DONATIONS EXPENSE	A A		PATIENT ACCOUNTS ADMINISTRATIVE & GENERAL	4. 04 5. 00	0	33. 25 33. 26
33. 27	ADVERTI SI NG	A		MENTAL HEALTH OH	17. 01	0	33. 27
33. 28	ADVERTI SI NG	A		SUBPROVI DER - I RF	41. 00	0	33. 28
33. 29	ADVERTI SI NG	A		RADI OLOGY-DI AGNOSTI C	54.00	0	33. 29
33. 30	ADVERTI SI NG	А		ELECTROCARDI OLOGY	69.00	0	33. 30
33. 31	ADVERTI SI NG	А	-66	HOSPI CE	116. 00	0	33. 31
33. 32	2012 BOND ISSUE COSTS	Α	45, 855	ADMINISTRATIVE & GENERAL	5. 00	0	33. 32
33. 33	AHA LOBBYING OFFSET	А		ADMINISTRATIVE & GENERAL	5. 00	0	33. 33
	I HA LOBBYI NG OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 34
33. 35	INDIANA CHAMBER LOBBYING OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	0	
33. 36	I HRA LOBBYI NG OFFSET	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 36
33. 37 33. 38	RENTAL RENTAL	B B		OPERATING ROOM ELECTROCARDIOLOGY	50. 00 69. 00	0	33. 37 33. 38
33. 38	RENTAL	В		I NPATI ENT DI ALYSIS	76. 01	0	33. 38
33. 40	MISC INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 40
33. 41	MISC INCOME	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 41
33. 42	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	Ö	33. 42
33. 43	RENTAL	В		ADMINISTRATIVE & GENERAL	5. 00	0	33. 43
50.00	TOTAL (sum of lines 1 thru 49)		-21, 940, 581		į		50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

⁽³⁾ Additional adjustments may be made on lines 33 thru 49 and subscripts thereof. Note: See instructions for column 5 referencing to Worksheet A-7.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0042

Peri od: Worksheet A-8-2 From 01/01/2018 To 12/31/2018 Date/Time Prepared:

1/20/2020 10:18 am

Physi ci an/Prov Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount I denti fi er ider Component Remuneration Component Component Hours 1.00 2.00 3. 00 4 00 5 00 6 00 7 00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 1.00 29, 555 29, 555 211,500 1.00 2.00 5. 00 ADMINISTRATIVE & GENERAL 240, 432 95, 599 144, 833 211, 500 1, 519 2.00 3.00 13. 00 NURSING ADMINISTRATION 11,000 11,000 211, 500 113 3.00 15. 00 PHARMACY 21, 930 11 930 10,000 211, 500 4 00 105 4 00 5.00 17. 01 MENTAL HEALTH OH 84,500 46,000 38, 500 211, 500 120 5.00 40. 00 SUBPROVI DER - I PF 317, 123 181, 300 6.00 317, 123 6.00 7.00 41. 00 SUBPROVI DER - I RF 55,000 55,000 0 211, 500 0 7.00 50. OOOPERATING ROOM 1, 306, 752 0 8.00 1, 306, 752 0 246, 400 8 00 9.00 54. 00 RADI OLOGY-DI AGNOSTI C 20, 400 20, 400 271, 900 9.00 10.00 55. 00 RADI OLOGY-THERAPEUTI C 1, 421, 447 1, 387, 007 34, 440 211, 500 182 10.00 60. 00 LABORATORY 95, 764 1, 775 131.976 211.500 11.00 11.00 36, 212 65. 00 RESPIRATORY THERAPY 929, 964 18,000 211, 500 300 12.00 911, 964 12.00 13.00 69. 00 ELECTROCARDI OLOGY 2, 690, 701 2, 630, 192 60, 509 211, 500 232 13.00 14.00 70. 01 NEURODI AGNOSTI CS 18,000 18,000 211, 500 14.00 66 15.00 75.00 ASC (NON-DISTINCT PART) 87, 881 33, 671 211, 500 15.00 300 54, 210 16.00 76. 01 INPATIENT DIALYSIS 40,000 0 40,000 211, 500 336 16.00 90. 01 WOUND CLINIC 211, 500 17.00 17.00 91. 00 EMERGENCY 60,000 36, 000 211, 500 18.00 96,000 120 18.00 7, 502, 661 6, 961, 944 540, 717 5, 168 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Cost of Provi der Physician Cost of Mal practice I denti fi er Li mi t Unadjusted RCE Memberships & Component Share of col Conti nui ng Insurance Limit Educati on 12 1.00 8.00 9.00 14.00 2.00 12.00 13.00 1.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 1.00 0 5. 00 ADMI NI STRATI VE & GENERAL 0 2.00 154, 456 7,723 0 0 2.00 0 13. OO NURSING ADMINISTRATION 0 3 00 11, 490 575 0 3 00 0 0 4.00 15.00 PHARMACY 10,677 534 4.00 0 5.00 17. 01 MENTAL HEALTH OH 12, 202 0 0 5.00 610 40. 00 SUBPROVI DER - I PF 0 0 0 0 6.00 6.00 0 0 0 41. 00 SUBPROVI DER - I RF 7.00 0 0 7.00 8.00 50.00 OPERATING ROOM 0 0 0 8.00 0 54. 00 RADI OLOGY-DI AGNOSTI C 0 9.00 9.00 0 0 10.00 55. 00 RADI OLOGY-THERAPEUTI C 18.506 925 0 10.00 60 OOL ABORATORY 9.024 0 0 11.00 180.487 11.00 0 12.00 65. 00 RESPIRATORY THERAPY 30, 505 12.00 1,525 69. 00 ELECTROCARDI OLOGY 0 0 0 13.00 23, 590 1, 180 13.00 0 70. 01 NEURODI AGNOSTI CS 0 0 6,711 14.00 14.00 336 75.00 ASC (NON-DISTINCT PART) 0 15.00 30, 505 1.525 15.00 16.00 76. 01 INPATIENT DIALYSIS 34, 165 1,708 0 0 0 16.00 17.00 90. 01 WOUND CLINIC 0 17.00 0 18.00 91. 00 EMERGENCY 12, 202 610 C 18.00 200.00 525, 496 26, 275 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCF Adjustment I denti fi er Di sal I owance Component Limit Share of col 14 1.00 2.00 15. 00 16.00 17.00 18.00 1. 00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 29, 555 1.00 5. 00 ADMI NI STRATI VE & GENERAL 2.00 0 154, 456 0 95, 599 2.00 3.00 13.00 NURSING ADMINISTRATION 0 11, 490 0 3 00 4.00 15.00 PHARMACY 10,677 11,930 4.00 17. 01 MENTAL HEALTH OH 5.00 o 12, 202 26, 298 72, 298 5.00 40. 00 SUBPROVI DER - I PF 0 6.00 317, 123 6.00 0 41. 00 SUBPROVI DER - I RF 7.00 0 0 55,000 7.00 50. 00 OPERATING ROOM 0 8.00 0 1, 306, 752 8.00 54. 00 RADI OLOGY-DI AGNOSTI C o 9.00 20.400 9.00 55. 00 RADI OLOGY-THERAPEUTI C 0 18, 506 15, 934 10.00 1, 402, 941 10.00 11.00 60. 00 LABORATORY 0 180, 487 36, 212 11.00 65. 00 RESPIRATORY THERAPY o 12.00 30, 505 911, 964 12.00 23, 590 36, 919 13.00 69. 00 ELECTROCARDI OLOGY 0 2, 667, 111 13.00 14.00 70. 01 NEURODI AGNOSTI CS 0 6, 711 11, 289 11, 289 14.00 30, 505 57, 376 75.00 ASC (NON-DISTINCT PART) 0 15.00 3, 166 15.00 0 16.00 76. 01 INPATIENT DIALYSIS 34, 165 5, 835 5,835 16.00 0 90. 01 WOUND CLINIC 17 00 17 00 Ω 18.00 91. 00 EMERGENCY 0 12, 202 23, 798 83.798 18.00 200.00 525, 496 123, 239 7, 085, 183 200.00

| Peri od: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0042

COST Center Description						To	12/31/2018	Date/Time Pre 1/20/2020 10:	
Part					CAPI TAL REI	ATED COSTS		172072020 10.	10 aiii
Part					DI DO A FLVT	10/01 5 50111 5	EUD! 0\/EE		
PRINCE PRINCE CONTROL PRINCE PRINCE CONTROL PRINCE CONTROL PRINCE			Cost Center Description		BLDG & FIXI	MVBLE EQUIP			
								3	
Company Comp									
CHERGAL SERVICE COST CENTERS 26, 152, 340, 25, 152, 346 20, 00000 CAR PRIL COSTS LORGE FERTINE 26, 152, 340, 25, 152, 346 21, 758 22, 391, 749 20, 00000 CAR PRIL COSTS LORGE FERTINE 29, 79, 79, 79, 79, 79, 79, 79, 79, 79, 7									
DOTOD CAP REL COSIS-HEIRG & FIXT		CENED	AL CEDVICE COST CENTEDS	0	1.00	2. 00	4. 00	4. 01	
2.00 00000 CAP REL COSTS-MARLE EDUIL P 21,758	1 00			25 152 346	25 152 346				1 00
4. 01 000001 COMANNI CALL TONS 293, 7341		1	•						
4. 02 00002 PURCHASIN C & RECEIVING 730, 143 455, 619 379 197, 648 2, 910 4, 02 4. 03 00040 PATTERY ACCOUNTS 3, 684, 944 1, 226, 269 1, 1, 16 692, 507 6, 952 4, 04 4. 04 00040 PATTERY ACCOUNTS 5, 271, 314 3, 324, 269 1, 1, 16 692, 507 6, 964 4. 05 00040 PATTERY ACCOUNTS 5, 271, 314 3, 322, 674 3, 322, 674 3, 322, 674 5. 00 000500 LANDORY & LINEN SERVICE 2, 297, 882 154, 885 1, 25, 674 3, 982 9, 00 6. 00 000500 LANDORY & LINEN SERVICE 2, 297, 882 154, 885 1, 25, 671 184 64, 641 5, 982 9, 00 6. 00 000500 LANDORY & LINEN SERVICE 2, 297, 882 1, 25, 671 184 64, 641 5, 982 9, 00 6. 00 000500 LANDORY & LINEN SERVICE 2, 297, 882 1, 25, 671 184 64, 641 5, 982 9, 00 6. 00 000500 LANDORY & LINEN SERVICE 2, 297, 882 1, 25, 671 184 144 1, 207 6. 00 000500 LANDORY & LINEN SERVICE 3, 152, 643 3, 27, 23 1, 20 6. 00 000500 LANDORY & LINEN SERVICE 3, 152, 643 3, 27, 23 1, 20 6. 00 010000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 010000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 010000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 010000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 010000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 010000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 01000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 01000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 01000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 01000 DIETARY 3, 152, 643 3, 27, 23 1, 20 6. 00 01000 DIETARY 3, 152, 643 3, 27, 24 6. 00 01000 DIETARY 3, 152, 643 3, 27, 24 6. 00 01000 DIETARY 3, 27, 27, 2514 3, 27, 24 6. 00 01000 DIETARY 3, 27, 27, 2514 3, 27, 24 6. 00 01000 DIETARY 3, 27, 24 6. 00 01000 DIETARY 3, 27, 24 3, 27, 2514 3, 27, 24 6. 00 01000 DIETARY 3, 27, 24 6. 00 01000 DIETARY 3, 27, 24 6. 00 01000 DIETARY 3, 27, 24 6. 00 01000 DIETAR									
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10.00 01000 DETARY									
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14.00 01400 CENTRAL SERVICES & SUPPLY \$5.6, 489 2, 639 2 104,536 1, 455 14.00 16.00 01500 MEDI CAL RECORDS & LIBRARY 2,772,514 131, 289 118 693,509 8, 407 16.00 17.01 01700 01700 01700 01700 0170 0 0 0 0 0 17.01 01701 MENTAL IERLITH OF MENTAL SERVICE 010 0 0 0 0 0 17.01 01701 MENTAL IERLITH OF MENTAL SERVICE 010 0 0 0 0 0 0 17.01 01701 MENTAL IERLITH OF MENTAL SERVICE 010 0 0 0 0 0 0 0 0									
15.00 0 1500 PHARMACY 3, 195, 943 111, 444 155 820, 757 5, 174 15, 00 17.00									
16.00 1600 MEDICAL RECORDS & LIBRARY 2, 772, 514 138, 299 118 693,000 8, 407 16.00 17.00 17.00 1700 1701 MENTAL HEALTH OH 830,808 100,910 86 204,321 35,570 17.01 17.00 17.									
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22.00 02200 RAY SERVICES-OTHER PROM COSTS APPRVD 0 0 0 0 0 0 0 0 22.00	17. 01			830, 808	100, 910	86	204, 321	35, 570	
23 00 02300 PARAMED ED PRIGNI-RADIOLOGY 174, 613 0 0 63, 403 0 23 00				0	_	_	0		
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40.00 04000 SUBPROVI DER - I PF									
A1. 00 04100 SUBROVI DER - 1 RF 1,729,631 504,051 431 493,109 11,318 41,00 A3,00 A3,00 A8,016 COST CONTERS CO									•
A3. 00 A3.00 NURSERY A0. 00 A9. 00 A9. 46.16 D4. 3. 00									
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54. 00 05400 RADI OLOGY-DI AGNOSTI C 5, 582, 099 967, 410 827 1, 089, 765 10, 671 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 2, 136, 482 225, 655 193 743, 056 5, 982 55. 00 60. 00 06000 LABORATIORY 6, 514, 887 212, 198 182 647, 918 5, 174 60. 00 63. 00 06300 BLODD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66. 00 66. 00 06600 PAYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66. 00 67. 00 07000 LECETROCABDI OLOGY 2, 873, 648 533, 017 456 1, 384, 180 12, 611 69, 90 67. 00 07000 LECETROCABDI OLOGY 2, 873, 648 533, 017 456 1, 384, 180 12, 611 69, 90 67. 00 07000 LECETROENCEPHALOGRAPHY 0 0 0 0 0 0 67. 00 07000 LECETROENCEPHALOGRAPHY 0 0 0 0 0 67. 00 07000 DIVIDIO MEDI CAL SUPPLIES CHARGED TO PATI ENTS 7, 240, 817 0 0 0 0 0 0 67. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 5, 349, 837 0 0 0 0 0 0 67. 00 07500 ASC (NON-DISTINCT PART) 1, 830, 230 0 0 0 0 0 0 0 67. 00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0 0 0 67. 00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0 0 0 67. 00 03950 INPATIENT DI ALYSIS 344, 195 251, 601 215 0 485 67. 00 04500 DURABER ENDI CALE COST CENTERS 67. 00 09100 EMERGENCY 0 0 0 0 0 0 0 67. 00 09100 DEERGENCY 0 0 0 0 0 0 67. 00 09100 DEERGENCY 0 0 0 0 0 0 67. 00 09000 DESERVATION BEDS (NON-DISTINCT PART) 115, 560 38, 449 35 1, 190, 039 16, 330 91. 00 67. 00 09000 DESERVATION BEDS (NON-DISTINCT PART) 177, 564, 545 155, 725, 064 13, 695 20, 498, 596 293, 938 118. 00 67. 00 09000 DESERVATION BEDS (COST CENTERS 0 0 0 0 0 0 0 0 0									
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6, 514, 887 212, 198 182 647, 918 5, 174 60. 00									
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 63.00 65.00 06500 RESPIRATORY THERAPY 2, 171, 162 166, 493 142 611, 923 6, 306 65.00 66.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 06600 PHYSI CAL THERAPY 3, 927, 264 646, 738 553 1, 082, 600 5, 335 66.00 69.00 07000 NEURODIA GROSTICS 614, 013 224, 130 192 114, 684 3, 234 70.01 71.00 07100 NEURODIA GROSTICS 7, 240, 817 0 0 0 0 0 0 72.00 07200 IMPL. DEDV. CHARGED TO PATIENTS 5, 349, 837 0 0 0 0 0 0 71.00 73.00 07300 DRUGS CHARGED TO PATIENTS 15, 512, 849 0 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 1, 830, 230 0 0 0 0 0 0 0 76.01 03951 INPATIENT DIALYSIS 344, 195 251, 601 215 0 485 76.01 76.01 03951 INPATIENT DIALYSIS 344, 195 251, 601 215 0 485 76.01 76.01 04950 WOUND CLINIC 1, 245, 447 84, 492 72 113, 867 1, 455 90.00 76.01 04950 WOUND CLINIC 1, 245, 447 84, 492 72 113, 867 1, 455 90.00 76.00 09200 095ERVATION BEDS (NON-DISTINCT PART) 10 0 0 0 0 0 0 0 76.00 09200 095ER							· ·		
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69.00 06900 ELECTROCARDI OLOGY 2, 873, 648 533, 017 456 1, 384, 180 12, 611 69.00 70									
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70. 01 07001 NEURODI AGNOSTI CS 614, 013 224, 130 192 114, 684 3, 234 70. 01 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 72. 00 72. 00 72. 00 72. 00 72. 00 73. 00 74. 0				2,873,648 0			1, 384, 180 N		
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 7, 240, 817 0 0 0 0 0 71. 00 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 5, 349, 837 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATIENTS 15, 512, 849 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 1, 830, 230 0 0 340, 966 0 75. 00 76. 00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0 0 0 76. 01 03951 INPATIENT DIALYSIS 344, 195 251, 601 215 0 485 00 07500 07500 07500 07500 07500 00 07500 07500 07500 07500 07500 00 07500 07500 07500 07500 00 07500 07500 07500 07500 00 07500 07500 07500 07500 00 07500 07500 07500 07500 00 07500 07500 07500 07500 00 07500 07500 07500 07500 00 07500 07500 07500 0 00 07500 07500 0 0 00 07500 0 0 0 00 0 0 0 0 00 0				614, 013			114, 684		
73. 00							0		•
75. 00 07500 ASC (NON-DISTINCT PART) 1,830,230 0 0 340,966 0 75. 00 76. 00 03950 MH ANCILLARY OUTPATIENT 0 0 0 0 0 0 76. 01 03951 INPATIENT DIALYSIS 344, 195 251,601 215 0 485 0UTPATIENT SERVICE COST CENTERS					_	· ·	0		
76. 00						· ·	340 966		
76. 01 03951 INPATI ENT DI ALYSI S 0 485 76. 01 0000				0 1, 030, 230	0	l ~	0 0		
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90. 01	00.00			445 570	70.040	(7	20.077	4 455	00.00
91. 00									
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 128, 170 11, 551 10 25, 961 0 96. 00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 SPECI AL PURPOSE COST CENTERS 113. 00 11500 INTEREST EXPENSE 114. 00 11600 HOSPI CE 1, 056, 830 116, 419 100 151, 125 3, 719 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 177, 564, 545 15, 725, 064 13, 695 20, 498, 596 293, 938 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 190. 00 190. 00 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 39, 219, 821 3, 378, 695 2, 890 7, 293, 732 60, 790 192. 00 194. 00 07950 COMMUNI TY HEALTH SERVI CES 16, 229 74, 349 64 0 3, 395 194. 00 194. 02 07952 MARKETI NG AND PUBLI C RELATIONS 587, 914 55, 322 47 47, 947 970 194. 02									
96. 00		09200	OBSERVATION BEDS (NON-DISTINCT PART)	, ,					
101. 00								T	
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 1,056,830 116,419 100 151,125 3,719 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 177,564,545 15,725,064 13,695 20,498,596 293,938 118.00 NONNEI MBURSABLE COST CENTERS 100 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 39,219,821 3,378,695 2,890 7,293,732 60,790 192.00 194.00 00 00 00 00 00 00 00									
113. 00	101.00			U	0	0	0	0	101.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 177, 564, 545 15, 725, 064 13, 695 20, 498, 596 293, 938 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 39, 219, 821 3, 378, 695 2, 890 7, 293, 732 60, 790 192. 00 194. 00 07950 COMMUNI TY HEALTH SERVI CES 16, 229 74, 349 64 0 3, 395 194. 00 194. 02 07952 MARKETI NG AND PUBLI C RELATI ONS 587, 914 55, 322 47 47, 947 970 194. 02	113.00								113. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 190. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 39, 219, 821 3, 378, 695 2, 890 7, 293, 732 60, 790 192. 00 194. 00 07950 COMMUNI TY HEALTH SERVI CES 16, 229 74, 349 64 0 3, 395 194. 00 194. 02 07952 MARKETI NG AND PUBLI C RELATI ONS 587, 914 55, 322 47 47, 947 970 194. 02	116.00	11600	HOSPI CE						
190. 00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 39, 219, 821 3, 378, 695 2, 890 7, 293, 732 60, 790 192. 00 194. 00 07950 COMMUNI TY HEALTH SERVI CES 16, 229 74, 349 64 0 3, 395 194. 00 194. 02 07952 MARKETI NG AND PUBLI C RELATI ONS 587, 914 55, 322 47 47, 947 970 194. 02	118. 00			177, 564, 545	15, 725, 064	13, 695	20, 498, 596	293, 938	118. 00
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 39, 219, 821 3, 378, 695 2, 890 7, 293, 732 60, 790 192.00 194.00 07950 COMMUNI TY HEALTH SERVI CES 16, 229 74, 349 64 0 3, 395 194.00 194.02 07952 MARKETI NG AND PUBLI C RELATI ONS 587, 914 55, 322 47 47, 947 970 194.02	190 00			n	0	n	n	0	190 00
194. 00 07950 COMMUNITY HEALTH SERVICES 16, 229 74, 349 64 0 3, 395 194. 00 194. 02 07952 MARKETING AND PUBLIC RELATIONS 587, 914 55, 322 47 47, 947 970 194. 02				_			7, 293, 732		
	194.00	07950	COMMUNITY HEALTH SERVICES	16, 229	74, 349	64	0	3, 395	194. 00
174. USID/753 NITE KESTUENTIAL 418, 318 593, 907 508 106, 726 0 194. 03									
	194. 03	101753	INIT INESTIDENTIAL	410,318	J43, 467	1 508	100, 726	1 0	1174. U3

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od: From 01/01/2018	Worksheet B Part I	
					Date/Time Pre 1/20/2020 10:	
		CAPI TAL REI	ATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ON	

						1/20/2020 10.	10 alli
			CAPITAL REL	LATED COSTS			
Cos	st Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI CATI ON S	
		col. 7)					
		0	1.00	2.00	4. 00	4. 01	
194. 04 07954 UNU	USED SPACE	0	3, 397, 487	2, 906	0	0	194. 04
194. 05 07955 MOE	В	36, 956	701, 972	600	0	0	194. 05
194. 06 07956 FOL	UNDATI ON	0	13, 662	12	0	323	194.06
194. 07 07957 KNO	OX COUNTY HEALTH DEPT	0	138, 143	118	0	2, 264	194.07
194. 08 07958 I NE	DUSTRI AL HEALTH	o	0	0	0	0	194. 08
194. 09 07959 COM	MMUNITY MENTAL HEALTH CENTER	5, 553, 936	1, 073, 685	918	1, 444, 748	0	194. 09
200.00 Crd	oss Foot Adjustments						200.00
201.00 Neg	gative Cost Centers		0	0	0	0	201.00
202. 00 T01	TAL (sum lines 118 through 201)	223, 397, 719	25, 152, 346	21, 758	29, 391, 749	361, 680	202.00

Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared:

					12/31/2018	1/20/2020 10:	
	Cost Center Description	PURCHASING &	REGI STRATI ON	PATI ENT	Subtotal	ADMI NI STRATI V	
		RECEI VI NG	4 02	ACCOUNTS 4. 04	4A. 04	E & GENERAL	
	GENERAL SERVICE COST CENTERS	4. 02	4. 03	4. 04	4A. U4	5. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401 COMMUNI CATI ONS						4. 01
4.02	00402 PURCHASING & RECEIVING	1, 386, 699					4. 02
4.03	00403 REGI STRATI ON	624	1, 646, 414				4. 03
4.04	00404 PATIENT ACCOUNTS	952	O	4, 385, 445			4.04
5.00	00500 ADMINISTRATIVE & GENERAL	4, 624	0	0	21, 497, 976	21, 497, 976	5.00
7.00	00700 OPERATION OF PLANT	12, 243	0	0	10, 364, 612	1, 103, 603	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	5, 361	0	0	507, 802	54, 070	8. 00
9.00	00900 HOUSEKEEPI NG	13, 344	0	0	2, 785, 374	296, 581	9. 00
10.00	01000 DI ETARY	96, 029	0	0	1, 046, 129	111, 390	10.00
11. 00	01100 CAFETERI A	0	0	0	1, 927, 063	205, 190	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	523	0	0	2, 266, 198		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	6, 353	0	0	651, 474	69, 368	14.00
15. 00	01500 PHARMACY	4, 399	0	0	4, 207, 872		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	441	0	0	3, 613, 278		16. 00
17. 00	01700 SOCI AL SERVI CE	0	0	0	0	0	17. 00
17. 01	01701 MENTAL HEALTH OH	50	0	0	1, 171, 745	124, 765	17. 01
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-RADI OLOGY	10	0	0	238, 026	25, 345	23.00
23. 01	O2301 PARAMED ED PRGM-LAB	435	0	0	257, 845	27, 455	23. 01
	INPATIENT ROUTINE SERVICE COST CENTERS	0, 107	70.400	101 750	0 105 510	200 500	
30.00	03000 ADULTS & PEDIATRICS	26, 437	73, 129	194, 753	8, 485, 513	903, 520	30.00
31.00	03100 INTENSI VE CARE UNI T	19, 853	49, 264	131, 197	5, 956, 525	634, 239	31.00
40.00	04000 SUBPROVI DER - I PF	1, 888	19, 886	52, 960	2, 679, 162	285, 272	40.00
41.00	04100 SUBPROVI DER - I RF	5, 858	19, 704	52, 475	2, 816, 577	299, 903	41.00
43. 00	04300 NURSERY	1, 172	3, 587	9, 553	416, 820	44, 382	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	33, 885	139, 347	371, 102	5, 464, 263	581, 824	50.00
51. 00	05100 RECOVERY ROOM	33, 663	139, 347	371, 102	0, 404, 203 0	0 361, 624	51.00
51. 00	05101 ENDOSCOPY	30, 209	29, 262	77, 928	2, 339, 809	249, 138	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	5, 677	16, 348	43, 537	1, 724, 314	183, 602	52.00
53. 00	05300 ANESTHESI OLOGY	3,077	10, 340	43, 337	1, 724, 314	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	10, 378	234, 210	624, 543	8, 519, 903	907, 182	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	5, 371	56, 669	150, 917	3, 324, 325	353, 967	55. 00
60.00	06000 LABORATORY	181, 266	168, 400	448, 473	8, 178, 498	870, 830	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	100, 100	0	0, 170, 170	0,000	63.00
65. 00	06500 RESPIRATORY THERAPY	5, 200	41, 555	110, 666	3, 113, 447	331, 514	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 849	63, 027	167, 849	5, 895, 215	627, 711	66.00
69. 00	06900 ELECTROCARDI OLOGY	5, 833	116, 104	309, 202	5, 235, 051	557, 418	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	2, 021	13, 884	36, 974	1, 009, 132	107, 450	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	310, 290	10	28	7, 551, 145	804, 031	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	359, 387	0	0	5, 709, 224	607, 907	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	173, 340	461, 629	16, 147, 818	1, 719, 387	73.00
75.00	07500 ASC (NON-DISTINCT PART)	22, 765	59, 614	158, 759	2, 412, 334	256, 860	75. 00
76.00	03950 MH ANCILLARY OUTPATIENT	o	0	0	0	0	76. 00
76. 01	03951 INPATIENT DIALYSIS	95	3, 520	9, 375	609, 486	64, 897	76. 01
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	97	392	1, 043	227, 809	24, 257	90.00
90. 01	04950 WOUND CLINIC	7, 145	37, 953	101, 075	1, 591, 668	169, 478	90. 01
91.00	09100 EMERGENCY	19, 905	134, 419	357, 978	6, 840, 039	728, 314	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	OTHER REIMBURSABLE COST CENTERS	,					
	09600 DURABLE MEDI CAL EQUI P-RENTED	1, 892	1, 377	3, 667	172, 628	· ·	
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	,					
	11300 INTEREST EXPENSE						113. 00
	11600 H0SPI CE	1, 105	8, 634	22, 994	1, 360, 926		
118.00	,	1, 204, 966	1, 463, 635	3, 898, 677	158, 317, 025	14, 568, 221	118. 00
	NONREI MBURSABLE COST CENTERS	1					105
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	177, 597	182, 199	485, 222	50, 800, 946	5, 409, 276	
	07950 COMMUNITY HEALTH SERVICES	159	0	0	94, 196	10, 030	
	07952 MARKETING AND PUBLIC RELATIONS	61	_ 0	0	692, 261	73, 711	
	07953 MH RESIDENTIAL	1, 893	580	1, 546	1, 123, 538		
	07954 UNUSED SPACE	0	0	0	3, 400, 393	362, 067	
	07955 MOB	0	0	0	739, 528	78, 743	
	07956 FOUNDATION	0	0	0	13, 997		194.06
	07957 KNOX COUNTY HEALTH DEPT	0	0	0	140, 525	14, 963	
194.08	07958 I NDUSTRI AL HEALTH	0	0	0	0	0	194. 08

Health Financial Systems	GOOD SAMARITAN H	HOSPI TAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-0042	From 01/01/2018	Worksheet B Part I Date/Time Prepared:

						1/20/2020 10.	io aiii
	Cost Center Description	PURCHASING &	REGI STRATI ON	PATI ENT	Subtotal	ADMI NI STRATI V	
		RECEI VI NG		ACCOUNTS		E & GENERAL	
		4. 02	4. 03	4. 04	4A. 04	5. 00	
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	2, 023	0	0	8, 075, 310	859, 843	194. 09
200. 00	Cross Foot Adjustments				0		200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1, 386, 699	1, 646, 414	4, 385, 445	223, 397, 719	21, 497, 976	202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | Date/Time Prepared: | 1/20/2020 10: 18 am | Output | O

Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	18 am
	7. 00	8. 00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT						1 00
1.00 00100 CAP REL COSTS-BLDG & FLXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01 00401 COMMUNI CATI ONS						4. 01
4. 02 00402 PURCHASING & RECEIVING						4. 02
4. 03 00403 REGI STRATI ON						4. 03
4. 04 00404 PATI ENT ACCOUNTS						4.04
5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT	11, 468, 215					5. 00 7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	90, 814	652, 686				8.00
9. 00 00900 HOUSEKEEPI NG	126, 512	42, 037				9. 00
10. 00 01000 DI ETARY	0	11, 146	84, 003	1, 252, 668		10.00
11. 00 01100 CAFETERI A	215, 895	0	21, 264	0	2, 369, 412	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	148, 138		0	0	33, 192	13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	1, 552 106, 732	6, 248 0	38, 316 30, 141	U O	23, 862 74, 207	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	81, 347	0	28, 937	0	107, 960	16.00
17. 00 01700 SOCI AL SERVI CE	01,017	Ö	0	o	0	17. 00
17.01 01701 MENTAL HEALTH OH	59, 359	10, 779	93, 883	O	27, 626	17. 01
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	O	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00 02300 PARAMED ED PRGM-RADI OLOGY	0	0	0	0	6, 469	23.00
23. 01 O2301 PARAMED ED PRGM-LAB	0	0	0	0	6, 413	23. 01
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	1, 204, 540	225, 715	711, 346	497, 511	203, 098	30.00
31. 00 03100 NTENSI VE CARE UNI T	461, 091	73, 946		271, 587	134, 331	31.00
40. 00 04000 SUBPROVI DER - PF	224, 777	0	0	167, 534	68, 736	40.00
41. 00 04100 SUBPROVI DER - RF	296, 500	39, 560	153, 062	278, 236	77, 043	41.00
43. 00 04300 NURSERY	0	2, 295	8, 877	37, 800	10, 286	43.00
ANCILLARY SERVICE COST CENTERS				. 1		
50. 00 05000 OPERATING ROOM	326, 024	23, 946	192, 681	0	82, 297	50.00
51. 00 05100 RECOVERY ROOM 51. 01 05101 ENDOSCOPY	0 211, 032	0 15, 865	0 50, 753	0	0 33, 858	51. 00 51. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM	211,032	6, 224	12, 187	0	41, 831	52.00
53. 00 05300 ANESTHESI OLOGY	0	0, 224	0	Ö	41, 031	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	569, 064	45, 758	-	Ö	136, 114	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	132, 738	0	0	o	59, 852	55. 00
60. 00 06000 LABORATORY	124, 822	0	47, 393	0	109, 978	60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	97, 937	241	36, 259	0	70, 770	65.00
66. 00 06600 PHYSI CAL THERAPY 69. 00 06900 ELECTROCARDI OLOGY	380, 434 313, 539	9, 544 12, 064	91, 877 143, 483	U O	127, 578 96, 471	66. 00 69. 00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	313, 339	12,004	143, 463	0	90, 471	70.00
70. 01 07001 NEURODI AGNOSTI CS	131, 841	8, 654	36, 159	0	16, 061	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	Ö	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	О	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	22, 722		0	46, 554	
76. 00 03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76. 01 03951 NPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	148, 000	0	0	0	0	76. 01
90. 00 09000 CLINIC	46, 011	185	55, 668	٥	4, 695	90.00
90. 01 04950 WOUND CLINIC	49, 701	11, 104		Ö	12, 735	90. 01
91. 00 09100 EMERGENCY	299, 087	63, 923		Ö	170, 831	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	·	·				92.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	6, 795			0	3, 940	96.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	101. 00
113. 00 11300 I NTEREST EXPENSE	1		Ι			113. 00
116. 00 11600 HOSPI CE	68, 482	0	46, 641	o	21, 253	116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	5, 922, 764			1, 252, 668	1, 808, 041	
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	1, 987, 465	20, 730		0	529, 372	
194.00 07950 COMMUNITY HEALTH SERVICES 194.02 07952 MARKETING AND PUBLIC RELATIONS	43, 734	0	17, 001	0		194. 00 194. 02
194.02 07952 MARKETING AND PUBLIC RELATIONS 194.03 07953 MH RESIDENTIAL	32, 542 349, 392	0	3, 059 0	0	6, 475 25, 524	
194. 04 07954 UNUSED SPACE	1, 998, 519	0	0	0		194. 03
194. 05 07955 MOB	412, 924	n	0	0		194. 04
194. 06 07956 FOUNDATI ON	8, 036		Ö	o		194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	81, 260		0	o	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0		0	o	0	194. 08

Health Financial Systems		GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SE	ERVI CE COSTS		Provi der (Peri od:	Worksheet B	
					From 01/01/2018	Part	
					To 12/31/2018	Date/Time Pre	pared:
						1/20/2020 10:	18 am
Cost Center Desc	cri pti on	OPERATION OF	LAUNDRY &	HOUSEKEEPI NO	DI ETARY	CAFETERI A	

						1/20/2020 10:	18 8111
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	631, 579	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 through 201)	11, 468, 215	652, 686	3, 250, 504	1, 252, 668	2, 369, 412	202. 00

Peri od: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 1/20/2020 10:18 am

						1/20/2020 10:	18 am
	Cost Center Description	NURSI NG ADMI NI STRATI O N	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS &	SOCI AL SERVI CE	
		13. 00	14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS	10.00		10.00	10.00	.,,,,,,	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4.01	00401 COMMUNI CATI ONS						4. 01
4. 02	00402 PURCHASING & RECEIVING						4. 02
4.03	00403 REGI STRATI ON						4. 03
4.04	00404 PATI ENT ACCOUNTS						4. 04
5. 00	00500 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	0 (00 000					11.00
13.00	01300 NURSING ADMINISTRATION	2, 688, 828	700 000				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	790, 820	4 0/0 700			14.00
15.00	01500 PHARMACY	0	2, 791	4, 869, 789	4 214 527		15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	280 0	0	4, 216, 537	0	16. 00 17. 00
17. 00	01700 SOCIAL SERVICE		31	0	0	0	17.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD		0	0	0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		0	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM-RADIOLOGY		6	0	0	0	23. 00
23. 01	02301 PARAMED ED PRGM-LAB		276	0	0	0	23. 01
20.01	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	270	<u> </u>	<u> </u>		20.01
30. 00	03000 ADULTS & PEDI ATRI CS	674, 435	16, 770	3, 874	1, 281, 562	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	446, 079	12, 594	2, 838	126, 164	0	31.00
40.00	04000 SUBPROVI DER - I PF	228, 254	1, 198	363	531, 217	0	40.00
41.00	04100 SUBPROVI DER - I RF	255, 839	3, 716	1, 856	199, 206	0	41.00
43.00	04300 NURSERY	34, 158	743	104	53, 122	0	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	273, 288	21, 495	18, 675	99, 603	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
51. 01	05101 ENDOSCOPY	0	19, 164	909	0	0	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	138, 912	3, 602	521	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	6, 583	35, 488	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	3, 407	891	0	0	55. 00
60.00	06000 LABORATORY	0	114, 989	764	0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0	3, 299	442	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 173	1, 198	0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	3, 700	17, 103	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	0	1, 282	8	O O	0	70.01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	196, 837	0	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	227, 976	4, 186, 505	0	0	73.00
	07500 ASC (NON-DISTINCT PART)	0	14, 441	13, 000	763, 625	0	75.00
76. 00	03950 MH ANCILLARY OUTPATIENT	0	14, 441	13,000	703, 023	0	76.00
	03951 I NPATIENT DI ALYSI S		60	1, 588	0	0	76. 01
70.0.	OUTPATIENT SERVICE COST CENTERS	<u> </u>		., 555	<u></u>		70.0.
90.00	09000 CLI NI C	0	62	72	0	0	90.00
90. 01	04950 WOUND CLINIC	o	4, 533	4, 740	159, 365	0	90. 01
91.00	09100 EMERGENCY	567, 287	12, 627	5, 173	1, 002, 673	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		·	•			92.00
	OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	1, 200	0	0	0	96.00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	70, 576	701	128	0		116. 00
118.00		2, 688, 828	675, 536	4, 296, 240	4, 216, 537	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	112, 661	573, 457	0		192. 00
	07950 COMMUNITY HEALTH SERVICES	0	101	0	0		194. 00
	07952 MARKETING AND PUBLIC RELATIONS	0	38	0	0		194. 02
	07953 MH RESI DENTI AL	0	1, 201	92	0		194. 03
	07954 UNUSED SPACE	0	0	0	0		194.04
	07955 MOB	0	0	0	0		194. 05
	07956 FOUNDATION	0	0	0	0		194.06
194.0	07957 KNOX COUNTY HEALTH DEPT	0	0	0	0	0	194. 07

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0042	Period: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

						1/20/2020 10:	18 am
C	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N	SUPPLY		LI BRARY		
		13. 00	14. 00	15. 00	16.00	17. 00	
194. 08 07958 I	NDUSTRI AL HEALTH	0	0	0	0	0	194. 08
194. 09 07959 C	COMMUNITY MENTAL HEALTH CENTER	0	1, 283	0	0	0	194.09
200.00	Cross Foot Adjustments						200.00
201. 00 N	Negative Cost Centers	0	0	0	0	0	201.00
202. 00 T	FOTAL (sum lines 118 through 201)	2, 688, 828	790, 820	4, 869, 789	4, 216, 537	0	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Peri od: Worksheet B From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared: Provider CCN: 15-0042

						1/20/2020 10:	
			INTERNS &	RESI DENTS			
	Cost Center Description	MENTAL HEALTH	SERVICES_SALA	SERVI CES-0THE	PARAMED ED	PARAMED ED	
	cost defiter bescription	OH	RY & FRINGES	R PRGM COSTS	PRGM-RADI OLOG	PRGM-LAB	
					Υ		
	CENEDAL CEDALCE COCT CENTEDS	17. 01	21. 00	22. 00	23. 00	23. 01	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00401 COMMUNI CATI ONS						4. 01
4. 02	00402 PURCHASING & RECEIVING						4. 02
	00403 REGI STRATI ON						4. 03
	00404 PATI ENT ACCOUNTS						4. 04
	00500 ADMINI STRATI VE & GENERAL						5.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
	00900 HOUSEKEEPI NG			•			9.00
	01000 DI ETARY						10.00
	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE	1 400 100					17.00
	01701 MENTAL HEALTH OH 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1, 488, 188	0				17. 01 21. 00
	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	٥) o			22.00
	02300 PARAMED ED PRGM-RADIOLOGY	0			269, 846		23. 00
	02301 PARAMED ED PRGM-LAB	0				291, 989	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	0	1		0	1
	03100 I NTENSI VE CARE UNI T	0	0	0		0	
	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	678, 885		0	0	0	40. 00 41. 00
	04300 NURSERY			1	_	0	1
	ANCILLARY SERVICE COST CENTERS				<u> </u>		43.00
	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	o	0	51.00
51. 01	05101 ENDOSCOPY	0	0	0	0	0	51.01
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		0	52.00
	05300 ANESTHESI OLOGY	0	0	0	_	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0	0		0	54. 00 55. 00
	06000 LABORATORY				0	291, 989	1
	06300 BLOOD STORING, PROCESSING & TRANS.	0	٥	Ö	=	271, 787	
	06500 RESPI RATORY THERAPY	0	0	ō	o	0	1
66. 00	06600 PHYSI CAL THERAPY	0	0	0	o	0	66.00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	0		0	
	07001 NEURODI AGNOSTI CS	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	1
	07500 ASC (NON-DISTINCT PART)	0		0		0	1
	03950 MH ANCILLARY OUTPATIENT	0	Ö	ő	=	0	1
	03951 INPATIENT DIALYSIS	0	0	0	o	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						ļ
	09000 CLI NI C	0	0	•		0	1
	04950 WOUND CLINIC	0	0	0		0	
	09100 EMERGENCY	0	0	0	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
	09600 DURABLE MEDICAL EQUIP-RENTED	Ο	Ο	0	O	0	96.00
	10100 HOME HEALTH AGENCY	0	l e	1			101.00
	SPECIAL PURPOSE COST CENTERS				·		
113. 00	11300 NTEREST EXPENSE						113. 00
	11600 HOSPI CE	0			0		116. 00
118. 00	, ,	678, 885	0	0	269, 846	291, 989	118. 00
	NONREI MBURSABLE COST CENTERS			1 ^		^	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES		0	0			190. 00 192. 00
	07950 COMMUNITY HEALTH SERVICES						194. 00
	07950 COMMONITY HEALTH SERVICES 07952 MARKETING AND PUBLIC RELATIONS						194.00
	07953 MH RESIDENTIAL	0	0	l ő			194. 02
194. 04	07954 UNUSED SPACE	0	0	Ō	o	0	194. 04
	07955 MOB	0	0	o	o	0	194. 05
-							

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

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0042
From 01/01/2018
To 12/31/2018
Date/Time Prepared:

				1	0 12/31/2018	Date/ITILE Pre	
						1/20/2020 10:	18 am
			INTERNS &	RESI DENTS			
	Cost Center Description	MENTAL HEALTH	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	PARAMED ED	
		OH	RY & FRINGES	R PRGM COSTS	PRGM-RADI OLOG	PRGM-LAB	
					Υ		
		17. 01	21. 00	22.00	23. 00	23. 01	
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	COMMUNITY MENTAL HEALTH CENTER	809, 303	0	0	0	0	194. 09
200. 00	Cross Foot Adjustments		0	0	0	0	200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	1, 488, 188	0		269, 846	291, 989	202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0042

			1	o 12/31/2018 Date/lime 1/20/2020) 10:18 am
Cost Center Description	Subtotal	Intern &	Total	,,	
		Resi dents			
		Cost & Post			
		Stepdown Adjustments			
	24. 00	25. 00	26.00		
GENERAL SERVICE COST CENTERS					
1. 00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P					2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4. 01 00401 COMMUNI CATIONS					4. 00 4. 01
4. 02 00402 PURCHASI NG & RECEI VI NG					4. 02
4. 03 00403 REGI STRATI ON					4. 03
4. 04 00404 PATIENT ACCOUNTS					4. 04
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A					10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00 01700 SOCIAL SERVICE					17. 00
17. 01 01701 MENTAL HEALTH OH					17. 01
21. 00 02100 1&R SERVICES-SALARY & FRINGES APPRVD					21.00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRVD 23. 00 02300 PARAMED ED PRGM-RADI OLOGY					22.00
23. 01 02300 PARAMED ED PRGM-RADI OLOGI 23. 01 02301 PARAMED ED PRGM-LAB					23.00
INPATIENT ROUTINE SERVICE COST CENTERS					20.01
30. 00 03000 ADULTS & PEDIATRICS	14, 207, 884	0	14, 207, 884		30.00
31.00 03100 INTENSIVE CARE UNIT	8, 383, 992	0	8, 383, 992		31.00
40. 00 04000 SUBPROVI DER - I PF	4, 865, 398	0	.,		40.00
41. 00 04100 SUBPROVI DER - I RF	4, 421, 498	0			41.00
43. 00 O4300 NURSERY	608, 587	0	608, 587		43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	7, 084, 096	0	7, 084, 096		50.00
51. 00 05100 RECOVERY ROOM	7,004,090	0			51.00
51. 01 05101 ENDOSCOPY	2, 920, 528	0			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 111, 193	0			52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 658, 496	0			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 875, 180	0	3, 875, 180		55.00
60. 00 06000 LABORATORY	9, 739, 263	0	9, 739, 263		60.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 65. 00 06500 RESPIRATORY THERAPY	3, 653, 909	0	0 3, 653, 909		63. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	7, 134, 730	0	7, 134, 730		66.00
69. 00 06900 ELECTROCARDI OLOGY	6, 378, 829	0	6, 378, 829		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
70. 01 07001 NEURODI AGNOSTI CS	1, 310, 587	0	1, 310, 587		70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 552, 013	0	8, 552, 013		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 545, 107	0	-, ,		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	22, 053, 710	0	22, 053, 710		73.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03950 MH ANCILLARY OUTPATIENT	3, 680, 893 0	0	3, 680, 893 0		75. 00 76. 00
76. 01 03951 INPATIENT DIALYSIS	824, 031	0	824, 031		76. 01
OUTPATIENT SERVICE COST CENTERS	021,001	0	021,001		70.01
90. 00 09000 CLI NI C	358, 759	0	358, 759		90.00
90. 01 04950 WOUND CLINIC	2, 020, 426	0			90. 01
91. 00 09100 EMERGENCY	9, 911, 572	0			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
OTHER REIMBURSABLE COST CENTERS 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	202, 944		202, 944		96.00
101.00 10100 HOME HEALTH AGENCY	202, 944	0			101.00
SPECIAL PURPOSE COST CENTERS					101.00
113. 00 11300 I NTEREST EXPENSE					113.00
116. 00 11600 HOSPI CE	1, 713, 616	0	1, 713, 616		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117	7) 143, 217, 241	0	143, 217, 241		118. 00
NONREI MBURSABLE COST CENTERS			-		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0 050 100	0			190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 COMMUNI TY HEALTH SERVI CES	59, 958, 188 165, 062	0	59, 958, 188 165, 062		192. 00 194. 00
194.0007930 COMMONTH HEALTH SERVICES 194.0207952 MARKETING AND PUBLIC RELATIONS	808, 086	0	808, 086		194. 00
194. 03 07953 MH RESIDENTIAL	1, 619, 379	0	1, 619, 379		194. 02
194. 04 07954 UNUSED SPACE	5, 760, 979	Ō	5, 760, 979		194.04
194. 05 07955 MOB	1, 231, 195	0			194. 05

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der 0	CCN: 15-0042	Peri od: From 01/01/2018 To 12/31/2018	Worksheet B Part I Date/Time Pre 1/20/2020 10:	
Cost Center Description	Subtotal	Intern & Residents	Total			

				1/20/2020 10: 1	8 am_
Cost Center Description	Subtotal	Intern &	Total		
		Resi dents			
		Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
194. 06 07956 FOUNDATI ON	23, 523	0	23, 523	[1	194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	236, 748	0	236, 748]1	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0]	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	10, 377, 318	0	10, 377, 318]1	194. 09
200.00 Cross Foot Adjustments	0	0	0)	200.00
201.00 Negative Cost Centers	0	0	0)	201.00
202.00 TOTAL (sum lines 118 through 201)	223, 397, 719	0	223, 397, 719)	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

				lo	12/31/2018	Date/lime Pre 1/20/2020 10:	
			CAPI TAL REI	LATED COSTS			
	Cost Contar Description	Directly	BLDG & FIXT	MVDLE FOLLID	Subtotal	EMPLOYEE	
	Cost Center Description	Directly Assigned New	BLDG & FIXI	MVBLE EQUIP	Subtotal	BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
	OFNEDAL CERVILOE COCT OFNITERS	0	1. 00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	131, 810	110	131, 920	131, 920	4.00
4. 01	00401 COMMUNI CATI ONS	0	0	0	0	359	4. 01
4. 02	00402 PURCHASING & RECEIVING	0	455, 619		455, 998	887	4. 02
4. 03 4. 04	OO4O3 REGI STRATI ON OO4O4 PATI ENT ACCOUNTS	0	0	0	0	1, 601 3, 108	4. 03 4. 04
5. 00	00500 ADMINISTRATIVE & GENERAL	0	1, 236, 249	- 1	1, 237, 394	11, 580	5.00
7. 00	00700 OPERATION OF PLANT	0	3, 832, 674		3, 836, 125	2, 785	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	154, 385		154, 517	264	8. 00
9.00	00900 HOUSEKEEPI NG	0	215, 071	184	215, 255	2, 547	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	0	0 367, 023	-	0 367, 337	550 1, 544	10.00 11.00
13. 00	01300 NURSING ADMINISTRATION	0	251, 835		252, 050	1, 824	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	O	2, 639		2, 641	469	14.00
15.00	01500 PHARMACY	0	181, 444		181, 599	3, 683	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	138, 289		138, 407	3, 112	16.00
17. 00 17. 01	O1700 SOCIAL SERVICE O1701 MENTAL HEALTH OH	0	0 100, 910	-	0 100, 996	0 917	17. 00 17. 01
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	100, 910	0	100, 970	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	Ō	0	0	22.00
23. 00	02300 PARAMED ED PRGM-RADIOLOGY	0	0	0	0	284	23. 00
23. 01	O2301 PARAMED ED PRGM-LAB	0	0	0	0	274	23. 01
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	O	2, 047, 721	1, 751	2, 049, 472	5, 637	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	783, 855		784, 525	4, 530	31.00
40.00	04000 SUBPROVI DER - I PF	0	382, 121	327	382, 448	2, 363	40.00
41.00	04100 SUBPROVI DER - I RF	0	504, 051		504, 482	2, 213	41.00
43.00	04300 NURSERY	0	0	0	0	380	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	554, 242	474	554, 716	4, 490	50.00
51. 00	05100 RECOVERY ROOM	0	034, 242		334, 710	4, 470	51.00
51. 01	05101 ENDOSCOPY	0	358, 755	307	359, 062	1, 284	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	1, 521	52. 00
53.00	05300 ANESTHESI OLOGY	0	0/7 410	1	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	967, 410 225, 655		968, 237 225, 848	4, 890 3, 334	54. 00 55. 00
60. 00	06000 LABORATORY	0	212, 198		212, 380	2, 907	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
65.00	06500 RESPI RATORY THERAPY	0	166, 493		166, 635	2, 746	65.00
66.00	06600 PHYSI CAL THERAPY	0	646, 738		647, 291	4, 858	66.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	533, 017 0		533, 473 0	6, 211 0	
	07001 NEURODI AGNOSTI CS	l o	224, 130		224, 322		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 75. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	1 530	73. 00 75. 00
76. 00	07500 ASC (NON-DISTINCT PART) 03950 MH ANCILLARY OUTPATIENT	0	0	0	0	1, 530 0	76. 00 76. 00
76. 01	03951 I NPATIENT DI ALYSI S	o	251, 601	215	251, 816	0	76.00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC	0	78, 218		78, 285	139	90.00
90. 01	04950 WOUND CLINIC 09100 EMERGENCY	0	84, 492		84, 564	511	90. 01
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	508, 449	435	508, 884 0	5, 340	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	11, 551	10	11, 561		96. 00
101.00	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
112 00	SPECIAL PURPOSE COST CENTERS				ı		112 00
	11300 INTEREST EXPENSE 11600 HOSPI CE	0	116, 419	100	116, 519		113. 00 116. 00
118.00		0	15, 725, 064		15, 738, 759	91, 981	
	NONREI MBURSABLE COST CENTERS	1					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES 07950 COMMUNITY HEALTH SERVICES	0	3, 378, 695		3, 381, 585	32, 762	
	07950 COMMUNITY HEALTH SERVICES		74, 349 55, 322		74, 413 55, 369		194. 00 194. 02
	07953 MH RESIDENTIAL		593, 967		594, 475		194. 02
	07954 UNUSED SPACE		3, 397, 487		3, 400, 393		194. 04
				·			

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der	From 01/01/2018	Worksheet B Part II Date/Time Prepared: 1/20/2020 10:18 am

					1/20/2020 10:	<u> 18 am</u>
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
194. 05 07955 MOB	0	701, 972	600	702, 572	0	194. 05
194. 06 07956 FOUNDATI ON	0	13, 662	12	13, 674	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	0	138, 143	118	138, 261	0	194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0	0	0	0	0	194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	0	1, 073, 685	918	1, 074, 603	6, 483	194. 09
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum Lines 118 through 201)	0	25, 152, 346	21. 758	25, 174, 104	131, 920	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0042

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

1/20/2020 10:18 am REGI STRATI ON Cost Center Description COMMUNICATION PURCHASING & PATI ENT ADMI NI STRATI V RECEI VI NG ACCOUNTS E & GENERAL 4. 01 4.03 4.04 5.00 4.02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4 00 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 00401 COMMUNICATIONS 4.01 359 4.01 4. 02 00402 PURCHASING & RECEIVING 456, 888 4.02 4.03 00403 REGI STRATI ON 5 206 1,812 4.03 00404 PATIENT ACCOUNTS 3, 429 4 04 314 0 4 04 5.00 00500 ADMINISTRATIVE & GENERAL 25 1, 523 0 0 1, 250, 522 5.00 7.00 00700 OPERATION OF PLANT 23 4,034 64, 198 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 1.766 0 0 3, 145 8.00 00900 HOUSEKEEPI NG 0 6 0 9 00 4.397 17. 253 9 00 4 0 6, 480 10.00 01000 DI ETARY 31, 640 0 10.00 11.00 01100 CAFETERI A 0 0 0 11, 936 11.00 0 01300 NURSING ADMINISTRATION 3 0 172 14.037 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 0 1 14.00 2.093 4.035 14.00 o 15.00 01500 PHARMACY 5 1, 450 0 26,064 15.00 01600 MEDICAL RECORDS & LIBRARY 8 0 22, 381 16 00 145 16.00 0 01700 SOCIAL SERVICE 0 17.00 0 17.00 C 0 01701 MENTAL HEALTH OH 0 17 01 35 16 7, 258 17 01 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 o 22.00 0 0 0 22.00 0 02300 PARAMED ED PRGM-RADIOLOGY 0 1.474 23.00 0 23.00 23.01 02301 PARAMED ED PRGM-LAB 143 0 1, 597 23.01 NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 8, 710 30.00 24 89 149 52, 559 31.00 03100 INTENSIVE CARE UNIT 15 6,541 60 100 36, 895 31 00 16, 595 04000 SUBPROVI DER - I PF 24 40 40.00 0 622 40.00 04100 SUBPROVI DER - I RF 41.00 1, 930 24 40 17, 446 41.00 11 04300 NURSERY 43.00 386 2, 582 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 24 11, 165 170 283 33, 846 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 51.00 05101 ENDOSCOPY 9, 953 14 493 51 01 36 60 51.01 52.00 05200 DELIVERY ROOM & LABOR ROOM 15 1,871 20 33 10,680 52.00 05300 ANESTHESI OLOGY 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 3.419 88 557 52.772 11 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 6 1, 770 69 115 20, 591 55.00 06000 LABORATORY 59, 724 60.00 5 206 343 50,658 60.00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 6 06500 RESPIRATORY THERAPY 1, 713 51 85 19, 285 65 00 65 00 06600 PHYSI CAL THERAPY 66.00 609 77 128 36, 515 66.00 06900 ELECTROCARDI OLOGY 13 69.00 1, 922 142 236 32, 426 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 3 0 0 0 07001 NEURODI AGNOSTI CS 6, 251 70 01 28 666 17 70 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 102, 235 0 0 46, 772 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 118, 408 0 0 35, 363 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 212 353 100.020 73.00 07500 ASC (NON-DISTINCT PART) 75 00 7,501 73 121 14, 942 75 00 76.00 03950 MH ANCILLARY OUTPATIENT 0 (0 0 0 76.00 03951 INPATIENT DIALYSIS 76.01 0 31 4 7 3,775 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 32 0 1, 411 90.00 04950 WOUND CLINIC 2, 354 77 90.01 46 9,859 90.01 09100 EMERGENCY 91.00 91.00 16 6.558 273 164 42, 367 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 623 2 1,069 96.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 116.00 11600 HOSPI CE 364 18 8, 430 116.00 11 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 118.00 290 397,009 1,589 3,057 847, 460 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 58, 515 222 371 314, 614 192. 00 63 194. 00 07950 COMMUNITY HEALTH SERVICES 583 194, 00 3 53 C 0 194. 02 07952 MARKETING AND PUBLIC RELATIONS 20 0 0 4, 288 194, 02 194.03 07953 MH RESIDENTIAL 1 6, 959 194. 03 0 0 624 194. 04 07954 UNUSED SPACE 0 0 21, 062 194. 04 C 194. 05 07955 MOB 4, 581 194. 05 0 0 C 194. 06 07956 FOUNDATI ON 0 C 0 0 87 194.06 194.07 07957 KNOX COUNTY HEALTH DEPT 2 0 870 194. 07 0 194. 08 07958 I NDUSTRI AL HEALTH 0 0 194.08

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0042	Peri od: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

						1/20/2020 10:	18 am
	Cost Center Description	COMMUNI CATI ON	PURCHASING &	REGI STRATI ON	PATI ENT	ADMI NI STRATI V	
		S	RECEI VI NG		ACCOUNTS	E & GENERAL	
		4. 01	4. 02	4. 03	4. 04	5. 00	
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	0	667	0	0	50, 018	194. 09
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	359	456, 888	1, 812	3, 429	1, 250, 522	202.00

					1/20/2020 10:	18 am
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
	PLANT	LINEN SERVICE	0.00	10.00	11 00	
OFNEDAL CERVILOE COCT OFNEDO	7. 00	8. 00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01 00401 COMMUNI CATI ONS						4. 01
4. 02 00402 PURCHASI NG & RECEI VI NG						4. 02
4. 03 00403 REGI STRATI ON						4.03
4. 04 00404 PATI ENT ACCOUNTS						4.04
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT	3, 907, 165					7.00
8.00 00800 LAUNDRY & LINEN SERVICE	30, 940	190, 632				8.00
9. 00 00900 HOUSEKEEPI NG	43, 102	12, 278	294, 838			9. 00
10. 00 01000 DI ETARY	0	3, 255		49, 549		10.00
11. 00 01100 CAFETERI A	73, 554	0		0	456, 300	11. 00
13. 00 01300 NURSING ADMINISTRATION	50, 470	0	0	0	6, 392	13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	529	1, 825	-	n	4, 595	14. 00
15. 00 01500 PHARMACY	36, 363	0	2, 734	0	14, 291	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	27, 714	0	2, 625	0	20, 791	16.00
· · · · · · · · · · · · · · · · · · ·		0		0		
17. 00 01700 SOCIAL SERVICE	0	0 110	0	0	0	17.00
17. 01 01701 MENTAL HEALTH OH	20, 223	3, 148	8, 516	0	5, 320	17. 01
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00 02300 PARAMED ED PRGM-RADIOLOGY	0	0	0	0	1, 246	23.00
23.01 02301 PARAMED ED PRGM-LAB	0	0	0	0	1, 235	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	410, 381	65, 926	64, 522	19, 678	39, 112	30.00
31.00 03100 INTENSIVE CARE UNIT	157, 091	21, 598	24, 000	10, 743	25, 869	31.00
40. 00 04000 SUBPROVI DER - I PF	76, 580	0	0	6, 627	13, 237	40.00
41. 00 04100 SUBPROVI DER - RF	101, 016	11, 554	13, 884	11, 006	14, 837	41. 00
43. 00 04300 NURSERY	0	670	805	1, 495	1, 981	43. 00
ANCI LLARY SERVI CE COST CENTERS		070	000	1, 475	1, 701	43.00
50. 00 05000 OPERATING ROOM	111, 075	6, 994	17, 477	ام	15, 849	50. 00
	111,075	0, 994	17,477	0	15, 649	51.00
51. 00 05100 RECOVERY ROOM	1	ŭ		0		
51. 01 05101 ENDOSCOPY	71, 898	4, 634		U	6, 520	51.01
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 818		0	8, 056	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	193, 877	13, 365	15, 289	0	26, 213	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	45, 223	0	0	0	11, 526	55.00
60. 00 06000 LABORATORY	42, 526	0	4, 299	0	21, 179	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	33, 367	70	3, 289	0	13, 629	65.00
66. 00 06600 PHYSI CAL THERAPY	129, 612	2, 787	8, 334	0	24, 569	66.00
69. 00 06900 ELECTROCARDI OLOGY	106, 821	3, 524	13, 015	o	18, 578	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	O	o	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	44, 918	2, 528	3, 280	0	3, 093	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.1,710	2,020	0,200	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ô	0	o o	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	73.00
75. 00 07500 ASC (NON-DISTINCT PART)				0	8, 965	
	0					
76. 00 03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	50, 423	0	0	0	0	76. 01
OUTPATIENT SERVICE COST CENTERS				_1		
90. 00 09000 CLI NI C	15, 676			0	904	90.00
90. 01 04950 WOUND CLINIC	16, 933	•		0	2, 452	90. 01
91. 00 09100 EMERGENCY	101, 898	18, 670	20, 102	0	32, 899	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	2, 315	0	0	0	759	96.00
101.00 10100 HOME HEALTH AGENCY	0		0	o	0	101.00
SPECIAL PURPOSE COST CENTERS			-1	-1		
113. 00 11300 NTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	23, 331	0	4, 231	0	1 003	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		184, 577		49, 549	348, 190	
	2,017,030	104, 577	245, 404	47, 347	340, 170	110.00
NONREI MBURSABLE COST CENTERS	1 ^			ol	^	190. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(77, 110	, , , , ,	0	-1		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	677, 119			0	101, 948	
194. 00 07950 COMMUNITY HEALTH SERVICES	14, 900	0	1, 542	0		194.00
194.02 07952 MARKETING AND PUBLIC RELATIONS	11, 087	0	277	0		194. 02
194. 03 07953 MH RESI DENTI AL	119, 036	0	0	0		194. 03
194. 04 07954 UNUSED SPACE	680, 887	0	0	0		194. 04
194. 05 07955 MOB	140, 681	0	0	o	0	194. 05
194. 06 07956 FOUNDATI ON	2, 738	0	0	ol	0	194. 06
194.07 07957 KNOX COUNTY HEALTH DEPT	27, 685		0	O		194. 07
194. 08 07958 I NDUSTRI AL HEALTH	0			Ö		194. 08
			,	۹۱		

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0042	Period: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 1/20/2020 10:18 am

						17 207 2020 10.	10 4111
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE				
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	215, 176	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 through 201)	3, 907, 165	190, 632	294, 838	49, 549	456, 300	202.00

				10	12/31/2010	Date/lime Pre 1/20/2020 10:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O N	SERVI CES & SUPPLY		RECORDS & LI BRARY	SERVI CE	
		13. 00	14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
4. 00	00401 COMMUNI CATI ONS						4. 00
4. 02	00402 PURCHASI NG & RECEI VI NG						4. 02
4.03	00403 REGI STRATI ON						4.03
4. 04	00404 PATIENT ACCOUNTS						4. 04
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	324, 948	10.440				13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	19, 663	244 250			14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY		69 7	266, 258 0	215, 190		16.00
17. 00	01700 SOCI AL SERVI CE		ó	Ö	213, 170	0	17.00
17. 01	01701 MENTAL HEALTH OH	0	1	0	0	0	17. 01
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23. 00 23. 01	02300 PARAMED ED PRGM-RADI OLOGY	0	0	0	0	0	23. 00 23. 01
23.01	O2301 PARAMED ED PRGM-LAB I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l ol	/]	U	<u>U</u>	0	23.01
30. 00	03000 ADULTS & PEDIATRICS	81, 506	417	212	65, 405	0	30.00
31.00	03100 INTENSIVE CARE UNIT	53, 909	313	155	6, 439	0	31.00
40.00	04000 SUBPROVI DER - I PF	27, 585	30	20	27, 111	0	40.00
41.00	04100 SUBPROVI DER – I RF	30, 919	92	102	10, 166	0	41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	4, 128	18	6	2, 711	0	43.00
50.00	05000 OPERATING ROOM	33, 027	535	1, 021	5, 083	0	50.00
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
51. 01	05101 ENDOSCOPY	0	477	50	0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	16, 788	90	28	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	164 85	1, 940 49	0	0	54. 00 55. 00
60.00	06000 LABORATORY		2, 860	42	0	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	O	0	0	o	0	63.00
65.00	06500 RESPI RATORY THERAPY	o	82	24	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	29	66	0	0	66.00
69. 00	06900 ELECTROCARDI OLOGY	0	92	935	0	0	69.00
70. 00 70. 01	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS	0	0 32	0	0	0	70. 00 70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	4, 895	0	0	0	70.01
	07200 I MPL. DEV. CHARGED TO PATIENTS	l o	5, 664	Ö	Ö	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	O	228, 897	0	0	73.00
75. 00		0	359	711	38, 971	0	75.00
76.00		0	0	0	0	0	76.00
76. 01	03951 INPATIENT DIALYSIS OUTPATIENT SERVICE COST CENTERS	0		87	U	0	76. 01
90.00		O	2	4	O	0	90.00
90. 01		o o	113	259	8, 133	0	90. 01
91.00	09100 EMERGENCY	68, 557	314	283	51, 171	0	91.00
92.00	,						92.00
0/ 00	OTHER REIMBURSABLE COST CENTERS		20		ما	0	0/ 00
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	0	30 0	0	0	0	96. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	l ol	- υ _լ	U	υ _l	0	1101.00
113.00	11300 NTEREST EXPENSE						113.00
116.00	11600 HOSPI CE	8, 529	17	7	0		116.00
118.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	324, 948	16, 795	234, 898	215, 190	0	118. 00
400.0	NONREI MBURSABLE COST CENTERS		ما				
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES	0	0 2, 802	0 31, 355	0		190. 00 192. 00
	07950 COMMUNITY HEALTH SERVICES		2, 002	31, 333 0	0		194.00
	2 07952 MARKETING AND PUBLIC RELATIONS		1	0	ol		194.00
	3 07953 MH RESIDENTIAL	o	30	5	ō	0	194. 03
	4 07954 UNUSED SPACE	0	o	0	o		194. 04
	5 07955 MOB	0	0	0	o		194.05
	5 07956 FOUNDATION 7 07957 KNOX COUNTY HEALTH DEPT	0	0	0	0		194. 06 194. 07
1,74.0	ALONS AND SOURT HEALTH DELT	<u>, </u>	<u> </u>	U _I	υĮ	0	1., 1.07

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0042	Period: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

						1/20/2020 10:	18 am_
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
		N	SUPPLY		LI BRARY		
		13. 00	14. 00	15. 00	16. 00	17. 00	
194. 08 07958	INDUSTRIAL HEALTH	0	0	0	0	0	194. 08
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	0	32	0	0	0	194. 09
200. 00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	0	201.00
202. 00	TOTAL (sum lines 118 through 201)	324, 948	19, 663	266, 258	215, 190	0	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

				1	o 12/31/2018	1/20/2020 10:	
			INTERNS &	RESI DENTS			
	Cost Center Description	MENTAL HEALTH	SERVI CES-SALA	SEDVI CES_OTHE	PARAMED ED	PARAMED ED	
	cost center bescription	OH	RY & FRINGES	R PRGM COSTS	PRGM-RADI OLOG	PRGM-LAB	
					Y		
	GENERAL SERVICE COST CENTERS	17. 01	21. 00	22.00	23. 00	23. 01	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01	00401 COMMUNI CATI ONS						4. 01
4. 02 4. 03	00402 PURCHASI NG & RECEI VI NG 00403 REGI STRATI ON		•				4. 02 4. 03
4. 04	00404 PATIENT ACCOUNTS						4. 04
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00							14. 00
15.00	1 1						15.00
16. 00 17. 00	1 1						16.00 17.00
17. 00	01701 MENTAL HEALTH OH	146, 430	,				17.00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	C	0				21.00
22. 00		C)	0			22.00
23. 00	+ +	C	1		3, 007	2 254	23.00
23. 01	O2301 PARAMED ED PRGM-LAB INPATIENT ROUTINE SERVICE COST CENTERS					3, 256	23. 01
30. 00		C					30.00
31.00	03100 INTENSIVE CARE UNIT	C)				31.00
40.00		66, 795	l .				40.00
41.00	+ +	C	l				41.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	C	1				43.00
50.00		C)				50.00
51.00	05100 RECOVERY ROOM	C)				51.00
51. 01	05101 ENDOSCOPY	C					51.01
52. 00 53. 00	+ I						52.00 53.00
54. 00	+ I						54.00
55. 00	+ I						55.00
60.00		C					60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	1				63.00
65. 00 66. 00	1 1						65. 00 66. 00
69.00							69.00
	07000 ELECTROENCEPHALOGRAPHY						70.00
	07001 NEURODI AGNOSTI CS	C)				70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS						72.00 73.00
	07500 ASC (NON-DISTINCT PART)						75.00
	03950 MH ANCILLARY OUTPATIENT	C					76.00
76. 01		C					76. 01
00.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC						90.00
90.00							90.00
	09100 EMERGENCY						91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	OTHER REIMBURSABLE COST CENTERS	1 -	1	T			4
	09600 DURABLE MEDICAL EQUIP-RENTED 10100 HOME HEALTH AGENCY	C	l .				96. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS		1				1101.00
113.00	11300 INTEREST EXPENSE						113. 00
	0 11600 H0SPI CE	C	l				116. 00
118. 00	. 9 /	66, 795	0	0	0	C	118. 00
190 0	NONREIMBURSABLE COST CENTERS D 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1				190. 00
	0 19200 PHYSICIANS' PRIVATE OFFICES						190.00
	07950 COMMUNITY HEALTH SERVICES						194.00
194. 0	2 07952 MARKETING AND PUBLIC RELATIONS	0					194. 02
	3 07953 MH RESI DENTI AL	C]				194. 03
	4 07954 UNUSED SPACE 5 07955 MOB						194. 04 194. 05
- 74.0	5 ₁ 5.,551mob	1	1	<u>I</u>	<u> </u>	1	11 / 1. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0042	Period: Worksheet B From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared:

					1/20/2020 10:	18 am
		INTERNS &	RESI DENTS			
Cost Center Description	MENTAL HEALTH	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	PARAMED ED	
	OH	RY & FRINGES	R PRGM COSTS	PRGM-RADI OLOG	PRGM-LAB	
				Υ		
	17. 01	21. 00	22. 00	23.00	23. 01	
194. 06 07956 FOUNDATI ON	C)				194.06
194.07 07957 KNOX COUNTY HEALTH DEPT	C)				194.07
194. 08 07958 I NDUSTRI AL HEALTH	C)				194. 08
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	79, 635					194. 09
200.00 Cross Foot Adjustments		0	0	3, 007	3, 256	200.00
201.00 Negative Cost Centers	C	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	146, 430	0	0	3, 007	3, 256	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0042

					11	o 12/31/2018 Date/lime Pr 1/20/2020 10	
		Cost Center Description	Subtotal	Intern &	Total	, ., = 3, = 3 = 3	
		·		Resi dents			
				Cost & Post			
				Stepdown			
		+	24. 00	Adjustments 25.00	26. 00		
	GENER	AL SERVICE COST CENTERS	24.00	25.00	20.00		
1.00		CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT					4. 00
4. 01	1	COMMUNI CATI ONS					4. 01
4. 02 4. 03		PURCHASING & RECEIVING REGISTRATION					4. 02 4. 03
4. 03	1	PATIENT ACCOUNTS					4.03
5. 00	1	ADMINISTRATIVE & GENERAL					5. 00
7.00	1	OPERATION OF PLANT					7. 00
8.00	00800	LAUNDRY & LINEN SERVICE					8. 00
9. 00	1	HOUSEKEEPI NG					9. 00
10.00	1	DIETARY					10.00
11. 00 13. 00	1	CAFETERIA NURSI NG ADMI NI STRATI ON					11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY					14.00
15. 00		PHARMACY					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17. 00	1	SOCIAL SERVICE					17.00
17. 01		MENTAL HEALTH OH					17. 01
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD					21. 00 22. 00
23. 00		PARAMED ED PRGM-RADIOLOGY					23.00
23. 01		PARAMED ED PRGM-LAB					23. 01
		IENT ROUTINE SERVICE COST CENTERS					
30.00	1	ADULTS & PEDI ATRI CS	2, 863, 799	0	,		30.00
31.00	1	I NTENSI VE CARE UNIT	1, 132, 783	0	, , , , , , , , , , , , , , , , , , , ,		31.00
40. 00 41. 00		SUBPROVI DER - I PF SUBPROVI DER - I RF	620, 077 719, 722	0			40. 00 41. 00
43.00	1	NURSERY	15, 173	0	'		43.00
		LARY SERVICE COST CENTERS					
50.00		OPERATI NG ROOM	795, 755	0	795, 755		50.00
51. 00 51. 01	1	RECOVERY ROOM ENDOSCOPY	473, 075	0	0 473, 075		51. 00 51. 01
52. 00	1	DELIVERY ROOM & LABOR ROOM	42, 025	0			52.00
53.00	1	ANESTHESI OLOGY	0	0	0		53.00
54.00		RADI OLOGY-DI AGNOSTI C	1, 280, 822	0	,		54.00
55.00	1	RADI OLOGY-THERAPEUTI C	308, 616	0	308, 616		55.00
60. 00 63. 00		LABORATORY BLOOD STORING, PROCESSING & TRANS.	397, 129	0	397, 129 0		60. 00 63. 00
65. 00		RESPI RATORY THERAPY	240, 982	0	240, 982		65.00
66. 00		PHYSI CAL THERAPY	854, 880	0	854, 880		66.00
69. 00		ELECTROCARDI OLOGY	717, 388	0	717, 388		69.00
70.00		ELECTROENCEPHALOGRAPHY	0	0			70.00
70. 01		NEURODI AGNOSTI CS	285, 653	0			70. 01
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	153, 902 159, 435	0	153, 902 159, 435		71. 00 72. 00
73.00	1	DRUGS CHARGED TO PATIENTS	329, 482	0	329, 482		73.00
75.00		ASC (NON-DISTINCT PART)	93, 538	0	93, 538		75.00
76.00	1	MH ANCILLARY OUTPATIENT	0	0			76. 00
76. 01		I NPATIENT DI ALYSI S	306, 144	0	306, 144		76. 01
90 00		TIENT SERVICE COST CENTERS CLINIC	101, 558	0	101, 558		90.00
90. 01		WOUND CLINIC	130, 097	0			90.01
91.00		EMERGENCY	857, 496	0			91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)		0			92. 00
04 00		REIMBURSABLE COST CENTERS	17 470	0	14 470		96.00
		DURABLE MEDICAL EQUIP-RENTED HOME HEALTH AGENCY	16, 478 0	0			101.00
101.00		AL PURPOSE COST CENTERS	<u> </u>			l .	101.00
113.00		INTEREST EXPENSE					113. 00
		HOSPI CE	166, 232	0	· ·		116.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13, 062, 241	0	13, 062, 241		118. 00
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0	0		190. 00
		PHYSI CLANS' PRI VATE OFFI CES	4, 654, 966	0	4, 654, 966		192.00
194.00	07950	COMMUNITY HEALTH SERVICES	91, 497	0	91, 497		194.00
		MARKETING AND PUBLIC RELATIONS	72, 505	0	72, 505		194. 02
		MH RESIDENTIAL UNUSED SPACE	726, 525 4, 102, 342	0	726, 525 4, 102, 342		194. 03 194. 04
194. 02			847, 834	0			194. 04
	,	ı	2, 201		,	1	1

Health Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provi der CO	CN: 15-0042	Peri od:	Worksheet B	
				From 01/01/2018		
				To 12/31/2018	Date/Time Prepared: 1/20/2020 10:18 am	
Cost Center Description	Subtotal	Intern &	Total		17 207 2020 10. 10 dill	
, , , , , , , , , , , , , , , , , , ,		Residents				
		Cost & Post				
		Stepdown				
		Adjustments				
	24. 00	25. 00	26.00			
194. 06 07956 FOUNDATI ON	16, 499	0	16, 49	99	194. 06	
194.07 07957 KNOX COUNTY HEALTH DEPT	166, 818	0	166, 8°	18	194. 07	
194. 08 07958 I NDUSTRI AL HEALTH	0	0		0	194. 08	
194.09 07959 COMMUNITY MENTAL HEALTH CENTER	1, 426, 614	0	1, 426, 6	14	194. 09	
200.00 Cross Foot Adjustments	6, 263	0	6, 20	53	200. 00	
201.00 Negative Cost Centers	0	0		0	201. 00	
202.00 TOTAL (sum lines 118 through 201)	25, 174, 104	0	25, 174, 10	04	202. 00	

Health Financial Systems GOOD SAMARITAN HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0042 Peri od: Worksheet B-1 From 01/01/2018 12/31/2018 Date/Time Prepared: 1/20/2020 10:18 am CAPITAL RELATED COSTS BLDG & FIXT MVBLE EQUIP **EMPLOYEE** COMMUNI CATI ON PURCHASING & Cost Center Description (SQUARE FEET) (SQUARE FEET) **BENEFITS RECEIVING** (NUMBER OF DEPARTMENT (SUPPLIES (GROSS PHONES) COST) SALARIES) 1. 00 2.00 4.00 4. 01 4. 02 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 857.937 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 867, 686 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 103, 277, 171 4.00 4.496 4.401 4.00 00401 COMMUNI CATI ONS 4.01 280, 900 2, 237 4 01 4.02 00402 PURCHASING & RECEIVING 15, 541 15, 121 694, 499 18 20, 639, 427 4.02 4.03 00403 REGI STRATI ON 1, 253, 808 32 9, 284 4.03 00404 PATIENT ACCOUNTS 4 04 C 2 433 659 43 14, 169 4 04 00500 ADMINISTRATIVE & GENERAL 5.00 42, 168 45,660 9, 068, 076 153 68,816 5.00 7.00 00700 OPERATION OF PLANT 130, 731 137, 503 2, 180, 898 145 182, 219 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 5, 266 5, 266 206, 759 0 79, 786 8.00 00900 HOUSEKEEPI NG 37 198 606 9 00 7.336 1 994 584 9 00 7, 336 10.00 01000 DI ETARY 430, 514 28 1, 429, 280 10.00 01100 CAFETERI A 12, 519 12, 519 1, 209, 046 11.00 0 11.00 01300 NURSING ADMINISTRATION 1, 428, 144 13.00 8.590 8.590 20 7.784 13.00 01400 CENTRAL SERVICES & SUPPLY 367, 321 9 94, 564 14 00 90 90 14 00 15.00 01500 PHARMACY 6, 189 6, 189 2, 883, 987 32 65, 481 15.00 16.00 2, 436, 861 01600 MEDICAL RECORDS & LIBRARY 4,717 52 6,570 16.00 4,717 01700 SOCIAL SERVICE 0 17 00 17 00 0 17.01 01701 MENTAL HEALTH OH 3, 442 3, 442 717, 946 220 739 17.01 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 0 ol 0 22.00 02300 PARAMED ED PRGM-RADIOLOGY 0 222, 786 0 147 23 00 0 23 00 23.01 02301 PARAMED ED PRGM-LAB 214, 465 6, 481 23.01 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 393, 477 69. 847 69.847 4, 414, 604 147 30.00 03100 INTENSIVE CARE UNIT 31.00 26, 737 26, 737 3, 547, 217 95 295, 487 31 00 04000 SUBPROVI DER - I PF 40.00 13,034 13,034 1, 850, 794 0 28, 104 40.00 04100 SUBPROVI DER - I RF 41 00 17, 193 17, 193 1, 732, 693 70 87, 191 41.00 04300 NURSERY 43.00 297, 324 43.00 17, 440 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 18, 905 18, 905 3, 516, 189 148 504, 337 50.00 05100 RECOVERY ROOM 51.00 0 0 51.00 1,005,330 05101 ENDOSCOPY 449, 630 51.01 12, 237 26 12, 237 51.01 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 191, 158 92 84, 502 52.00 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 32, 998 32, 998 3, 829, 231 154, 462 66 54.00 2, 610, 961 79, 947 05500 RADI OLOGY-THERAPEUTI C 7,697 7, 697 37 55 00 55 00 60.00 06000 LABORATORY 7, 238 7, 238 2, 276, 662 32 2, 697, 931 60.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 06500 RESPIRATORY THERAPY 5, 679 5, 679 2, 150, 183 39 77, 400 65.00 65.00 06600 PHYSI CAL THERAPY 33 27, 519 66.00 22,060 22,060 3, 804, 055 66.00 69.00 06900 ELECTROCARDI OLOGY 18, 181 18, 181 4, 863, 753 78 86, 812 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07001 NEURODI AGNOSTI CS 402.980 20 30,077 70 01 7,645 7,645 70 01 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 C 0 0 4, 618, 301 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 0 0 5, 349, 101 72.00 07300 DRUGS CHARGED TO PATIENTS o 73.00 0 73.00 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 C 1, 198, 091 338, 831 75.00 76.00 03950 MH ANCILLARY OUTPATIENT 0 0 76.00 03951 INPATIENT DIALYSIS 76.01 8,582 8,582 1, 407 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2,668 2,668 108, 848 1,450 90.00 04950 WOUND CLINIC 2,882 2, 882 400, 108 10 106, 349 90.01 90.01 91.00 09100 EMERGENCY 17, 343 17, 343 4, 181, 575 101 91.00 296, 265 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92 00 92.00 OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 394 394 91, 223 0 28, 158 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 3, 971 3, 971 16, 450 116.00 116. 00 11600 HOSPI CE 531,026 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 1, 818 118.00 536, 376 72, 028, 258 17, 934, 554 118. 00 546, 125 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 115, 246 115, 246 25, 628, 847 376 2, 643, 320 192. 00 194. 00 07950 COMMUNITY HEALTH SERVICES 2, 536 2, 373 194. 00 2,536 21 Ω 194. 02 07952 MARKETING AND PUBLIC RELATIONS 1,887 1, 887 168, 477 902 194. 02

20, 260

20, 260

375, 014

28, 168 194. 03

194. 03 07953 MH RESIDENTIAL

				1	0 12/31/2018	1/20/2020 10:	
		CAPI TAL REL	ATED COSTS			.,,,	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	COMMUNI CATI ON		
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	S	RECEI VI NG	
				DEPARTMENT	(NUMBER OF	(SUPPLI ES	
				(GROSS	PHONES)	COST)	
		1. 00	2.00	SALARI ES) 4. 00	4. 01	4. 02	
104 04 07054	UNUSED SPACE	115, 887			4.01		194. 04
194. 05 07955	•	23, 944			0		194. 05
194. 06 07956		466		0	2		194.06
	KNOX COUNTY HEALTH DEPT	4, 712		0	14		194. 07
	I NDUSTRI AL HEALTH	7, 712	7, 712	0	0		194. 08
	COMMUNITY MENTAL HEALTH CENTER	36, 623	36, 623	5, 076, 575	0		194. 09
200.00	Cross Foot Adjustments	00,020	00,020	0,0,0,0,0	J	00, 110	200.00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	25, 152, 346	21, 758	29, 391, 749	361, 680	1, 386, 699	202.00
	Part I)				·		
203. 00	Unit cost multiplier (Wkst. B, Part I)	29. 317241	0. 025076	0. 284591	161. 680823	0. 067187	203.00
204. 00	Cost to be allocated (per Wkst. B,			131, 920	359	456, 888	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 001277	0. 160483	0. 022137	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						I

Health Financial Systems	GOOD SAMARITAI				u of Form CMS-2	
COST ALLOCATION - STATISTICAL BASIS		Provi der C		eriod: rom 01/01/2018	Worksheet B-1	
			To		Date/Time Pre	pared:
Cost Center Description	REGI STRATI ON	PATI ENT	Reconciliatio	ADMINISTRATIV	1/20/2020 10: OPERATION OF	18 am
cost center bescription	(GROSS	ACCOUNTS	n	E & GENERAL	PLANT	
	CHARGES)	(GROSS		(ACCUM. COST)	(SQUARE FEET)	
	4.00	CHARGES)	5.4	5.00	7.00	
GENERAL SERVICE COST CENTERS	4. 03	4. 04	5A	5. 00	7. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
4. 01 00401 COMMUNI CATI ONS						4. 01
4. 02 00402 PURCHASI NG & RECEI VI NG 4. 03 00403 REGI STRATI ON	440 045 044					4. 02 4. 03
4. 03 00403 REGI STRATI ON 4. 04 00404 PATI ENT ACCOUNTS	669, 945, 864	669, 945, 864				4.03
5. 00 00500 ADMINISTRATIVE & GENERAL	O	0	-21, 497, 976	201, 899, 743		5.00
7.00 OO700 OPERATION OF PLANT	O	0	0	10, 364, 612	665, 001	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE	0	0	0	507, 802	5, 266	8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	0	0	0	2, 785, 374	7, 336	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A		0	0	1, 046, 129 1, 927, 063	0 12, 519	10.00 11.00
13. 00 01300 NURSING ADMINISTRATION	l o	0	Ö	2, 266, 198		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	o	0	0	651, 474	90	14.00
15. 00 01500 PHARMACY	0	0	0	4, 207, 872	6, 189	15.00
16.00 01600 MEDI CAL RECORDS & LI BRARY 17.00 01700 SOCI AL SERVI CE	0	0	0	3, 613, 278	4, 717	16.00
17. 00 01700 SOCI AL SERVI CE 17. 01 01701 MENTAL HEALTH OH		0	0	1, 171, 745	0 3, 442	17. 00 17. 01
21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRVD		0	Ö	0	0, 442	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	o	0	0	o	0	22.00
23. 00 02300 PARAMED ED PRGM-RADIOLOGY	0	0	_	238, 026	0	23. 00
23. 01 02301 PARAMED ED PRGM-LAB	0	0	0	257, 845	0	23. 01
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS	29, 751, 482	29, 751, 482	0	8, 485, 513	69, 847	30.00
31. 00 03100 NTENSI VE CARE UNIT	20, 042, 310	20, 042, 310		5, 956, 525	26, 737	1
40. 00 04000 SUBPROVI DER - PF	8, 090, 436	8, 090, 436		2, 679, 162	13, 034	1
41. 00 04100 SUBPROVI DER - I RF	8, 016, 365	8, 016, 365	1	2, 816, 577	17, 193	1
43. 00 04300 NURSERY	1, 459, 353	1, 459, 353	0	416, 820	0	43.00
ANCILLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROOM	56, 691, 384	56, 691, 384	0	5, 464, 263	18, 905	50.00
51. 00 05100 RECOVERY ROOM	0	0, 071, 304	1	0, 404, 203	10, 703	51.00
51. 01 05101 ENDOSCOPY	11, 904, 684	11, 904, 684		2, 339, 809	12, 237	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 650, 915	6, 650, 915	0	1, 724, 314	0	52.00
53. 00 05300 ANESTHESI OLOGY	0 0 411 5 4	05 411 5(4	0	0 510 003	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	95, 411, 564 23, 054, 825	95, 411, 564 23, 054, 825		8, 519, 903 3, 324, 325	32, 998 7, 697	54. 00 55. 00
60. 00 06000 LABORATORY	68, 511, 021	68, 511, 021	1	8, 178, 498	7, 238	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	o	0	63.00
65. 00 06500 RESPIRATORY THERAPY	16, 905, 871	16, 905, 871		3, 113, 447	5, 679	65.00
66. 00 06600 PHYSI CAL THERAPY	25, 641, 478	25, 641, 478	1	5, 895, 215		ı
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	47, 235, 284	47, 235, 284	0	5, 235, 051	18, 181 0	70.00
70. 01 07001 NEURODI AGNOSTI CS	5, 648, 354	5, 648, 354	· ·	1, 009, 132	7, 645	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 213	4, 213		7, 551, 145	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1 "	5, 709, 224	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	70, 520, 752	70, 520, 752		16, 147, 818	0	73.00
75.00 07500 ASC (NON-DISTINCT PART) 76.00 03950 MH ANCILLARY OUTPATIENT	24, 252, 866	24, 252, 866	0	2, 412, 334	0	75. 00 76. 00
76. 01 03951 NPATIENT DIALYSIS	1, 432, 189	1, 432, 189	· ·	609, 486	8, 582	76.00
OUTPATIENT SERVICE COST CENTERS				·	·	
90. 00 09000 CLI NI C	159, 344	159, 344		227, 809	2, 668	1
90. 01 04950 WOUND CLINIC	15, 440, 730	15, 440, 730	1	1, 591, 668	2, 882	90.01
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	54, 686, 500	54, 686, 500	0	6, 840, 039	17, 343	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	560, 220	560, 220	0	172, 628	394	96.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						111 00
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE	3, 512, 644	3, 512, 644	0	1, 360, 926	3 971	113. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	595, 584, 784	595, 584, 784	1	136, 819, 049		
NONREI MBURSABLE COST CENTERS		, ,			2.57.10	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	74, 124, 970	74, 124, 970	0	50, 800, 946	115, 246	
194.00 07950 COMMUNITY HEALTH SERVICES 194.02 07952 MARKETING AND PUBLIC RELATIONS	0	0		94, 196 692, 261		194. 00 194. 02
194. 03 07953 MH RESIDENTIAL	236, 110	236, 110		1, 123, 538	20, 260	1
194. 04 07954 UNUSED SPACE	230, 110	233, 110	l ől	3, 400, 393	115, 887	1
194. 05 07955 MOB	0	0	· ·	739, 528	23, 944	194. 05
194. 06 07956 FOUNDATI ON	0	0	0	13, 997	466	194. 06

Health Financial Systems	GOOD SAMARITA	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2018 To 12/31/2018	Worksheet B-1 Date/Time Pre	
Cost Center Description	REGI STRATI ON (GROSS CHARGES)	PATI ENT ACCOUNTS (GROSS CHARGES)	Reconciliation	ADMINISTRATIV E & GENERAL (ACCUM. COST)	PLANT	

						1/20/2020 10.	10 aiii
	Cost Center Description	REGI STRATI ON	PATI ENT	Reconciliatio	ADMI NI STRATI V	OPERATION OF	
		(GROSS	ACCOUNTS	n	E & GENERAL	PLANT	
		CHARGES)	(GROSS		(ACCUM. COST)	(SQUARE FEET)	
			CHARGES)				
		4. 03	4. 04	5A	5. 00	7. 00	
194. 07 0795	7 KNOX COUNTY HEALTH DEPT	0	0	0	140, 525	4, 712	194. 07
194. 08 0795	8 I NDUSTRI AL HEALTH	0	0	0	0	0	194. 08
194. 09 0795	9 COMMUNITY MENTAL HEALTH CENTER	0	0	0	8, 075, 310	36, 623	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, 646, 414	4, 385, 445		21, 497, 976	11, 468, 215	202.00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 002458	0. 006546		0. 106478	17. 245410	203. 00
204.00	Cost to be allocated (per Wkst. B,	1, 812	3, 429		1, 250, 522	3, 907, 165	204.00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000003	0. 000005		0. 006194	5. 875427	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems	GOOD SAMARITA				u of Form CMS-2	
COST A	ALLOCATION - STATISTICAL BASIS		Provider CO		eriod: rom 01/01/2018 o 12/31/2018	Worksheet B-1 Date/Time Pre 1/20/2020 10:	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (PATI ENT DAYS)	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI O N	
		LAUNDRY)				(DI RECT NURSI NG)	
		8. 00	9. 00	10.00	11. 00	13. 00	
1 00	GENERAL SERVI CE COST CENTERS	1					1 00
1.00 2.00 4.01 4.02 4.03 4.04 5.00 7.00 8.00 9.00 11.00 13.00 14.00 15.00 17.01 21.00 22.00 23.00	OO100 CAP REL COSTS-BLDG & FIXT	986, 451 63, 534 16, 845 0 9, 443 0 0 16, 291 0	64, 814 1, 675 424 0 764 601 577 0 1, 872 0 0	32, 974 0 0	2, 286, 691 32, 033 23, 029 71, 616 104, 191 0 26, 662 0 0	781, 437 0 0 0 0 0 0 0	1.00 2.00 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 17.01 22.00 23.00
23. 01	INPATIENT ROUTINE SERVICE COST CENTERS	0	U	0	6, 189	0	23.01
30.00	03000 ADULTS & PEDIATRICS	341, 140	14, 184	13, 096	196, 007	196, 007	30.00
31.00	03100 NTENSI VE CARE UNI T	111, 760	5, 276			129, 641	1
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0 59, 790	0 3, 052	4, 410 7, 324		66, 336 74, 353	
43. 00	04300 NURSERY	3, 468	177	995		9, 927	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	36, 192	3, 842 0	0		79, 424 0	1
51. 00 51. 01	05100 RECOVERT ROOM 05101 ENDOSCOPY	23, 978	1, 012	0		0	51. 00 51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	9, 407	243	Ö	,	40, 371	
53.00	05300 ANESTHESI OLOGY	0	0	0		0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	69, 157	3, 361	0	131, 362 57, 762	0	54. 00 55. 00
60.00	06000 LABORATORY	0	945	0	106, 138	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	l l	364	723		68, 299	0	
	06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY	14, 424 18, 233	1, 832 2, 861	0		0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2, 001	o o		0	1
70. 01	07001 NEURODI AGNOSTI CS	13, 079	721	0	15, 500	0	70. 01
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73.00		0	0	0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	34, 341	3, 018	0	44, 929	0	75. 00
	03950 MH ANCI LLARY OUTPATIENT	0	0	0	0	0	
76. 01	03951 NPATI ENT DI ALYSI S OUTPATI ENT SERVI CE COST CENTERS	0	U	0	0	0	76. 01
90.00	09000 CLI NI C	280	1, 110	0	4, 531	0	90.00
90. 01	04950 WOUND CLINIC	16, 783	341	0	,	0	90. 01
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	96, 611	4, 419	0	164, 867	164, 867	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						72.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
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	930				116. 00
118.00		955, 120	53, 960	32, 974	1, 744, 916	781, 437	118.00
190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	31, 331	10, 454	0	-	0	192. 00
	07950 COMMUNITY HEALTH SERVICES	0	339	0	0		194.00
	207952 MARKETING AND PUBLIC RELATIONS 307953 MH RESIDENTIAL	0	61 0	0	6, 249 24, 633		194. 02 194. 03
194.04	07954 UNUSED SPACE		0			0	194. 04
194. 05	07955 MOB	0	0	0	0		194. 05

| Peri od: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

						1/20/2020 10:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	
		LINEN SERVICE	(HOURS OF	(PATI ENT	(MAN HOURS)	ADMI NI STRATI O	
		(POUNDS OF	SERVI CE)	DAYS)		N	
		LAUNDRY)				(DI RECT	
						NURSI NG)	
		8. 00	9. 00	10.00	11. 00	13. 00	
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	INDUSTRIAL HEALTH	0	0	0	0	0	194. 08
194. 09 07959	COMMUNITY MENTAL HEALTH CENTER	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,	652, 686	3, 250, 504	1, 252, 668	2, 369, 412	2, 688, 828	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 661651	50. 151264	37. 989568	1. 036175	3. 440876	203. 00
204. 00	Cost to be allocated (per Wkst. B,	190, 632	294, 838	49, 549	456, 300	324, 948	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 193250	4. 548986	1. 502669	0. 199546	0. 415834	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems	GUUD SAMARITAN				u or form CMS-2	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2018	Worksheet B-1	
					o 12/31/2018	Date/Time Pre	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL	1/20/2020 10: MENTAL HEALTH	18 am
	cost center bescription	SERVICES &	(COSTED	RECORDS &	SERVI CE	OH	
		SUPPLY	REQUIS.)	LI BRARY	(NET CHARGES)	(NET CHARGES)	
		(SUPPLI ES	Í	(TIME SPENT)	,	l` ´	
		COST)					
	OFFICE ALL OFFICE OF A CONTROL	14. 00	15. 00	16. 00	17. 00	17. 01	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT			I			1.00
2. 00	00200 CAP REL COSTS-BEDG & TTAT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
4. 01	00401 COMMUNI CATI ONS						4. 01
4.02	00402 PURCHASING & RECEIVING						4. 02
4.03	00403 REGI STRATI ON						4. 03
4. 04	00404 PATIENT ACCOUNTS						4. 04
5. 00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	,					11.00
13. 00	01300 NURSING ADMINISTRATION						13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	18, 554, 919					14.00
15.00	01500 PHARMACY	65, 481	16, 440, 038				15.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 570	0	635	5		16.00
17. 00	01700 SOCI AL SERVI CE	0	0	(0		17. 00
17. 01	01701 MENTAL HEALTH OH	739	0	(1	17, 735, 173	
21.00	02100 &R SERVICES-SALARY & FRINGES APPRVD	0	0		,	0	21.00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	1	1	0	22.00
23. 00	02300 PARAMED ED PRGM-RADI OLOGY 02301 PARAMED ED PRGM-LAB	147 6, 481	0	1	-		23. 00
23.01	INPATIENT ROUTINE SERVICE COST CENTERS	0, 401) 0		23.01
30. 00	03000 ADULTS & PEDI ATRI CS	393, 477	13, 078	193	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	295, 487	9, 582	1		l	31.00
40.00	04000 SUBPROVI DER - I PF	28, 104	1, 224	80	0	8, 090, 436	40.00
41. 00	04100 SUBPROVI DER - I RF	87, 191	6, 267			1	41.00
43.00	04300 NURSERY	17, 440	352	3	0	0	43.00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	E04 227	42.047	15	j 0	0	F0 00
50. 00 51. 00	05100 RECOVERY ROOM	504, 337 0	63, 047 0	1		l	50. 00 51. 00
51. 00	05101 ENDOSCOPY	449, 630	3, 068	1	-	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	84, 502	1, 759		-	Ö	52.00
53. 00	05300 ANESTHESI OLOGY	0	0		-	Ō	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	154, 462	119, 804	(0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	79, 947	3, 008		0	0	55.00
60.00	06000 LABORATORY	2, 697, 931	2, 580	1	1	0	60.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	1	-	0	63.00
65.00	06500 RESPI RATORY THERAPY	77, 400	1, 492	1		0	65.00
66.00	06600 PHYSI CAL THERAPY	27, 519	4, 045 57, 737		.1	1	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	86, 812	07,737			0	
70. 00	07001 NEURODI AGNOSTI CS	30, 077	28	1		0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 618, 301	0		o o	Ö	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	5, 349, 101	0		o o	Ō	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	14, 133, 319	(0	0	73.00
75. 00	07500 ASC (NON-DISTINCT PART)	338, 831	43, 886	115	0	0	75. 00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	(-	0	76. 00
76. 01	03951 I NPATI ENT DI ALYSI S	1, 407	5, 362	(0	0	76. 01
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	1, 450	242			0	90.00
90.00	04950 WOUND CLINIC	106, 349	16, 002	1		0	90.00
91. 00	09100 EMERGENCY	296, 265	17, 462	1		0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	270, 200	17, 102			Ĭ	92.00
	OTHER REIMBURSABLE COST CENTERS				II.	l	
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	28, 158	0	(0	0	96.00
101.00	10100 HOME HEALTH AGENCY	0	0	(0	0	101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
	11600 HOSPI CE	16, 450	432			l	116.00
118.00	9 /	15, 850, 046	14, 503, 776	635	5 0	8, 090, 436	1118.00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0		0	0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 643, 320	1, 935, 950	l .			190.00
	07950 COMMUNITY HEALTH SERVICES	2, 043, 320	1, 733, 730 N		1		194.00
	07952 MARKETING AND PUBLIC RELATIONS	902	0		0		194. 02
	07953 MH RESIDENTIAL	28, 168	312		o o		194. 03
194. 04	07954 UNUSED SPACE	0	0		0	0	194. 04
194. 05	07955 MOB	o	0	(0	0	194. 05
		<u> </u>	<u> </u>			<u> </u>	

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS	Provi der CCN: 15-0042	Period: Worksheet B-1 From 01/01/2018

				Ť.	o 12/31/2018	Date/Time Pre 1/20/2020 10:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	MENTAL HEALTH	
		SERVICES &	(COSTED	RECORDS &	SERVI CE	OH	
		SUPPLY	REQUIS.)	LI BRARY	(NET CHARGES)	(NET CHARGES)	
		(SUPPLI ES		(TIME SPENT)			
		COST)					
		14. 00	15. 00	16.00	17. 00	17. 01	
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 INDUSTRIAL HEALTH	0	0	0	0	0	194. 08
194. 09	07959 COMMUNITY MENTAL HEALTH CENTER	30, 110	0	0	0	9, 644, 737	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,	790, 820	4, 869, 789	4, 216, 537	0	1, 488, 188	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 042621	0. 296215	6, 640. 215748	0. 000000	0. 083912	203.00
204.00	Cost to be allocated (per Wkst. B,	19, 663	266, 258	215, 190	0	146, 430	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 001060	0. 016196	338. 881890	0. 000000	0. 008256	205.00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	ALLOCATION STATISTICAL DASIS	GOOD SAMARI I		CN. 1E 0042 D		Workshoot B 1
COST	ALLOCATION - STATISTICAL BASIS		Provi der C		eriod: rom 01/01/2018	Worksheet B-1
				Т	o 12/31/2018	Date/Time Prepared:
		INTERNS &	RESI DENTS			1/20/2020 10: 18 am
	Cost Center Description		SERVI CES-OTHE		PARAMED ED	
		RY & FRINGES (ASSIGNED	R PRGM COSTS (ASSIGNED	PRGM-RADI OLOG Y	PRGM-LAB (ASSIGNED	
		TIME)	TIME)	(ASSI GNED	TIME)	
				TIME)		
		21. 00	22. 00	23. 00	23. 01	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT	1	I			1 00
2. 00	00200 CAP REL COSTS-BLDG & FIXT					1.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
4. 01	00401 COMMUNI CATI ONS					4. 01
4. 02	00402 PURCHASING & RECEIVING					4. 02
4. 03 4. 04	00403 REGI STRATI ON 00404 PATI ENT ACCOUNTS					4. 03 4. 04
5. 00	00500 ADMINISTRATIVE & GENERAL					5.00
7. 00	00700 OPERATION OF PLANT					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00	00900 HOUSEKEEPI NG					9.00
10. 00 11. 00						10.00
13. 00	I I					13.00
14. 00	I I					14. 00
15.00	01500 PHARMACY					15. 00
16. 00						16.00
	01700 SOCIAL SERVICE					17.00
	01701 MENTAL HEALTH OH 02100 L&R SERVICES-SALARY & FRINGES APPRVD	0				17. 01 21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		0			22.00
23. 00	1 1			100		23. 00
23. 01	02301 PARAMED ED PRGM-LAB				100	23. 01
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 0	1	J		20.00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0		1		30. 00 31. 00
40. 00		0			-	40.00
41. 00	· · · · · · · · · · · · · · · · · · ·	0	Ö	1	-	41.00
43.00		0	0	0	0	43.00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	T 0	Ιο	0	0	50.00
	05100 RECOVERY ROOM		•	1		51.00
51. 01		0	•	1	-	51. 01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	52. 00
53. 00		0	0	0		53.00
54. 00 55. 00	I I	0	0	100		54.00
60.00	1	0				55. 00 60. 00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö	1		63.00
65.00		0	0	0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0	0	0	66.00
69.00		0	0	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY 07001 NEURODI AGNOSTI CS	0			0	70. 00 70. 01
71. 00			ĺ	o o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72. 00
73.00	I I	0	0	0	0	73.00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76. 00 76. 01	03950 MH ANCILLARY OUTPATIENT 03951 INPATIENT DIALYSIS	0	0	0	-	76. 00 76. 01
70.01	OUTPATIENT SERVICE COST CENTERS			,,	<u> </u>	70.01
	09000 CLI NI C	0	0	0	0	90.00
	04950 WOUND CLINIC	0	0	1		90. 01
	09100 EMERGENCY	0	0	0	0	91. 00 92. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS					92.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
101.00	0 10100 HOME HEALTH AGENCY	0	0	0	0	101. 00
112 0	SPECIAL PURPOSE COST CENTERS	I	I	1		112.00
	D 11300 I NTEREST EXPENSE D 11600 HOSPI CE			0	0	113. 00 116. 00
118. 00	I I	0	0	100	-	118.00
	NONREI MBURSABLE COST CENTERS					
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
	D 19200 PHYSI CI ANS' PRI VATE OFFI CES D 07950 COMMUNI TY HEALTH SERVI CES	0			0	192. 00 194. 00
	207952 MARKETING AND PUBLIC RELATIONS	0	0	0	0	194.00
	3 07953 MH RESIDENTIAL	Ö	0	Ö		194. 03

| Peri od: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

				''	3 12/31/2010	1/20/2020 10: 18 am
		INTERNS &	RESI DENTS			
	Cost Center Description	SERVI CES-SALA		PARAMED ED	PARAMED ED	
		RY & FRINGES	R PRGM COSTS	PRGM-RADI OLOG	PRGM-LAB	
		(ASSI GNED	(ASSI GNED	Υ	(ASSI GNED	
		TIME)	TIME)	(ASSI GNED	TIME)	
		04.00	00.00	TIME)	00.01	
104 04 0705	LIAULCED, CDAOF	21. 00	22. 00	23. 00	23. 01	104.04
	UNUSED SPACE	0	0	0	0	194. 04
194. 05 07955		0	0	0	0	194. 05
194. 06 07956	l control of the cont	0	0	0	0	194.06
	KNOX COUNTY HEALTH DEPT	0	0	0	0	194. 07
	I NDUSTRI AL HEALTH	0	0	0	0	194. 08
	COMMUNITY MENTAL HEALTH CENTER	0	0	0	O	194. 09
200. 00	Cross Foot Adjustments					200.00
201. 00	Negative Cost Centers	_	_			201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	0	269, 846	291, 989	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	2, 698. 460000	2, 919. 890000	203. 00
204.00	Cost to be allocated (per Wkst. B,	o	0	3, 007	3, 256	204. 00
	Part II)					
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	30. 070000	32. 560000	205. 00
	[11]					
206. 00	NAHE adjustment amount to be allocated			0	0	206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,			0. 000000	0. 000000	207. 00
	Parts III and IV)					

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0042	Peri od: Worksheet C
		From 01/01/2018 Part I
		T- 10 /01 /0010 D-+- /T: D

			T	o 12/31/2018	Date/Time Pre	pared:
		Title	XVIII	Hospi tal	PPS	10 aiii
		11110	XVIII	Costs	110	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
oost conten boson per on	(from Wkst.	Adj.	Total oosts	Di sal I owance	10141 00313	
	B, Part I,	7.69		21 041 1 01141100		
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	14, 207, 884		14, 207, 884	0	14, 207, 884	30.00
31.00 03100 INTENSIVE CARE UNIT	8, 383, 992		8, 383, 992	0	8, 383, 992	
40. 00 04000 SUBPROVI DER - 1 PF	4, 865, 398		4, 865, 398	0	4, 865, 398	40.00
41. 00 04100 SUBPROVI DER - RF	4, 421, 498		4, 421, 498	0	4, 421, 498	
43. 00 04300 NURSERY	608, 587		608, 587	0	608, 587	1
ANCILLARY SERVICE COST CENTERS		<u>'</u>				
50. 00 05000 OPERATING ROOM	7, 084, 096		7, 084, 096	0	7, 084, 096	50.00
51. 00 05100 RECOVERY ROOM	0		0	0	0	51.00
51. 01 05101 ENDOSCOPY	2, 920, 528		2, 920, 528	0	2, 920, 528	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	2, 111, 193		2, 111, 193	0	2, 111, 193	
53. 00 05300 ANESTHESI OLOGY	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 658, 496		10, 658, 496	0	10, 658, 496	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	3, 875, 180		3, 875, 180	15, 934	3, 891, 114	55.00
60. 00 06000 LABORATORY	9, 739, 263		9, 739, 263	0	9, 739, 263	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	3, 653, 909	0	3, 653, 909	0	3, 653, 909	65.00
66. 00 06600 PHYSI CAL THERAPY	7, 134, 730	0	7, 134, 730	0	7, 134, 730	66.00
69. 00 06900 ELECTROCARDI OLOGY	6, 378, 829		6, 378, 829	36, 919	6, 415, 748	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	1, 310, 587		1, 310, 587	11, 289	1, 321, 876	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 552, 013		8, 552, 013	0	8, 552, 013	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 545, 107		6, 545, 107	0	6, 545, 107	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	22, 053, 710		22, 053, 710	0	22, 053, 710	73.00
75.00 07500 ASC (NON-DISTINCT PART)	3, 680, 893		3, 680, 893	3, 166	3, 684, 059	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	824, 031		824, 031	5, 835	829, 866	76. 01
OUTPATIENT SERVICE COST CENTERS		<u> </u>			·	
90. 00 09000 CLI NI C	358, 759		358, 759	0	358, 759	90.00
90. 01 04950 WOUND CLINIC	2, 020, 426		2, 020, 426	0	2, 020, 426	90. 01
91. 00 09100 EMERGENCY	9, 911, 572		9, 911, 572	23, 798	9, 935, 370	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 444, 730		3, 444, 730		3, 444, 730	
OTHER REIMBURSABLE COST CENTERS		<u>'</u>				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	202, 944		202, 944	0	202, 944	96.00
101.00 10100 HOME HEALTH AGENCY	0		0		0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
116. 00 11600 HOSPI CE	1, 713, 616		1, 713, 616		1, 713, 616	116.00
200.00 Subtotal (see instructions)	146, 661, 971	0	146, 661, 971	96, 941	146, 758, 912	200.00
201.00 Less Observation Beds	3, 444, 730		3, 444, 730		3, 444, 730	
202.00 Total (see instructions)	143, 217, 241	0	143, 217, 241	96, 941	143, 314, 182	202.00
	•		•	'		•

| Peri od: | Worksheet C | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared:

					0 12/31/2018	1/20/2020 10:	
			Title	XVIII	Hospi tal	PPS	TO dill
			Charges				
	Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	'	'	'	+ col. 7)	Ratio	I npati ent	
				, i		Rati o	
		6. 00	7. 00	8. 00	9. 00	10.00	
	NPATIENT ROUTINE SERVICE COST CENTERS						
	3000 ADULTS & PEDIATRICS	26, 518, 818		26, 518, 818	В		30.00
	3100 INTENSIVE CARE UNIT	18, 525, 338		18, 525, 338			31.00
40.00 0	4000 SUBPROVI DER - I PF	8, 036, 814		8, 036, 814			40.00
41.00 0	4100 SUBPROVI DER - I RF	7, 995, 044		7, 995, 044			41.00
43.00 0	4300 NURSERY	1, 433, 876		1, 433, 876			43.00
	NCILLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM	20, 622, 420	20, 850, 285	41, 472, 705	0. 170813	0. 000000	
	5100 RECOVERY ROOM	0	0		0. 000000	0.000000	51.00
	5101 ENDOSCOPY	1, 501, 784	10, 103, 869	11, 605, 653	0. 251647	0. 000000	51.01
	5200 DELIVERY ROOM & LABOR ROOM	6, 145, 272	195, 481	6, 340, 753	0. 332956	0. 000000	52.00
53.00 0	5300 ANESTHESI OLOGY	0	0	C	0. 000000	0. 000000	53.00
54.00 0	5400 RADI OLOGY-DI AGNOSTI C	16, 310, 470	76, 627, 022	92, 937, 492	0. 114685	0.000000	54.00
55.00 0	5500 RADI OLOGY-THERAPEUTI C	412, 904	22, 442, 634	22, 855, 538	0. 169551	0.000000	55.00
60.00 0	6000 LABORATORY	21, 390, 714	47, 120, 307	68, 511, 021	0. 142156	0.000000	60.00
63.00 0	6300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0. 000000	0.000000	63.00
65.00 0	6500 RESPI RATORY THERAPY	11, 899, 184	3, 020, 829	14, 920, 013	0. 244900	0.000000	65.00
66.00 0	6600 PHYSI CAL THERAPY	14, 941, 685	10, 690, 366	25, 632, 051	0. 278352	0.000000	66.00
69.00 0	6900 ELECTROCARDI OLOGY	16, 336, 356	20, 174, 171	36, 510, 527	0. 174712	0.000000	69.00
70.00 0	7000 ELECTROENCEPHALOGRAPHY	0	0	0	0. 000000	0.000000	70.00
70. 01 0	7001 NEURODI AGNOSTI CS	86, 356	5, 534, 998	5, 621, 354	0. 233144	0.000000	70. 01
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 785, 698	4, 077, 745	7, 863, 443	1. 087566	0.000000	71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENTS	8, 132, 871	6, 036, 676	14, 169, 547	0. 461914	0.000000	72.00
73.00 0	7300 DRUGS CHARGED TO PATIENTS	21, 371, 626	59, 692, 989	81, 064, 615	0. 272051	0.000000	73.00
75.00 0	7500 ASC (NON-DISTINCT PART)	195, 657	20, 444, 245	20, 639, 902	0. 178339	0.000000	75.00
76.00 0	3950 MH ANCILLARY OUTPATIENT	0	0	0	0. 000000	0.000000	76.00
76. 01 0	3951 INPATIENT DIALYSIS	1, 327, 405	104, 784	1, 432, 189	0. 575365	0.000000	76. 01
	UTPATIENT SERVICE COST CENTERS						
	9000 CLI NI C	0	159, 344	159, 344	2. 251475	0.000000	90.00
90.01 0	4950 WOUND CLINIC	186, 129	7, 199, 681	7, 385, 810	0. 273555	0. 000000	90. 01
91.00 0	9100 EMERGENCY	10, 916, 458	41, 893, 031	52, 809, 489	0. 187685	0. 000000	91.00
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 453, 029	5, 386, 921	6, 839, 950	0. 503619	0. 000000	92.00
	THER REIMBURSABLE COST CENTERS						
	9600 DURABLE MEDICAL EQUIP-RENTED	0	560, 220	560, 220	0. 362258	0.000000	96.00
	0100 HOME HEALTH AGENCY	0	0	C)		101.00
	PECIAL PURPOSE COST CENTERS						
	1300 I NTEREST EXPENSE						113. 00
	1600 HOSPI CE	4, 994	3, 507, 651	3, 512, 645	5		116. 00
200.00	Subtotal (see instructions)	219, 530, 902	365, 823, 249	585, 354, 151			200. 00
201. 00	Less Observation Beds						201. 00
202.00	Total (see instructions)	219, 530, 902	365, 823, 249	585, 354, 151			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: 15-0042	Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Time Prepared:

				10 12/31/2016	1/20/2020 10:	
			Title XVIII	Hospi tal	PPS	
Cost Center Descri	oti on	PPS Inpatient				
		Ratio				
		11. 00				
INPATIENT ROUTINE SERVICE	E COST CENTERS					
30. 00 03000 ADULTS & PEDIATRIC	S					30.00
31.00 03100 INTENSIVE CARE UNI	Т					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 C	ENTERS					
50.00 05000 OPERATING ROOM		0. 170813				50.00
51.00 05100 RECOVERY ROOM		0. 000000				51.00
51. 01 05101 ENDOSCOPY		0. 251647				51. 01
52.00 05200 DELIVERY ROOM & LA	BOR ROOM	0. 332956				52.00
53. 00 05300 ANESTHESI OLOGY		0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOST		0. 114685				54.00
55. 00 05500 RADI OLOGY-THERAPEU	TIC	0. 170248				55.00
60. 00 06000 LABORATORY		0. 142156				60.00
63.00 06300 BLOOD STORING, PRO		0. 000000				63.00
65. 00 06500 RESPI RATORY THERAP	Y	0. 244900				65.00
66. 00 06600 PHYSI CAL THERAPY		0. 278352				66.00
69. 00 06900 ELECTROCARDI OLOGY		0. 175723				69. 00
70. 00 07000 ELECTROENCEPHALOGR	APHY	0. 000000				70. 00
70. 01 07001 NEURODI AGNOSTI CS		0. 235153				70. 01
71. 00 07100 MEDI CAL SUPPLI ES C		1. 087566				71.00
72. 00 07200 IMPL. DEV. CHARGED		0. 461914				72.00
73. 00 07300 DRUGS CHARGED TO P		0. 272051				73. 00
75. 00 07500 ASC (NON-DISTINCT		0. 178492				75. 00
76.00 03950 MH ANCILLARY OUTPA	TIENT	0. 000000				76.00
76. 01 03951 INPATIENT DIALYSIS		0. 579439				76. 01
OUTPATIENT SERVICE COST	CENTERS	0.054475				
90. 00 09000 CLI NI C		2. 251475				90.00
90. 01 04950 WOUND CLINIC		0. 273555				90.01
91. 00 09100 EMERGENCY	NON DICTINGT DART)	0. 188136				91.00
92. 00 09200 OBSERVATION BEDS (0. 503619				92.00
OTHER REIMBURSABLE COST		0.040050				
96. 00 09600 DURABLE MEDI CAL EQ	UIP-RENTED	0. 362258				96.00
101. 00 10100 HOME HEALTH AGENCY	TEDC					101.00
SPECIAL PURPOSE COST CEN	TERS					112 00
113. 00 11300 I NTEREST EXPENSE 116. 00 11600 HOSPI CE						113. 00 116. 00
200.00 Subtotal (see inst	ructions)					200.00
201.00 Subtotal (see first Less Observation B	,					200.00
201.00 Less observation B 202.00 Total (see instruc						201.00
ZUZ. UU TUTAT (SEE TIISTIUC	LI UIIS)	1				1202. UU

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0042	Period: Worksheet C
		From 01/01/2018 Part I

				T	o 12/31/2018	Date/Time Pre	pared:
			Ti tl	e XIX	Hospi tal	Cost	TO GIII
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	, , , , , , , , , , , , , , , , , , ,	(from Wkst.	Adj .		Di sal I owance		
		B, Part I,	,				
		col. 26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	14, 207, 884		14, 207, 884	0	14, 207, 884	30.00
31.00	03100 INTENSIVE CARE UNIT	8, 383, 992		8, 383, 992	0	8, 383, 992	31.00
40.00	04000 SUBPROVI DER - I PF	4, 865, 398		4, 865, 398	0	4, 865, 398	40.00
41.00	04100 SUBPROVI DER - I RF	4, 421, 498		4, 421, 498	0	4, 421, 498	41.00
43.00	04300 NURSERY	608, 587		608, 587	0	608, 587	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7, 084, 096		7, 084, 096	0	7, 084, 096	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
	05101 ENDOSCOPY	2, 920, 528		2, 920, 528	0	2, 920, 528	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 111, 193		2, 111, 193	0	2, 111, 193	52.00
53.00	05300 ANESTHESI OLOGY	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	10, 658, 496		10, 658, 496	0	10, 658, 496	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	3, 875, 180		3, 875, 180	15, 934	3, 891, 114	55.00
60.00	06000 LABORATORY	9, 739, 263		9, 739, 263	0	9, 739, 263	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
65.00	06500 RESPI RATORY THERAPY	3, 653, 909	0	3, 653, 909	0	3, 653, 909	65.00
66.00	06600 PHYSI CAL THERAPY	7, 134, 730	0	7, 134, 730	0	7, 134, 730	66.00
69.00	06900 ELECTROCARDI OLOGY	6, 378, 829		6, 378, 829	36, 919	6, 415, 748	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	1, 310, 587		1, 310, 587	11, 289	1, 321, 876	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	8, 552, 013		8, 552, 013	0	8, 552, 013	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	6, 545, 107		6, 545, 107	0	6, 545, 107	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22, 053, 710		22, 053, 710	0	22, 053, 710	73.00
75.00	07500 ASC (NON-DISTINCT PART)	3, 680, 893		3, 680, 893	3, 166	3, 684, 059	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0		0	0	0	76.00
76. 01	03951 INPATIENT DIALYSIS	824, 031		824, 031	5, 835	829, 866	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	358, 759		358, 759	0	358, 759	90.00
90. 01	04950 WOUND CLINIC	2, 020, 426		2, 020, 426	0	2, 020, 426	90. 01
	09100 EMERGENCY	9, 911, 572		9, 911, 572	23, 798	9, 935, 370	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 444, 730		3, 444, 730		3, 444, 730	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	202, 944		202, 944	0	202, 944	
101.00	10100 HOME HEALTH AGENCY	0		0		0	101.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113.00
116.00	11600 H0SPI CE	1, 713, 616		1, 713, 616		1, 713, 616	116. 00
200.00	Subtotal (see instructions)	146, 661, 971	0	146, 661, 971	96, 941	146, 758, 912	200.00
201.00	Less Observation Beds	3, 444, 730		3, 444, 730		3, 444, 730	201.00
202.00	Total (see instructions)	143, 217, 241	0	143, 217, 241	96, 941	143, 314, 182	202.00

Peri od: Worksheet C From 01/01/2018 Part I To 12/31/2018 Date/Ti me Prepared:

						1/20/2020 10:	18 am
			Ti tl	e XIX	Hospi tal	Cost	
			Charges				
	Cost Center Description	Inpatient	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	
I NPA	ATIENT ROUTINE SERVICE COST CENTERS						
30.00 0300	00 ADULTS & PEDIATRICS	26, 518, 818		26, 518, 81	8		30.00
31.00 0310	DO INTENSIVE CARE UNIT	18, 525, 338		18, 525, 33	8		31.00
40.00 0400	00 SUBPROVIDER - IPF	8, 036, 814		8, 036, 81	4		40.00
41.00 0410	00 SUBPROVI DER - I RF	7, 995, 044		7, 995, 04	4		41.00
	00 NURSERY	1, 433, 876		1, 433, 87			43.00
	LLARY SERVICE COST CENTERS				,		
50.00 0500	OO OPERATING ROOM	20, 622, 420	20, 850, 285	41, 472, 70	5 0. 170813	0.000000	50.00
	OO RECOVERY ROOM	0	0		0. 000000	0.000000	51.00
51. 01 0510	D1 ENDOSCOPY	1, 501, 784	10, 103, 869	11, 605, 65	0. 251647	0.000000	51.01
	DO DELIVERY ROOM & LABOR ROOM	6, 145, 272	195, 481			0.000000	
	OO ANESTHESI OLOGY	0	0		0. 000000	0. 000000	
	DO RADI OLOGY-DI AGNOSTI C	16, 310, 470	76, 627, 022	92, 937, 49		0. 000000	1
	00 RADI OLOGY-THERAPEUTI C	412, 904	22, 442, 634			0. 000000	
	DO LABORATORY	21, 390, 714	47, 120, 307			0. 000000	
	DO BLOOD STORING, PROCESSING & TRANS.	21, 370, 714	47, 120, 307		0. 000000	0.000000	
	00 RESPIRATORY THERAPY	11, 899, 184	3, 020, 829			0.000000	
	00 PHYSI CAL THERAPY	14, 941, 685	10, 690, 366			0.000000	
	DO ELECTROCARDI OLOGY	16, 336, 356	20, 174, 171			0.000000	
	OO ELECTROENCEPHALOGRAPHY	10, 330, 330	20, 174, 171		0. 000000	0.000000	
4	D1 NEURODI AGNOSTI CS	86, 356	5, 534, 998			0.000000	
	00 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 785, 698	4, 077, 745			0.000000	
	00 IMPL. DEV. CHARGED TO PATIENTS	8, 132, 871	6, 036, 676			0.000000	
	DO DRUGS CHARGED TO PATIENTS	21, 371, 626	59, 692, 989			0.000000	
	DO ASC (NON-DISTINCT PART)	195, 657	20, 444, 245			0.000000	
	50 MH ANCILLARY OUTPATIENT	193,037	20, 444, 243		0. 178339	0.000000	
	51 INPATIENT DIALYSIS	1, 327, 405	104, 784			0.000000	
	PATIENT SERVICE COST CENTERS	1, 327, 403	104, 764	1, 432, 10	9 0. 575505	0.000000	70.01
	DO CLINIC	0	159, 344	159, 34	4 2. 251475	0.000000	90.00
	50 WOUND CLINIC	186, 129	7, 199, 681			•	
	DO EMERGENCY	10, 916, 458	41, 893, 031				
	00 OBSERVATION BEDS (NON-DISTINCT PART)	1, 453, 029	5, 386, 921			0.000000	
	ER REIMBURSABLE COST CENTERS	1, 455, 027	5, 300, 721	0,037,73	0. 303019	0.000000	72.00
	DO DURABLE MEDICAL EQUIP-RENTED	0	560, 220	560, 22	0. 362258	0.000000	96.00
	DO HOME HEALTH AGENCY		0 0		0.302230	0.000000	101.00
	CLAL PURPOSE COST CENTERS	U_	U		<u>U</u>		101.00
	00 INTEREST EXPENSE						112 00
116. 00 1160		4 004	2 E07 /E1	2 512 44	=	l	113. 00 116. 00
200. 00	Subtotal (see instructions)	4, 994	3, 507, 651			l	200.00
4	,	219, 530, 902	365, 823, 249	585, 354, 15	'	l	
201.00	Less Observation Beds	210 520 622	2/5 022 040	FOE 254 45			201.00
202. 00	Total (see instructions)	219, 530, 902	365, 823, 249	585, 354, 15	П	l	202. 00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 15-0042	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared:

				10 12/31/2018	1/20/2020 10:	
			Title XIX	Hospi tal	Cost	10 4111
	Cost Center Description	PPS Inpatient				
	, , , , , , , , , , , , , , , , , , ,	Ratio				
		11. 00				
I	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
40.00	04000 SUBPROVI DER - I PF					40.00
41.00	04100 SUBPROVI DER – I RF					41.00
	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0. 000000				50.00
	05100 RECOVERY ROOM	0. 000000				51.00
	05101 ENDOSCOPY	0. 000000				51. 01
	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
	05300 ANESTHESI OLOGY	0. 000000				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
1	06000 LABORATORY	0. 000000				60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
	06500 RESPI RATORY THERAPY	0. 000000				65.00
	06600 PHYSI CAL THERAPY	0. 000000				66.00
	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
	07001 NEURODI AGNOSTI CS	0. 000000				70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 000000				73. 00
	07500 ASC (NON-DISTINCT PART)	0. 000000				75.00
	03950 MH ANCILLARY OUTPATIENT	0. 000000				76. 00
	03951 INPATIENT DIALYSIS	0. 000000				76. 01
	OUTPATIENT SERVICE COST CENTERS	0.00000				4
	09000 CLI NI C	0. 000000				90.00
	04950 WOUND CLINIC	0. 000000				90. 01
	09100 EMERGENCY	0.000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92.00
	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
	10100 HOME HEALTH AGENCY	0.000000				
	SPECIAL PURPOSE COST CENTERS					101.00
	11300 INTEREST EXPENSE					113.00
	11600 HOSPI CE					116.00
200.00	Subtotal (see instructions)					200.00
200.00	Less Observation Beds					200.00
201.00	Total (see instructions)					202.00
202.00	Total (See Thistructions)	t I				1202.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	TAL COSTS	Provi der Co	1	Period: From 01/01/2018 Fo 12/31/2018		pared: 18 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	2, 863, 799	0	2, 863, 799	7 17, 158		
31.00 INTENSIVE CARE UNIT	1, 132, 783		1, 132, 783			31.00
40. 00 SUBPROVI DER - I PF	620, 077	0	620, 07	7 4, 410	140. 61	40.00
41. 00 SUBPROVI DER - I RF	719, 722	0	719, 722	7, 324	98. 27	41.00
43. 00 NURSERY	15, 173		15, 17	995	15. 25	43.00
200.00 Total (lines 30 through 199)	5, 351, 554		5, 351, 554	4 37, 036		200.00
Cost Center Description	I npati ent	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	8, 314					30.00
31.00 INTENSIVE CARE UNIT	4, 530	717, 779				31.00
40. 00 SUBPROVI DER - I PF	1, 645					40.00
41. 00 SUBPROVI DER - I RF	6, 323	621, 361				41.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30 through 199)	20, 812	2, 958, 133				200. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	TAL COSTS	Provi der C		Period: From 01/01/2018 To 12/31/2018		
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	to Charges (col. 1 ÷ col. 2)	Program Charges	Capital Costs (column 3 x column 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	795, 755	41, 472, 705	•	,	212, 243	ł
51. 00 05100 RECOVERY ROOM	0	0	0.00000	0	0	51.00
51. 01 05101 ENDOSCOPY	473, 075	11, 605, 653	0. 04076	2 936, 648	38, 180	51.01
52 OO O5200 DELLVERY ROOM & LABOR ROOM	42 025	6 340 753	0 00662	8 3 697	25	52 00

			AVIII	nospi tai	113	
Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			,			
50.00 05000 OPERATING ROOM	795, 755	41, 472, 705		11, 061, 820	212, 243	
51.00 05100 RECOVERY ROOM	0	0	0. 000000	0	0	51.00
51. 01 05101 ENDOSCOPY	473, 075	11, 605, 653	0. 040762	936, 648	38, 180	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	42, 025	6, 340, 753	0. 006628	3, 697	25	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 280, 822	92, 937, 492	0. 013782	9, 812, 380	135, 234	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	308, 616	22, 855, 538	0. 013503	244, 548	3, 302	55.00
60. 00 06000 LABORATORY	397, 129	68, 511, 021	0. 005797	12, 893, 811	74, 745	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	240, 982	14, 920, 013	0. 016152	6, 273, 199	101, 325	65.00
66.00 06600 PHYSI CAL THERAPY	854, 880	25, 632, 051	0. 033352	3, 984, 960	132, 906	66.00
69. 00 06900 ELECTROCARDI OLOGY	717, 388	36, 510, 527	0. 019649	8, 414, 658	165, 340	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	285, 653	5, 621, 354	0. 050816	45, 819	2, 328	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	153, 902	7, 863, 443	0. 019572	2, 200, 771	43, 073	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	159, 435	14, 169, 547	0. 011252	4, 721, 754	53, 129	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	329, 482	81, 064, 615	0.004064	11, 391, 050	46, 293	73.00
75.00 07500 ASC (NON-DISTINCT PART)	93, 538	20, 639, 902	0. 004532	0	0	75. 00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	0. 000000	0	0	76.00
76. 01 03951 INPATIENT DIALYSIS	306, 144	1, 432, 189	0. 213759	1, 000, 921	213, 956	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	101, 558	159, 344	0. 637351	0	0	90.00
90. 01 04950 WOUND CLINIC	130, 097	7, 385, 810	0. 017614	25, 305	446	90. 01
91. 00 09100 EMERGENCY	857, 496	52, 809, 489	0. 016238	6, 384, 619	103, 673	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	694, 334	6, 839, 950	0. 101512	1, 082, 631	109, 900	92.00
OTHER REIMBURSABLE COST CENTERS			<u>'</u>		·	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	16, 478	560, 220	0. 029413	0	0	96.00
200.00 Total (lines 50 through 199)	8, 238, 789	· ·		80, 478, 591	1, 436, 098	
, , , , , , , , , , , , , , , , , , , ,			'			

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	ASS THROUGH COS			In Lie Period: From 01/01/2018 To 12/31/2018	Worksheet D Part III Date/Time Pre 1/20/2020 10:	epared: 18 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng School Post-Stepdown Adj ustments	Nursi ng School	Allied Healt Post-Stepdow Adjustments		All Other Medical Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0 0 0 0	0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	31. 00 40. 00 41. 00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patien Days	t Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
	4. 00	5. 00	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 INTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0 0	0 0	7, 14 4, 41 7, 32 99	0.00 0.00 0.00 4 0.00 5 0.00	4, 530 1, 645 6, 323 0	31.00 40.00 41.00 43.00
200.00 Total (lines 30 through 199) Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	0	37, 03	<u>o</u>	20, 812	200.00
INPATIENT ROUTINE SERVICE COST CENTERS	•					
30. 00	0 0 0 0					30.00 31.00 40.00 41.00 43.00
200.00 Total (lines 30 through 199)						200.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0042	Period: Worksheet D
THROUGH COSTS		From 01/01/2018 Part IV

				1	o 12/31/2018	Date/Time Pre	
			Title	xVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	School	School	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	(0	0	00.00
	05100 RECOVERY ROOM	0	0	(0	0	51.00
	05101 ENDOSCOPY	0	0	(0	0	51.01
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	
	05300 ANESTHESI OLOGY	0	0	(0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(0	269, 846	
	05500 RADI OLOGY-THERAPEUTI C	0	0	(0	0	
	06000 LABORATORY	0	0	(0	291, 989	
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0	
	06500 RESPI RATORY THERAPY	0	0	(0	0	65.00
	06600 PHYSI CAL THERAPY	0	0	(0	0	66.00
	06900 ELECTROCARDI OLOGY	0	0	(0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	0	0	(0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(0	0	75. 00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0	(0	0	76. 00
76. 01	03951 INPATIENT DIALYSIS	0	0	(0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	C	0	0	90.00
90. 01	04950 WOUND CLINIC	0	0	(0	0	90. 01
91.00	09100 EMERGENCY	0	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		C)	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDICAL EQUIP-RENTED	0		1	0		1 /0.00
200.00	Total (lines 50 through 199)	0	0	(0	561, 835	200.00

Health Financial Systems	GOOD SAMARITAN	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0042		Worksheet D
THROUGH COSTS			From 01/01/2018	Part IV

THROUGH COSTS				o 12/31/2018	Date/Time Pre 1/20/2020 10:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
	Educati on	1, 2, 3, and	Cost (sum of	C, Part I,	(col. 5 ÷	
	Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
			and 4)			
	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0	0	41, 472, 705	0.000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0.000000	51.00
51. 01 05101 ENDOSCOPY	0	0	0	11, 605, 653	0.000000	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	6, 340, 753	0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0.000000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	269, 846	269, 846	92, 937, 492	0. 002904	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	22, 855, 538	0.000000	55.00
60. 00 06000 LABORATORY	0	291, 989	291, 989	68, 511, 021	0. 004262	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRA	NS. 0	0	0	0	0.000000	63.00
65. 00 06500 RESPIRATORY THERAPY	0	0	0	14, 920, 013	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	0	25, 632, 051	0.000000	66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	36, 510, 527	0.000000	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
70. 01 07001 NEURODI AGNOSTI CS	0	0	0	5, 621, 354	0.000000	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	TENTS 0	0	0	7, 863, 443	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14, 169, 547	0.000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	81, 064, 615	0.000000	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	20, 639, 902	0.000000	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	0	0	0.000000	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0	0	1, 432, 189	0.000000	76. 01
OUTPATIENT SERVICE COST CENTERS	<u>.</u>					
90. 00 09000 CLI NI C	0	0	C	159, 344	0.000000	90.00
90. 01 04950 WOUND CLINIC	0	0	0	7, 385, 810	0.000000	90. 01
91. 00 09100 EMERGENCY	0	0	0	52, 809, 489	0.000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART) 0	0	O	6, 839, 950	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS		•				
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	560, 220	0.000000	96.00
200.00 Total (lines 50 through 199)	0	561, 835	561, 835	519, 331, 616		200.00
	•	•	•			

	0000 CMMDLTNI JOSDITAL								
	Financial Systems TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	GOOD SAMARITAN	_	CN 15 0040	In Lie Period:	u of Form CMS-2	2552-10		
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SER SH COSTS	RVICE UTHER PASS	Provider C		erioa: From 01/01/2018	Worksheet D Part IV			
TTIKOOC	00010				Γο 12/31/2018	Date/Time Pre			
			T: ±1 -	WILL	11! +-1	1/20/2020 10: PPS	18 am_		
	Cost Contan Decement on	Outpati ent		XVIII	Hospi tal Outpati ent				
	Cost Center Description	Ratio of Cost	Inpatient Program	Inpatient Program	Program	Outpatient Program			
		to Charges	Charges	Pass-Through		Pass-Through			
		(col. 6 ÷	criai ges	Costs (col. 8		Costs (col. 9			
		col. 7)		x col. 10)	1	x col . 12)			
		9.00	10. 00	11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS	7. 00	10.00	11.00	12.00	10.00			
50.00	05000 OPERATING ROOM	0. 000000	11, 061, 820		8, 499, 760	0	50.00		
51. 00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00		
51. 01	05101 ENDOSCOPY	0. 000000	936, 648		3, 824, 870	0	51. 01		
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	3, 697		5, 662	0	52.00		
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53.00		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 002904	9, 812, 380	28, 49	30, 323, 928	88, 061	54.00		
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	244, 548		12, 888, 776	0	55.00		
60.00	06000 LABORATORY	0. 004262	12, 893, 811	54, 95	7, 806, 081	33, 270	60.00		
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00		
65.00	06500 RESPI RATORY THERAPY	0. 000000	6, 273, 199		1, 527, 229	0	65.00		
66.00	06600 PHYSI CAL THERAPY	0. 000000	3, 984, 960		388, 156	0	66.00		
69.00	06900 ELECTROCARDI OLOGY	0. 000000	8, 414, 658		10, 011, 241	0	69. 00		
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00		
70. 01	07001 NEURODI AGNOSTI CS	0. 000000	45, 819		2, 114, 651	0	70. 01		
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	2, 200, 771		1, 701, 199	0	71.00		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	4, 721, 754		3, 198, 385	0	72.00		
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	11, 391, 050		29, 106, 295	0	73.00		
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		7, 170, 237	0	75. 00		
76. 00	03950 MH ANCILLARY OUTPATIENT	0. 000000	0		0	0	76. 00		
76. 01	03951 I NPATI ENT DI ALYSI S	0. 000000	1, 000, 921		63, 648	0	76. 01		

0.000000

0. 000000 0. 000000

0.000000

0. 000000

25, 305

6, 384, 619

1, 082, 631

80, 478, 591

0

0

0 83, 448 302

4, 534, 776 10, 774, 214

3, 386, 551

137, 325, 961

90.00

0 91.00

0 96.00

0

0 90.01

0 92.00

121, 331 200. 00

OUTPATIENT SERVICE COST CENTERS

92. 00 09200 | 085ERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
96. 00 09600 | DURABLE | MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

90. 00 | 09000 | CLI NI C 90. 01 | 04950 | WOUND CLI NI C

91. 00 09100 EMERGENCY

200.00

From 01/01/2018 Part V Date/Time Prepared: 12/31/2018 1/20/2020 10:18 am Title XVIII Hospi tal Charges Costs PPS Services Cost Center Description Cost to PPS Cost Cost Charge Ratio Rei mbursed Rei mbursed Rei mbursed (see inst.) From Services (see Servi ces Services Not Worksheet C, Subject To Subject To inst.) Part I, col. Ded. & Coins. Ded. & Coins. 9 (see inst.) (see inst.) 2.00 5.00 1.00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0. 170813 8, 499, 760 1, 451, 870 50.00 05100 RECOVERY ROOM 0 0.000000 0 51.00 51.00 05101 ENDOSCOPY 0 51.01 0. 251647 3, 824, 870 962, 517 51.01 05200 DELIVERY ROOM & LABOR ROOM 0. 332956 5, 662 0 1,885 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 0 0 0 0 0 0 0 3, 477, 700 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.114685 30, 323, 928 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.169551 12, 888, 776 2, 185, 305 55.00 60.00 06000 LABORATORY 0.142156 7, 806, 081 1, 109, 681 60.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 C 63.00 0 06500 RESPIRATORY THERAPY 0 1, 527, 229 0.244900 374, 018 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0.278352 388, 156 108, 044 66.00 06900 ELECTROCARDI OLOGY 0 69.00 0.174712 10, 011, 241 0 0 1, 749, 084 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0.000000 70 00 70 00 0 0 07001 NEURODI AGNOSTI CS 493, 018 70.01 0. 233144 2, 114, 651 70.01 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 1. 087566 1, 701, 199 0 0 1, 850, 166 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.461914 3, 198, 385 0 0 1, 477, 379 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0 272051 29, 106, 295 7, 918, 397 73 00 44.042 0 75.00 07500 ASC (NON-DISTINCT PART) 0.178339 7, 170, 237 0 1, 278, 733 75.00 03950 MH ANCILLARY OUTPATIENT 0.000000 0 0 76.00 76.00 03951 INPATIENT DIALYSIS <u>36</u>, 621 76.01 0.575365 63.648 0 0 76.01 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2. 251475 302 0 0 680 90.00 04950 WOUND CLINIC 0. 273555 4, 534, 776 0 0 1, 240, 511 90.01 90.01 09100 EMERGENCY 0. 187685 10, 774, 214 0 91.00 91.00 144 2, 022, 158 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0.503619 1, 705, 531 92.00 3, 386, 551 92.00 OTHER REIMBURSABLE COST CENTERS 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.362258 0 0 96.00 200.00 137, 325, 961 0 44, 186 29, 443, 298 200. 00 Subtotal (see instructions) 0 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges

137, 325, 961

0

44, 186

29, 443, 298 202. 00

202.00

Net Charges (line 200 - line 201)

Health Financial Systems	GOOD SAMARITAN	HOSPI TAL	In Lieu	of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provi der CCN: 15-0042		Worksheet D
			From 01/01/2018	Part V Doto/Time Dropored

				From 01/01/2018 To 12/31/2018		epared: 18 am
		Title	: XVIII	Hospi tal	PPS	
	Cos	sts		<u> </u>		
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.)	-			
ANCILLARY SERVICE COST CENTERS	6. 00	7. 00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	-	1			51.00
51. 01 05101 ENDOSCOPY	0	0				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	,			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	,			55.00
60. 00 06000 LABORATORY	0	Ö	,			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	0	1			66.00
69. 00 06900 ELECTROCARDI OLOGY	0	0)			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
70. 01 07001 NEURODI AGNOSTI CS	0	0				70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	1			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	11, 982				73.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	1			75. 00
76.00 03950 MH ANCILLARY OUTPATIENT	0	ŀ	1			76. 00
76. 01 03951 I NPATI ENT DI ALYSI S	0	0	1			76. 01
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	1 0		ı			1 00 00
90. 00 09000 CLI NI C 90. 01 04950 WOUND CLI NI C	0 0		1			90.00
91. 00 09100 EMERGENCY	0					91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
OTHER REIMBURSABLE COST CENTERS		0	1			72.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00 Subtotal (see instructions)	0	12, 009				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	1 .2,007				201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	12, 009				202. 00

Health Financial Systems	GOOD SAMARITA				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0042	Peri od:	Worksheet D	
		Component	CCN: 15-S042	From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	narod:
		Component	CCN. 13-3042	10 12/31/2010	1/20/2020 10:	18 am
		Title	XVIII	Subprovi der -	PPS	10 a
				IPF		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
'	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)	3	ĺ	
	col. 26)	Í	'			
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	795, 755	41, 472, 705	0. 01918	1, 254	24	50.00
51.00 05100 RECOVERY ROOM	0	0	0. 00000	00	0	51.00
51. 01 05101 ENDOSCOPY	473, 075	11, 605, 653	0. 04076	1, 507	61	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	42, 025			28 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0			00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 280, 822	92, 937, 492	0. 01378	32, 897	453	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	308, 616	22, 855, 538	0. 01350		0	55.00
60. 00 06000 LABORATORY	397, 129	68, 511, 021	0.00579	86, 290	500	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0					63.00
65. 00 06500 RESPIRATORY THERAPY	240, 982	14, 920, 013	0. 01615	185, 098	2, 990	65.00
66. 00 06600 PHYSI CAL THERAPY	854, 880	25, 632, 051	0. 03335	19, 845	662	66.00
69. 00 06900 ELECTROCARDI OLOGY	717, 388	36, 510, 527	0. 01964	6, 546	129	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		1			70.00
70. 01 07001 NEURODI AGNOSTI CS	285, 653	5, 621, 354			0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	153, 902				56	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	159, 435		1	•		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	329, 482	1			1, 383	
75. 00 07500 ASC (NON-DISTINCT PART)	93, 538				1	
76. 00 03950 MH ANCILLARY OUTPATIENT	0	1	1		0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	306, 144	1	1		_	76. 01
OUTPATIENT SERVICE COST CENTERS	000/ 111	17 1027 107	0.2.070	,,,		70.0.
90. 00 09000 CLINIC	101, 558	159, 344	0. 63735	51 0	0	90.00
90. 01 04950 WOUND CLINIC	130, 097				1	90. 01
91. 00 09100 EMERGENCY	857, 496				148	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0					
OTHER REIMBURSABLE COST CENTERS		5,557,700	2. 23000			1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	16, 478	560, 220	0. 02941	3 0	0	96.00
200.00 Total (lines 50 through 199)	7, 544, 455			685, 642	_	200.00
	., ., ., .,	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	1 2227012	_,,	

	Financial Systems COMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	GOOD SAMARITA RVICE OTHER PAS		CN: 15-0042		eriod: com 01/01/2018	u of Form CMS-2 Worksheet D Part IV	1002 10
THROUG	1 COSTS		Component	CCN: 15-S042	To			pared: 18 am
			Title	XVIII	5	Subprovi der – I PF	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	Allied Health	
		Anesthetist	School	School		Post-Stepdown		
		Cost	Post-Stepdown			Adjustments		
		4.00	Adjustments	0.00		0.4	2.00	
	ANCILLARY SERVICE COST CENTERS	1. 00	2A	2. 00		3A	3. 00	
	O5000 OPERATING ROOM	0	0		0	0	0	50.00
	05100 RECOVERY ROOM		0		0	0	0	51.00
	05100 RECOVERT ROOM 05101 ENDOSCOPY	0	0		0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	0	52.00
	05300 ANESTHESI OLOGY		0		0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C		0		0	0	269, 846	54.00
	05500 RADI OLOGY-THERAPEUTI C		0		0	0	207, 040	55.00
	06000 LABORATORY	0	0		0	0	291, 989	60.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	271, 787	63.00
	06500 RESPI RATORY THERAPY	0	0		0	0	0	65.00
	06600 PHYSI CAL THERAPY	0	Ö		0	Ö	0	66.00
	06900 ELECTROCARDI OLOGY	0	0		0	O	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	0	0		0	0	0	70. 01
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	o	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
	07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	75. 00
	03950 MH ANCILLARY OUTPATIENT	0	0		0	0	0	76.00
	03951 INPATIENT DIALYSIS	0	0		0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	0	0		0	0	0	90.00
	04950 WOUND CLINIC	0	0		0	0	0	90.01
	09100 EMERGENCY	0	0		0	0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
	OTHER REIMBURSABLE COST CENTERS 09600 DURABLE MEDICAL EQUIP-RENTED		_			ما	0	04 00
96. 00 200. 00	Total (lines 50 through 199)	0	l .		0	0	0 561, 835	
	TIOLAL CITTLES SO LITTOUULI 1991		ı U		U	()	001.830	1/1/1/1/1/1

	Financial Systems	GOOD SAMARITA				u of Form CMS-2	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C		Period: From 01/01/2018	Worksheet D Part IV	
THROUG	SH COSTS		Component		To 12/31/2018		nared:
			Component	OCIV. 15 3042	10 12/31/2010	1/20/2020 10:	18 am
			Title	XVIII	Subprovi der -	PPS	
					I PF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col . 5 ÷	
		Cost	4)	col s. 2, 3,	col. 8)	col. 7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 41, 472, 705		
51.00	05100 RECOVERY ROOM	0	0		0	0. 000000	
51. 01	05101 ENDOSCOPY	0	0	•	0 11, 605, 653	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 6, 340, 753	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	269, 846			0. 002904	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 22, 855, 538	0. 000000	
60.00	06000 LABORATORY	0	291, 989			0. 004262	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0		0 14, 920, 013	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 25, 632, 051	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 36, 510, 527	0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0. 000000	
70. 01	07001 NEURODI AGNOSTI CS	0	0		5, 621, 354	0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		7, 863, 443	0. 000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 14, 169, 547	0. 000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 81, 064, 615		
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 20, 639, 902	0. 000000	
76.00	03950 MH ANCILLARY OUTPATIENT	0	0		0	0. 000000	
76. 01	03951 I NPATI ENT DI ALYSI S	0	0		0 1, 432, 189	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS			1			
90.00	09000 CLI NI C	0	0		0 159, 344		
	04950 WOUND CLINIC	0	0		7, 385, 810		
91.00	09100 EMERGENCY	0	0		52, 809, 489		
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 6, 839, 950	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS	1					
96.00		0			560, 220		
200.00	Total (lines 50 through 199)	0	561, 835	561, 83	519, 331, 616		200.00

Health Financial Systems	NUTRATION AND LABOR OF	GOOD SAMARITAI		N 15 0010		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/	DUTPATTENT ANCILLARY SE	RVICE OTHER PASS	Provi der C		Peri od: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS			Component	CCN: 15-S042	To 12/31/2018		nared:
			Component	30N. 13 3042	10 12/31/2010	1/20/2020 10:	
			Title	XVIII	Subprovi der - PPS		
					I PF		
Cost Center Desc	cri pti on	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷		Costs (col.	3	Costs (col. 9	
		col. 7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13.00	
ANCILLARY SERVICE COS	T CENTERS						
50.00 05000 OPERATING ROOM		0. 000000	1, 254		0 0	0	50.00
51.00 05100 RECOVERY ROOM		0. 000000	0		0 0	0	51.00
51. 01 05101 ENDOSCOPY		0. 000000	1, 507		0 0	0	51.01
52.00 05200 DELIVERY ROOM &	LABOR ROOM	0. 000000	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 000000	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNO	OSTI C	0. 002904	32, 897	9	6 0	0	54.00
55. 00 05500 RADI 0L0GY-THERAI	PEUTIC	0. 000000	0		0 0	0	55.00
60. 00 06000 LABORATORY		0. 004262	86, 290	36	8 0	0	60.00
63.00 06300 BLOOD STORING, I	PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65. 00 06500 RESPIRATORY THEI		0. 000000	185, 098		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAP	(0. 000000	19, 845		0 0	0	66.00
69. 00 06900 ELECTROCARDI OLO	GΥ	0. 000000	6, 546		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALO	GRAPHY	0. 000000	0		0 0	0	70.00
70. 01 07001 NEURODI AGNOSTI C	5	0. 000000	0		0 0	0	70. 01
71. 00 07100 MEDICAL SUPPLIES	S CHARGED TO PATIENTS	0. 000000	2, 846		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARG	GED TO PATIENTS	0. 000000	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO		0. 000000	340, 229		0	0	73.00
75. 00 07500 ASC (NON-DISTING	CT PART)	0. 000000	0		0 0	0	75.00
76.00 03950 MH ANCILLARY OU		0. 000000	0		0 0	0	76.00
76. 01 03951 NPATI ENT DI ALYS		0. 000000	0		0 0	0	76. 01
OUTPATIENT SERVICE CO		2.000000			-		
90. 00 09000 CLINIC	or services	0. 000000	0		0 0	0	90.00
90. 01 04950 WOUND CLINIC		0. 000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY		0. 000000	9, 130		0 943		91.00
92. 00 09200 OBSERVATION BEDS	S (NON-DISTINCT PART)	0. 000000	0		0 0	l e	
OTHER REIMBURSABLE CO		0. 000000	0		<u> </u>		1 2.00
96. 00 09600 DURABLE MEDICAL		0. 000000	0		0 0	0	96.00
200.00 Total (lines 50		0.000000	685, 642				200.00
		1	555, 612	1	,10		1-30.00

	Financial Systems	GOOD SAMARITA				u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provi der Co		Peri od: From 01/01/2018	Worksheet D Part V	
			Component	CCN: 15-S042	To 12/31/2018	Date/Time Pre 1/20/2020 10:	pared: 18 am
			Title	XVIII	Subprovi der - I PF	PPS	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Services Not		
		Worksheet C, Part I, col.	inst.)	Subject To Ded. & Coins	Subject To . Ded. & Coins.		
		9		(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	
	05000 OPERATING ROOM	0. 170813	0		0 0	0	50.00
	05100 RECOVERY ROOM	0. 000000	l .		0 0	Ō	
	05101 ENDOSCOPY	0. 251647	0		0 0	0	51.01
	05200 DELIVERY ROOM & LABOR ROOM	0. 332956	0		0 0	0	1
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 114685	0		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 169551	0		0 0	0	55.00
60.00	06000 LABORATORY	0. 142156	0		0	0	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
	06500 RESPI RATORY THERAPY	0. 244900	0		0	0	65.00
	06600 PHYSI CAL THERAPY	0. 278352	0		0	0	
	06900 ELECTROCARDI OLOGY	0. 174712	0		0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000			0	0	70.00
	07001 NEURODI AGNOSTI CS	0. 233144	0		0	0	70. 01
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	1. 087566	0		0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 461914	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATLENTS 07500 ASC (NON-DISTINCT PART)	0. 272051 0. 178339	0		0 364	0	
	03950 MH ANCILLARY OUTPATIENT	0. 178339			0 0	0	
	03951 INPATIENT DIALYSIS	0. 575365			0 0	0	1
70.01	OUTPATIENT SERVICE COST CENTERS	0. 575305			0 0	U	76.01
90 00	09000 CLINIC	2. 251475	О		0 0	0	90.00
	04950 WOUND CLINIC	0. 273555	l e		0 0	0	90.01
	09100 EMERGENCY	0. 187685	l e			177	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 503619				0	
	OTHER REIMBURSABLE COST CENTERS				-1		1
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 362258	0		0 0	0	96.00
200.00			943		0 364	177	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges	1					

943

364

177 202. 00

202.00

Only Charges Net Charges (line 200 - line 201)

	Financial Systems	GOOD SAMARITA		ON 45 0040	_	of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C	CN: 15-0042	Peri od: From 01/01/2018	Worksheet D Part V	
			Component	CCN: 15-S042	To 12/31/2018 Date/Time Pr 1/20/2020 10		epared:
			Title	· XVIII	Subprovi der -	PPS	TO UIII
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.) 6.00	(see inst.) 7.00				
	ANCILLARY SERVICE COST CENTERS	0.00	7.00				
	05000 OPERATING ROOM	1 0	0				50.00
	05100 RECOVERY ROOM	0		1			51.00
	05101 ENDOSCOPY	0	1	l .			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	1				52.00
	05300 ANESTHESI OLOGY	0	1				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	1			54.00
	05500 RADI OLOGY-THERAPEUTI C	0	l o				55.00
	06000 LABORATORY	0	0				60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
65.00	06500 RESPI RATORY THERAPY	0	0				65.00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
	07001 NEURODI AGNOSTI CS	0	0				70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	99				73.00
	07500 ASC (NON-DISTINCT PART)	0		1			75. 00
	03950 MH ANCILLARY OUTPATIENT	0		1			76.00
76. 01	03951 I NPATI ENT DI ALYSI S	0	0				76. 01
00.00	OUTPATIENT SERVICE COST CENTERS			1			
	09000 CLINIC	0		1			90.00
	04950 WOUND CLINIC 09100 EMERGENCY	0 0		1			90.01
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			1			92.00
	OTHER REIMBURSABLE COST CENTERS						72.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
200.00				1			200.00
201.00		0	1				201.00
	Only Charges						

99

202.00

202.00

Only Charges Net Charges (line 200 - line 201)

Health Financial Systems	GOOD SAMARITA				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0042	Peri od: From 01/01/2018	Worksheet D Part II	
		Component	CCN: 15-T042	To 12/31/2018	Date/Time Pre	nared:
		Component	OON. 15 1042	10 12/31/2010	1/20/2020 10:	18 am
		Title	: XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	795, 755				l e	
51.00 05100 RECOVERY ROOM	0		0.0000		0	51.00
51. 01 05101 ENDOSCOPY	473, 075					
52.00 05200 DELIVERY ROOM & LABOR ROOM	42, 025	6, 340, 753			3	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.0000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 280, 822	92, 937, 492			6, 201	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	308, 616				9	55.00
60. 00 06000 LABORATORY	397, 129	68, 511, 021	0.00579	1, 206, 747	6, 996	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	00	0	63.00
65. 00 06500 RESPIRATORY THERAPY	240, 982	14, 920, 013	0. 01615	1, 218, 453	19, 680	65.00
66. 00 06600 PHYSI CAL THERAPY	854, 880	25, 632, 051	0. 03335	8, 235, 922	274, 684	66.00
69. 00 06900 ELECTROCARDI OLOGY	717, 388	36, 510, 527	0. 01964	92, 471	1, 817	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	00	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	285, 653	5, 621, 354	0. 05081	7, 371	375	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	153, 902	7, 863, 443	0. 01957	169, 576	3, 319	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	159, 435	14, 169, 547	0. 01125	9, 557	108	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	329, 482	81, 064, 615	0. 00406	1, 563, 468	6, 354	73.00
75.00 07500 ASC (NON-DISTINCT PART)	93, 538	20, 639, 902	0.00453	32 0	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0	0	0. 00000	00	0	76.00
76. 01 03951 I NPATI ENT DI ALYSI S	306, 144	1, 432, 189	0. 21375	101, 189	21, 630	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	101, 558	159, 344	0. 63735	51 0	0	90.00
90. 01 04950 WOUND CLINIC	130, 097			4 9	0	90. 01
91. 00 09100 EMERGENCY	857, 496	52, 809, 489	0. 01623	8, 069	131	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	6, 839, 950	0. 00000	00	0	92.00
OTHER REIMBURSABLE COST CENTERS	•		•	•		1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	16, 478	560, 220	0. 02941	3 0	0	96.00
200.00 Total (lines 50 through 199)	7, 544, 455	519, 331, 616		13, 080, 986	341, 766	200.00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	GOOD SAMARITA		CN: 15-0042	Pe	eri od:	u of Form CMS-2 Worksheet D	2552-10
	SH COSTS				Fr	om 01/01/2018	Part IV	
			Component	CCN: 15-T042	To	12/31/2018	Date/Time Pre 1/20/2020 10:	
			Title	XVIII	5	Subprovi der -	PPS	TO dill
						I RF		
	Cost Center Description	Non Physician		Nursi ng		Allied Health	Allied Health	
		Anesthetist	School	School		Post-Stepdown		
		Cost	Post-Stepdown			Adjustments		
		1.00	Adjustments					
	ANOLI LADV CEDVICE COCT CENTERS	1. 00	2A	2.00		3A	3. 00	
EO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1 0	1 0			٥	0	
50. 00 51. 00	05100 RECOVERY ROOM	0			0	0	0	50.00 51.00
51.00	05100 RECOVERT ROOM		0		0	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0		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		0		0	0	269, 846	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	209, 640	55.00
60.00	06000 LABORATORY				0	0	291, 989	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0	0	271, 707	63.00
65.00	06500 RESPIRATORY THERAPY	0	0		0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0	0	0	66.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	0	70.00
70. 01	07001 NEURODI AGNOSTI CS	0	0		0	0	0	70. 01
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	l o		0	Ö	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	O	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	0	73.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	0	75.00
76.00	03950 MH ANCILLARY OUTPATIENT	0	0		0	0	0	76.00
76. 01	03951 INPATIENT DIALYSIS	0	0		0	0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0	0		0	0	0	90.00
90. 01	04950 WOUND CLINIC	0	0		0	0	0	90. 01
91.00	09100 EMERGENCY	0	0		0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0		0	92.00
	OTHER REIMBURSABLE COST CENTERS					. 1		
	09600 DURABLE MEDICAL EQUIP-RENTED	0	-		0	0	0	96.00
200.00	Total (lines 50 through 199)	0	1 0	ı	0	O	561, 835	ואטט מטכו

	Financial Systems	GOOD SAMARITA				u of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der C		Peri od:	Worksheet D	
THROUG	SH COSTS		Component		From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre	nared:
			Component	CCN. 13-1042	10 12/31/2010	1/20/2020 10:	18 am
			Title	XVIII	Subprovi der -	PPS	
					. I RF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpati ent	(from Wkst.	to Charges	
		Educati on	1, 2, 3, and	Cost (sum of		(col. 5 ÷	
		Cost	4)	col s. 2, 3,	col . 8)	col. 7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 41, 472, 705	0. 000000	
51.00	05100 RECOVERY ROOM	0	0	•	0 0	0. 000000	
51. 01	05101 ENDOSCOPY	0	0	•	0 11, 605, 653	0. 000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	•	0 6, 340, 753	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	269, 846			0. 002904	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 22, 855, 538	0.000000	
60.00	06000 LABORATORY	0	291, 989			0. 004262	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	l	0 0	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0	•	0 14, 920, 013	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	0		0 25, 632, 051	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	0	l	36, 510, 527	0. 000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 0	0. 000000	
70. 01	07001 NEURODI AGNOSTI CS	0	0		5, 621, 354	0. 000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		7, 863, 443	0. 000000	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 14, 169, 547	0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	0	0		81, 064, 615	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		20, 639, 902	0. 000000	
76.00	03950 MH ANCILLARY OUTPATIENT	0	0		0 0	0. 000000	
76.01	03951 I NPATI ENT DI ALYSI S	0	0		0 1, 432, 189	0. 000000	76. 01
	OUTPATIENT SERVICE COST CENTERS				450.044		
90.00	09000 CLINIC	0	1		0 159, 344	0. 000000	
90. 01	04950 WOUND CLINIC	0	ľ		7, 385, 810	0.000000	
		0	0		52, 809, 489	0.000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 6, 839, 950	0. 000000	92.00
0/ 00	OTHER REIMBURSABLE COST CENTERS	_	_		0 5/0 000	0.000000	0, 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	l e		560, 220		
200.00	Total (lines 50 through 199)	0	561, 835	561, 83	5 519, 331, 616		200.00

Health Financial Systems	GOOD SAMARITAN				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	Provi der C		Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T042	From 01/01/2018 To 12/31/2018		nonod.
		Component	CCN. 13-1042	10 12/31/2010	1/20/2020 10:	pareu. 18 am
		Title	XVIII	Subprovi der -	PPS	TO dill
			,,,,,,	I RF		
Cost Center Description	Outpati ent	I npati ent	I npati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through	n Charges	Pass-Through	
	(col. 6 ÷		Costs (col.	8	Costs (col. 9	
	col. 7)		x col. 10)		x col. 12)	
	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 000000	10, 943		0	0	50.00
51.00 05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
51. 01 05101 ENDOSCOPY	0. 000000	6, 107		0	0	51.01
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	453		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. 002904	449, 949	1, 30	14, 145	41	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	702		0	0	55.00
60. 00 06000 LABORATORY	0. 004262	1, 206, 747	5, 14	2, 318	10	60.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	1, 218, 453		0 14	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	8, 235, 922		0	0	66.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	92, 471		0 288	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70.00
70. 01 07001 NEURODI AGNOSTI CS	0. 000000	7, 371		0	0	70. 01
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	169, 576		0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	9, 557		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	1, 563, 468		0 301	0	73.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75.00
76.00 03950 MH ANCILLARY OUTPATIENT	0. 000000	0		0	0	76.00
76. 01 03951 INPATIENT DIALYSIS	0. 000000	101, 189		0 0	0	76. 01
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0		0 1	0	90.00
90. 01 04950 WOUND CLINIC	0. 000000	9		0 0	0	90. 01
91. 00 09100 EMERGENCY	0. 000000	8, 069		0 1, 037	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	·					
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0		0 0	0	96.00
200.00 Total (lines 50 through 199)		13, 080, 986	6, 45	18, 104	51	200.00
	•					•

Heal th	Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	· ·	CCN: 15-T042	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 1/20/2020 10:	epared: 18 am
			Title	· XVIII	Subprovi der - I RF	PPS	
	·		·	Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
	•	Charge Ratio	Rei mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.			
		9		(see inst.)	(see inst.)		
		1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 170813	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
51. 01	05101 ENDOSCOPY	0. 251647	0		0	0	51.01
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 332956	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 114685	14, 145		0 0	1, 622	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 169551	0		0 0	0	55.00
60.00	06000 LABORATORY	0. 142156	2, 318		0 0	330	60.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0. 244900	14		0 0	3	65.00
66.00	06600 PHYSI CAL THERAPY	0. 278352			o o	l o	66.00
69.00	06900 ELECTROCARDI OLOGY	0. 174712	288		o o	50	69.00
	07000 ELECTROENCEPHALOGRAPHY	0. 000000	l .	•	0 0	0	1
	07001 NEURODI AGNOSTI CS	0. 233144	0		0 0	0	70. 01
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 087566	0		0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 461914	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 272051	301		0 1, 392	82	1
75.00	07500 ASC (NON-DISTINCT PART)	0. 178339	0		0 0	0	75.00
	03950 MH ANCILLARY OUTPATIENT	0. 000000	0		0 0	0	76.00
76. 01	03951 I NPATI ENT DI ALYSI S	0. 575365	0		0 0	0	76. 01
	OUTPATIENT SERVICE COST CENTERS					•	
90.00	09000 CLI NI C	2. 251475	1		0 0	2	90.00
90. 01	04950 WOUND CLINIC	0. 273555	0		0 0	0	90. 01
91.00	09100 EMERGENCY	0. 187685	1, 037		o o	195	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 503619			0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 362258	0		0 0	0	96.00
200.00			18, 104		0 1, 392	2, 284	200.00
201.00					0 0		201.00
	Only Charges						

Only Charges Net Charges (line 200 - line 201)

18, 104

0

1, 392

2, 284 202. 00

202.00

	O VACCINE COST	Provider CCN Component CC		Peri od: From 01/01/2018 To 12/31/2018		
		Title X	(VIII	Subprovi der -	PPS	10 diii
	Cos	sts		I RF		
Cost Center Description	Cost Rei mbursed Servi ces Subj ect To Ded. & Coi ns. (see i nst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
ANOLILIARY OFFICE OFFICE	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS 0.00 05000 OPERATING ROOM 1.00 05100 RECOVERY ROOM 0.01 05101 ENDOSCOPY 2.00 05200 DELIVERY ROOM & LABOR ROOM 3.00 05300 ANESTHESIOLOGY 4.00 05400 RADIOLOGY-DIAGNOSTIC 0.00 05500 RADIOLOGY-THERAPEUTIC 0.00 06500 LABORATORY 3.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.00 06600 PHYSICAL THERAPY 0.00 06600 PHYSICAL THERAPY 0.00 06900 ELECTROCARDIOLOGY 0.00 07000 ELECTROCARDIOLOGY 0.01 07001 NEURODIAGNOSTICS 1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3.00 07300 DRUGS CHARGED TO PATIENTS 5.00 03950 MH ANCILLARY OUTPATIENT 5.01 03951 INPATIENT DIALYSIS	0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				50. 0 51. 0 51. 0 52. 0 53. 0 60. 0 63. 0 65. 0 66. 0 70. 0 71. 0 72. 0 75. 0
OUTPATIENT SERVICE COST CENTERS		<u> </u>				1 70.0
D. 00	0 0 0 0	0 0 0 0				90. 00 90. 0 91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS 0.00 OD OURABLE MEDICAL EQUIP-RENTED Subtotal (see instructions) Less PBP Clinic Lab. Services-Program	0 0	0 379				96. 0 200. 0 201. 0

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0042	Peri od: From 01/01/2018		
		To 12/31/2018	Date/Time Pre 1/20/2020 10:	
	Title XVIII	Hospi tal	PPS	
Cost Center Description				

				1/20/2020 10:	18 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1 00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				1
1. 00	Inpatient days (including private room days and swing-bed day	vs excluding newborn)		17, 158	1.00
2. 00	Inpatient days (including private room days, excluding swing-			17, 158	
3. 00	Private room days (excluding swing-bed and observation bed da		rivate room days.	0	3.00
	do not complete this line.	-y-y y-= y p.		_	
4.00	Semi-private room days (excluding swing-bed and observation b	ped days)		12, 998	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5.00
	reporting period	<i>3</i> ,			
6.00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	0	7.00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8.00
0.00	reporting period (if calendar year, enter 0 on this line)	II. B		0.044	
9. 00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	8, 314	9.00
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII o	only (including privato r	coom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instruc		oon days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.00
11.00	December 31 of the cost reporting period (if calendar year, e		com days) arter	J	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI		e room davs)	0	12.00
	through December 31 of the cost reporting period	3 (3 3)	, , , , , , , , , , , , , , , , , , ,		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar y	ear, enter 0 on this lir	ne)		
14.00	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 o	of the cost	0. 00	17.00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	ces after December 31 of	the cost	0. 00	18.00
40.00	reporting period			0.00	
19. 00		es through December 31 of	the cost	0.00	19.00
20.00	reporting period	a often December 21 of t	ho cost	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es arter becember 31 or i	THE COST	0. 00	20.00
21. 00	Teporting period Total general inpatient routine service cost (see instruction	ne)		14, 207, 884	21.00
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22.00
22.00	5 x line 17)	ber 31 of the cost report	ing period (ind		22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	na period (line 6	0	23.00
20.00	x line 18)	or or the edet report.	.g po ou (, and the second se	20.00
24.00	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	na period (line	0	24.00
	7 x line 19)		3 1		
25.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25.00
	x line 20)				
26.00	Total swing-bed cost (see instructions)			0	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		14, 207, 884	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi-private room charges (excluding swing-bed charges)			0	
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
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 mi		ctions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	
36.00	Private room cost differential adjustment (line 3 x line 35)		66	0	36.0
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	TTerential (line	14, 207, 884	37.00
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	HICTMENTS			1
	IDENT-PART TRIDATTERS ODEDATING COST REFORE DACK THROUGH COST AND			000.04	38.00
20.00					
38.00	Adjusted general inpatient routine service cost per diem (see			828. 06	
39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	9 38)		6, 884, 491	39.00
39. 00 40. 00	Adjusted general inpatient routine service cost per diem (see	e 38) ram (line 14 x line 35)			39. 00 40. 00

Heal th	Financial Systems	GOOD SAMARITAN	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der C		Peri od: From 01/01/2018	Worksheet D-1	
					To 12/31/2018		
			Title	× XVIII	Hospi tal	1/20/2020 10: PPS	<u>18 am</u>
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.00
43.00	INTENSIVE CARE UNIT	8, 383, 992	7, 149	1, 172. 7	5 4, 530	5, 312, 558	43. 00
44.00	CORONARY CARE UNIT						44.00
46.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (Wkst					19, 268, 071	
49. 00	Total Program inpatient costs (sum of lines 41 PASS THROUGH COST ADJUSTMENTS	through 48)(s	see instructi	ons)		31, 465, 120	49. 00
50.00	Pass through costs applicable to Program inpat	ient routine s	services (fro	m Wkst. D, su	m of Parts I and	2, 105, 469	50.00
51. 00	III Pass through costs applicable to Program inpat	iont ancillar	, condicos (f	rom Wkst D	cum of Dorts II	1 510 544	51.00
51.00	and IV)	Tent andiriary	y services (i	TOIII WKSt. D,	Sum of Parts II	1, 519, 546	31.00
52.00	Total Program excludable cost (sum of lines 50				h-4:-4	3, 625, 015	
53. 00	Total Program inpatient operating cost excludi medical education costs (line 49 minus line 52		ated, non-pn	ysician anesti	netist, and	27, 840, 105	53. 00
F.4.00	TARGET AMOUNT AND LIMIT COMPUTATION						F4 00
54.00	Program discharges Target amount per discharge					0 0. 00	
56.00	Target amount (line 54 x line 55)		_			0	56.00
57. 00 58. 00	Difference between adjusted inpatient operating Bonus payment (see instructions)	g cost and tar	rget amount (line 56 minus	line 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repo	rting period e	endi ng 1996,	updated and c	ompounded by the		
60. 00	market basket Lesser of lines 53/54 or 55 from prior year co	st roport un	dated by the	markot baskot		0. 00	60.00
61.00	1					0.00	61.00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see in		s (lines 54 x	60), or 1% o	f the target		
62.00	Relief payment (see instructions)	structions)				0	62.00
63.00	Allowable Inpatient cost plus incentive paymen PROGRAM INPATIENT ROUTINE SWING BED COST	t (see instruc	ctions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine costs	through Decer	mber 31 of th	e cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs</pre>	after Decembe	er 31 of the	cost reporting	a narind (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient routine CAH (see instructions)	costs (line 6	64 plus line	65)(title XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	costs through	December 31	of the cost r	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	costs after De	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	<pre>(line 13 x line 20) Total title V or XIX swing-bed NF inpatient ro</pre>	utine costs (I	ine 67 + lin	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NUR	SING FACILITY,	AND ICF/IID	ONLY		-	
70. 00 71. 00	Skilled nursing facility/other nursing facilit Adjusted general inpatient routine service cos	,		•)		70. 00 71. 00
72.00	Program routine service cost (line 9 x line 71)		ŕ			72.00
73. 00 74. 00	Medically necessary private room cost applicable. Total Program general inpatient routine service						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient ro	•		,	Part II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ line	2)					76. 00
77. 00	Program capital -related costs (line 9 x line 7	•					77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		sovi don rocon	de)			78. 00 79. 00
80.00	Total Program routine service costs for compar				nus line 79)		80.00
81.00	Inpatient routine service cost per diem limita		\				81.00
82. 00 83. 00	Inpatient routine service cost limitation (lin Reasonable inpatient routine service costs (se						82. 00 83. 00
84.00	Program inpatient ancillary services (see inst	ructi ons)					84. 00
85. 00 86. 00	Utilization review - physician compensation (s Total Program inpatient operating costs (sum of						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per di	em (line 27 ÷	line 2)			4, 160 828. 06	
	Observation bed cost (line 87 x line 88) (see	•	,			3, 444, 730	

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		pared: 18 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 863, 799	14, 207, 884	0. 20156	4 3, 444, 730	694, 334	90.00
91.00 Nursing School cost	0	14, 207, 884	0.00000	0 3, 444, 730	0	91.00
92.00 Allied health cost	0	14, 207, 884	0.00000	0 3, 444, 730	0	92.00
93.00 All other Medical Education	О	14, 207, 884	0. 00000	0 3, 444, 730	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: 15-0042		Worksheet D-1
	Component CCN: 15-S042	From 01/01/2018 To 12/31/2018	
	Title XVIII	Subprovi der -	PPS
		I PF	

Cost Center Description	1. 00	
PART I - ALL PROVIDER COMPONENTS	1.00	
INPATIENT DAYS		
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 410	
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days) 3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room day	4, 410 s. 0	
do not complete this line.	3,	3.00
4.00 Semi-private room days (excluding swing-bed and observation bed days)	4, 410	4.00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the co	st 0	5.00
reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
reporting period (if calendar year, enter 0 on this line)	0	0.00
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cos	t 0	7.00
reporting period		
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 645	9.00
newborn days)	1,043	7.00
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
through December 31 of the cost reporting period (see instructions)		
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	r 0	11.00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	12.00
through December 31 of the cost reporting period		12.00
13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only)	0	15. 00 16. 00
SWI NG BED ADJUSTMENT		10.00
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17.00
reporting period		
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18.00
reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
reporting period	0.00	17.00
20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20.00
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 (li	4, 865, 398	1
5 x line 17)	ne 0	22.00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line	0	23.00
x line 18)		
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (lin	e 0	24.00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line	8 0	25. 00
x line 20)	0	25.00
26.00 Total swing-bed cost (see instructions)	0	26.00
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 865, 398	27.00
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	1 0	00.00
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges)	0	
30.00 Semi -private room charges (excluding swing-bed charges)	0	30.00
31.00 [General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00 Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35)	0.00	35. 00 36. 00
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (li		
27 minus line 36)	1 ., 555, 576]
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, 103. 26	
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, 814, 863 0	ı
41.00 Total Program general inpatient routine service cost (line 39 + line 40)	1, 814, 863	
1 3 3 3 3 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, ,

	Financial Systems	GOOD SAMARITA				eu of Form CMS-2		
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-0042 CCN: 15-S042	Period: From 01/01/2018 To 12/31/2018			
	Title XVIII Subprovider -						18 am	
	Cost Center Description Total Total Average Per Program Days Inpatient Inpatient Diem (col. 1							
		1.00	Days 2.00	÷ col . 2) 3.00	4.00	col . 4) 5.00		
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42.00	
43. 00	INTENSIVE CARE UNIT	0	0	0.	00 0	0	43.00	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00	
46.00							46.00	
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00	
	Cost Center Description					1.00		
48. 00	Program inpatient ancillary service cost (Wk					166, 011		
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructi	ons)		1, 980, 874	49.00	
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sı	um of Parts I and	231, 303	50.00	
51. 00		ationt ancillar	ry sarvicas (f	rom Wkst D	sum of Darte II	6, 870	51.00	
31.00	and IV)	atrent anerrai	y services (i	rom wkst. b,	3411 01 141 (3 11	0,070	31.00	
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated non nh	velei an anac	thatist and	238, 173 1, 742, 701	1	
55.00	medical education costs (line 49 minus line		erateu, non-pri	ysi ci aii ailes	thetist, and	1, 742, 701	33.00	
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION						- A 00	
54.00	Program discharges Target amount per discharge					0.00		
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 ta	arget amount (line 56 minus	s line 53)	0 0		
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and o	compounded by the		1	
60.00	market basket	rost renort ur	ndated by the	market haske	t	0.00	60.00	
61.00								
	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)							
62. 00	1	0	62.00					
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00					
64. 00		0	64.00					
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Necemb	oer 31 of the	cost reporti	na neriod (See	0	65.00	
03.00	instructions)(title XVIII only)			·				
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	III only). For	0	66. 00				
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost i	reporting period	0	67.00	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs after [Occombor 21 of	the cost ro	porting ported	0	68. 00	
00.00	(line 13 x line 20)	e costs after L	becember 31 of	the cost rep	on tring perrou		08.00	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00	
70. 00	Skilled nursing facility/other nursing facil				7)		70.00	
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00	
73.00	Medically necessary private room cost applic		n (line 14 x l	ine 35)			73.00	
74.00	Total Program general inpatient routine serv	•		•	David III. aaliima		74.00	
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	worksneet B,	Part II, Column		75.00	
76.00	Per diem capital -related costs (line 75 ÷ li	•					76.00	
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00	
79. 00	Aggregate charges to beneficiaries for exces	s costs (from p			: 11 7 83		79. 00	
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ost ilmitatio	ıı (ııne /8 mi	inus iine /9)		80.00	
82.00	Inpatient routine service cost limitation (I	ine 9 x line 81	* .				82.00	
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		ıs)				83. 00 84. 00	
85.00	Utilization review - physician compensation	(see instructio					85.00	
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PAS:		nrough 85)				86.00	
87. 00	Total observation bed days (see instructions)				0	1	
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•				1	88. 00 89. 00	
07.00	100001 vation bed cost (Time of A Time oo) (Se	c manactions)				1	1 07.00	

Health Financial Systems GOOD SAMARITAN H				In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2018	Worksheet D-1	
		Component (Component CCN: 15-S042		Date/Time Pre 1/20/2020 10:	
		Title	XVIII	Subprovi der -	PPS	
				IPF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
				ŕ	instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	620, 077	4, 865, 398	0. 12744	16 0	0	90.00
91.00 Nursing School cost	0	4, 865, 398	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	4, 865, 398	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 865, 398	0. 00000	0 0	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: 15-0042	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T042		
	Title XVIII	Subprovi der -	PPS
		IRF	

	IR	F		
	Cost Center Description		1. 00	
	PART I - ALL PROVIDER COMPONENTS		1.00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7, 324	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room	m davs	7, 324 0	2. 00 3. 00
3. 00	do not complete this line.	m days,	o l	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		7, 324	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of 1	he cost	0	5.00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the	. cost	0	6. 00
6.00	reporting period (if calendar year, enter 0 on this line)	COST	U	0.00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of th	ne cost	0	7. 00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the	cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-be	hae ha	6, 323	9. 00
7. 00	newborn days)	and	0, 323	7. 00
10.00			0	10.00
	through December 31 of the cost reporting period (see instructions)			
11. 00		after	0	11.00
12. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	we)	0	12.00
12.00	through December 31 of the cost reporting period	iya)	O	12.00
13.00		ıys)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			
14.00			0	14.00
15. 00 16. 00	1		0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT		U	10.00
17. 00		st	0.00	17.00
	reporting period			
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		0. 00	18.00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost		0.00	19. 00
17.00	reporting period	•	0.00	17.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost		0. 00	20.00
	reporting period			
21.00		ام دان م	4, 421, 498	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period 5 x line 17)	od (TITTE	0	22.00
23. 00		(line 6	0	23. 00
	x line 18)	`		
24.00		l (line	0	24.00
25 00	7 x line 19)	line o	0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (x line 20)	Tine 8	U	25. 00
26. 00	Total swing-bed cost (see instructions)		0	26.00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4, 421, 498	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	
30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)		0	29. 00 30. 00
31.00			0. 000000	31.00
32. 00			0. 00	32.00
33.00			0. 00	33.00
34.00			0.00	
35.00			0.00	35.00
36. 00 37. 00	· · · · · · · · · · · · · · · · · · ·	al (line		36. 00 37. 00
57.00	27 minus line 36)	(,,,,,,	1, 721, 770	57.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00			603. 70	
39.00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35)		3, 817, 195 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 + line 40)		3, 817, 195	
	10.10 2	ļ	2, 3,	

	Financial Systems ATION OF INPATIENT OPERATING COST	GOOD SAWART I	AN HOSPITAL Provi der	CCN: 15-0042	Peri od:	In Lieu	u of Form CMS-2 Worksheet D-1	
				CCN: 15-T042	From 01/0	01/2018 31/2018		
			· ·				1/20/2020 10:	
			liti	e XVIII	Subprovi I RF		PPS	
	Cost Center Description	Total	Total	Average P	er Progran		Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. + col. 2			(col. 3 x col. 4)	
10.00	NUDGEDY (1) II - V o VIV - I - V	1. 00	2.00	3.00	4. (5. 00	40.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0 0	0. 00	0	0	42.00
43. 00	INTENSIVE CARE UNIT	0		0 0	0. 00	0	0	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							44.00
	SURGICAL INTENSIVE CARE UNIT							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description						1. 00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col.	3, line 200)				3, 510, 027	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instruct	ons)			7, 327, 222	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (fr	om Wkst. D,	sum of Part	s I and	621, 361	50.00
51. 00	III) Pass through costs applicable to Program inp	atient ancilla	ry services (:	from Wket D	sum of Do	rts II	348, 216	51 00
31.00	and IV)		ry services (ITOIII WKSt. D	, Suill OI Fa	1 (5)	340, 210	31.00
52.00	Total Program excludable cost (sum of lines		010+04	weleler	c+bo+! c+	nd	969, 577 4 357 445	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		erated, non-p	nysician ane	stnetist, a	na	6, 357, 645	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	-						ļ
54. 00 55. 00	Program di scharges Target amount per di scharge					1		54. 00 55. 00
56. 00	Target amount (line 54 x line 55)						0.00	I
57.00	Difference between adjusted inpatient operat	ing cost and t	arget amount	(line 56 min	us line 53)		0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and	compounded	by the		59.00
	market basket		9	•	·			
60. 00 61. 00								60.00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							01.00
62. 00	amount (line 56), otherwise enter zero (see instructions) .00 Relief payment (see instructions)							
	3.00 Allowable Inpatient cost plus incentive payment (see instructions)							62.00
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See							0	64.00
04.00	instructions)(title XVIII only)	ts through bec	elliber 31 01 ti	ie cost repo	iting perio	u (see	U	04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decem	ber 31 of the	cost report	ing period	(See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title X	VIII only).	For	0	66.00
.	CAH (see instructions)						0	/7.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs throug	n December 31	or the cost	reporting	peri oa	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin	e costs after	December 31 o	f the cost r	eporting pe	ri od	0	68.00
69. 00	(line 13 x line 20) 10 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)							69.00
	PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILIT	Y, AND ICF/III	ONLY			Ü	
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c	•		•	37)			70.00
72. 00	Program routine service cost (line 9 x line	71)		•				72.00
73.00	Medically necessary private room cost applic							73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			*	, Part II,	col umn		74.00
	26, line 45)		•		•			
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line							76.00
78. 00	Inpatient routine service cost (line 74 minu	s line 77)						78.00
79.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				minus line	791		79.00
81. 00	Inpatient routine service costs for comp		cost iiiii talii	איי (ווווב 10	minus iiile	' 7)		81.00
82.00	Inpatient routine service cost limitation (ine 9 x line 8	· * .					82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		ns)					83.00
85. 00	Utilization review - physician compensation	(see instructi						85.00
	Total Program inpatient operating costs (sum		hrough 85)					86.00
86. 00		LUNUMUM LUNI						I .
86. 00 87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					$\neg \neg$	0	87.00

Health Financial Systems	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018		
		Title	XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	col. 4) (see	
				ŕ	instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	719, 722	4, 421, 498	0. 16277	8 0	0	90.00
91.00 Nursing School cost	0	4, 421, 498	0.00000	0 0	0	91.00
92.00 Allied health cost	0	4, 421, 498	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	4, 421, 498	0.00000	0 0	0	93.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0042	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-1 Date/Time Pre 1/20/2020 10:	
	Title XIX	Hospi tal	Cost	

		Title XIX	Hospi tal	1/20/2020 10: Cost	10 alli		
	Cost Center Description	1 1					
	PART I - ALL PROVIDER COMPONENTS			1. 00			
	INPATIENT DAYS						
1.00	Inpatient days (including private room days and swing-bed day			17, 158	1.00		
2.00	Inpatient days (including private room days, excluding swing-	<i>3</i> /		17, 158			
3. 00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ys). If you have only pr	ivate room days,	0	3. 00		
4. 00	Semi-private room days (excluding swing-bed and observation b	ed days)		12, 998	4. 00		
5.00	Total swing-bed SNF type inpatient days (including private ro		r 31 of the cost		5.00		
/ 00	reporting period		21 -6 +6	0	/ 00		
6. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 of the cost	0	6. 00		
7.00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00		
	reporting period			_			
8. 00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8. 00		
9. 00	Total inpatient days including private room days applicable t	o the Program (excluding	swing-bed and	232	9. 00		
	newborn days)						
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10. 00		
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII o		oom davs) after	0	11. 00		
	December 31 of the cost reporting period (if calendar year, e	nter O on this line)	,				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	12.00		
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	Y only (including privat	e room days)	0	13. 00		
13.00	after December 31 of the cost reporting period (if calendar y				13.00		
14.00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0			
15.00	Total nursery days (title V or XIX only)			995			
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			43	16. 00		
17. 00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	f the cost	0. 00	17. 00		
	reporting period						
18. 00	Medicare rate for swing-bed SNF services applicable to servic reporting period	es after December 31 of	the cost	0.00	18. 00		
19. 00	Medicald rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00		
	reporting period						
20. 00	00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost 0.0						
21. 00	reporting period Total general inpatient routine service cost (see instruction	s)		14, 207, 884	21. 00		
22. 00	Swing-bed cost applicable to SNF type services through Decemb		ing period (line		22. 00		
	5 x line 17)						
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23. 00		
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reporti	ng period (line	0	24. 00		
	7 x line 19)						
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00		
26. 00	Total swing-bed cost (see instructions)			0	26. 00		
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		14, 207, 884	27. 00		
20.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	dd		0	20.00		
28. 00 29. 00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed ch	larges)	0	28. 00 29. 00		
30.00	Semi -private room charges (excluding swing-bed charges)			Ö	30.00		
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000			
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00			
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33)(see instruc	tions)	0. 00 0. 00			
35. 00	Average per diem private room cost differential (line 34 x li	, ,	5115)	0.00			
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00		
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	14, 207, 884	37. 00		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see	•		828. 06			
39.00	Program general inpatient routine service cost (line 9 x line	•		192, 110	39. 00 40. 00		
40. 00 41. 00	Medically necessary private room cost applicable to the Progr Total Program general inpatient routine service cost (line 39	,		0 192, 110			
	, 5 . 5	· ···/	'	,			

	Financial Systems	GOOD SAMARITA		ov. 15 0010 5		u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C	F	eriod: rom 01/01/2018 o 12/31/2018		
						1/20/2020 10:	
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
		I npati ent	I npati ent	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)	4.00	col . 4)	
42 00	NURSERY (title V & XIX only)	1. 00 608, 587	2. 00 995	3. 00 611. 65	4.00	5. 00 26, 301	42 00
42.00	Intensive Care Type Inpatient Hospital Units	000, 507	,,,	011.00	+3	20, 301	72.00
43.00	INTENSIVE CARE UNIT	8, 383, 992	7, 149	1, 172. 75	0	0	
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	·					
48. 00	Program inpatient ancillary service cost (Wk	st D_3 col 3	! line 200)			1. 00 301, 715	48. 00
	Total Program inpatient costs (sum of lines			ons)		520, 126	1
	PASS THROUGH COST ADJUSTMENTS			,			
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	0	50.00
51. 00		ationt ancillar	v sarvicas (f	rom Wket D e	um of Darte II	0	51.00
31.00	and IV)	atrent andiria	y services (i	TOIII WKSt. D, S	um or rarts ir		31.00
52.00	Total Program excludable cost (sum of lines					0	
53. 00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line I TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	54.00
	Target amount per discharge					0.00	1
56.00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and to	rgot amount (lino E4 minus	lino E2)	0	
58. 00	Bonus payment (see instructions)	ing cost and ta	irget alliourit (Title 36 IIITius	111le 55)	0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	_	
(0.00	market basket		1.1.1.				
60.00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				the amount by	0.00	1
01.00	which operating costs (line 53) are less that						01.00
	amount (line 56), otherwise enter zero (see						
62.00	Relief payment (see instructions)	0					
63.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00				
64. 00							
4E 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	to after Decemb	or 21 of the	cost roporting	noriad (Soc	0	65.00
65. 00	instructions)(title XVIII only)	ts arter beceilib	er 31 or the	cost reporting	perrod (see	0	05.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	a costs through	December 31	of the cost re	norting period	0	67.00
07.00	(line 12 x line 19)	e costs through	i beceiibei 31	or the cost re	por tring perrou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repo	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routino costs (lino 67 : lin	n 60)		0	69.00
09.00	PART III - SKILLED NURSING FACILITY, OTHER NU					0	09.00
70.00	Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service of		ine 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	,	(line 14 v l	ine 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B, P	art II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line						77.00
78. 00	Inpatient routine service cost (line 74 minus	,					78. 00
79.00	Aggregate charges to beneficiaries for excess	, ,		,	1: 70)		79.00
80. 00 81. 00	Total Program routine service costs for company inpatient routine service cost per diem limi		ost iimitatio	ı (ııne /ʊ min	us line /9)		80. 00 81. 00
82. 00							
83. 00							
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ine)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS		<u> </u>				
87.00	Total observation bed days (see instructions	•	line 2)			4, 160	1
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•				828. 06 3, 444, 730	
	(30)					2,, .00	,

Health Financial Systems	GOOD SAMARITAN HOSPITAL			In Lieu of Form CMS-2552		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		pared: 18 am
		Ti tl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	2, 863, 799	14, 207, 884	0. 20156	4 3, 444, 730	694, 334	90.00
91.00 Nursing School cost	0	14, 207, 884	0.00000	0 3, 444, 730	0	91.00
92.00 Allied health cost	0	14, 207, 884	0.00000	0 3, 444, 730	0	92.00
93.00 All other Medical Education	0	14, 207, 884	0. 00000	0 3, 444, 730	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: 15-0042	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-S042		
	Title XIX	Subprovi der -	Cost
		I PF	

		I PF		
	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		4, 410	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed da		4, 410 avs. 0	
3.00	do not complete this line.	ys). If you have only private room c	ays, 0	3.00
4.00	Semi-private room days (excluding swing-bed and observation b	ed days)	4, 410	4.00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through December 31 of the	cost 0	5. 00
	reporting period	d) - 		, 00
6. 00	Total swing-bed SNF type inpatient days (including private round reporting period (if calendar year, enter 0 on this line)	om days) after becember 31 of the co	st 0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December 31 of the c	ost 0	7. 00
	reporting period	3,7		
8. 00	Total swing-bed NF type inpatient days (including private room	m days) after December 31 of the cos	t 0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (eycluding swing-hed a	nd 179	9. 00
7. 00	newborn days)	o the frogram (exertaining swring bed a	177	7.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private room days)	0	10.00
44 00	through December 31 of the cost reporting period (see instruc			44.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII of December 31 of the cost reporting period (if calendar year, etc.)		ter 0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		0	12.00
	through December 31 of the cost reporting period	3 (31		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI		0	13.00
14. 00	after December 31 of the cost reporting period (if calendar y Medically necessary private room days applicable to the Progra		0	14.00
15. 00	Total nursery days (title V or XIX only)	all (excluding swing-bed days)		15.00
16. 00	Nursery days (title V or XIX only)		43	1
	SWING BED ADJUSTMENT			
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of the cost	0.00	18. 00
	reporting period			
19. 00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s after December 31 of the cost	0.00	20. 00
	reporting period			
21.00	Total general inpatient routine service cost (see instruction	· ·	4, 865, 398	1
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporting period (line 0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting period (li	ne 6 0	23. 00
	x line 18)			
24. 00	Swing-bed cost applicable to NF type services through Decembe 7×1 ine 19)	r 31 of the cost reporting period (I	i ne 0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting period (lin	e 8 0	25. 00
20.00	x line 20)	or or the east reperting period (iii		20.00
	Total swing-bed cost (see instructions)	(II)	0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)	4, 865, 398	27.00
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	,	0	1
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)	0.000000	1
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00 0. 00	1
34. 00	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instructions)	0.00	1
35.00	Average per diem private room cost differential (line 34 x li		0.00	1
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost differential (line 4, 865, 398	37.00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see	•	1, 103. 26	•
39.00	Program general inpatient routine service cost (line 9 x line	· ·	197, 484	1
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39)	·	0 197, 484	
00	1.2.2 2g. d go.lo. dpat. o routillo del vido dost (11116 d)		1 177, 404	

	Financial Systems	GOOD SAMARITA				u of Form CMS-:	
COMPUT	TATION OF INPATIENT OPERATING COST			CN: 15-0042 CCN: 15-S042	Peri od: From 01/01/2018 To 12/31/2018		pared:
			Ti tI	e XIX	Subprovi der - I PF	1/20/2020 10: Cost	<u>18 am</u>
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
40.00	AMIDOEDY (1: 11 - V o VIV - 1)	1. 00	2. 00	3. 00	4.00	5. 00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.	00 0	0	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) Cost Center Description	O	0	0.	00 0	0	43.00 44.00 45.00 46.00 47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3, line 200)			1. 00 17, 055	48. 00
	Total Program inpatient costs (sum of lines			ons)		214, 539	
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, s	um of Parts I and	0	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu medical education costs (line 49 minus line	ding capital re	elated, non-ph	ysician anes	thetist, and	0	
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0. 00	55.00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	s line 53)	0	1
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	9			ŕ	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost report un	ndated by the	market baske	ŧ	0. 00	60.00
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less than	s 55, 59 or 60 n expected cost	enter the les	ser of 50% o	f the amount by	0	1
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 PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	uctions)			0	63.00
64. 00		ts through Dece	ember 31 of th	e cost repor	ting period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 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 CAH (see instructions)</pre>	ne costs (line	64 plus line	65)(title XV	II only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	n December 31	of the cost	reporting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after [December 31 of	the cost re	porting period	0	
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	utine service	cost (line 3	7)		70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
73.00	Medically necessary private room cost applic		•				73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient 26, line 45)	•		•	Part II, column		74. 00 75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	•					76. 00 77. 00
	Inpatient routine service cost (line 74 minu						78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 70)		79. 00 80. 00
81.00	Inpatient routine service cost per diem limi		SSC TIMI LALIU	(11116-70 1111	indo Tille /7)		81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	n Jugir 65)				1
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		- line 2)			0 00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (se	•					89.00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (CCN: 15-S042	From 01/01/2018 To 12/31/2018		
		Ti tl	e XIX	Subprovi der -	Cost	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		21)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	col. 4) (see	
					instructions)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	620, 077	4, 865, 398	0. 12744	16 0	0	90.00
91.00 Nursing School cost	0	4, 865, 398	0. 00000	00	0	91.00
92.00 Allied health cost	0	4, 865, 398	0. 00000	00	0	92.00
93.00 All other Medical Education	0	4, 865, 398	0. 00000	00 0	0	93. 00

Heal th	Financial Systems	GOOD SAMARITAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	NT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-0042	Peri od: From 01/01/2018 To 12/31/2018	Worksheet D-3	
						1/20/2020 10:	18 am
			Title	XVIII	Hospi tal	PPS	
	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	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS				15, 332, 458		30.00
31.00	03100 INTENSIVE CARE UNIT				11, 095, 578		31.00
	04000 SUBPROVI DER - I PF				6, 262		40.00
	04100 SUBPROVI DER - I RF				138, 054		41.00
	04300 NURSERY						43.00
	ANCILLARY SERVICE COST CENTERS						
	O5000 OPERATING ROOM			0. 1708			
	05100 RECOVERY ROOM			0.0000			
	D5101 ENDOSCOPY D5200 DELIVERY ROOM & LABOR ROOM			0. 2516 0. 3329			
	05300 ANESTHESI OLOGY			0. 3329			1
	05400 RADI OLOGY-DI AGNOSTI C			0. 0000		1	
	05500 RADI OLOGY-THERAPEUTI C			0. 1702			1
	06000 LABORATORY			0. 1421			
	06300 BLOOD STORING, PROCESSING & TRANS.			0.0000			63.00
65.00	06500 RESPI RATORY THERAPY			0. 2449	00 6, 273, 199	1, 536, 306	65.00
	D6600 PHYSI CAL THERAPY			0. 2783			
	06900 ELECTROCARDI OLOGY			0. 1757		1, 478, 649	69.00
	07000 ELECTROENCEPHALOGRAPHY			0.0000		_	
	07001 NEURODI AGNOSTI CS			0. 2351		·	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			1. 0875			
	07200 IMPL. DEV. CHARGED TO PATIENTS			0. 4619			
	07300 DRUGS CHARGED TO PATIENTS			0. 2720 0. 1784			
	07500 ASC (NON-DISTINCT PART) 03950 MH ANCILLARY OUTPATIENT			0.1784			
	03951 INPATIENT DIALYSIS			0. 5794			
	DUTPATIENT SERVICE COST CENTERS			0.5794	37 1,000,921	019,913	76.01
	09000 CLINIC			2. 2514	75 0	0	90.00
	04950 WOUND CLINIC			0. 2735			
	09100 EMERGENCY			0. 1881			1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 5036			1
	OTHER REIMBURSABLE COST CENTERS]
96.00	09600 DURABLE MEDICAL EQUIP-RENTED			0. 3622	58 0	0	96.00

80, 478, 591

80, 478, 591

201. 00 202. 00

0 96.00 19,268,071 200.00

201.00

202.00

96. 00 O9600 DURABLE MEDICAL EQUIP-RENTED
200. 00 Total (sum of lines 50 through 94 and 96 through 98)

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

Health Financial Systems GOOD SAMARI'	TAN HOSPITAL Provider C	CN: 15-0042	Peri od:	u of Form CMS-: Worksheet D-3	
	Component	CCN, 1E CO42	From 01/01/2018	Doto/Time Dro	norod.
	Component	CCN: 15-S042	To 12/31/2018	Date/Time Pre 1/20/2020 10:	
	Title	× XVIII	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col . 1 x	
		1.00	2.00	col. 2) 3.00	\vdash
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS			6, 600		30.0
31.00 03100 INTENSIVE CARE UNIT			0		31.00
40. 00 04000 SUBPROVI DER - 1 PF			2, 613, 400		40.0
41. 00 04100 SUBPROVI DER - I RF			0		41.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS					4
50. 00 05000 OPERATING ROOM		0. 1708	· ·	214	
51. 00 05100 RECOVERY ROOM		0.00000		0	
51.01 05101 ENDOSCOPY 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 25164	· ·	379	1
52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESIOLOGY		0. 33295 0. 00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11468		3, 773	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 17024	·	0,779	
60. 00 06000 LABORATORY		0. 1421		12, 267	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	
65. 00 06500 RESPIRATORY THERAPY		0. 24490		45, 331	65.0
66. 00 06600 PHYSI CAL THERAPY		0. 2783	52 19, 845	5, 524	66.0
69. 00 06900 ELECTROCARDI OLOGY		0. 17572	23 6, 546	1, 150	69.0
70.00 07000 ELECTROENCEPHALOGRAPHY		0.00000		0	
70. 01 07001 NEURODI AGNOSTI CS		0. 2351		0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 08756	·	3, 095	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 46191		0	1
73. 00 O7300 DRUGS CHARGED TO PATIENTS		0. 27205	·	92, 560	
75.00 07500 ASC (NON-DISTINCT PART) 76.00 03950 MH ANCILLARY OUTPATIENT		0. 17849		0	
76.00 03950 MH ANCILLARY OUTPATIENT 76.01 03951 INPATIENT DIALYSIS		0. 00000 0. 57943		0	
OUTPATIENT SERVICE COST CENTERS		0.5774	37 0	0	1 70.0
90. 00 09000 CLI NI C		2. 2514	75 0	0	90.0
90. 01 04950 WOUND CLINIC		0. 2735!		0	
91. 00 09100 EMERGENCY		0. 18813			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5036	· ·	0	1
OTHER REIMBURSABLE COST CENTERS					1
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 36225		0	
Total (sum of lines 50 through 94 and 96 through 98)			685, 642	166, 011	
201.00 Less PBP Clinic Laboratory Services-Program only cha	rges (line 61)		0		201. 0
202.00 Net charges (line 200 minus line 201)			685, 642		202. C

	Financial Systems GOOD SAMARITA NT ANCILLARY SERVICE COST APPORTIONMENT	_	CN: 15-0042	Peri od:	u of Form CMS- Worksheet D-3	
			0011 45 7040	From 01/01/2018		
		Component	CCN: 15-T042	To 12/31/2018	Date/Time Pre 1/20/2020 10:	
		Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
	p		To Charges	•	Program Costs	
				Charges	(col. 1 x	
					col. 2)	
1			1.00	2. 00	3. 00	
	NPATIENT ROUTINE SERVICE COST CENTERS					
	3000 ADULTS & PEDI ATRI CS			540, 605		30.
	13100 I NTENSI VE CARE UNI T			48, 596		31.
	14000 SUBPROVI DER - I PF			0		40.
	14100 SUBPROVI DER - I RF 14300 NURSERY			6, 216, 981		41.
	NCI LLARY SERVI CE COST CENTERS					43.
	15000 OPERATING ROOM		0. 1708	13 10, 943	1, 869	50.
	5100 RECOVERY ROOM		0. 0000	·	1,809	1
- 1	5101 ENDOSCOPY		0. 2516		1, 537	
- 1	5200 DELIVERY ROOM & LABOR ROOM		0. 3329		1, 357	
	5300 ANESTHESI OLOGY		0.0000		0	1
4	5400 RADI OLOGY-DI AGNOSTI C		0. 1146		51, 602	
	5500 RADI OLOGY-THERAPEUTI C		0. 1702	·	120	
	16000 LABORATORY		0. 1421		171, 546	60.
3.00 0	6300 BLOOD STORING, PROCESSING & TRANS.		0.0000	00 0	0	63.
	6500 RESPI RATORY THERAPY		0. 2449	00 1, 218, 453	298, 399	65.
	6600 PHYSI CAL THERAPY		0. 2783	52 8, 235, 922	2, 292, 485	66.
	6900 ELECTROCARDI OLOGY		0. 1757	·	16, 249	
	7000 ELECTROENCEPHALOGRAPHY		0.0000		0	
	17001 NEURODI AGNOSTI CS		0. 2351	·	1, 733	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 0875	·	184, 425	
	17200 IMPL. DEV. CHARGED TO PATIENTS		0. 4619	·	4, 415	
	17300 DRUGS CHARGED TO PATIENTS		0. 2720		425, 343	
	17500 ASC (NON-DISTINCT PART)		0. 1784		0	
	13950 MH ANCILLARY OUTPATIENT 13951 INPATIENT DIALYSIS		0. 0000 0. 5794		-	1
	UTPATIENT DIALTSIS UTPATIENT SERVICE COST CENTERS		0.5794	39 101, 189	58, 033	/6.
	19000 CLINIC		2. 2514	75 0	0	90.
	14950 WOUND CLINIC		0. 2735		2	
	19100 EMERGENCY		0. 2733		1, 518	
	19200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5036	·	1,310	1
	THER REIMBURSABLE COST CENTERS		0.0000	,		´~.
	9600 DURABLE MEDI CAL EQUI P-RENTED		0. 3622	58 0	0	96.
00.00	Total (sum of lines 50 through 94 and 96 through 98)			13, 080, 986		
201.00	Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		0	-,, -	201.
202.00	Net charges (line 200 minus line 201)	, , , ,		13, 080, 986		202.

Health Financial Systems	GOOD SAMARITAN HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Period: From 01/01/2018 To 12/31/2018	Worksheet D-3 Date/Time Pre 1/20/2020 10:	pared:
	Ti ti	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			_		
30. 00 03000 ADULTS & PEDIATRICS			211, 944		30.00
31.00 03100 INTENSIVE CARE UNIT			140, 226		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			69, 926		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 17081	3 190, 132	32, 477	50.00

0. 251647

0.332956

0.000000

0.114685

0. 169551

0.142156

0.000000

0. 244900

0.278352

0.174712

0.000000

0. 233144

1.087566

0.461914

0.272051

0.178339

0.000000

0.575365

2. 251475

0. 273555

0.187685

0.503619

0

3, 684

68, 978

18, 248

33, 336

24, 172

11, 621

17, 286

58, 572

244

760

1, 422

28, 024

2, 696

0

0

0

0

79

116

0 63.00

14.638

207, 168

159, 112

234, 504

98, 703

41, 750

98, 940

1, 046

215, 299

4, 264

2, 472

288

149, 314

5, 354

685

51.00

51.01

53.00

54.00

55.00

60.00

65.00

66.00

69.00

70.00

70.01

71.00

72.00

73 00

75.00

76.00

76.01

90.00

90.01

91.00

92.00

05100 RECOVERY ROOM

05300 ANESTHESI OLOGY

05200 DELIVERY ROOM & LABOR ROOM

06300 BLOOD STORING, PROCESSING & TRANS.

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

09200 OBSERVATION BEDS (NON-DISTINCT PART)

07200 IMPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

07500 ASC (NON-DISTINCT PART)

03950 MH ANCILLARY OUTPATIENT

03951 INPATIENT DIALYSIS

09000 CLI NI C

04950 WOUND CLINIC

09100 EMERGENCY

05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C

06500 RESPIRATORY THERAPY

07000 ELECTROENCEPHALOGRAPHY

06600 PHYSI CAL THERAPY

06900 ELECTROCARDI OLOGY

07001 NEURODI AGNOSTI CS

05101 ENDOSCOPY

06000 LABORATORY

51.00

51.01

52.00

53.00

54.00

55.00

60.00

63.00

65.00

66.00

69.00

70.00

70.01

71.00

72.00

73 00

75.00

76. 01

90.00

90.01

91 00

92.00

	Financial Systems GOOD SAMARITAN ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0042	Peri od:	u of Form CMS-2 Worksheet D-3	
				From 01/01/2018		
		Component	CCN: 15-S042	To 12/31/2018	Date/Time Pre 1/20/2020 10:	
		Ti tl	e XIX	Subprovi der – I PF	Cost	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col . 1 x	
			1.00	2. 00	col. 2) 3.00	_
T	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
	03000 ADULTS & PEDIATRICS			0		30.00
	03100 INTENSIVE CARE UNIT			0		31.00
40.00	04000 SUBPROVI DER - I PF			356, 953		40.00
41.00	04100 SUBPROVI DER – I RF			0		41.00
	04300 NURSERY			0		43.00
	ANCILLARY SERVICE COST CENTERS					4
	05000 OPERATING ROOM		0. 17081		0	
	05100 RECOVERY ROOM		0. 00000		0	
	05101 ENDOSCOPY		0. 25164		32	
	05200 DELIVERY ROOM & LABOR ROOM		0. 33295		0	
	05300 ANESTHESI OLOGY		0.00000		1 201	
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C		0. 11468 0. 16955	· ·	1, 201 0	
	06000 LABORATORY		0. 14215		3, 353	1
	06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		0, 333	1
	06500 RESPIRATORY THERAPY		0. 24490		1, 616	
	06600 PHYSI CAL THERAPY		0. 27835	· ·	1, 608	
	06900 ELECTROCARDI OLOGY		0. 17471		304	
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 00000	00	0	70.0
70. 01	07001 NEURODI AGNOSTI CS		0. 23314	14 510	119	70.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 08756		1, 315	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 46191		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 27205	· ·	7, 238	
	07500 ASC (NON-DISTINCT PART)		0. 17833		0	
	03950 MH ANCILLARY OUTPATIENT		0.00000		0	
	03951 INPATIENT DIALYSIS DUTPATIENT SERVICE COST CENTERS		0. 57536	55 468	269	76.0
	09000 CLINIC		2. 25147	75 0	0	90.0
	04950 WOUND CLINIC		0. 27355		0	
	09100 EMERGENCY		0. 18768		0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 50361		0	1
	OTHER REIMBURSABLE COST CENTERS		2.2300			1
	09600 DURABLE MEDI CAL EQUI P-RENTED		0. 36225	58 0	0	96.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)			77, 107	17, 055	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)			77, 107		202.0

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	From 01/01/2018	Worksheet E Part A Date/Time Prepared: 1/20/2020 10:18 am

		Title XVIII	Hospi tal	1/20/2020 10: PPS	18 am
		TI LI C XVIII	nospi tai	113	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		ı	0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1 (see	0 18, 339, 364	1. 00 1. 01
1. 02	2 DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			5, 348, 587	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCl f 1 (see instructions)	or discharges occurring	prior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCl f October 1 (see instructions)	or di scharges occurri ng	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			292, 942 0	2. 00 2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	rting period (see instru	ıcti ons)	0 85. 74	3. 00 4. 00
	Indirect Medical Education Adjustment				
5. 00	FTE count for allopathic and osteopathic programs for the mos or before 12/31/1996. (see instructions)				5. 00
6. 00	FTE count for allopathic and osteopathic programs that meet t new programs in accordance with 42 CFR 413.79(e)			0.00	6. 00
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified ACA \S 5503 reduction amount to the IME cap as specified under			0. 00 0. 00	7. 00 7. 01
8. 00	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap sl report straddles July 1, 2011, see instructions.	ots under § 5503 of the	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slunder § 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02) (see	0. 00	9. 00
11.00	FTE count for allopathic and osteopathic programs in the curr FTE count for residents in dental and podiatric programs.	ent year from your recor	rds	0.00	10.00 11.00
12.00	Current year allowable FTE (see instructions)				12.00
14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Sep	otember 30, 1997,	0. 00 0. 00	1
15. 00	Sum of lines 12 through 14 divided by 3.			0. 00	15. 00
	Adjustment for residents in initial years of the program			0.00	16.00
17. 00	Adjustment for residents displaced by program or hospital clo	sure			17. 00
18. 00	Adjusted rolling average FTE count				18. 00
	Current year resident to bed ratio (line 18 divided by line 4).		0. 000000	
	Prior year resident to bed ratio (see instructions)			0. 000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0. 000000	
	IME payment adjustment (see instructions)			0	22.00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 42			0	
	Number of additional allopathic and osteopathic IME FTE resid (f)(1)(iv)(C).	ent cap slots under 42 (CFR 412.105	0. 00	
24. 00 25. 00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the	lower of line 23 or line	e 24 (see		24. 00 25. 00
	instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000	1
	IME payments adjustment factor. (see instructions)			0. 000000	ı
	IME add-on adjustment amount (see instructions)			0	ł
	IME add-on adjustment amount - Managed Care (see instructions)		0	1
29. 00 29. 01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)		0	29. 00 29. 01
30 00	Disproportionate Share Adjustment Percentage of SSI recipient patient days to Medicare Part A p	ationt days (soo instruc	rtions)	4. 53	30.00
	Percentage of Medicaid patient days (see instructions)	atrent days (See FiiStruc	LI UIIS)	13. 31	•
	Sum of lines 30 and 31			17. 84	1
	Allowable disproportionate share percentage (see instructions)		4. 35	1
	Disproportionate share adjustment (see instructions)	,		257, 607	1
			'		•

	Financial Systems GOOD SAMARITA ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 1/20/2020 10:	pared:
		Title XVIII	Hospi tal	PPS On/After 10/1	
			1.00	2. 00	
	Uncompensated Care Adjustment		1, 7,, ,05, 1,,	0.070.070.447	05.0
35. 00 35. 01	Total uncompensated care amount (see instructions) Factor 3 (see instructions)		6, 766, 695, 164 0. 000195298	8, 272, 872, 447 0. 000269449	
35. 02	1	nter zero on this line) (s			
35. 03 36. 00	Total uncompensated care (sum of columns 1 and 2 on line 3	5. 03)	988, 424 1, 550, 284		35. 00 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges on Worksheet S-3, Part I excludi 652, 682, 683, 684 and 685 (see instructions)		ugn 46) 0		40.00
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682 instructions)	•	0		41.00
41. 01 42. 00	Total ESRD Medicare covered and paid discharges excluding an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not qu		0 0.00		41.0
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, instructions)				43. 0
44. 00	Ratio of average length of stay to one week (line 43 divididays)	3	0. 000000		44.0
45. 00 46. 00	Average weekly cost for dialysis treatments (see instruction Total additional payment (line 45 times line 44 times line		0.00		45. 00 46. 00
47. 00	Subtotal (see instructions)	41.01)	25, 788, 784		47. 0
48. 00	Hospital specific payments (to be completed by SCH and MDH only. (see instructions)	, small rural hospitals	0		48. 0
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instruction	ons)		25, 788, 784	49.0
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I)	1, 958, 836	
51. 00 52. 00	Exception payment for inpatient program capital (Wkst. L, Direct graduate medical education payment (from Wkst. E-4,			0	51. 0 52. 0
53. 00	Nursing and Allied Health Managed Care payment			10, 014	1
54.00	Special add-on payments for new technologies			0	
54. 01 55. 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, lin	e 69)		0	54. C
6. 00	Cost of physicians' services in a teaching hospital (see i	ntructions)		0	56.0
57.00	Routine service other pass through costs (from Wkst. D, Pt		through 35).	0	57.0
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, P Total (sum of amounts on lines 49 through 58)	t. TV, Cot. 11 Time 200)		83, 448 27, 841, 082	
50.00	Primary payer payments			7, 445	60.0
61. 00 62. 00	Total amount payable for program beneficiaries (line 59 mi	nus line 60)		27, 833, 637	
53.00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			2, 787, 820 63, 620	
54. 00	Allowable bad debts (see instructions)			192, 417	64.0
55.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see i	notructi ana)		125, 071	
56. 00 57. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	listructions)		91, 496 25, 107, 268	
58. 00	Credits received from manufacturers for replaced devices for	or applicable to MS-DRGs (see instructions)	0	
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 9	6).(For SCH see instruction	ns)	0	
70. 00 70. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demo	nstration) adjustment (see	instructions)	0	70. 0 70. 5
70. 87	Demonstration payment adjustment amount before sequestration			0	70.8
70. 88	SCH or MDH volume decrease adjustment (contractor use only	•		0	70.8
70. 89 70. 90	Pioneer ACO demonstration payment adjustment amount (see i HSP bonus payment HVBP adjustment amount (see instructions			0	70.8
70. 91				0	1
70. 92	Bundled Model 1 discount amount (see instructions)			0	70. 9
	IIIIIII normant adirectment amount (acc instructions)			81, 498	70.9
70. 93 70. 94	, , ,			-85, 964	

Heal th Fir	nancial Systems GOOD SAMARITAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATIO	ON OF REIMBURSEMENT SETTLEMENT	Provi der C	CN: 15-0042	Peri od:	Worksheet E	
				From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		T' 11	V0.01.1.1	Here it had	1/20/2020 10:	<u>18 am</u>
		l litie	XVIII FEV	Hospi tal	PPS Amount	
			- 111	0	1. 00	
	w volume adjustment for federal fiscal year (yyyy) (Enter i	n column 0		0	0	70. 96
	e corresponding federal year for the period prior to 10/1)			0		70.07
	w volume adjustment for federal fiscal year (yyyy) (Enter i e corresponding federal year for the period ending on or af			0	0	70. 97
	w Volume Payment-3	10/1/			0	70. 98
70. 99 HAC	C adjustment amount (see instructions)				277, 431	70. 99
71. 00 Amo	ount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			24, 825, 371	71.00
71. 01 Sec	questration adjustment (see instructions)				496, 507	71. 01
	monstration payment adjustment amount after sequestration				0	
	terim payments				24, 331, 705	
	ntative settlement (for contractor use only)	. 70 .			0	73.00
74. 00 Bal	lance due provider/program (line 71 minus lines 71.01, 71.0)	2, 72, and			-2, 841	74.00
75.00 Pro	otested amounts (nonallowable cost report items) in accorda	nce with			392, 591	75.00
	S Pub. 15-2, chapter 1, §115.2 BE COMPLETED BY CONTRACTOR (lines 90 through 96)					-
	erating outlier amount from Wkst. E, Pt. A, line 2, or sum	of 2 03			0	90.00
	us 2.04 (see instructions)	01 2.00				70.00
	pital outlier from Wkst. Ĺ, Pt. I, line 2				0	91.00
92. 00 Ope	erating outlier reconciliation adjustment amount (see instr	uctions)			0	92.00
	pital outlier reconciliation adjustment amount (see instruc	,			0	,
	e rate used to calculate the time value of money (see instr	,			0.00	
	me value of money for operating expenses (see instructions)				0	
96.00 lin	me value of money for capital related expenses (see instruc	tions)		D:: -:- +- 10 /1	0 (45+ 10 /1	96.00
				1.00	0n/After 10/1 2.00	
HSP	P Bonus Payment Amount			1.00	2.00	
	P bonus amount (see instructions)			0	0	100.00
	BP Adjustment for HSP Bonus Payment					
	BP adjustment factor (see instructions)			0. 0000000000	0. 0000000000	101.00
	BP adjustment amount for HSP bonus payment (see instruction	s)		0	0	102.00
	R Adjustment for HSP Bonus Payment					
	R adjustment factor (see instructions)			0. 0000		
	R adjustment amount for HSP bonus payment (see instructions			0	0	104.00
	ral Community Hospital Demonstration Project (§410A Demonst					1000 00
	this the first year of the current 5-year demonstration pe	riod under	the 21st			200.00
	ntury Cures Act? Enter "Y" for yes or "N" for no.					1
	dicare inpatient service costs (from Wkst. D-1, Pt. II, lin	e 49)				201.00
	dicare discharges (see instructions)	· ///				202.00
	se-mix adjustment factor (see instructions)					203. 00
	nputation of Demonstration Target Amount Limitation (N/A in	first year	of the curre	ent 5-year demons		1
	i od)					
	dicare target amount					204. 00
205. 00 Cas	se-mix adjusted target amount (line 203 times line 204) dicare inpatient routine cost cap (line 202 times line 205)					205. 00 206. 00

207. 00

208. 00

209.00 210. 00 211. 00

212. 00 213. 00

218. 00

210.00 Reserved for future use

211.00 Total adjustment to Medicare IPPS payments (see instructions)

212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)

209.00 Adjustment to Medicare IPPS payments (see instructions)

Comparision of PPS versus Cost Reimbursement

(line 212 minus line 213) (see instructions)

213.00 Low-volume adjustment (see instructions)

Adjustment to Medicare Part A Inpatient Reimbursement

207.00 Program reimbursement under the §410A Demonstration (see instructions)

208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)

218.00 Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement)

noar en i i nanor ar o jo como	0000 07.1111.1111 17.111 17.112		0 0 0 2002 .0
LOW VOLUME CALCULATION EXHIBIT 4	Provi der CCN: 15-0042	Peri od:	Worksheet E
		From 01/01/2018	Part A Exhibit 4
		To 12/31/2018	Date/Time Prepared:
			1/20/2020 10·18 am

					To	12/31/2018	Date/Time Pre 1/20/2020 10:	
					XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od 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 payments	1. 00	0	0	0	0	0	1. 00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	18, 339, 364	0	18, 339, 364		18, 339, 364	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	5, 348, 587	0		5, 348, 587	5, 348, 587	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0		0	1. 03
1.04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for	2. 00	292, 942	0	201, 496	91, 446	292, 942	2. 00
2. 01	discharges (see instructions) Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	О	0	0	2. 01
3. 00	Operating outlier	2. 01	О	0	0	О	0	3. 00
4. 00	reconciliation Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adj				0.00000			
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions)	22. 01	0	0	0	0	0	6. 01
	Indirect Medical Education Adj							
7. 00	IME payment adjustment factor (see instructions)	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	IME adjustment (see instructions)	28. 00	0	0	0	0	0	8. 00
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	0	0	0	0	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	О	0	0	0	0	9. 01
	Disproportionate Share Adjustm	ent						
10.00	Allowable disproportionate share percentage (see instructions)	33. 00	0. 0435	0. 0435	0. 0435	0. 0435		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	257, 607	0	199, 441	58, 166	257, 607	11. 00
11. 01	Uncompensated care payments	36.00	1, 550, 284	di cabargas	988, 424	561, 860	1, 550, 284	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment (see instructions)	rcentage of ESI 46.00	RD beneficiary 0	di scharges 0	0	0	0	12.00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	25, 788, 784 0	0	19, 728, 725 0	6, 060, 059 0	25, 788, 784 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	25, 788, 784	0	19, 728, 725	6, 060, 059	25, 788, 784	15. 00
16. 00	instructions) Payment for inpatient program capital (from Wkst. L, Pt. I,	50. 00	1, 958, 836	0	1, 514, 637	444, 199	1, 958, 836	16. 00
17. 00	if applicable) Special add-on payments for new technologies	54. 00	0	0	0	0	0	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 01 17. 02

	Financial Systems LUME CALCULATION EXHIBIT 4		GOOD SAMARITA	Provi der C		Period: From 01/01/2018 To 12/31/2018		t 4 pared:
				Title	XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2. 00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0			0 0	0	18. 00
19. 00	SUBTOTAL			0	21, 243, 36	2 6, 504, 258	27, 747, 620	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		1, 910, 545 0	l	1, 480, 30	8 430, 237 0 0	1, 910, 545 0	1
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	48, 291 0	0	34, 32	9 13, 962 0 0	48, 291 0	1
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0. 000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	_		0 0	0	
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0.0000	0.0000	0. 000	0.0000		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	0		0 0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	1, 958, 836	0	1, 514, 63	7 444, 199	1, 958, 836	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A)		0.00	4.00		
27.00	I am and and add a second	0	1. 00	2.00	3. 00 0. 00000	4. 00 0 0. 000000	5. 00	27.00
27. 00 28. 00	Low volume adjustment factor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	0	27. 00 28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				O	0	29. 00
100. 00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

From 01/01/2018 Part A Exhibit 5 Date/Time Prepared: 1/20/2020 10:18 am 12/31/2018 Hospi tal Title XVIII Period to Total (cols. Wkst. E, Pt. Amt. from Period on Wkst. E, Pt. 10/01 after 10/01 A. line 2 and 3) A) 0 1.00 2.00 3.00 4.00 1.00 DRG amounts other than outlier payments 1. 00 1.00 DRG amounts other than outlier payments for 1.01 1.01 18, 339, 364 18, 339, 364 18, 339, 364 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1 02 5.348.587 5.348.587 5.348.587 1.02 discharges occurring on or after October 1 DRG for Federal specific operating payment 1.03 1.03 0 1.03 for Model 4 BPCI occurring prior to October 1 04 DRG for Federal specific operating payment 1 04 0 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 292, 942 201, 496 91, 446 292, 942 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 0 2.01 **BPCI** 3.00 2.01 О 3.00 Operating outlier reconciliation 0 Managed care simulated payments 4.00 4.00 3.00 0 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 O 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0. 000000 7.00 IME payment adjustment factor (see 27.00 0.000000 0.000000 7.00 instructions) 28 00 8 00 IME adjustment (see instructions) 8 00 0 0 8.01 IME payment adjustment add on for managed 28. 01 0 0 0 8.01 care (see instructions) 9 00 Total IME payment (sum of lines 6 and 8) 29. 00 0 0 9.00 Total IME payment for managed care (sum of 29.01 0 0 9.01 9.01 0 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.0435 0.0435 0.0435 10.00 (see instructions) 11.00 Di sproporti onate share adjustment (see 34.00 257, 607 199.441 58. 166 257, 607 11.00 instructions) 11.01 Uncompensated care payments 36.00 1,550,284 988, 424 561,860 1, 550, 284 11.01 Additional payment for high percentage of ESRD beneficiary discharges Total ESRD additional payment (see 12.00 12.00 46.00 instructions) 13.00 Subtotal (see instructions) 47.00 25, 788, 784 19, 728, 725 6,060,059 25, 788, 784 13.00 Hospital specific payments (completed by SCH 48.00 14.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 25, 788, 784 15.00 49.00 25, 788, 784 19, 728, 725 6, 060, 059 15.00 (see instructions) 16,00 Payment for inpatient program capital (from 50.00 1, 958, 836 1, 514, 637 444.199 1, 958, 836 16.00

54 00

68. 00

93.00

17.00

17.01

18.00

0

0 17.02

0

27, 747, 620 19.00

0

0

21, 243, 362

0

6, 504, 258

17.00

17.01

17.02

19. 00 | SUBTOTAL

Wkst. L, Pt. I, if applicable)

Net organ acquisition cost

amount (see instructions)

Special add-on payments for new technologies

Credits received from manufacturers for

replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment

Health Financial Systems		GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) RE	DUCTION CALCULA	ATION EXHIBIT 5		F	Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 1/20/2020 10:	pared:
				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 outlie	r	1. 00	1, 910, 545	1, 480, 308	430, 237	1, 910, 545	20.00
20.01 Model 4 BPCI Capital DRG othe	r than outlier	1. 01	0	O	o	0	20. 01
21.00 Capital DRG outlier payments		2. 00	48, 291	34, 329	13, 962	48, 291	21.00
21.01 Model 4 BPCI Capital DRG outl	ier payments	2. 01	0	O	o	0	21. 01
22.00 Indirect medical education pe	rcentage (see	5. 00	0. 0000	0.0000	0. 0000		22. 00
23.00 Indirect medical education ad instructions)	ustment (see	6. 00	0	C	0	0	23. 00
24.00 Allowable disproportionate sh. (see instructions)	are percentage	10. 00	0. 0000	0.0000	0. 0000		24.00
25.00 Disproportionate share adjusti	ment (see	11. 00	0	О	0	0	25. 00
26.00 Total prospective capital payl instructions)	ments (see	12. 00	1, 958, 836	1, 514, 637	444, 199	1, 958, 836	26. 00
		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	o October 1	70. 96	0	0		0	28. 00
29.00 Low volume adjustment on or a	fter October 1	70. 97	0		0	0	29.00
30.00 HVBP payment adjustment (see	instructions)	70. 93	81, 498	78, 177	3, 321	81, 498	30.00
30.01 HVBP payment adjustment for H payment (see instructions)	SP bonus	70. 90	0	C	0	0	30. 01
31.00 HRR adjustment (see instruction	ons)	70. 94	-85, 964	-71, 523	-14, 441	-85, 964	31.00
31.01 HRR adjustment for HSP bonus instructions)	payment (see	70. 91	0	C	0	0	31. 01
						(Amt to	

1.00

(Amt. to Wkst. E, Pt.

2. 00 212, 500

3.00

64, 931

E, A) 4.00 277, 431

32. 00 100. 00

32.00 HAC Reduction Program adjustment (see instructions)
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part B Date/Time Prepared: 1/20/2020 10:18 am

			12/01/2010	1/20/2020 10:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			12, 009	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		29, 321, 967	2.00
3.00	OPPS payments			26, 490, 932	3.00
4.00	Outlier payment (see instructions)			121, 531	4.00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instru	ictions)		0. 000	
6.00	Line 2 times line 5	,		0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	
8. 00	Transitional corridor payment (see instructions)			0	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV col 13 line 200		121, 331	
10.00	Organ acquisitions	11, 601. 10, 11116 200		121,001	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			12, 009	
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			12,007	11.00
	Reasonable charges				
12. 00	Ancillary service charges			44, 186	12 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I	ino 60)		44, 180	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	1116 07)		44, 186	
14.00				44, 100	14.00
15. 00	Customary charges Aggregate amount actually collected from patients liable for	normant for convices on	a charge basis	0	15. 00
				0	
16. 00	Amounts that would have been realized from patients liable fo		on a chargebasis	U	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(Ratio of line 15 to line 16 (not to exceed 1.000000)	e)		0. 000000	17 00
17.00	,				
18.00	Total customary charges (see instructions)	I : € I : 10 I :	11) (44, 186	
19. 00	Excess of customary charges over reasonable cost (complete on	iry ii iine 18 exceeds ii	ne ii) (see	32, 177	19. 00
20.00	instructions)	lv if limo 11 ovecede li	no 10) (coo	0	20.00
20. 00	Excess of reasonable cost over customary charges (complete on	iry ir rine ir exceeds ir	ne 18) (See	0	20. 00
21 00	instructions)			12 000	21 00
21.00	Lesser of cost or charges (see instructions)			12, 009	
22. 00	Interns and residents (see instructions)			0	
23.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	23.00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			26, 733, 794	24. 00
05 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
25.00	Deductibles and coinsurance amounts (for CAH, see instruction	•		0	
26.00	Deductibles and Coinsurance amounts relating to amount on lin			5, 213, 235	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)	plus the sum of lines 22	2 and 23] (see	21, 532, 568	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, I			0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30.00	Subtotal (sum of lines 27 through 29)			21, 532, 568	•
31.00	Primary payer payments			1, 552	
32. 00	Subtotal (line 30 minus line 31)			21, 531, 016	32.00
00.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)		0	00.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
	Allowable bad debts (see instructions)			717, 410	•
35.00	Adjusted reimbursable bad debts (see instructions)			466, 317	•
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		523, 728	•
	Subtotal (see instructions)			21, 997, 333	
38. 00	MSP-LCC reconciliation amount from PS&R			-69	•
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	
39. 98	Partial or full credits received from manufacturers for repla	iced devices (see instruc	ctions)	2, 600	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40. 00	Subtotal (see instructions)			21, 997, 402	
40. 01	Sequestration adjustment (see instructions)			439, 948	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41. 00	Interim payments			21, 363, 847	41.00
42. 00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			193, 607	
44.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92.00	The rate used to calculate the Time Value of Money			0.00	92.00
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	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0042		Worksheet E
		Component CCN: 15-S042	From 01/01/2018 To 12/31/2018	Date/Time Prepared:
				1/20/2020 10:18 am
		Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der – I PF	PPS	
			IPF		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			99	1.00
2.00	Medical and other services reimbursed under OPPS (see instruc	tions)		177	2. 00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			456 0	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)			0	4.00
5. 00	Enter the hospital specific payment to cost ratio (see instru	ctions)		0. 000	5. 00
6. 00 7. 00	Line 2 times line 5			0 0. 00	6. 00 7. 00
7. 00 8. 00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt.	IV, col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0 99	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			99	11. 00
	Reasonabl e charges				
12.00		ino (0)		364	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, I Total reasonable charges (sum of lines 12 and 13)	The 69)		0 364	13. 00 14. 00
	Customary charges				
15.00	1 33 3			0	15.00
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(on a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	<i>-</i> ,		0. 000000	17. 00
18.00	Total customary charges (see instructions)	ly if line 10 eyesede li	no 11) (coo	364	18.00
19. 00	Excess of customary charges over reasonable cost (complete on instructions)	Ty IT TIME 18 exceeds IT	ne ii) (see	265	19. 00
20.00	Excess of reasonable cost over customary charges (complete on	ly if line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions)			99	21. 00
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			0	22.00
23. 00	Cost of physicians' services in a teaching hospital (see inst	ructi ons)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			456	24. 00
25. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Deductibles and coinsurance amounts (for CAH, see instruction	s)		0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on lin	e 24 (for CAH, see instr		0	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	plus the sum of lines 22	2 and 23] (see	555	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29)			555 0	30. 00 31. 00
	Primary payer payments Subtotal (line 30 minus line 31)			555	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVI	CES)			
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	33. 00 34. 00
	Adjusted reimbursable bad debts (see instructions)			0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		0	36.00
	Subtotal (see instructions)			555 0	
39. 00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.00
39. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration	and dovices (see instru	stions)	0	39. 97 39. 98
39. 98 39. 99	Partial or full credits received from manufacturers for repla RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instruc	trons)	0	39. 98 39. 99
40.00				555	
40. 01	Sequestration adjustment (see instructions)			11	40. 01
40. 02 41. 00	Demonstration payment adjustment amount after sequestration Interim payments			0 553	40. 02 41. 00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)	with ONC Dub 15 0		-9	43.00
44. 00	Protested amounts (nonallowable cost report items) in accorda §115.2	nce with CMS Pub. 15-2,	chapter I,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	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 0. 00	91. 00 92. 00
93.00				0	93.00
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: 15-0042		Worksheet E
	Component CCN: 15-T042	From 01/01/2018	
	component con. 13-1042	10 12/31/2010	1/20/2020 10: 18 am
	Title XVIII	Subprovi der -	PPS

	litte :	XVIII	Subprovider -	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			11 00	
1.00	Medical and other services (see instructions)			379	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			2, 233	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			1, 485 0	3. 00 4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	5.00
6.00	Line 2 times line 5			0	6.00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7.00
8.00	Transitional corridor payment (see instructions)	Line 200		0	8.00
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, Organ acquisitions	11 ne 200		51 0	9. 00 10. 00
11. 00				379	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES			Ţ	
	Reasonabl e charges				
12.00				1, 392	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			1, 392	14. 00
15. 00	3 0	services on	a charge basis	0	15. 00
16. 00				Ö	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00				0. 000000	
18.00	Total customary charges (see instructions)	2 avasada Li	no 11) (coo	1, 392	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 instructions)	s exceeds 11	ne II) (see	1, 013	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11	I exceeds Li	ne 18) (see	0	20.00
	instructions)		, (_	
21. 00	g ,			379	
22. 00	,			0	22.00
	Cost of physicians' services in a teaching hospital (see instructions)			1 524	23. 00 24. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			1, 536	24.00
25. 00				0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH	H, see instr	ructions)	193	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum	of lines 22	2 and 23] (see	1, 722	27. 00
20.00	instructions) Direct graduate modical advantion normanta (from What F 4 Line 50)			0	20.00
28. 00 29. 00				0	28. 00 29. 00
30.00				1, 722	
31.00	,			0	31.00
32.00				1, 722	32. 00
22.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			0	22.00
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	33. 00 34. 00
35. 00				0	35.00
	Allowable bad debts for dual eligible beneficiaries (see instructions)			Ö	36.00
37.00	Subtotal (see instructions)			1, 722	37.00
	MSP-LCC reconciliation amount from PS&R				38. 00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39. 50 39. 97
39. 98	Partial or full credits received from manufacturers for replaced devices ((see instru	ctions)	0	39. 98
39. 99	,	,500 111511 40	311 0113)	0	39. 99
40.00				1, 722	40.00
40. 01	Sequestration adjustment (see instructions)			34	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41. 00 42. 00				1, 673 0	41. 00 42. 00
42.00	,			15	
44. 00	, , , , , , , , , , , , , , , , , , , ,	Pub. 15-2.	chapter 1,	0	44.00
	§115. 2		<u> </u>		
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)				90.00
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 00	91. 00 92. 00
92.00	,			0.00	
	Total (sum of lines 91 and 93)				94.00
			'	'	•

Health Financial Systems G000
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10 GOOD SAMARITAN HOSPITAL Peri od: Worksheet E-1
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 1/20/2020 10: 18 am Provider CCN: 15-0042 Title XVIII Hospi tal

		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 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		24, 207, 452 0		20, 975, 367	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER	12/31/2018	197, 112	12/31/2018	456, 499	3. 01
3. 01	ADJUSTIMENTS TO PROVIDER	12/31/2010	197, 112	07/16/2018	29, 200	3. 01
3. 02			0	077 107 2016	24, 200	3. 02
3. 04			0			3. 04
3. 05			0			3. 05
0.00	Provider to Program		<u> </u>			0.00
3.50	ADJUSTMENTS TO PROGRAM	12/31/2018	72, 859	12/31/2018	97, 219	3.50
3. 51			0		0	3. 51
3. 52			0		0	3. 52
3. 53			0		0	3. 53
3.54			0		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		124, 253		388, 480	3. 99
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		24, 331, 705		21, 363, 847	4. 00
	TO BE COMPLETED BY CONTRACTOR	'	ļ		•	
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		0		0	5. 01
5. 02			0		0	5. 02
5. 03	Describing to Describe		0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	TENTALI VE TO TROURAW	1	0			5. 50
5. 51			0			5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		0		193, 607	6. 01
6. 02	SETTLEMENT TO PROGRAM		2, 841		0	6. 02
7. 00	Total Medicare program liability (see instructions)		24, 328, 864		21, 557, 454	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
		•	ı		. '	

Health Financial Systems	GOOD SA	AMARITAN HOSPITAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	R SERVICES RENDERED	Provi der CCN: 15-0042	Peri od: From 01/01/2018	Worksheet E-1
		Component CCN: 15-S042		
		Title XVIII	Subprovi der -	PPS

		Titl∈	e XVIII	Subprovi der -	PPS	18 am
		I npati er	nt Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 107, 333		553	1.00
2.00	Interim payments payable on individual bills, either		0	1	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 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					
	ADJUSTMENTS TO PROVIDER	12/31/2018	488		0	3. 01
3. 02			0		0	3. 02
3. 03					0	3. 03 3. 04
3. 04 3. 05						3.04
	Provider to Program				0	3.03
3. 50	ADJUSTMENTS TO PROGRAM				0	3. 50
3. 51	· · · · · · · · · · · · · · · · · · ·				o	3. 51
3. 52			0		0	3.52
3. 53			C		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		488		0	3. 99
4 00	3.50-3.98)		1 107 001		EEO	4. 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as		1, 107, 821		553	4.00
	appropriate)					
	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)					
5. 01	Program to Provider TENTATIVE TO PROVIDER				0	5. 01
5. 02	TENTATIVE TO PROVIDER					5. 01
5. 03						5. 02
	Provider to Program		_			
5. 50	TENTATI VE TO PROGRAM		C		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C		0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		7, 056		0	6. 01
	SETTLEMENT TO PROGRAM		0		9	6. 02
7. 00	Total Medicare program liability (see instructions)		1, 114, 877		544	7. 00
				Contractor	NPR Date	
			•	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		0	1. 00	2. 00	8. 00
0.00	Name of Contractor	I		1	ı l	0.00

Health Financial Systems	GOOD SAMARITAN	I HOSPITAL		In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR	SERVI CES RENDERED	Provider CCN: 15-		Peri od: From 01/01/2018	Worksheet E-1 Part I
		Component CCN: 15	5-T042	To 12/31/2018	Date/Time Prepared: 1/20/2020 10:18 am

		'			1/20/2020 10:	18 a
		Title	XVIII	Subprovi der - I RF	PPS	
		I npati en	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
	Total interim payments paid to provider		9, 032, 96	6	1, 682	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
ļ	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider	T	T			
01 02	ADJUSTMENTS TO PROVIDER			0	0 0	3
03				0		3
04				0		3
05				0	l ol	
Ì	Provider to Program					
	ADJUSTMENTS TO PROGRAM	12/31/2018	76, 02	7 12/31/2018	9	3
51				0	0	3
52				0	0	3
53 54				0		3
	Subtotal (sum of lines 3.01-3.49 minus sum of lines		-76, 02	-	-9	3
	3. 50-3. 98)		, 0, 02		[
00	Total interim payments (sum of lines 1, 2, and 3.99)		8, 956, 93	9	1, 673	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
-	appropriate) TO BE COMPLETED BY CONTRACTOR					ł
	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
	TENTATI VE TO PROVI DER			0	0	
)2				0	0	
	Provider to Program			O _I	0	"
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	
52				0	0	-
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on					6
	the cost report. (1)					0
01	SETTLEMENT TO PROVIDER		20, 18	1	15	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		8, 977, 12		1, 688	7
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
00	Name of Contractor		,	1.00	2.00	8

Heal th F	Financial Systems GOOD SAMAR	ITAN HOSPITAL	In Lie	u of Form CMS-	2552-10
CALCULAT				Worksheet E- Part II	1
			To 12/31/2018	Date/Time Pro 1/20/2020 10	
		Title XVIII	Hospi tal	PPS	
				1. 00	
TO	O BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR	TS			
	EALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL				
	Fotal hospital discharges as defined in AARA §4102 from '		e 14		1.00
4	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12			2.00
4	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4	Total inpatient days from S-3, Pt. I col. 8 sum of lines	· · · · · · · · · · · · · · · · · · ·			4.00
	Fotal hospital charges from Wkst C, Pt. I, col. 8 line 2				5.00
6. 00 T	Total hospital charity care charges from Wkst. S-10, col	. 3 line 20			6. 00
	CAH only - The reasonable cost incurred for the purchase	of certified HIT technology	Wkst. S-2, Pt. I		7. 00
4	ine 168 Calculation of the HIT incentive payment (see instructio	na)			8.00
	Sequestration adjustment amount (see instructions)	115)			9.00
1	•	tion (occ instructions)			
	Calculation of the HIT incentive payment after sequestra NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	tron (see mstructrons)			10.00
		`			30.00
	nitial/interim HIT payment adjustment (see instructions)			30.00
	Other Adjustment (specify)	and line 21) (see instruction	no)		
32. UU B	Balance due provider (line 8 (or line 10) minus line 30	and time 31) (see instruction	115)		32.00

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2	552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0042	Peri od: From 01/01/2018	Worksheet E-3	
	Component CCN: 15-S042			
	Title XVIII	Subprovi der -	PPS	
		I PF		

	IPF	_	
		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, 374, 457	1.00
2.00	Net IPF PPS Outlier Payments	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 November	0.00	4. 00
4. 01	15, 2004. (see instructions) Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
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 "ne	v 0.00	6.00
	teaching program" (see instuctions)		
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "ne' teaching program" (see instuctions)	N 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. 082192	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	
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, 374, 457	12.00
13. 00		0	13.00
14. 00	Organ acquisition (DO NOT USE THIS LINE)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16. 00		1, 374, 457	
17. 00		0	17.00
18.00	,	1, 374, 457	18.00
19.00		172, 812	
20.00		1, 201, 645	
21. 00		71, 690	
22. 00	· · · · · · · · · · · · · · · · · · ·	1, 129, 955	
23. 00		11, 094	
24.00		7, 211	24.00
25. 00	J	3, 194	
26.00		1, 137, 166	
27. 00		0	27. 00
28. 00 29. 00	Other pass through costs (see instructions)	464	28. 00 29. 00
30.00			30.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		30. 00
30. 50 30. 99	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration		30. 50
30. 99		1, 137, 630	
31.00	Total amount payable to the provider (see instructions) Sequestration adjustment (see instructions)	22, 753	
31.01		22, 753	31.01
31.02		1, 107, 821	31.02
32.00	Interim payments Tentative settlement (for contractor use only)	1, 107, 821	32.00
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	7, 056	34.00
35. 00		7,030	35. 00
33.00	§115. 2		33.00
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	GOOD SAMARITAN HO	OSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT				Worksheet E-3
			From 01/01/2018	Part III
		Component CCN: 15-T042	To 12/31/2018	Date/Time Prepared:
		·		1/20/2020 10:18 am
		Title XVIII	Subprovi der -	PPS
			LRF	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1. 00	Net Federal PPS Payment (see instructions)	8, 913, 465	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0209	2.00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	111, 418	3.00
4. 00	Outlier Payments	240, 019	4.00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 01
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 new program growth 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 new program growth period of a "new teaching program" (see instructions)	0.00	8. 00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9.00
10.00	Average Daily Census (see instructions)	20. 065753	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	9, 264, 902	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15. 00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	9, 264, 902	
18. 00	Pri mary payer payments	0	18.00
19. 00	Subtotal (line 17 less line 18).	9, 264, 902	19.00
20.00		112, 347	20.00
21. 00	Subtotal (line 19 minus line 20)	9, 152, 555	21.00
22.00	Coi nsurance	19, 765	22.00
23. 00	Subtotal (line 21 minus line 22)	9, 132, 790	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	32, 441	24.00
25. 00	Adjusted reimbursable bad debts (see instructions)	21, 087	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	27, 609	26.00
27.00	Subtotal (sum of lines 23 and 25)	9, 153, 877	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28. 00
29. 00	Other pass through costs (see instructions)	6, 450	
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32. 00	Total amount payable to the provider (see instructions)	9, 160, 327	32.00
32. 01	Sequestration adjustment (see instructions)	183, 207	32. 01
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33.00	Interim payments	8, 956, 939	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, 32.02, 33, and 34)	20, 181	35.00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36. 00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	240, 019	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0. 00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

Heal th Financial	Systems	GOOD SAMARITAN HOSE	PI TAL	In Li	eu of Form CMS-2552-10
CALCULATION OF RE	ELMBURSEMENT SETTLEMENT	Pro	ovider CCN: 15-004	From 01/01/201	Worksheet E-3 B Part VII B Date/Time Prepared:

			0 12/31/2018	1/20/2020 10:	
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SEI	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		520, 126		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		o		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		520, 126	0	4.00
5.00	Inpatient primary payer payments		o		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		520, 126	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable Charges]
8.00	Routine service charges		422, 097		8.00
9.00	Ancillary service charges		1, 423, 669	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		1, 845, 766	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment fo	r services on a charge	0	0	13.00
	basis				
14. 00	Amounts that would have been realized from patients liable fo	1 3	0	0	14.00
	a charge basis had such payment been made in accordance with	42 CFR §413.13(e)			
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0. 000000	1
16.00	Total customary charges (see instructions)		1, 845, 766	0	
17. 00	1	ly if line 16 exceeds	1, 325, 640	0	17.00
10.00	line 4) (see instructions)	l ! & ! == 4 =====	0	0	10.00
18. 00	Excess of reasonable cost over customary charges (complete on	Ty IT Time 4 exceeds Time	U	0	18. 00
19. 00	16) (see instructions) Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)	0	0	
	Cost of covered services (enter the lesser of line 4 or line		520, 126	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22 00	Other than outlier payments	compreted for 113 provid	0	0	22. 00
	Outlier payments		0	0	
	Program capital payments		o	Ü	24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		o	0	1
27. 00			o	0	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	1
29. 00	Titles V or XIX (sum of lines 21 and 27)		520, 126	0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				1
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	520, 126	0	31.00
32.00	Deducti bl es		0	0	32.00
33.00	Coi nsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	520, 126	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38. 00	Subtotal (line 36 ± line 37)		520, 126	0	
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		520, 126	0	
41.00	Interim payments		845, 933	0	
42.00	Balance due provider/program (line 40 minus line 41)		-325, 807	0	
43.00	Protested amounts (nonallowable cost report items) in accorda	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2		1		I

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Peri od: From 01/01/2018	Worksheet E-3
	Component CCN: 15-S042		Date/Time Prepared: 1/20/2020 10:18 am
	Title XIX	Subprovi der -	Cost
		l PF	

	THE MA	,	I PF	0031	
		<u> </u>	Inpatient	Outpati ent	
			1.00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES	S V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpati ent hospital/SNF/NF services		214, 539		1.00
2. 00	Medical and other services		, , , , , , , , , , , , , , , , , , , ,	0	
3.00	Organ acquisition (certified transplant centers only)		ol		3.00
4. 00	Subtotal (sum of lines 1, 2 and 3)		214, 539	0	1
5. 00	Inpatient primary payer payments		o		5.00
6.00	Outpatient primary payer payments			0	1
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		214, 539	0	
	COMPUTATION OF LESSER OF COST OR CHARGES		, , , , ,		
	Reasonable Charges				1
8.00	Routi ne servi ce charges		356, 953		8.00
9.00	Ancillary service charges		77, 107	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		o		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		434, 060	0	12.00
	CUSTOMARY CHARGES		<u> </u>		
13.00	Amount actually collected from patients liable for payment for services on a	charge	0	0	13.00
	basis	Ü			
14.00	Amounts that would have been realized from patients liable for payment for se	rvi ces or	o o	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		434, 060	0	16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 ex	ceeds	219, 521	0	17.00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exc	eeds line	0	0	18. 00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00			0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		214, 539	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for Pl	PS provic			
	Other than outlier payments		0	0	
	Outlier payments		0	0	
	Program capital payments		0		24. 00
	Capital exception payments (see instructions)		0		25. 00
26. 00			0	0	
	Subtotal (sum of lines 22 through 26)		0	0	
28. 00			0	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)		214, 539	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		1		
30. 00	Excess of reasonable cost (from line 18)		0	0	
31.00			214, 539	0	
32. 00			0	0	
	Coinsurance		0	0	
34. 00	·		0	0	
			0		35.00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		214, 539	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		014 500	0	
38.00			214, 539	0	
39. 00			0	_	39.00
	Total amount payable to the provider (sum of lines 38 and 39)		214, 539	0	
41. 00			170, 343	0	
42.00	Balance due provider/program (line 40 minus line 41)	15.0	44, 196	0	
43. 00		15-2,	0	0	43. 00
	chapter 1, §115.2				I

Health Financial Systems	GOOD SAMARITAN HOSPITAL	In Lie	u of Form CMS-2	552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0042	Peri od: From 01/01/2018	Worksheet E-3	
	Component CCN: 15-T042			
	Title XIX	Subprovi der -	Cost	
		I RF		
		Innotiont	Outnot: ont	

		I RF		
		I npati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR	XIX SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES	•		
	Reasonable Charges			
8.00	Routine service charges	0		8.00
9. 00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11. 00	Incentive from target amount computation	0		11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)	0		12.00
12.00	CUSTOMARY CHARGES	, , ,		12.00
13. 00	Amount actually collected from patients liable for payment for services on a charge	0	0	13. 00
13.00	basis		0	13.00
14. 00	Amounts that would have been realized from patients liable for payment for services	on 0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	011	0	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0. 000000	15. 00
16. 00		0.000000		16.00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	0	_	17. 00
17.00	line 4) (see instructions)	0	U	17.00
18. 00		ne 0	0	18. 00
16.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds li 16) (see instructions)	TIE U	U	16.00
19. 00	Interns and Residents (see instructions)	0	0	19. 00
		0	_	20.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)			
21. 00		0	U	21. 00
22 00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS prov			22.00
	Other than outlier payments	0		22.00
23.00		0		23.00
24.00		0		24.00
25.00		0		25. 00
26.00	Routine and Ancillary service other pass through costs	0	_	26.00
27. 00	Subtotal (sum of lines 22 through 26)	0		27. 00
28. 00	J 3 1	0		28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	0	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0		30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	_	31.00
32.00	Deducti bl es	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)	0		38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0	_	39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0		40. 00
41. 00		0	_	41.00
42. 00	Balance due provider/program (line 40 minus line 41)	0		42.00
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0		43.00
45.00	chapter 1, §115.2			45.00
	Chapter 1, 3110.2	l .	I	

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

Provi der CCN: 15-0042

Peri od: Worksheet G
From 01/01/2018
To 12/31/2018 Date/Time Prepared: 1/20/2020 10:18 am

——————————————————————————————————————					1/20/2020 10:	18 am_
		General Fund	Speci fi c	Endowment	Plant Fund	
		1 00	Purpose Fund	Fund	4.00	
	CURRENT ASSETS	1.00	2.00	3. 00	4. 00	
1. 00	Cash on hand in banks	26, 116, 732	0	0	0	1.00
2. 00	Temporary investments	0	Ö	Ö	0	
3.00	Notes receivable	0	0	0	0	1
4.00	Accounts recei vable	86, 803, 328	0	0	0	4.00
5.00	Other recei vabl e	3, 567, 372	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable			0	0	
7. 00	Inventory	2, 262, 980		0	0	
8.00	Prepai d expenses	3, 999, 245		0	0	
9. 00 10. 00	Other current assets Due from other funds	96, 036		0	0	
11. 00	Total current assets (sum of lines 1-10)	69, 875, 704		ol O	0	
11.00	FIXED ASSETS	07,073,704	١	<u> </u>		11.00
12.00	Land	6, 781, 448	0	0	0	12.00
13.00	Land improvements	4, 687, 184		0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15. 00	Bui I di ngs	161, 037, 809		0	0	1
16.00	Accumulated depreciation	-66, 349, 557		0	0	
17. 00	Leasehold improvements	862, 950		0	0	
18.00	Accumulated depreciation	0	-	0	0	
19. 00 20. 00	Fixed equipment Accumulated depreciation		0	0	0	19. 00 20. 00
21. 00	Automobiles and trucks		0	0	0	21.00
22. 00	Accumulated depreciation			0	0	22.00
	Major movable equipment	217, 206, 153	- 1	Ö	0	1
24. 00	Accumulated depreciation	-136, 563, 781		0	0	1
25.00	Mi nor equi pmen't depreci abl e	0	0	0	0	1
26.00	Accumulated depreciation	0	0	0	0	
27. 00	HIT designated Assets	0	0	0	0	
28. 00	Accumulated depreciation	0	0	0	0	
29. 00	Mi nor equi pment-nondepreci abl e	107 ((2 20)	0	0	0	29.00
30. 00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	187, 662, 206	0	0	0	30.00
31. 00	Investments	41, 857, 447	0	0	0	31.00
32. 00	Deposits on Leases	0	Ö	o	0	
33. 00	Due from owners/officers	0	0	0	0	
34.00	Other assets	735, 598	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	42, 593, 045		0	0	
36. 00	Total assets (sum of lines 11, 30, and 35)	300, 130, 955	0	0	0	36. 00
27.00	CURRENT LI ABI LI TI ES	2 250 041		ما	0	27.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	3, 250, 041 2, 533, 090		0	0	1
39. 00	Payroll taxes payable	11, 003, 946		0	0	1
40. 00	Notes and Loans payable (short term)	2, 567, 666		0	0	
41. 00	Deferred income	1, 127, 801		o	0	1
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	1, 816, 618		0	0	1
45. 00	Total current liabilities (sum of lines 37 thru 44)	22, 299, 162	0	0	0	45. 00
47 00	LONG TERM LIABILITIES	111 004 227				47.00
46. 00 47. 00	Mortgage payable Notes payable	111, 984, 227	0	0	0	1
48.00	Unsecured Loans			0	0	
49. 00	Other long term liabilities			0	0	1
50. 00	Total long term liabilities (sum of lines 46 thru 49)	111, 984, 227		Ö	0	
51.00	Total liabilities (sum of lines 45 and 50)	134, 283, 389		0	0	
	CAPITAL ACCOUNTS					
52.00	General fund balance	165, 847, 566				52.00
53. 00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			٩	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				Ü	
59. 00	Total fund balances (sum of lines 52 thru 58)	165, 847, 566	О	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	300, 130, 955	0	0	0	60.00
	[59]	I				l

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Peri od: Worksheet G-1
From 01/01/2018 Date/Time Prep Provi der CCN: 15-0042

					To	12/31/2018	Date/Time Pro	epared: 18 am
		General	Fund	Speci al	Pui	rpose Fund	Endowment Fund	
		1.00	2. 00	3.00		4. 00	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0 0 0 0	177, 301, 758 -11, 454, 191 165, 847, 567		0 0 0 0 0	0	((5. 00 6. 00 7. 00 8. 00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 165, 847, 567 0 165, 847, 567		0 0 0 0	0 0	()	13.00 14.00 15.00 16.00
		Endowment Fund	PI ant	Fund				
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9)	6.00	7.00 0 0 0 0		0			1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0 0 0 0 0		0 0			11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0042

		10	0 12/31/2018	Date/lime Pre 1/20/2020 10:	
	Cost Center Description	I npati ent	Outpati ent	Total	
	······································	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>	•		
	General Inpatient Routine Services				
1.00	Hospi tal	27, 952, 694		27, 952, 694	1.00
2.00	SUBPROVI DER - I PF	8, 036, 814		8, 036, 814	2.00
3. 00	SUBPROVIDER - IRF	7, 995, 044		7, 995, 044	3. 00
4. 00	SUBPROVI DER	1,112,211		.,,	4. 00
5. 00	Swing bed - SNF	0		0	5. 00
6. 00	Swing bed - NF			0	6. 00
7. 00	SKILLED NURSING FACILITY			J.	7. 00
8. 00	NURSING FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	43, 984, 552		43, 984, 552	10.00
10.00	Intensive Care Type Inpatient Hospital Services	1 43, 704, 332		43, 704, 332	10.00
11. 00	INTENSIVE CARE UNIT	18, 525, 338		18, 525, 338	11. 00
12. 00	CORONARY CARE UNIT	10, 323, 330		10, 323, 330	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGI CAL I NTENSI 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 line	s 18, 525, 338		18, 525, 338	16.00
10.00	111-15)	5 16, 525, 536		10, 525, 550	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	62, 509, 890		62, 509, 890	17. 00
18. 00	Ancillary services	144, 460, 402	307, 116, 399	451, 576, 801	18.00
19. 00	Outpatient services	12, 555, 595	54, 638, 999	67, 194, 594	
20. 00	RURAL HEALTH CLINIC	12, 555, 595	54, 638, 999	07, 194, 594	20.00
20.00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	20.00
		0	0	0	
22. 00	HOME HEALTH AGENCY		U	U	22.00
23. 00	AMBULANCE SERVICES				23.00
24. 00	CMHC				24.00
25. 00	AMBULATORY SURGI CAL CENTER (D. P.)		0 507 (54	0 540 / 45	25.00
26. 00	HOSPI CE	4, 994	3, 507, 651	3, 512, 645	26. 00
27. 00	COMMUNITY MENTAL HEALTH CENTER	99, 262	9, 545, 475	9, 644, 737	27. 00
27. 01	DME	0	560, 220	560, 220	27. 01
27. 02	MH RESI DENTI AL	0	236, 110	236, 110	27. 02
27. 03	PHYSI CI AN FEES	8, 110, 301	66, 014, 669	74, 124, 970	27. 03
27. 04	PROFESSI ONAL FEES		10, 230, 635	10, 230, 635	27. 04
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to W	kst. 227, 740, 444	451, 850, 158	679, 590, 602	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES		0.15 000 000		
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		245, 338, 300		29. 00
30.00	ADD (SPECIFY)	0			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)		0		36.00
37. 00	DEDUCT (SPECIFY)	0			37.00
38. 00		0			38.00
39. 00		0			39.00
40.00		0			40.00
41. 00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr	ansfer	245, 338, 300		43.00
	to Wkst. G-3, line 4)				

	_	ARITAN HOSPITAL	_	u of Form CMS-2	
STATE	IENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0042	Peri od:	Worksheet G-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
				1/20/2020 10:	18 am
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column	1 3 line 28)		679, 590, 602	1.00
2.00	Less contractual allowances and discounts on patients'			455, 968, 611	1
3.00	Net patient revenues (line 1 minus line 2)	a000 a to		223, 621, 991	
4. 00	Less total operating expenses (from Wkst. G-2, Part II	. line 43)		245, 338, 300	1
5.00	Net income from service to patients (line 3 minus line			-21, 716, 309	1
	OTHER I NCOME				1
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7.00
8.00	Revenues from telephone and other miscellaneous commur	nication services		0	8.00
9.00	Revenue from television and radio service		0	9.00	
10.00					10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15.00
16.00	Revenue from sale of medical and surgical supplies to	other than patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
		1		0	
21. 00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			3, 543, 983	23.00
24.00	OTHER REVENUE			2, 952, 973	24.00
24. 01	INVESTMENT INCOME			-755, 757	
24. 02				0	24. 02
24. 03	OTHER NONOPERATING			1, 072, 643	24. 03
	INTERCOMPANY TRANSFERS			2, 825, 013	1
	DI ETARY REVENUE			622, 663	1
24. 06	PSYCH REVENUE			0	
24 07	ADMI N			600	24 07

600

-11, 454, 191 29. 00

18 | 25.00 91 | 26.00 0 | 27.00

0 28.00

10, 262, 118 -11, 454, 191

24. 07 | ADMI N

25.00 Total other income (sum of lines 6-24) 26.00 Total (line 5 plus line 25) 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)

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68.00

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70.00

100.00 TOTAL

PALLIATIVE CARE PROGRAM*

OTHER PHYSICIAN SERVICES*

TELEHEALTH/TELEMONI TORI NG*

71.00 OTHER NONREIMBURSABLE (SPECIFY)*

NURSING FACILITY ROOM & BOARD*

RESIDENTIAL CARE*

ADVERTI SI NG*

THRIFT STORE*

^{*} Transfer the amounts in column 7 to Wkst. O-5, column 1, line as appropriate.

 $[\]ensuremath{^{**}}$ See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

				Hospi ce I	17 207 2020 10: 10 dill
		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
	OFFICE AND ADDRESS OF A SENTENCE	6. 00	7. 00		
4 00	GENERAL SERVICE COST CENTERS				1.00
1.00	CAP REL COSTS-BLDG & FIXT*	0			1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0			2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0			3.00
4.00	ADMI NI STRATI VE & GENERAL*	-66			4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	3, 580		5.00
6. 00	LAUNDRY & LINEN SERVICE*	0	0		6.00
7. 00	HOUSEKEEPI NG*	0	0		7.00
8. 00	DI ETARY*	0	0		8.00
9. 00	NURSI NG ADMI NI STRATI ON*	0	0		9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0			10.00
11. 00	MEDI CAL RECORDS*	0	1		11.00
12. 00	STAFF TRANSPORTATION*	0	•		12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	0		13.00
14. 00	PHARMACY*	0	432		14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	1		15. 00
16. 00	OTHER GENERAL SERVI CE*	0	0		16.00
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES				17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25. 00	I NPATI ENT CARE-CONTRACTED**	0			25. 00
26. 00	PHYSI CI AN SERVI CES**	0			26. 00
27. 00	NURSE PRACTITIONER**	0	375		27. 00
28. 00	REGI STERED NURSE**	0	233, 441		28. 00
29. 00	LPN/LVN**	0	0		29. 00
30.00	PHYSI CAL THERAPY**	0	0		30.00
31.00	OCCUPATIONAL THERAPY**	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES**	0	112, 400		33.00
34.00	SPIRITUAL COUNSELING**	0	0		34.00
35.00	DI ETARY COUNSELI NG**	0	0		35.00
36.00	COUNSELING - OTHER**	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	77, 132		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0		38.00
39.00	PATI ENT TRANSPORTATI ON**	0	0		39.00
40.00	I MAGING SERVICES**	0	0		40.00
41.00	LABS & DI AGNOSTI CS**	0	0		41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0		42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0		42. 50
43.00	OUTPATIENT SERVICES**	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0		44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY) **	0	74, 645		46.00
	NONREI MBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0		60.00
61.00	VOLUNTEER PROGRAM *	0	0		61.00
62.00	FUNDRAI SI NG*	0	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0		64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0		65.00
66.00	RESI DENTI AL CARE*	0	0		66.00
67.00	ADVERTI SI NG*	0	0		67. 00
68.00	TELEHEALTH/TELEMONI TORI NG*	0	0		68. 00
69.00	THRI FT STORE*	0	0		69. 00
70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0		71.00
100.00	TOTAL	-66	1, 056, 830		100.00
- T	efor the amounts in column 7 to Wket 0-5 co	Jump 1 line a	s annronri ata		

^{*} Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

		SALARIES	UTHER	SUBTUTAL	RECLASSIFI -	SUBTUTAL	
				(col . 1 +	CATI ONS		
		1. 00	2.00	col. 2) 3.00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	1.00	2.00	5.00	4.00	3.00	
25. 00	I NPATI ENT CARE-CONTRACTED						25.00
26. 00	PHYSI CI AN SERVI CES	12, 743	3, 660	16, 403	0	16, 403	
27. 00	NURSE PRACTITIONER	268	77	345	0	345	1
28. 00	REGISTERED NURSE	166, 908	47, 938		0	214, 846	
29. 00	LPN/LVN	0	0	0	0	0	1
30.00	PHYSI CAL THERAPY	o	0	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	o	o	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	O	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	80, 365	23, 082	103, 447	0	103, 447	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG	O	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	55, 148	15, 839	70, 987	0	70, 987	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATI ENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	I MAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
	OUTPATI ENT SERVI CES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45.00
	OTHER PATIENT CARE SERVICES (SPECIFY)	53, 370	15, 329		0	68, 699	1
100.00	TOTAL *	368, 802	105, 925	474, 727	0	474, 727	100.00
* Tran	sfer the amount in column 7 to Wkst 0-5 col	umn 1 line 51					

 $^{^{\}star}$ Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6. 00	7. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25.00	INPATIENT CARE-CONTRACTED			25. 00
26.00	PHYSI CI AN SERVI CES	0	16, 403	26.00
27.00	NURSE PRACTITIONER	0	345	27. 00
28.00	REGI STERED NURSE	0	214, 846	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	103, 447	33.00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	70, 987	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATI ENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0	42. 50
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	68, 699	46.00
100.00	TOTAL *	0	474, 727	100.00

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

Hool +b	Financial Systems	GOOD SAMARITAN	LUCCDITAL		Inlio	u of Form CMS-2	neen 10
	Financial Systems IS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPIC		Provider CC	N. 1E 0042	Peri od:	Worksheet 0-3	
RESPI T		LE INPAILENT	Provider CC		From 01/01/2018		
KLJFII	L CARL		Hospi ce CCN		To 12/31/2018	Date/Time Pre	pared:
						1/20/2020 10:	<u>18 am</u>
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSIFI -	SUBTOTAL	
				(col . 1 +	CATI ONS		
		1.00	0.00	col . 2)	4.00	F 00	
	DI DECT. DATIENT CADE CEDVI OF COCT OFNITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
	DI RECT PATIENT CARE SERVICE COST CENTERS		ما				05 00
25. 00	I NPATI ENT CARE-CONTRACTED	100	0	10	0	0	
26.00	PHYSI CI AN SERVI CES	102	29	13	0	131	26.00
	NURSE PRACTITIONER	4 224	1	4 70	3 0	3	27.00
	REGI STERED NURSE	1, 336	384	1, 72	0	1, 720	1
29. 00	LPN/LVN	0	0		0	0	29.00
	PHYSI CAL THERAPY	0	0		0	0	30.00
	OCCUPATI ONAL THERAPY	0	0		0	0	31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0	0.0	0	0	32.00
	MEDICAL SOCIAL SERVICES	643	185	82	8 0	828	
	SPIRITUAL COUNSELING	0	0		0	0	34.00
	DI ETARY COUNSELI NG	0	0		0	0	35.00
36.00	COUNSELING - OTHER	0	0		0	0	36.00
	HOSPICE AIDE & HOMEMAKER SERVICES	442	127	56	9 0	569	37.00
	DURABLE MEDI CAL EQUI PMENT/OXYGEN	0	0		0	0	38. 00
	PATI ENT TRANSPORTATI ON	0	0		0	0	39.00
40.00	I MAGI NG SERVI CES	0	0		0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0		0	0	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0		0	0	42.00
42. 50	DRUGS CHARGED TO PATIENTS	0	0		0	0	42. 50

0

0

123

849

0 0 0

550

0 43.00 0 44.00

0 45.00

550 46.00

3, 801 100. 00

43.00 OUTPATIENT SERVICES
44.00 PALLIATIVE RADIATION THERAPY

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

45. 00 PALLIATIVE CHEMOTHERAPY

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col . 6) 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	_
25. 00	I NPATI ENT CARE-CONTRACTED	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES	0	131	26. 00
27. 00	NURSE PRACTITIONER		3	27. 00
28. 00	REGI STERED NURSE	0	1, 720	28. 00
29. 00	LPN/LVN	0	0,720	29. 00
30.00	PHYSI CAL THERAPY	0	o	30.00
31. 00	OCCUPATIONAL THERAPY	0	o	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33. 00	MEDICAL SOCIAL SERVICES	0	828	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	569	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	550	46. 00
100.00	TOTAL *	0	3, 801	100.00

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

^{100.00|}TOTAL * 2,952|
* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Hool +h	Financial Systems	GOOD SAMARITA	N HOSDITAL		In Lie	u of Form CMS-2	neen 10
	Financial Systems		Provider CO	N. 15 0040	Peri od:	Worksheet 0-4	
ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL INPATIENT CARE			Provider CC	JN: 15-0042	From 01/01/2018 Worksheet 0-4		
INPAII	ENT CARE		Hospi ce CCN	N: 15-1526	To 12/31/2018		pared:
			'			1/20/2020 10:	
					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL	RECLASSI FI -	SUBTOTAL	
				(col. 1 +	CATI ONS		
				col. 2)			
		1. 00	2. 00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS				-T		
25. 00	I NPATI ENT CARE-CONTRACTED		0		0 0	0	20.00
26. 00	PHYSI CI AN SERVI CES	1, 001	287	1, 28		1, 288	
	NURSE PRACTITIONER	21	6		27 0	27	27. 00
28. 00	REGI STERED NURSE	13, 110	3, 765	16, 87	75 0	16, 875	
29. 00	LPN/LVN	0	0		0	0	
30.00	PHYSI CAL THERAPY	0	0		0	0	30.00
31. 00	OCCUPATI ONAL THERAPY	0	0		0	0	31.00
	SPEECH/LANGUAGE PATHOLOGY	0	0		0	0	02.00
	MEDICAL SOCIAL SERVICES	6, 312	1, 813	8, 12	25 0	8, 125	
	SPI RI TUAL COUNSELI NG	0	0		0	0	
	DI ETARY COUNSELI NG	0	0		0	0	00.00
36. 00	COUNSELING - OTHER	0	0		0	0	00.00
	HOSPICE AIDE & HOMEMAKER SERVICES	4, 332	1, 244	5, 57	76 0	5, 576	
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0		0	0	38.00
39. 00	PATI ENT TRANSPORTATION	0	0		0	0	39.00
40.00	I MAGING SERVICES	0	0		0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0		0 0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	42.50
43.00	OUTPATIENT SERVICES	0	0		0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0		0	0	44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	0		0	0	45. 00

5, 396 46. 00 37, 287 100. 00

46.00 OTHER PATIENT CARE SERVICES (SPECIFY)

		ADJUSTMENTS	TOTAL (col. 5	
		6. 00	± col . 6) 7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	_
25. 00	I NPATI ENT CARE-CONTRACTED		0	25. 00
26. 00	PHYSI CI AN SERVI CES		1, 288	26.00
27. 00	NURSE PRACTITIONER		27	27. 00
28. 00	REGI STERED NURSE		16, 875	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATIONAL THERAPY	0	0	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	o	32.00
33. 00	MEDICAL SOCIAL SERVICES	0	8, 125	33. 00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DI ETARY COUNSELI NG	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	5, 576	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	I MAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDI CAL SUPPLI ES-NON-ROUTI NE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	5, 396	46.00
100.00	TOTAL *	0	37, 287	100.00

1, 204

8, 319

5, 396

^{100.00} TOTAL * 28, 968 * Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

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

Health Financial Systems	GOOD SAMARITAN	I HOSPITAL		In Lie	u of Form CMS-2	552-
COST ALLOCATION - DETERMINATION OF HOS EXPENSES FOR ALLOCATION	PITAL-BASED HOSPICE NET	Provi der Co		Peri od: From 01/01/2018	Worksheet 0-5	
EN ENGES FOR ALLOGATION		Hospi ce CCI	N: 15-1526	To 12/31/2018	Date/Time Prep 1/20/2020 10:	oared 18 an
				Hospi ce I		
Descri pti ons			HOSPI CE	GENERAL	TOTAL	
			DI RECT		EXPENSES (sum	
			EXPENSES (see	EXPENSES FROM	of cols. 1 +	
			instructions)	WKST B PART I	2)	
				(see		
				instructions)		
			1.00	2.00	3. 00	
GENERAL SERVICE COST CENTERS						
OAR REL COOTO RURO & FLVT					444 440	-

	Descriptions Descriptions	HOSPI CE	GENERAL	TOTAL	
		DI RECT	SERVI CE	EXPENSES (sum	
		EXPENSES (see	EXPENSES FROM	of cols. 1 +	
		instructions)	WKST B PART I	2)	
			(see		
			instructions)		
		1. 00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	0	116, 419	116, 419	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	100	100	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	187, 577	187, 577	3.00
4.00	ADMINISTRATIVE & GENERAL	533, 344	166, 162	699, 506	4.00
5.00	PLANT OPERATION & MAINTENANCE	3, 580	68, 482	72, 062	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPI NG	0	46, 641	46, 641	7.00
8. 00	DIETARY	0	0	0	8.00
9. 00	NURSI NG ADMI NI STRATI ON	0	70, 576	70, 576	9.00
10.00	ROUTINE MEDICAL SUPPLIES	3, 659	701	4, 360	10.00
11.00	MEDICAL RECORDS	0	0	0	11.00
12.00	STAFF TRANSPORTATION	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0	13.00
14.00	PHARMACY	432	128	560	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0	15. 00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATI ENT/RESI DENTI AL CARE SERVI CES		0	0	17. 00
	LEVEL OF CARE	•			
50.00	HOSPICE CONTINUOUS HOME CARE	0		0	50.00
51.00	HOSPICE ROUTINE HOME CARE	474, 727		474, 727	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	3, 801		3, 801	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	37, 287		37, 287	53.00
	NONREI MBURSABLE COST CENTERS		<u>'</u>	·	
60.00	BEREAVEMENT PROGRAM	0		0	60.00
61.00	VOLUNTEER PROGRAM	l o		0	61.00
62.00	FUNDRAI SI NG	l 0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	l 0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0	64.00
	OTHER PHYSICIAN SERVICES	0		0	65.00
66. 00	RESI DENTI AL CARE	0		0	66.00
	ADVERTI SI NG	1 0		Ö	67.00
	TELEHEALTH/TELEMONI TORI NG	1 0		0	68.00
	THRI FT STORE	l		0	69.00
	NURSING FACILITY ROOM & BOARD	l		0	70.00
	OTHER NONREIMBURSABLE (SPECIFY)			0	71.00
	NEGATI VE COST CENTER			0	99.00
100.00		1, 056, 830	656, 786	_	
100.00	TO THE	1, 000, 000	030, 700	1, 713, 010	1.00.00

Health FinancialSystemsGOOD SAMARITAN HOSPITALCOST ALLOCATION - HOSPITAL-BASED HOSPICE GENERALSERVICE COSTSProvider In Lieu of Form CMS-2552-10 Peri od: Worksheet 0-6
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 1/20/2020 10: 18 am Provider CCN: 15-0042 Hospi ce CCN: 15-1526 Hospi ce I

					Hospi ce I		
	Descriptions	TOTAL	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	SUBTOTAL	
		EXPENSES	& FIX	EQUI P	BENEFITS		
					DEPARTMENT		
		0	1. 00	2.00	3. 00	3A	
	GENERAL SERVICE COST CENTERS				'		
1.00	CAP REL COSTS-BLDG & FIXT	116, 419	116, 419				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	100		100			2.00
3. 00	EMPLOYEE BENEFITS DEPARTMENT	187, 577	0	0	187, 577		3. 00
4.00	ADMINISTRATIVE & GENERAL	699, 506	0	0	0	699, 506	4.00
5. 00	PLANT OPERATION & MAINTENANCE	72, 062	0	0	0	72, 062	5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6. 00
7. 00	HOUSEKEEPI NG	46, 641	0	l o	0	46, 641	7. 00
8. 00	DI ETARY	0	0	ا	0	0	8.00
9. 00	NURSI NG ADMI NI STRATI ON	70, 576	0	Ĭ	o o	70, 576	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	4, 360	0	Ĭ	o o	4, 360	10.00
11. 00	MEDI CAL RECORDS	1, 000	0	Ĭ	o o	0	11.00
12. 00	STAFF TRANSPORTATION	0	0		0	0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION		0		0	0	13.00
14. 00	PHARMACY	560	0		0	560	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	300	0		0	0	15.00
16. 00	OTHER GENERAL SERVICES	0	0		0	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		۷	0	17.00
17.00	LEVEL OF CARE			<u> </u>		0	17.00
50. 00	HOSPICE CONTINUOUS HOME CARE	0			0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	474, 727			172, 634	647, 361	51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	3, 801	11, 540	10	1, 383	16, 734	52.00
53. 00	HOSPICE GENERAL INPATIENT CARE	37, 287	104, 879		13, 560	155, 816	53.00
33.00	NONREI MBURSABLE COST CENTERS	37, 207	104, 077	70	13, 300	133, 010	33.00
60. 00	BEREAVEMENT PROGRAM	1 0	0	0	0	0	60.00
61. 00	VOLUNTEER PROGRAM	0	0		o o	0	61.00
62. 00	FUNDRAI SI NG	0	0	j o	o o	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	i o	ĺ	Ĭ	o l	0	63.00
64. 00	PALLIATIVE CARE PROGRAM	0	0			0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0	0			0	65.00
66. 00	RESI DENTI AL CARE	0	0			0	66.00
67. 00	ADVERTI SI NG	0	0			0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0	0		0	0	68.00
69. 00	THRIFT STORE	0			0	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD	0		١	٥	0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		_			0	70.00
99. 00	NEGATI VE COST CENTER				0	U	99.00
	TOTAL	1, 713, 616	116, 419	100	187, 577	1, 713, 616	
100.00	7101112	1, 713, 010	110,417	1 100	107, 377	1, 713,010	1.00.00

Heal th FinancialSystemsGOOD SAMARITAN HOSPITALCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTSProvide Provider CCN: 15-0042 | Period: | Worksheet 0-6 | From 01/01/2018 | Part | Hospice CCN: 15-1526 | To 12/31/2018 | Date/Time Prepared: | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 | 10/2020 |

			nospi ce oo		10 12/01/2010	1/20/2020 10	D: 18 am
					Hospi ce I		
	Descriptions	ADMI NI STRATI V	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		E & GENERAL	OPERATION &	LINEN SERVICE			
			MAI NTENANCE				
		4. 00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL	699, 506					4.00
5.00	PLANT OPERATION & MAINTENANCE	49, 706	121, 768				5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0		6.00
7.00	HOUSEKEEPI NG	32, 172	0		78, 813		7. 00
8.00	DI ETARY	0	0		0		0 8.00
9.00	NURSI NG ADMI NI STRATI ON	48, 681	0		0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	3, 007	0)	0		10.00
11.00	MEDI CAL RECORDS	O	0		0		11.00
12.00	STAFF TRANSPORTATION	0	0	1	0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	o	0		0		13.00
14.00	PHARMACY	386	0		0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	o	0		0		15.00
16.00	OTHER GENERAL SERVICE	o	0		0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	o	0		0		17.00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51.00	HOSPICE ROUTINE HOME CARE	446, 533					51.00
52.00	HOSPICE INPATIENT RESPITE CARE	11, 543	12, 070		7, 812		0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	107, 478	109, 698		71, 001		0 53.00
	NONREI MBURSABLE COST CENTERS			•			
60.00	BEREAVEMENT PROGRAM	0	0		0		60.00
61.00	VOLUNTEER PROGRAM	o	0		0		61.00
62.00	FUNDRAI SI NG	0	0)	0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o	0		0		63.00
64.00	PALLIATIVE CARE PROGRAM	o	0		0		64.00
65.00	OTHER PHYSICIAN SERVICES	o	0		0		65.00
66.00	RESI DENTI AL CARE	0	0		o o		0 66.00
67.00	ADVERTI SI NG	0	0		0		67.00
68.00	TELEHEALTH/TELEMONI TORI NG	0	0		0		68. 00
69.00	THRI FT STORE	o	0		o		69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	o	0		ol ol		0 71.00
99.00	, , ,	o	0		olo		0 99.00
100.00	TOTAL	699, 506	121, 768		78, 813		0 100.00
	'			•			

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS Provider CCN: 15-0042 Peri od: Worksheet 0-6 From 01/01/2018 Part I Date/Time Prepared: Hospi ce CCN: 15-1526 12/31/2018 1/20/2020 10:18 am Hospi ce I NURSI NG ROUTI NE MEDI CAL VOLUNTEER Descriptions STAFF ADMI NI STRATI O MEDI CAL RECORDS TRANSPORTATI O SERVI CE COORDI NATI ON SUPPLI ES Ν N 9.00 10.00 11.00 12.00 13.00 GENERAL SERVICE COST CENTERS 1.00 CAP REL COSTS-BLDG & FIXT 1.00 2 00 CAP REL COSTS-MVBLE EQUIP 2.00 3.00 EMPLOYEE BENEFITS DEPARTMENT 3.00 ADMINISTRATIVE & GENERAL 4.00 4.00 5.00 PLANT OPERATION & MAINTENANCE 5.00 LAUNDRY & LINEN SERVICE 6.00 6.00 7.00 HOUSEKEEPI NG 7.00 8.00 DI ETARY 8.00 NURSING ADMINISTRATION 9.00 119, 257 9.00 ROUTINE MEDICAL SUPPLIES 7, 367 10.00 10.00 11.00 MEDICAL RECORDS 0 0 11.00 12.00 STAFF TRANSPORTATION 0 12.00 0 VOLUNTEER SERVICE COORDINATION 13.00 0 0 13.00 0 14.00 PHARMACY 0 0 14.00 PHYSICIAN ADMINISTRATIVE SERVICES 0 15.00 15.00 0 0 OTHER GENERAL SERVICE 0 0 16,00 16.00 PATIENT/RESIDENTIAL CARE SERVICES 17.00 17.00 LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE 0 50.00 0 0 0 50.00 0 HOSPICE ROUTINE HOME CARE 0 109, 757 51.00 51.00 6,781 0 52.00 HOSPICE INPATIENT RESPITE CARE 879 54 0 52.00 53.00 HOSPICE GENERAL INPATIENT CARE 8, 621 532 0 0 0 53.00 NONREIMBURSABLE COST CENTERS BEREAVEMENT PROGRAM 60.00 0 0 60.00 VOLUNTEER PROGRAM 0 61.00 0 61.00 FUNDRAI SI NG 62.00 62.00 0000000 0 0 0 0 0 0 0 63.00 HOSPICE/PALLIATIVE MEDICINE FELLOWS 0 63.00 PALLIATIVE CARE PROGRAM 64.00 0 64.00 65.00 OTHER PHYSICIAN SERVICES 0 65.00 RESIDENTIAL CARE 66.00 0 66.00 67 00 ADVERTI SI NG 0 67.00 TELEHEALTH/TELEMONI TORI NG 68.00 0 68.00 0 69.00 THRIFT STORE 0 0 69.00 NURSING FACILITY ROOM & BOARD 70.00 70.00 OTHER NONREIMBURSABLE (SPECIFY) 71 00 0 0 Ω 71.00 0 99.00 NEGATIVE COST CENTER 0 0 99.00

119, 257

7, 367

0 100.00

100.00 TOTAL

Heal th FinancialSystemsGOOD SAMARITAN HOSPITALCOST ALLOCATION- HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTSProvide Provider CCN: 15-0042

			nospi ce co	IV. 13-1320 1	0 12/31/2010	1/20/2020 10:	
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	PATI ENT/	TOTAL	
			ADMI NI STRATI V	SERVI CE	RESI DENTI AL		
			E SERVICES		CARE SERVICES		
	T	14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1. 00	CAP REL COSTS-BLDG & FIXT						1.00
2. 00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4. 00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5.00
6. 00	LAUNDRY & LINEN SERVICE						6.00
7. 00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13. 00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	946	_				14.00
15. 00	PHYSI CI AN ADMI NI STRATI VE SERVI CES	0	C				15.00
16. 00	OTHER GENERAL SERVICE	0)		16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
F0 00	LEVEL OF CARE			J			
50.00	HOSPICE CONTINUOUS HOME CARE	0	C	Ί '	1	1 211 202	
51.00	HOSPICE ROUTINE HOME CARE	870	C	1		1, 211, 302	
52.00	HOSPICE INPATIENT RESPITE CARE	7 69	C	1		49, 099	
53. 00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	69	C) ()	453, 215	53.00
60. 00	BEREAVEMENT PROGRAM	0			\	0	60.00
61. 00	VOLUNTEER PROGRAM	0				0	
62. 00	FUNDRAI SI NG	0			()	0	
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				í l	0	
64. 00	PALLIATIVE CARE PROGRAM	0				0	1
65. 00	OTHER PHYSICIAN SERVICES				Í	0	1
66. 00	RESI DENTI AL CARE	0	C		ار	0	
67. 00	ADVERTI SI NG			1	j j	0	1
68. 00	TELEHEALTH/TELEMONI TORI NG	0				0	1
69. 00	THRI FT STORE	o				0	
70.00	NURSING FACILITY ROOM & BOARD					0	1
71. 00	OTHER NONREI MBURSABLE (SPECIFY)	0	C	ol c	ol ol	0	
99. 00	NEGATI VE COST CENTER	o o	Č	1	ol ol	0	
	TOTAL	946				1, 713, 616	
	1	1		1	1		

He	ealth Financial	Systems		GOOD	SAMARI TA	AN H	OSPI TAL				In Lie	u of Form CMS-2	552-10
CC	OST ALLOCATION	- HOSPI TAL-BASED	HOSPI CE GENERAL	SERVI CE	COSTS		Provi der	CCN	: 15-0042	Peri d	od:	Worksheet 0-6	
ST	TATISTICAL BASIS	S								From	01/01/2018	Part II	
		_					Hospi ce (CCN:	15-1526	To	12/31/2018	Date/Time Pre	
												1/20/2020 10:	18 am_
										_ Ho	ospi ce I		
	Cost	Center Descripti	ons	CAP R	EL BLDG	CAP	REL MVBL	.E	EMPLOYEE	REC	ONCILIATIO	ADMI NI STRATI V	
				&	FIX		EQUI P		BENEFITS		N	E & GENERAL	
				(SOLIAI	RE FEFT)		(DOLLAR		DEPARTMENT			(ACCUMULATED	

						1/20/2020 10:	18 am
					Hospi ce I		
	Cost Center Descriptions	CAP REL BLDG	CAP REL MVBLE	EMPLOYEE	RECONCI LI ATI O	ADMI NI STRATI V	
		& FIX	EQUI P	BENEFITS	N	E & GENERAL	
		(SQUARE FEET)	(DOLLAR	DEPARTMENT		(ACCUMULATED	
			VALUE)	(GROSS		COSTS)	
				SALARI ES)			
		1. 00	2. 00	3.00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
. 00	CAP REL COSTS-BLDG & FIXT	686					1.0
2. 00	CAP REL COSTS-MVBLE EQUIP		686				2.0
3. 00	EMPLOYEE BENEFITS DEPARTMENT	0	0	209, 613			3.0
1. 00	ADMINISTRATIVE & GENERAL	0	0		-699, 506	1, 014, 110	4.0
. 00	PLANT OPERATION & MAINTENANCE	0	0	l	0	72, 062	5.0
5. 00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.0
7. 00	HOUSEKEEPI NG	0	0	0	0	46, 641	7.0
3. 00	DI ETARY		0	l o	0	0	8.0
9. 00	NURSING ADMINISTRATION				0	70, 576	9.0
	ROUTINE MEDICAL SUPPLIES				0	4, 360	
11.00	MEDICAL RECORDS				0	4, 300	11. (
		0			0	-	
	STAFF TRANSPORTATION	0	0		0	0	12. (
3.00	VOLUNTEER SERVICE COORDINATION	0	0		0	0	13. (
	PHARMACY	0	0	0	0	560	
	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15. (
	OTHER GENERAL SERVICE	0		0	0	0	16.0
17. 00	PATI ENT/RESI DENTI AL CARE SERVI CES	0	0		0	0	17.0
	LEVEL OF CARE						
	HOSPICE CONTINUOUS HOME CARE			0		0	
	HOSPICE ROUTINE HOME CARE			192, 915	0	647, 361	
2.00	HOSPICE INPATIENT RESPITE CARE	68	68			16, 734	52.0
3.00	HOSPICE GENERAL INPATIENT CARE	618	618	15, 153	0	155, 816	53.0
	NONREI MBURSABLE COST CENTERS						
0.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60. (
1.00	VOLUNTEER PROGRAM	0	0	0	0	0	61. (
2. 00	FUNDRAI SI NG	0	0	l 0	0	0	62. (
3. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0	0	63.0
4. 00	PALLIATIVE CARE PROGRAM	0	0		0	0	64. (
	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65. (
	RESI DENTI AL CARE	0	l 0	l o	0	0	66. (
	ADVERTI SI NG	1 0	١	1	n	Ö	67. (
	TELEHEALTH/TELEMONI TORI NG		0		0	0	68.0
	THRIFT STORE				0	0	69. (
	NURSING FACILITY ROOM & BOARD						70. (
	OTHER NONREIMBURSABLE (SPECIFY)	0		0	0	0	
				١		١	99.
	NEGATIVE COST CENTER	11/ 110	100	107 577		/00 50/	
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)					699, 506	
101.00	UNIT COST MULTIPLIER	169. 706997	0. 145773	0. 894873		0. 689773	1101. (

Health Financial Systems	GOOD SAMARITAN	HOSPI TAL	In Lieu	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GE	NERAL SERVICE COSTS	Provider CCN: 15-0042		Worksheet 0-6
STATISTICAL BASIS		H CON 15 152/	From 01/01/2018	

STATI S	TICAL BASIS		Hospi ce CCI		From 01/01/2018 To 12/31/2018		
					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI O	
		MAI NTENANCE	(IN-FACILITY		DAYS)	N	
		(SQUARE FEET)	DAYS)		,	(DI RECT NURS.	
						HRS.)	
		5. 00	6. 00	7.00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	686					5.00
6. 00	LAUNDRY & LINEN SERVICE	0	0				6, 00
7. 00	HOUSEKEEPI NG	ام		68	6		7.00
8. 00	DI ETARY	ام		•	o o		8.00
9. 00	NURSI NG ADMI NI STRATI ON	ام			0	127, 948	9. 00
10.00	ROUTINE MEDICAL SUPPLIES				0	0	10.00
11. 00	MEDI CAL RECORDS				0	0	11.00
12. 00	STAFF TRANSPORTATION	ام			0	0	12.00
13. 00	VOLUNTEER SERVICE COORDINATION				0	0	13.00
14. 00	PHARMACY				0	0	14.00
					0		
15. 00 16. 00	PHYSICIAN ADMINISTRATIVE SERVICES OTHER GENERAL SERVICE				0	0	15. 00 16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0			0	0	17. 00
17.00	LEVEL OF CARE	U _I U _I			U		17.00
50. 00	HOSPICE CONTINUOUS HOME CARE			1		0	50.00
50.00	HOSPICE CONTINUOUS HOME CARE						
		4.0	0	,	0	117, 756	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	68 618	0	•			
53. 00	HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS	618	0	61	8 0	9, 249	53.00
40.00				1		0	40.00
60.00	BEREAVEMENT PROGRAM	0		•	0		60.00
61.00	VOLUNTEER PROGRAM	0		•	0	0	61.00
62.00	FUNDRAL SI NG	0			0	ľ	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	o o			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	o o		1	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	o o			0	0	65.00
66.00	RESI DENTI AL CARE	o o	0		0		66.00
67.00	ADVERTI SI NG	O			0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	O			0	0	68.00
69. 00	THRI FT STORE	١			0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD		_				70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	71.00
	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Pa	- 1	0	78, 81		119, 257	
101. 00	UNIT COST MULTIPLIER	177. 504373	0. 000000	114. 88775	5 0. 000000	0. 932074	101. 00

Health Financial Systems	GOOD SAMARITA	AN HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENE STATISTICAL BASIS	RAL SERVICE COSTS	Provi der C		Peri od: From 01/01/2018		
		Hospi ce CC	:N: 15-1526	To 12/31/2018	Date/Time Pre 1/20/2020 10:	epared: 18 am
				Hospi ce I		
Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
	MEDI CAL	RECORDS	TRANSPORTATION	O SERVICE	(CHARGES)	
	SUPPLI ES	(PATI ENT	N	COORDI NATI ON		
	(PATI ENT	DAYS)	(MI LEAGE)	(HOURS OF		
	DAYS)	· ·	, ,	SERVICE)		
	10.00	11. 00	12.00	13.00	14. 00	
GENERAL SERVICE COST CENTERS	·					
1. 00 CAP REL COSTS-BLDG & FLXT						1.00
2.00 CAP REL COSTS-MVBLE EQUIP						2.00
3 00 EMPLOYEE BENEFITS DEPARTMENT						3 00

	Cost Center Descriptions	ROUTI NE MEDI CAL SUPPLI ES (PATI ENT DAYS)	MEDI CAL RECORDS (PATI ENT DAYS)	STAFF TRANSPORTATIO N (MI LEAGE)	VOLUNTEER SERVI CE COORDI NATI ON (HOURS OF SERVI CE)	PHARMACY (CHARGES)	
	CENEDAL SERVICE COST CENTERS	10. 00	11. 00	12.00	13. 00	14. 00	
1. 00	GENERAL SERVICE COST CENTERS CAP REL COSTS-BLDG & FLXT			I			1. 00
2. 00	CAP REL COSTS-BLDG & FIXT						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPI NG						7.00
8.00	DI ETARY						8.00
9.00	NURSI NG ADMI NI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES	8, 614					10.00
11.00	MEDI CAL RECORDS		0				11.00
12.00				0			12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	0		13.00
14.00				0	0	1, 269	14.00
15.00				0	0	0	15.00
16.00				0	0	0	16.00
17. 00							17.00
	LEVEL OF CARE						
50.00		0	0	_	· ·	0	50.00
51.00		7, 929	0		- I	1, 168	51.00
52.00	4	63	0		· ·	9	52.00
53.00		622	0	0	0	92	53.00
(0.00	NONREI MBURSABLE COST CENTERS			1 0		0	(0.00
60.00				0	0	0	60.00
61. 00 62. 00				0	0	0	61. 00 62. 00
63.00	1			0	0	0	63.00
64.00	1			0	0	0	64.00
65.00	·				0	0	65.00
66.00	1				0	0	66.00
67. 00	1				0	0	67.00
68. 00					0	0	68.00
69. 00						0	69.00
70.00	·				٥	O	70.00
71.00				0	0	0	71.00
99. 00	1					Ö	99.00
	O COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	7, 367	0	0	0	946	100.00
	O UNIT COST MULTIPLIER	0. 855236	0. 000000	0. 000000	0. 000000	0. 745469	

Health Financial Systems		GOOD SAMARITAN	HOSPI TAL			In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HI STATISTICAL BASIS	OSPICE GENERAL SER	RVI CE COSTS	Provi der	CCN:	15-0042	Peri od: From 01/01/2018	Worksheet 0-6 Part II
OTHER DIGITS			Hospi ce C	CN:	15-1526	To 12/31/2018	Date/Time Prepared:

						1/20/2020 10:	18 am
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL				
		ADMI NI STRATI V		RESI DENTI AL			
		E SERVICES	(SPECI FY	CARE SERVICES			
		(PATI ENT	BASIS)	(IN-FACILITY			
		DAYS)		DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS				-		
1.00	CAP REL COSTS-BLDG & FLXT						1. (
2. 00	CAP REL COSTS-MVBLE EQUIP						2. (
3. 00	EMPLOYEE BENEFITS DEPARTMENT						3.
1. 00	ADMINISTRATIVE & GENERAL						4.
5. 00	PLANT OPERATION & MAINTENANCE						5.
5. 00	LAUNDRY & LINEN SERVICE						6. (
7. 00	HOUSEKEEPI NG						7.
3. 00	DIETARY						8.
9. 00	NURSING ADMINISTRATION						9. (
10.00	ROUTINE MEDICAL SUPPLIES						10. (
	MEDI CAL RECORDS						11.
	STAFF TRANSPORTATION						12. (
13. 00	VOLUNTEER SERVICE COORDINATION						13.
14. 00	PHARMACY						14.
	PHYSICIAN ADMINISTRATIVE SERVICES		ŀ				15.
15.00			l .				
	OTHER GENERAL SERVICE		0	1			16.0
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. (
0 00	LEVEL OF CARE HOSPICE CONTINUOUS HOME CARE	C		ı			E0 /
0.00			1	1			50.
51.00	HOSPICE ROUTINE HOME CARE	C	ł	1			51.
	HOSPICE INPATIENT RESPITE CARE	C	1		0		52.
3. 00	HOSPICE GENERAL INPATIENT CARE		0	1	0		53.
	NONREI MBURSABLE COST CENTERS			1	1		
	BEREAVEMENT PROGRAM		0	1			60.
1. 00	VOLUNTEER PROGRAM		0				61.
	FUNDRAI SI NG		0	1			62.
3. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0				63.
			0	1			64.
	OTHER PHYSICIAN SERVICES		0	1			65.
6.00		C	0	1	0		66.
57.00	ADVERTI SI NG		0				67.
8. 00	TELEHEALTH/TELEMONI TORI NG		0				68.
9.00	THRI FT STORE		0				69.
0.00	NURSING FACILITY ROOM & BOARD						70.
1.00	OTHER NONREIMBURSABLE (SPECIFY)	C	0		0		71.
	NEGATIVE COST CENTER						99.
	COST TO BE ALLOCATED (per Wkst. 0-6, Part	(1)	0		ol		100.
	UNIT COST MULTIPLIER	0. 000000	0. 000000	0. 00000			101.

Health Financial Systems	GOOD SAMARITAN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF HOSPITAL-BASED HOSPICE SH	HARED SERVICE COSTS BY	Provi der Co	CN: 15-0042	Peri od: From 01/01/2018	Worksheet 0-7	
LEVEL OF CARE		Hospi ce CCI	N: 15-1526	To 12/31/2018		
				Hospi ce I		_
				LOC (from Provi		
0 - 1 0 - 1 - 0 - 1 - 1 - 1 - 1	F	C+ +-	110110	LIDLIO	III DO	

			·			1/20/2020 10:	18 am
					Hospi ce I		
	·			Charges by	LOC (from Provi	der Records)	
					,	,	
	Cost Center Descriptions	From Wkst. C,	Cost to	HCHC	HRHC	HI RC	
	0031 0011101 203011 pti 0113	Part I, Col.	Charge Ratio	110110	111110	"""	
		9 line	Charge Katro				
		0	1. 00	2.00	3. 00	4. 00	
	ANOLLI ADV. CEDVI OF COCT CENTEDS	0	1.00	2.00	3.00	4.00	
	ANCILLARY SERVICE COST CENTERS		0.070050				
1.00	PHYSI CAL THERAPY	66.00			0	0	1
2.00	OCCUPATI ONAL THERAPY	67.00					2.00
3.00	SPEECH PATHOLOGY	68. 00					3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00	0. 272051		0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED	96.00	0. 362258		0	0	5.00
6.00	LABORATORY	60.00	0. 142156		0 0	l 0	6.00
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00			0	0	1
8. 00	OTHER OUTPATIENT SERVICE COST CENTER	93.00				Ĭ	8.00
9. 00	RADI OLOGY-THERAPEUTI C	55.00			0	0	1
10.00	MH ANCI LLARY OUTPATIENT	76.00			0	0	
					0	0	
10. 01	INPATIENT DIALYSIS	76. 01	0. 575365		0	0	1
11.00	Totals (sum of lines 1-11)			L			11.00
		Charges by		Shared Servi	ce Costs by LOC		
		LOC (from					
		Provi der					
		Records)					
	Cost Center Descriptions	HGI P	HCHC (col. 1	HRHC (col. 1	HIRC (col. 1	HGIP (col. 1	
			x col. 2)	x col. 3)	x col. 4)	x col. 5)	
		5. 00	6. 00	7.00	8. 00	9. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY	0	0		0	0	1.00
2. 00	OCCUPATIONAL THERAPY	1	_			_	2.00
3. 00	SPEECH PATHOLOGY						3.00
4. 00	DRUGS CHARGED TO PATIENTS	_	_		0	0	
5.00		0	0		-		1
	DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	
6.00	LABORATORY	0	0		0	0	
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
8.00	OTHER OUTPATIENT SERVICE COST CENTER						8.00
9.00	RADI OLOGY-THERAPEUTI C	0	0		0	0	
10.00	MH ANCILLARY OUTPATIENT	0	0		0	0	10.00
10. 01	INPATIENT DIALYSIS	0	0		0 0	0	
	Totals (sum of lines 1-11)		Ö		o o		
	1	1	ı	ı	-1	1	1 00

Hospice Hosp						1/20/2020 10:	18 am
HOSPICE CONTINUOUS HOME CARE 1.00 2.00 3.00					Hospi ce I		
Note 1.00 2.00 3.00				TITLE XVIII	TITLE XIX	TOTAL	
HOSPICE CONTINUOUS HOME CARE				MEDI CARE	MEDI CAI D		
Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)				1.00	2. 00	3. 00	
Inine 11 Total unduplicated days (Wkst. S-9, col. 4, line 10 0 0 0 0 0 0 0 0 0		HOSPICE CONTINUOUS HOME CARE					
Total unduplicated days (Wkst. S-9, col. 4, line 10) 0 0 0 0 0 0 0 0 0	1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-	7, col. 6,			0	1.00
3.00		line 11)					
4.00 Unduplicated program days (Wkst. S-9 col. as appropriate, line 10) 0 0 0 0 0 0 0 0 0	2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2.00
5.00 Program cost (line 3 times line 4)	3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3.00
HOSPICE ROUTINE HOME CARE	4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, lin	e 10)		0		4.00
6.00 Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11) 7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 8.00 Total average cost per diem (line 6 divided by line 7) 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 10.00 HOSPICE INPATIENT RESPITE CARE 11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 13.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 18.00 Total average cost per diem (line 16 divided by line 17) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 19.00 Total average cost per diem (line 16 divided by line 17) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Total average cost per diem (line 16 divided by line 17) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Program cost (line 18 times line 19) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Program cost (line 18 times line 19) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Unduplicated days (Unduplicated days (Unduplic	5.00	Program cost (line 3 times line 4)			0		5.00
Iine 11)		HOSPICE ROUTINE HOME CARE					
7.00 Total unduplicated days (Wkst. S-9, col. 4, line 11) 8.00 Total average cost per diem (line 6 divided by line 7) 9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 9.00 Program cost (line 8 times line 9) 10.00 HOSPICE INPATIENT RESPITE CARE 11.00 Total cost (Wkst. O-6, Part I, col. 18, line 52 plus Wkst. O-7, col. 8, line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 13.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) 16.00 Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11) 17.00 Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11) 17.00 Total cost (Wkst. O-6, Part I, col. 18, line 53 plus Wkst. O-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 18.00 Total average cost per diem (line 16 divided by line 17) 19.00 Unduplicated program days (Wkst. S-9, col. 3 appropriate, line 13) 19.00 Unduplicated program days (Wkst. S-9, col. 4, line 13) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Total unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 10.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 10.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14)	6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-	7, col. 7,			1, 211, 302	6.00
8.00 Total average cost per diem (line 6 divided by line 7) 152.77 8.00 10.0		line 11)					
9.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 11) 6,873 1,049,988 18,943 10.00 Program cost (line 8 times line 9) 10.00 HOSPICE INPATIENT RESPITE CARE 11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 49,099 11.00 13.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 779.35 13.00 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 32 7 14.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 728.64 18.00 19.00 Unduplicated days (Wkst. S-9, col. 4, line 13) 728.64 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 514 15 19.00 10.00 Program cost (line 18 times line 19) 728.64 18.00 19.00 Program cost (line 18 times line 19) 728.64 18.00 10.00	7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				7, 929	7.00
10.00 Program cost (line 8 times line 9) 1,049,988 18,943 10.00 HOSPICE INPATIENT RESPITE CARE	8.00	Total average cost per diem (line 6 divided by line 7)				152. 77	8.00
HOSPICE INPATIENT RESPITE CARE	9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 11)	6, 87	'3 124		9.00
11.00 Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 13.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) 16.00 HOSPICE GENERAL INPATIENT CARE 17.00 Total unduplicated days (Wkst. S-9, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 17.00 Total average cost per diem (line 16 divided by line 17) 18.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Total unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 20.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 11.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 16) 13.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 15.00 Total unduplicated days (Wkst. S-9, col. 4, line 14)	10.00	Program cost (line 8 times line 9)	•	1, 049, 98	18, 943		10.00
I ine 11)		HOSPICE INPATIENT RESPITE CARE					
12.00 Total unduplicated days (Wkst. S-9, col. 4, line 12) 13.00 Total average cost per diem (line 11 divided by line 12) 14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) 16.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 18.00 Total average cost per diem (line 16 divided by line 17) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Program cost (line 18 times line 19) 10.00 Total unduplicated days (Wkst. S-9, col. as appropriate, line 13) 10.00 Total unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 10.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 11.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 12.00 Total unduplicated days (Wkst. S-9, col. 4, line 14)	11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-	7, col. 8,			49, 099	11.00
13.00 Total average cost per diem (line 11 divided by line 12) 13.00 14.00 15.00 15.00 16.00 1		line 11)					
14.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 12) 15.00 Program cost (line 13 times line 14) 15.00 HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 18.00 Total average cost per diem (line 16 divided by line 17) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 17.00 Program cost (line 18 times line 19) 18.00 Total cost (Sum of line 1 + line 6 + line 11 + line 16) 20.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 19.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 19.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 19.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 19.00 Total unduplicated days (Wkst. S-9, col. 4, line 14)	12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)				63	12.00
15. 00 Program cost (line 13 times line 14)	13.00					779. 35	13.00
HOSPICE GENERAL INPATIENT CARE 16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 622 17.00 18.00 Total average cost per diem (line 16 divided by line 17) 728.64 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 514 15 19.00 19.00 10.00	14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 12)	3	32 7		14.00
16.00 Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 18.00 Total average cost per diem (line 16 divided by line 17) 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 19.00 Program cost (line 18 times line 19) 10.00 Total unduplicated cost (sum of line 1 + line 6 + line 11 + line 16) 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 16.00 453, 215 16.00 17.00 728.64 18.00 728.64 19.0	15.00	Program cost (line 13 times line 14)		24, 93	5, 455		15.00
I ine 11) 17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 622 17.00 18.00 Total average cost per diem (line 16 divided by line 17) 728.64 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 514 15 19.00 20.00 TOTAL HOSPICE CARE Total cost (Sum of line 1 + line 6 + line 11 + line 16) 1,713,616 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 8,614 22.00 20.0		HOSPICE GENERAL INPATIENT CARE					
17.00 Total unduplicated days (Wkst. S-9, col. 4, line 13) 622 17.00 18.00 Total average cost per diem (line 16 divided by line 17) 728.64 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 514 15 19.00 20.00 Total HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,713,616 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 8,614 22.00	16.00		7, col. 9,			453, 215	16.00
18.00 Total average cost per diem (line 16 divided by line 17) 728.64 18.00 19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 514 15 19.00 20.00 Program cost (line 18 times line 19) 374,521 10,930 20.00 TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,713,616 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 8,614 22.00							
19.00 Unduplicated program days (Wkst. S-9, col. as appropriate, line 13) 514 15 19.00 20.00 Program cost (line 18 times line 19) 374,521 10,930 20.00 TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,713,616 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 8,614 22.00	17.00						
20.00 Program cost (line 18 times line 19) 374,521 10,930 20.00 TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,713,616 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 8,614 22.00	18.00					728. 64	
TOTAL HOSPICE CARE 21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 1,713,616 21.00 8,614 22.00	19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, li	ne 13)	51	4 15		19.00
21.00 Total cost (sum of line 1 + line 6 + line 11 + line 16) 1,713,616 21.00 22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 8,614 22.00	20.00			374, 52	10, 930		20.00
22.00 Total unduplicated days (Wkst. S-9, col. 4, line 14) 8,614 22.00		TOTAL HOSPICE CARE					
	21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				1, 713, 616	21.00
23.00 Average cost per diem (line 21 divided by line 22) 198.93 23.00	22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				8, 614	22.00
	23.00	Average cost per diem (line 21 divided by line 22)				198. 93	23.00

Heal th	Financial Systems	GOOD SAMARITAN	HOSDI TAI	In lie	u of Form CMS-2	2552_10		
	ATION OF CAPITAL PAYMENT	GOOD SAWART TAIN	Provi der CCN: 15-0042	Period: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III	pared:		
	Title XVIII Hospital							
					1. 00			
	PART I - FULLY PROSPECTIVE METHOD							
1 00	CAPITAL FEDERAL AMOUNT			1	1 010 545	1 00		
1.00	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier	1, 910, 545 0	1. 00 1. 01					
1. 01 2. 00	Capital DRG outlier payments				48, 291	2.00		
2. 00	Model 4 BPCI Capital DRG outlier payments				40, 291	2.00		
3. 00	Total inpatient days divided by number of days	e in the cost re	aparting pariod (see ins	tructions)	55. 47	3.00		
4. 00	Number of interns & residents (see instruction		eporting period (see ins	tructrons)	0.00	4.00		
5.00	Indirect medical education percentage (see ins	,			0.00	5.00		
6. 00	Indirect medical education adjustment (multiple		e sum of lines 1 and 1 0	1 columns 1 and	0.00	6.00		
0.00	1.01) (see instructions)	ry fille 5 by the	c sum of fiftes f and f. o	i, cordiniis r drid	٥	0.00		
7. 00	Percentage of SSI recipient patient days to Me 30) (see instructions)	edicare Part A p	oatient days (Worksheet	E, part A line	0. 00	7. 00		
8. 00	Percentage of Medicaid patient days to total d	davs (see instri	ictions)		0. 00	8.00		
9. 00	Sum of lines 7 and 8	adys (see Thistire	de trons)		0.00	9.00		
10.00	Allowable disproportionate share percentage (s	see instructions	5)		0. 00			
11. 00	Disproportionate share adjustment (see instruc		-,		0.00	11.00		
12. 00	Total prospective capital payments (see instru				1, 958, 836			
	, , , , , , , , , , , , , , , , , , ,				.,			
					1. 00			
	PART II - PAYMENT UNDER REASONABLE COST							
1.00	Program inpatient routine capital cost (see in	nstructions)			0	1.00		
2.00	Program inpatient ancillary capital cost (see	instructions)			0	2.00		
3.00	Total inpatient program capital cost (line 1 p	olus line 2)			0	3.00		
4.00	Capital cost payment factor (see instructions)				0	4.00		
5. 00	Total inpatient program capital cost (line 3 x	x line 4)			0	5. 00		
					1. 00			
	PART III - COMPUTATION OF EXCEPTION PAYMENTS							
1. 00	Program inpatient capital costs (see instructi	,			0	1. 00		
2.00	Program inpatient capital costs for extraordin		ces (see instructions)		0	2.00		
3. 00	Net program inpatient capital costs (line 1 mi				0	3.00		
4.00	Applicable exception percentage (see instructi				0. 00	4.00		
5.00	Capital cost for comparison to payments (line	,			0	5.00		
6.00	,				0. 00	6.00		
7.00	Adjustment to capital minimum payment level fo	-	y circumstances (line 2	x line 6)	0	7.00		
8.00					0	8.00		
9.00	Current year capital payments (from Part I, Ii			1 1: 0)	0	9.00		
10.00	Current year comparison of capital minimum pay				0	10.00		
11. 00	Carryover of accumulated capital minimum payme Worksheet L, Part III, line 14)			,	0	11. 00		
12.00					0	12.00		
13.00					0	13.00		
14. 00	Carryover of accumulated capital minimum payme (if line 12 is negative, enter the amount on t		capital payment for the	following period	0	14. 00		
15. 00	Current year allowable operating and capital p		structions)		0	15. 00		
16. 00	, , , , , , , , , , , , , , , , , , , ,				Ö	16.00		
17. 00	Current year exception offset amount (see inst				0	17.00		
				·				